Before Starting the CoC Application

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

The Collaborative Applicant is responsible for reviewing the following:

1. The FY 2019 CoC Program Competition Notice of Funding Available (NOFA) for specific application and program requirements.
2. The FY 2019 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.
6. Questions marked with an asterisk (*), which are mandatory and require a response.

1A. Continuum of Care (CoC) Identification

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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1A-1. CoC Name and Number: TX-600 - Dallas City & County, Irving CoC

1A-2. Collaborative Applicant Name: Metro Dallas Homeless Alliance

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Metro Dallas Homeless Alliance

1B. Continuum of Care (CoC) Engagement

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1B-1. CoC Meeting Participants.

For the period of May 1, 2018 to April 30, 2019, applicants must indicate whether the Organization/Person listed:
1. participated in CoC meetings;
2. voted, including selecting CoC Board members; and
3. participated in the CoC's coordinated entry system.

Organization/Person	Participates in CoC Meetings	Votes, including selecting CoC Board Members	Participates in Coordinated Entry System
Local Government Staff/Officials	Yes	Yes	Yes
CDBG/HOME/ESG Entitlement Jurisdiction	Yes	Yes	Yes
Law Enforcement	Yes	Yes	No
Local Jail(s)	Yes	No	No
Hospital(s)	Yes	Yes	No
EMS/Crisis Response Team(s)	Yes	No	No
Mental Health Service Organizations	Yes	Yes	Yes
Substance Abuse Service Organizations	Yes	Yes	No
Affordable Housing Developer(s)	Yes	Yes	No
Disability Service Organizations	Yes	No	No
Disability Advocates	Yes	Yes	No
Public Housing Authorities	Yes	Yes	No
CoC Funded Youth Homeless Organizations	Yes	Yes	Yes
Non-CoC Funded Youth Homeless Organizations	Yes	No	Yes

Youth Advocates	Yes	Yes	Yes
School Administrators/Homeless Liaisons	Yes	Yes	No
CoC Funded Victim Service Providers	Yes	Yes	Yes
Non-CoC Funded Victim Service Providers	Yes	No	Yes
Domestic Violence Advocates	Yes	Yes	No
Street Outreach Team(s)	Yes	Yes	No
Lesbian, Gay, Bisexual, Transgender (LGBT) Advocates	Yes	Yes	No
LGBT Service Organizations	Yes	No	No
Agencies that serve survivors of human trafficking	Yes	No	No
Other homeless subpopulation advocates	Yes	Yes	No
Homeless or Formerly Homeless Persons	Yes	Yes	Yes
Mental Illness Advocates	Yes	Yes	No
Substance Abuse Advocates	Yes	Yes	No
Other:(limit 50 characters)			

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

1B-1a. CoC's Strategy to Solicit/Consider Opinions on Preventing/Ending Homelessness.

Applicants must describe how the CoC:
1. solicits and considers opinions from a broad array of organizations and individuals that have knowledge of homelessness, or an interest in preventing and ending homelessness;
2. communicates information during public meetings or other forums the CoC uses to solicit public information;
3. takes into consideration information gathered in public meetings or forums to address improvements or new approaches to preventing and ending homelessness; and
4. ensures effective communication with individuals with disabilities, including the availability of accessible electronic formats, e.g., PDF. (limit 2,000 characters)

Several meeting structures are in place that support the solicitation/consideration of opinions on preventing/ending homelessness from organizations/individuals across our CoC. The CoC solicits opinions and communicates information orally, in writing, and electronically (text/audio/video) to accommodate persons of all abilities. There is a public State of the Homeless Address where the results of our annual CoC survey from our providers is presented. This report is available through our website and hard copies are provided to groups/individuals upon request. Monthly the CoC facilitates a general assembly for providers, a case manager's roundtable, and 10 different CoC committee meetings, including the Alliance Homeless Forum which is comprised solely of homeless/formerly homeless individuals. The CoC Board, which includes a formerly homeless person, meets bi-monthly. The CoC

coordinates Hard Conversations events where an expert engages the audience in open dialogue on a complex topic related to homelessness. All CoC meetings are open to the public and encourage comment. For every meeting, MDHA staff take notes, and when appropriate minutes, and actively discuss and incorporate new ideas into each of the meetings, trainings and events. Every CoC committee has stipends to encourage homeless/formally homeless people to attend and be involved in the decision-making process. The Policy Review and Action Committee is comprised solely of homeless/formerly homeless individuals and community members. All meetings are held in ADA accessible locations. The CoC publishes flyers/informational sheets for general distribution. The CoC maintains a robust website, Constant Contact email list of 6,000+ addresses, and a Facebook page. It provides electronic communications through multiple media formats including audio/ video. It publicizes the contact information of all team members on its website. The website was substantially upgraded in 2019 to be ADA compliant.

1B-2. Open Invitation for New Members.

Applicants must describe:
1. the invitation process;
2. how the CoC communicates the invitation process to solicit new members;
3. how the CoC ensures effective communication with individuals with disabilities, including the availability of accessible electronic formats;
4. how often the CoC solicits new members; and
5. any special outreach the CoC conducted to ensure persons experiencing homelessness or formerly homeless persons are encouraged to join the CoC.
(limit 2,000 characters)

The CoC's main membership drive occurs during October-February. New members are incentivized to join in October, November or December and get not only the upcoming year's membership, but membership for the remaining month(s) of that year. The CoC invites new members orally, in writing, and electronically to accommodate persons of all abilities. The CoC uses its monthly general assembly, which is open to the public, to encourage new members to join the CoC and current members to renew. The CoC also holds monthly Alliance Homeless Forum meetings for homeless/formerly homeless individuals to give input and discuss changes needed for their CoC. Attendees are encouraged to become members and are given a waiver for membership dues. Two of our largest recruitment opportunities happen after the New Year: the Point In Time count in January which regularly has over 1,500 volunteers from the community and the State of the Homeless Address in March, where over 500 community members gather to learn about homelessness. All CoC meeting/events are held in ADA accessible locations. The CoC prints membership applications and distributes them at those meetings/events. The CoC also sends private emails to potential members, inviting them to join during the main membership drive and then every few months, if they have not already joined. The CoC maintains a membership page on its ADA compliant website and sends out calls to join the CoC through its Constant Contact email list, and on its blog. Additionally, the CoC celebrates and highlights the news of members joining on its Facebook page, and invites others to do the same.

1B-3. Public Notification for Proposals from Organizations Not Previously Funded.

Applicants must describe:
1. how the CoC notifies the public that it is accepting project application proposals, and that it is open to and will consider applications from organizations that have not previously received CoC Program funding, as well as the method in which proposals should be submitted;
2. the process the CoC uses to determine whether the project application will be included in the FY 2019 CoC Program Competition process;
3. the date(s) the CoC publicly announced it was open to proposal;
4. how the CoC ensures effective communication with individuals with disabilities, including the availability of accessible electronic formats; and
5. if the CoC does not accept proposals from organizations that have not previously received CoC Program funding or did not announce it was open to proposals from non-CoC Program funded organizations, the applicant must state this fact in the response and provide the reason the CoC does not accept proposals from organizations that have not previously received CoC Program funding.
(limit 2,000 characters)

The local RFP was released on July 26, 2019, posted and distributed. The CoC notifies the public that it will accept any and all applications orally and in writing at its CoC General Assembly Meetings and at briefings held for this explicit purpose in both Dallas and Collin Counties. This year MDHA held two application workshops for new and current providers at the beginning of the application process, to answer questions and help promote new organizations applying for funding. This allowed 6 new agencies to apply and 9 new projects were recommended for funding. Meetings were held in ADA accessible locations, to accommodate persons of all abilities. The CoC notified the public that it will accept applications in hard copy format or through electronic means. It posted this information on a dedicated page on its website, blog, Facebook and was sent out through its Constant Contact email list. Prior to the application scoring process MDHA staff submitted HUD priorities to the CoC Board. Additionally, the CoC Board, with input from the CoC and community, determined CoC priorities. Together, these two sets of priorities formed the basis of the project scoring criteria. Each project submitted was reviewed by MDHA staff, who utilized provider's Annual Progress Reports to score projects on subjective performance criteria. The project applications were then given to a Performance Review and Allocations Committee (PRAC), which scored each application on program narrative criteria. These scores were combined to create a final score which the PRAC reviewed a final time and discussed to determine prioritization. After project applications were prioritized by the PRAC, results are shared with applicants. At that time, any applicant may submit a grievance within 72 hours to a Grievance Committee who, in turn, may make a different recommendation to the CoC board. The board then makes the final decision based on the recommendations of both committees.

1C. Continuum of Care (CoC) Coordination

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1C-1. CoCs Coordination, Planning, and Operation of Projects.

Applicants must select the appropriate response for each federal, state, local, private, other organizations, or program source the CoC included in the planning and operation of projects that serve individuals experiencing homelessness, families experiencing homelessness, unaccompanied youth experiencing homelessness, persons who are fleeing domestic violence, or persons at risk of homelessness.

Entities or Organizations the CoC coordinates planning and operation of projects	Coordinates with Planning and Operation of Projects
Housing Opportunities for Persons with AIDS (HOPWA)	Yes
Temporary Assistance for Needy Families (TANF)	No
Runaway and Homeless Youth (RHY)	Yes
Head Start Program	No
Funding Collaboratives	Yes
Private Foundations	Yes
Housing and services programs funded through U.S. Department of Justice (DOJ) Funded Housing and Service Programs	Yes
Housing and services programs funded through U.S. Health and Human Services (HHS) Funded Housing and Service Programs	Yes
Housing and service programs funded through other Federal resources	Yes
Housing and services programs funded through State Government	Yes
Housing and services programs funded through Local Government	Yes
Housing and service programs funded through private entities, including foundations	Yes
Other:(limit 50 characters)	

1C-2. CoC Consultation with ESG Program Recipients.

Applicants must describe how the CoC:
1. consulted with ESG Program recipients in planning and allocating ESG funds;
2. participated in the evaluating and reporting performance of ESG Program recipients and subrecipients; and
3. ensured local homelessness information is communicated and addressed in the Consolidated Plan updates.
(limit 2,000 characters)

Every year, prior to the allocation of funds or request for proposals for ESG funding, the City of Dallas and the Texas Department of Health and Community Affairs (ESG program recipients) meet with the MDHA staff and present planning documents before the CoC General Assembly to garner public comment and consultation from the CoC membership. During the summer 2019, MDHA held a meeting with all possible ESG subrecipients to coordinate their applications for new and renewal funding to ensure the goals of the CoC were included as targets with this funding. MDHA employs a CoC Coordinator who monitors and evaluates ESG subrecipients annually.

The CoC consults with the ESG program recipients regularly throughout the year regarding their respective consolidated plan to convey needs and priorities based off HIC/PIT data, HMIS data, and the CoC strategic plan.

1C-2a. Providing PIT and HIC Data to Consolidated Plan Jurisdictions. **Applicants must indicate whether the CoC provided Point-in-Time (PIT) and Housing Inventory Count (HIC) data to the Consolidated Plan jurisdictions within its geographic area.**	Yes to both
1C-2b. Providing Other Data to Consolidated Plan Jurisdictions. **Applicants must indicate whether the CoC ensured local homelessness information is communicated to Consolidated Plan Jurisdictions within its geographic area so it can be addressed in Consolidated Plan updates.**	Yes

1C-3. Addressing the Safety Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors.

Applicants must describe:

1. the CoC's protocols, including protocols for coordinated entry and the CoC's emergency transfer plan, that prioritize safety and incorporate trauma-informed, victim-centered services; and
2. how the CoC, through its coordinated entry, maximizes client choice for housing and services while ensuring safety and confidentiality.
(limit 2,000 characters)

It is the policy of the CoC to support survivors of domestic violence (DV) and ensure that housing, services, and shelter options are safe, trauma-informed, and victim-centered. To guide policy and improve collaboration, the CoC has a Family and Domestic Violence committee which meets monthly. All attending providers are consulted on prospective policy or policy changes related to domestic violence prior to CoC adoption. In the CoC Coordinated Access System (CAS) policy it states that those fleeing DV, dating violence, sexual assault, or stalking that seek shelter or services, and where safety is a concern, will be immediately connected to a homeless help line and linked to the assigned DV access point. These access point staff have been fully trained in safety, trauma-informed, and victim-centered practices and are able to make determination of proper intervention, including safe transfer where necessary, using pre-determined safety screening tools while considering severity of risk and client choice. CoC and ESG housing is available for survivors through CAS. As MDHA transitions to a new HMIS database, the need for a DV specific CAS is needed to ensure the safety and privacy of all fleeing DV. By implementing a CAS for DV, it is ensured that any personal information needed to prioritize is protected and not shared with the community. As housing units become available each agency will receive referrals directly from the DV CAS. HHS funds CoC partner DV shelters and DOJ funds CoC community-based legal advocacy and counseling services. Legal advocacy and counseling are available to any victim of DV and are accessible through a 24-hour hotline. To ensure all survivors have access, DV service providers have met with general shelters and offered community services to clients who have a history of DV. Onsite legal advocacy and therapy at day centers through DOJ funding is pending as part of effort to expand services in our CoC for survivors.

1C-3a. Training–Best Practices in Serving DV Survivors.

Applicants must describe how the CoC coordinates with victim services providers to provide training, at least on an annual basis, for:
1. CoC area project staff that addresses safety and best practices (e.g., trauma-informed, victim-centered) on safety and planning protocols in serving survivors of domestic violence; and
2. Coordinated Entry staff that addresses safety and best practices (e.g., Trauma Informed Care) on safety and planning protocols in serving survivors of domestic violence.
(limit 2,000 characters)

Our CoC's Family and Domestic Violence Services committee meets monthly to coordinate and cross-train between general homeless shelters and domestic violence (DV) service providers. Meeting topics have ranged from education on criteria for local DV shelter eligibility to DV safety protocols, client choice and comprehension of trauma-informed and victim-centered best practices. Regular training sessions are hosted by local DV partners as well which focus on safety planning, ethics training, defining assault and stalking, safety planning while pregnant and equal employment rights for survivors of domestic violence. Our

CoC also participates in the Crimes Against Women Conference which is hosted within our CoC geographic area annually. All CoC partner agencies are encouraged to attend at least one day of the conference. Our CoC Coordinated Entry staff attend this training annually. At this conference trauma-informed care, victim-center best practices, and how to integrate these approaches into agency and community policy are discussed and training is provided on these topics by experts in the field. Our Coordinated Entry staff also offer monthly training on coordinated entry processes and includes in each presentation protocol instruction on how to administer community approved assessment tools in a way that is trauma-informed and places priority on restoring a survivor's feelings of safety, choice and control. This training is available at any time online on our CoC public website. Additionally, the CoC has partnered with area local experts to provide CEU training on trauma-informed care annually.

1C-3b. Domestic Violence–Community Need Data.

Applicants must describe how the CoC uses de-identified aggregate data from a comparable database to assess the special needs related to domestic violence, dating violence, sexual assault, and stalking. (limit 2,000 characters)

The CoC and its partner agencies participate in national as well as local studies that give feedback about our local needs related to domestic violence, dating violence, sexual assault, and stalking. United Way and our local Center for Non-Profit Management provide studies at least annually where agencies report out their observations on services available and gaps in services. Each DV shelter in the CoC currently has its own VAWA complaint database/data system that provides de-identified aggregate data to the HMIS system on a regular basis. Additionally, this year's application for funding includes a request to fund a DV compliant module within our new HMIS system. This will allow DV providers to use the HMIS system as their main database instead of maintaining a separate one.

*1C-4. PHAs within CoC. Attachments Required.

Applicants must submit information for the two largest PHAs or the two PHAs with which the CoC has a working relationship within the CoC's geographic area.

Public Housing Agency Name	% New Admissions into Public Housing and Housing Choice Voucher Program during FY 2018 who were experiencing homelessness at entry	PHA has General or Limited Homeless Preference	PHA has a Preference for current PSH program participants no longer needing intensive supportive services, e.g., Moving On
Dallas Housing Authority	28.00%	Yes-HCV	No
Housing Authority of McKinney	35.00%	Yes-Both	No

1C-4a. PHAs' Written Policies on Homeless Admission Preferences.

Applicants must:

1. provide the steps the CoC has taken, with the two largest PHAs within the CoC's geographic area or the two PHAs the CoC has working relationships with, to adopt a homeless admission preference–if the CoC only has one PHA within its geographic area, applicants may respond for one; or
2. state that the CoC does not work with the PHAs in its geographic area. (limit 2,000 characters)

The Dallas Housing Authority, the largest within our CoC, has a homeless preference in their administrative plan. The Housing Authority of McKinney has a preference listed for homeless individuals and families and prioritizes those eligible for Mainstream Vouchers. To encourage increased homeless preference within the CoC in 2018 the CoC encouraged local PHAs to partner with CoC service agencies using creative reallocation in the NOFA process to actualize unused vouchers and add them to the Housing Inventory Chart as dedicated homeless vouchers. In this partnership, the CoC agency, through reallocation, provides services to activate HCV vouchers that otherwise would not have been used for homeless. In 2019, the CoC conducted a veteran housing challenge in collaboration with the Dallas Housing Authority. This led to an increase in VASH voucher utilization and a decrease in veteran homelessness within the continuum. The CoC has recently engaged local PHAs, nine total in the geographic area, in order to create a homeless preference and to encourage those PHAs to apply for additional housing choice vouchers for the Move On Strategy. The CoC has offered to lead the Move On Strategy and establish a coordinated process for identifying qualified clients. The CoC will also network with other leadership to illicit CoC-wide support of homeless admission preferences in all PHAs to reduce homelessness within our geographic area.

1C-4b. Moving On Strategy with Affordable Housing Providers.

Applicants must indicate whether the CoC has a Moving On Strategy with affordable housing providers in its jurisdiction.

Yes

If "Yes" is selected above, describe the type of provider, for example, multifamily assisted housing owners, PHAs, Low Income Tax Credit (LIHTC) developments, or local low-income housing programs. (limit 1,000 characters)

In February 2019, the CoC conducted a system analysis to identify the number of
PHA program participants and discussed the idea of a Move On Strategy at the State of the Homeless Address in March. Approximately 750 households were identified who could use this type of assistance. In April, the CoC submitted a request for an AmeriCorps VISTA specifically to help implement the Move On Strategy across the CoC. From April through June the CoC held meetings with local PHAs to discuss this strategy. In July, HUD issued the Mainstream Voucher NOFA, including eligible funds for the Move On Strategy. The CoC reached out to local PHAs again and coordinated applying for 350 Mainstream Vouchers to use with a Move On Strategy with 5 different eligible PHAs in our area. The Move On Strategy process and Mainstream Voucher application letters of support are included as attachments.

1C-5. Protecting Against Discrimination.

**Applicants must describe the actions the CoC has taken to address all forms of discrimination, such as discrimination based on any protected classes under the Fair Housing Act and 24 CFR 5.105(a)(2) – Equal Access to HUD-Assisted or -Insured Housing.
(limit 2,000 characters)**

Multiple actions have been implemented to address all forms of housing discrimination including:
1) Training has been provided to CoC Provider Agencies individually by Outlast Youth to improve their ability to make their programs and facilities more LGBTQ inclusive.
2) ESG funding is being used by Legal Aid of Northwest Texas to provide free Housing Clinics to homeless and formerly homeless individuals. They are held in their main location in downtown Dallas on the 1st and 3rd Tuesday of each month. The clinics are set up with a housing presentation followed by individual consult with an attorney for those who qualify. The presentation primarily covers intake for housing concerns, including discrimination, utility shut-off, wrongful lockout, security deposit, evictions, property tax, foreclosures, title issues, contracts for deed and other housing related issues.
3) The City of Dallas Fair Housing Department also conducted training last fall using the Ready To Rent curriculum to address fair housing practices and what to do in the event that tenants felt they were being discriminated against.

*1C-5a. Anti-Discrimination Policy and Training.

Applicants must indicate whether the CoC implemented an anti-discrimination policy and conduct training:

1. Did the CoC implement a CoC-wide anti-discrimination policy that applies to all projects regardless of funding source?	Yes
2. Did the CoC conduct annual CoC-wide training with providers on how to effectively address discrimination based on any protected class under the Fair Housing Act?	Yes
3. Did the CoC conduct annual training on how to effectively address discrimination based on any protected class under 24 CFR 5.105(a)(2) – Equal Access to HUD-Assisted or -Insured Housing?	Yes

*1C-6. Criminalization of Homelessness.

Applicants must select all that apply that describe the strategies the CoC implemented to prevent the criminalization of homelessness in the CoC's geographic area.

1. Engaged/educated local policymakers:	X
2. Engaged/educated law enforcement:	X

3. Engaged/educated local business leaders:	X
4. Implemented communitywide plans:	X
5. No strategies have been implemented:	
6. Other:(limit 50 characters)	

1C-7. Centralized or Coordinated Assessment System. Attachment Required.

Applicants must:
1. demonstrate the coordinated entry system covers the entire CoC geographic area;
2. demonstrate the coordinated entry system reaches people who are least likely to apply for homelessness assistance in the absence of special outreach; and
3. demonstrate the assessment process prioritizes people most in need of assistance and ensures they receive assistance in a timely manner. (limit 2,000 characters)

Coordinated Assessment System provides neighbors experiencing homelessness access to services to ensure a fair and consistent access to services. CAS covers the entire CoC area through several outlets. Entry into the system may be initiated in person at an access point, through our homeless helpline and/or homeless outreach teams. The homeless helpline has been established linking a single toll-free number to identified access points to streamline assessment and intervention for all individuals seeking assistance, including neighbors that are not able to physically go to an access point. For homeless neighbors that do not choose to, or are unable to, reach out to the CAS, our CoC provides outreach teams to triage, assess and assist. These teams include social workers and trained outreach workers from the CoC. Those who are homeless will enter one of the access points where an attempt to divert is the first step. If diversion is not possible, the neighbor will then be assessed using the VI-SPDAT (Vulnerability Index Service Prioritization Assistance Tool), documentation is gathered (Verification of Disability, Homeless documentation, etc.) by the case manager. The Case manager will then provide the information to the DOPS Expert. Each agency has determined its agency-wide process for this step. DOPS Experts will review all the neighbor's information and prioritize the neighbor based DOPS Matrix. The DOPS Expert is responsible are;
•Added the neighbor to the HPL,
•Updating the neighbor's priority status every 90 days and
•Informing the CAS staff on the neighbors housing status.
Information gathered is used to determine which priority status is the most appropriate for the neighbor. Once the housing intervention is determined,

neighbors are placed on HPL with the most vulnerable at the top of the HPL. The CAS team will connect neighbors to housing programs as housing program openings become available.

1D. Continuum of Care (CoC) Discharge Planning

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1D-1. Discharge Planning Coordination.

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

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

1E. Local CoC Competition

Instructions

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*1E-1. Local CoC Competition–Announcement, Established Deadline, Applicant Notifications. Attachments Required.

Applicants must indicate whether the CoC:

1. informed project applicants in its local competition announcement about point values or other ranking criteria the CoC would use to rank projects on the CoC Project Listings for submission to HUD for the FY 2019 CoC Program Competition;	Yes
2. established a local competition deadline, and posted publicly, for project applications that was no later than 30 days before the FY 2019 CoC Program Competition Application submission deadline;	Yes
3. notified applicants that their project application(s) were being rejected or reduced, in writing along with the reason for the decision, outside of e-snaps, at least 15 days before the FY 2019 CoC Program Competition Application submission deadline; and	Yes
4. notified applicants that their project applications were accepted and ranked on the CoC Priority Listing in writing, outside of e-snaps, at least 15 days before the FY 2019 CoC Program Competition Application submission deadline.	Yes

1E-2. Project Review and Ranking–Objective Criteria.

Applicants must indicate whether the CoC used the following to rank and select project applications for the FY 2019 CoC Program Competition:

1. Used objective criteria to review and rank projects for funding (e.g., cost effectiveness of the project, performance data, type of population served);	Yes
2. Included one factor related to improving system performance (e.g., exits to permanent housing (PH) destinations, retention of PH, length of time homeless, returns to homelessness, job/income growth, etc.); and	Yes
3. Included a specific method for evaluating projects submitted by victim services providers that utilized data generated from a comparable database and evaluated these projects on the degree they improve safety for the population served.	Yes

1E-3. Project Review and Ranking–Severity of Needs and Vulnerabilities.

Applicants must describe:
1. the specific severity of needs and vulnerabilities the CoC considered when reviewing and ranking projects; and
2. how the CoC takes severity of needs and vulnerabilities into account when reviewing and ranking projects.
(limit 2,000 characters)

Prior to the release of the FY2019 NOFA, MDHA conducted a CoC system analysis to get a sense of the Continuum's severity of needs and vulnerabilities. The results of the system analysis showed a need for an increase in Rapid Rehousing units within our CoC. It also showed an abundance of permanent supportive housing units, which are essential in continuing to house the chronically homeless. Based on the results of the analysis, MDHA staff recommended to the CoC five priorities that would right-size our system and decrease the length of homelessness. The five priorities are: 1) increasing rapid rehousing units, 2) removing projects from the NOFA that do not have housing dollars attached, 3) expanding the current HMIS, 4) reallocating funding from projects that scored below a threshold of 50% to new projects that provide Rapid Rehousing, and 5) increasing funding to a county within our system that makes up 8% of the homeless population within our CoC. The CoC accepted the MDHA staff's recommendation and used the priorities as a guide to providing fund when reviewing and ranking projects. Project applications outside of the five priorities were allowed to participate in the NOFA process but were informed of the CoC's priorities. The Performance Review and Allocations Committee (PRAC) received and reviewed all project applications submitted. Following the review, the PRAC agreed to not recommend projects that did not include housing dollars within the application for FY2019 NOFA as they were of no priority to the CoC based on the system analysis. Project applications that scored below the 50% scoring threshold were eliminated from the competition as a minimum scoring of 50% was needed for inclusion.

1E-4. Public Postings–CoC Consolidated Application. Attachment Required.

Applicants must:
1. indicate how the CoC made public the review and ranking process the CoC used for all project applications; or
2. check 6 if the CoC did not make public the review and ranking process; and
3. indicate how the CoC made public the CoC Consolidated Application–including the CoC Application and CoC Priority Listing that includes all project applications accepted and ranked or rejected–which HUD required CoCs to post to their websites, or partners websites, at least 2 days before the FY 2019 CoC Program Competition application submission deadline; or
4. check 6 if the CoC did not make public the CoC Consolidated Application.

Public Posting of Objective Review and Ranking Process	Public Posting of CoC Consolidated Application including: CoC Application, CoC Priority Listing, Project Listings

1. Email	X	**1. Email**	X
2. Mail		**2. Mail**	
3. Advertising in Local Newspaper(s)		**3. Advertising in Local Newspaper(s)**	
4. Advertising on Radio or Television		**4. Advertising on Radio or Television**	
5. Social Media (Twitter, Facebook, etc.)	X	**5. Social Media (Twitter, Facebook, etc.)**	X
6. Did Not Publicly Post Review and Ranking Process		**6. Did Not Publicly Post CoC Consolidated Application**	

1E-5. Reallocation between FY 2015 and FY 2018.

Applicants must report the percentage of the CoC's ARD that was reallocated between the FY 2015 and FY 2018 CoC Program Competitions.

Reallocation: 12%

1E-5a. Reallocation–CoC Review of Performance of Existing Projects.

Applicants must:
1. describe the CoC written process for reallocation;
2. indicate whether the CoC approved the reallocation process;
3. describe how the CoC communicated to all applicants the reallocation process;
4. describe how the CoC identified projects that were low performing or for which there is less need; and
5. describe how the CoC determined whether projects that were deemed low performing would be reallocated.
(limit 2,000 characters)

The CoC utilizes a tiered process to review all applications and reallocate resources of existing projects. The CoC board first reviews and votes on the CoC priorities for the
Consolidated Application. MDHA staff presents the CoC priorities to the CoC general assembly and holds an open workshop to go over the priorities and review process at the beginning of the NOFA competition. A Performance Review and Allocations Committee (PRAC) is created out of community members not affiliated with any of the applicant agencies. After reviewing and scoring the applications the PRAC determines where the CoC priorities have been met and reallocates funds accordingly. The PRAC decision making process is written into our CoC Policies and Procedures. Our two tier scoring process consists of utilizing the most recent APRs (approximately 75% of the total score) and a program narrative (approximately 25% of the total score). The CoC set the minimum threshold for funding at 50% of the total score this year. Any programs falling below that score were deemed low performing. MDHA

staff looked at last year's scoring levels and made a recommendation to the CoC Board for the 50% total score threshold. The CoC board discussed and voted on that threshold as a CoC Priority. The PRAC followed through after the scoring was complete to reallocate funding from those agencies. This process was approved by the CoC general assembly and the CoC Board of Directors.

DV Bonus

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
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The FY 2019 CoC Program Competition Notice of Funding Availability at: https://www.hudexchange.info/programs/e-snaps/fy-2019-coc-program-nofa-coc-program-competition/#nofa-and-notices

Warning! The CoC Application score could be affected if information is incomplete on this formlet.

1F-1 DV Bonus Projects.

Applicants must indicate whether the CoC is requesting DV Bonus projects which are included on the CoC Priority Listing: Yes

1F-1a. Applicants must indicate the type(s) of project(s) included in the CoC Priority Listing.

1. PH-RRH	
2. Joint TH/RRH	X
3. SSO Coordinated Entry	X

*1F-2. Number of Domestic Violence Survivors in CoC's Geographic Area.

Applicants must report the number of DV survivors in the CoC's geographic area that:

Need Housing or Services	2,491.00
the CoC is Currently Serving	535.00

1F-2a. Local Need for DV Projects.

Applicants must describe:
1. how the CoC calculated the number of DV survivors needing housing or service in question 1F-2; and
2. the data source (e.g., HMIS, comparable database, other administrative data, external data source).
(limit 500 characters)

National Violence Call Center reported that in 2018, approximately 1,568 + our CAS line number of 923 individuals reached out for help from domestic violence in areas within the CoC. The CoC is currently able to serve 535 clients, as reported on the FY2019 HIC.

1F-3. : SSO-CE Project–CoC including an SSO-CE project for DV Bonus funding in their CoC Priority Listing must provide information in the chart below about the project applicant and respond to Question 1F-3a.

DUNS Number	002933091
Applicant Name	The Family Place

1F-3a. Addressing Coordinated Entry Inadequacy.

Applicants must describe how:
1. the current Coordinated Entry is inadequate to address the needs of survivors of domestic violence, dating violence, or stalking; and
2. the proposed project addresses inadequacies identified in 1. above.
(limit 2,000 characters)

The existing Coordinated Entry process in the Dallas/Collin/Irving CoC is designed to address the needs of over 3,500 homeless persons during a year. Within that homeless population, there are 8 special sub populations including youth, families with children, veterans, chronically homeless, HIV/AIDS, mental illness, substance abuse and DV. While the CoC has made efforts to create a process for victims within the larger system, the current CE plan routes victims through a recorded call tree and requires that they select one of a series of options for the different subpopulations, to connect to The Family Place, the current access point for DV services.

Due to the size of our continuum, The Family Place, in coordination with local victim services providers, is proposing a separate (but equal) CE access point for DV victims in line with HUD guidelines to ensure access to resources with a safety and trauma focused lens. This DV CE process will address gaps in the existing system by: 1) focusing on the specific safety need of victims at high risk for lethality by providing services using trained DV professionals; 2) putting specific protocols in place to address the needs of families fleeing violent situations including safe and confidential access to the process. In addition to in person communication, this process will provide a virtual domestic access point for victims who are unable to directly meet with CE staff; 3) this process will be embedded in our 24-hour hotline which will allow supported by from a live staff person 24/7. Communicating with a staff member is important for

fleeing victims if they need to safety plan during the call. All CE staff will be trained domestic violence providers who can meet the ever-changing crisis needs of this population; 4) this DV specific CE point will allow the continuum to collect DV specific data to review with service providers in efforts to address gaps in service provision.

1F-4. PH-RRH and Joint TH and PH-RRH Project Applicant Capacity.

Applicants must provide information for each unique project applicant applying for PH-RRH and Joint TH and PH-RRH DV Bonus projects which the CoC is including in its CoC Priority Listing–using the list feature below.

Applicant Name	DUNS Number
This list contains no items	

2A. Homeless Management Information System (HMIS) Implementation

Intructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
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2A-1. HMIS Vendor Identification. Pieces IRIS

Applicants must review the HMIS software vendor name brought forward from FY 2018 CoC Application and update the information if there was a change.

2A-2. Bed Coverage Rate Using HIC and HMIS Data.

Using 2019 HIC and HMIS data, applicants must report by project type:

Project Type	Total Number of Beds in 2019 HIC	Total Beds Dedicated for DV in 2019 HIC	Total Number of 2019 HIC Beds in HMIS	HMIS Bed Coverage Rate
Emergency Shelter (ES) beds	1,871	270	1,279	79.89%
Safe Haven (SH) beds	45	0	45	100.00%
Transitional Housing (TH) beds	1,311	386	164	17.73%
Rapid Re-Housing (RRH) beds	373	15	358	100.00%
Permanent Supportive Housing (PSH) beds	2,191	0	2,191	100.00%
Other Permanent Housing (OPH) beds	733	0	733	100.00%

2A-2a. Partial Credit for Bed Coverage Rates at or Below 84.99 for Any Project Type in Question 2A-2.

For each project type with a bed coverage rate that is at or below 84.99 percent in question 2A-2., applicants must describe:

1. steps the CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type; and
2. how the CoC will implement the steps described to increase bed coverage to at least 85 percent.
(limit 2,000 characters)

Spring 2019, the CoC clarified the criteria for emergency shelter and transitional housing, thus causing a decrease in the number of emergency beds identified within the CoC. This is because some emergency shelters were reclassified as transitional housing based on the clarified criteria. This brought the CoCs bed coverage rate below 85%.

The CoC's new HMIS has emergency shelter bed management bed capability, while the prior system did not. The CoC anticipates this will allow more emergency shelter agencies to utilize and benefit directly from the HMIS system. As the CoC transitions to a new HMIS during FY2019, we are looking to improve participation within HMIS through a system enhancement fund granted by the City of Dallas. This grant covers HMIS user fees which serve as a major barrier for new agencies wanting to enter data in the HMIS. In this NOFA, an expansion to the HMIS renewal grant is being requested to cover user fees moving forward. The CoC has added 4 new agencies to the HMIS, one being a location that serves as an inclement weather shelter during cold weather. Included in the transition of the HMIS database, is a data warehouse, which provides a collection tool for agencies who choose not to enter directly into HMIS. Once implemented, agencies will be asked to upload data monthly.

*2A-3. Longitudinal System Analysis (LSA) Submission.

Applicants must indicate whether the CoC submitted its LSA data to HUD in HDX 2.0.	Yes

*2A-4. HIC HDX Submission Date.

Applicants must enter the date the CoC submitted the 2019 Housing Inventory Count (HIC) data into the Homelessness Data Exchange (HDX). (mm/dd/yyyy)	04/30/2019

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

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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2B-1. PIT Count Date. Applicants must enter the date the CoC conducted its 2019 PIT count (mm/dd/yyyy).	01/24/2019
2B-2. PIT Count Data–HDX Submission Date. Applicants must enter the date the CoC submitted its PIT count data in HDX (mm/dd/yyyy).	04/30/2019

2B-3. Sheltered PIT Count–Change in Implementation.

Applicants must describe:
1. any changes in the sheltered count implementation, including methodology or data quality methodology changes from 2018 to 2019, if applicable; and
2. how the changes affected the CoC's sheltered PIT count results; or
3. state "Not Applicable" if there were no changes.
(limit 2,000 characters)

Prior to the submission of the 2019 PIT Count, the CoC voted to update the CoC Policies and Procedures during which the criteria for meeting the definition of emergency shelter and transitional housing were clarified. The P&P defined emergency shelters as being low barrier. This change caused the transference of some emergency shelter beds to transitional housing.

***2B-4. Sheltered PIT Count–Changes Due to Presidentially-declared Disaster.**

Applicants must select whether the CoC added or removed emergency shelter, transitional housing, or Safe-Haven inventory because of funding specific to a Presidentially-declared disaster, resulting in a change to the CoC's 2019 sheltered PIT count.	No

2B-5. Unsheltered PIT Count–Changes in Implementation.

Applicants must describe:
1. any changes in the unsheltered count implementation, including methodology or data quality methodology changes from 2018 to 2019, if applicable; and
2. how the changes affected the CoC's unsheltered PIT count results; or
3. state "Not Applicable" if there were no changes.
(limit 2,000 characters)

Annually, the CoC strives to improve training and recruit more volunteers. This year's PIT Count included slightly more volunteers and advance training, which was recorded and shared via YouTube. Volunteers were asked to watch the video prior to the night of the Count and encouraged to ask questions at the training. Training provided on PIT Count night was brief and focused on providing clarity to volunteers.

***2B-6. PIT Count–Identifying Youth Experiencing Homelessness.**

Applicants must:

Indicate whether the CoC implemented specific measures to identify youth experiencing homelessness in their 2019 PIT count.	Yes

2B-6a. PIT Count–Involving Youth in Implementation.

Applicants must describe how the CoC engaged stakeholders serving youth experiencing homelessness to:
1. plan the 2019 PIT count;
2. select locations where youth experiencing homelessness are most likely to be identified; and
3. involve youth in counting during the 2019 PIT count.
(limit 2,000 characters)

The CoC's Youth Committee implemented the 2019 Youth Counts in Dallas as a youth specific PIT this year. Youth from the youth action board participated in the planning and implementation of the count, providing valuable input on the survey design and logistics of the count. With insight from youth, the CoC was able to revise the survey to ask the most effective questions while being more user-friendly and understandable. Youth voice and guidance were also critical in

implementing PIT outreach sessions for youth as they helped determine the youth outreach locations (identifying where young people are most likely to be found) and suggested the the days and times of outreach sessions to maximize the number of encounters outside organizations.
Based on youth feedback and input, we also changed what items were distributed during outreach sessions and in facilities conducting the PIT survey. For instance, we distributed more gift cards and coupons for free food and drinks than in past surveys. We also added an option, as requested by youth, to take the survey independently, via a QR code or short URL. This ensured that youth could participate even when not comfortable enough to talk with volunteers and they could share the link with friends and encourage greater participation in the PIT. Youth were invited to join volunteer teams conducting the survey and helped design the training for volunteers to include information on how volunteers should engage appropriately with youth they encounter.

2B-7. PIT Count–Improvements to Implementation.

Applicants must describe the CoC's actions implemented in its 2019 PIT count to better count:
1. individuals and families experiencing chronic homelessness;
2. families with children experiencing homelessness; and
3. Veterans experiencing homelessness.
(limit 2,000 characters)

During the 2019 PIT count, the CoC recruited extra volunteers for the unsheltered count to provide additional coverage to areas that normally are not captured. Volunteer routes were prioritized based on the area's history and most recent outreach information on where homeless individuals would likely be found. These routes were prioritized from 1 to 3, with tier 1 routes most likely to have significant numbers of homeless individuals or encampments. Experienced volunteer groups and street outreach teams received more than one route to assist with covering areas where a homeless encampment was not guaranteed. Local police and street outreach teams were assigned higher tier routes where volunteers were expected to find encampments with veterans, families with children, and/or individuals and families experiencing chronic homelessness. Volunteer teams were asked to specifically identify veterans; therefore, this question was moved closer to the top of the survey. Additionally, MDHA staff worked closely with family shelters to ensure data entry was completed in a timely manner so that each family was counted. Lastly, Collin County hosted several different new nighttime events to help draw unsheltered people in to participate in the PIT survey.

3A. Continuum of Care (CoC) System Performance

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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Warning! The CoC Application score could be affected if information is incomplete on this formlet.

*3A-1. First Time Homeless as Reported in HDX.

Applicants must:

Report the Number of First Time Homeless as Reported in HDX.	5,830

3A-1a. First Time Homeless Risk Factors.

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

The CoC strategy is conducted on two levels (the CoC System and the Homeless Person) which each consists of three phases: Assess, Prioritize and Implement.
CoC System Level - 1) An annual assessment of the CoC System was done after the FY2019 PIT Count. One of the measures assessed is the length of time homeless. The results of this assessment are shared at the annual State of Homelessness Address in March.; 2) Based on this assessment, the CoC General Assembly and Board determine priorities for the CoC overall for the year; 3) This information is used to determine NOFA decisions, ESG recommendations, and implementation of Consolidated Plans across CoC.

Homeless Person Level - 1 and 2) Individuals are assessed and prioritized using the VI-SPDAT and length of time homeless through our DOPS and HPL process. 3) Providers connect individuals to the appropriate services.

From this analysis, the CoC has implemented several diversion best practices at system access points (i.e. youth, DV, individuals, families, and veterans). Dedicated diversion specialists with access to resources (e.g. homeless prevention funds, local community benevolent funds, and the CoC flex fund) are being established where possible. Such resources provide funds for short term hotel stays, application fees, deposits, or other small expenses that can divert individuals or families from homelessness.

MDHA employs a CoC Coordinator who is responsible for monitoring, measuring and encouraging the implementation of this strategy overall. The coordinator ensures this process takes place through monitoring of program performance, HMIS data reviews, and the provision of training and technical assistance for the community. As another layer of oversight, the CoC has created a System Performance committee to monitor the progress of this measurement throughout the year.

*3A-2. Length of Time Homeless as Reported in HDX.

Applicants must:

Report Average Length of Time Individuals and Persons in Families Remained Homeless as Reported in HDX.	71

3A-2a. Strategy to Reduce Length of Time Homeless.

Applicants must:
1. describe the CoC's strategy to reduce the length of time individuals and persons in families remain homeless;
2. describe how the 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 the CoC's strategy to reduce the length of time individuals and families remain homeless.
(limit 2,000 characters)

The CoC strategy is conducted on two levels (the CoC System and the Homeless Person) which each consists of three phases: Assess, Prioritize and Implement.
CoC System Level - 1) An annual assessment of the CoC System was done after the FY2019 PIT Count. One of the measures assessed is the length of time homeless. The results of this assessment are shared at the annual State of Homelessness Address in March.; 2) Based on this assessment, the CoC General Assembly and Board determine priorities for the CoC overall for the year; 3) This information is used to determine NOFA decisions, ESG recommendations, and implementation of Consolidated Plans across CoC.
Homeless Person Level - 1 and 2) Individuals are assessed and prioritized using the VI-SPDAT and length of time homeless through our DOPS and HPL process. 3) Providers connect individuals to the appropriate services.

From this analysis, the CoC identified increased need for RRH units as more individuals and families on the list are not chronically homeless. To decrease the length of time individuals and families remain homeless, the CoC voted to prioritize RRH units during the FY2019 application process. With this NOFA, the CoC will add 150 units of RRH to the system. Additionally, the CoC has implemented By Name List meetings for all subpopulations of homelessness (i.e. youth, veterans, and the chronically homeless) to ensure that individuals with the longest lengths of time homeless get priority access to housing.

MDHA employs a CoC Coordinator who is responsible for monitoring, measuring and encouraging the implementation of this strategy overall. The coordinator ensures this process takes place through monitoring of program performance, HMIS data reviews, and the provision of training and technical assistance for the community. As another layer of oversight, the CoC has created the System Performance and the Adult Shelter committees to monitor the progress of this measurement throughout the year.

*3A-3. Successful Permanent Housing Placement and Retention as Reported in HDX.

Applicants must:

	Percentage
1. Report the percentage of individuals and persons in families in emergency shelter, safe havens, transitional housing, and rapid rehousing that exit to permanent housing destinations as reported in HDX.	21%
2. Report the percentage of individuals and persons in families in permanent housing projects, other than rapid rehousing, that retain their permanent housing or exit to permanent housing destinations as reported in HDX.	97%

3A-3a. Exits to Permanent Housing Destinations/Retention of Permanent Housing.

Applicants must:
1. describe the CoC's strategy to increase the rate at which individuals and persons in families in emergency shelter, safe havens, transitional housing and rapid rehousing exit to permanent housing destinations;
2. provide the organization name or position title responsible for overseeing the CoC's strategy to increase the rate at which individuals and persons in families in emergency shelter, safe havens, transitional housing and rapid rehousing exit to permanent housing destinations;
3. describe the CoC's strategy to increase the rate at which individuals and persons in families in permanent housing projects, other than rapid rehousing, retain their permanent housing or exit to permanent housing destinations; and
4. provide the organization name or position title responsible for overseeing the CoC's strategy to increase the rate at which individuals and persons in families in permanent housing projects, other than rapid rehousing, retain their permanent housing or exit to permanent housing destinations.
(limit 2,000 characters)

The CoC strategy is conducted on two levels (the CoC System and the Homeless Person) which each consists of three phases: Assess, Prioritize and Implement. CoC System Level - 1) An annual assessment of the CoC System was done after the FY2019 PIT Count. One of the measures assessed is exits to and retention of permanent housing. The results of this assessment are shared at the annual State of Homelessness Address in March.; 2) Based on this assessment, the CoC General Assembly and Board determine priorities for the CoC overall for the year; 3) This information is used to determine NOFA decisions, ESG recommendations, and implementation of Consolidated Plans across CoC.
Homeless Person Level - 1 and 2) Individuals are assessed and prioritized using the VI-SPDAT and length of time homeless through our DOPS and HPL process. 3) Providers connect individuals to the appropriate services.
From this analysis, the CoC implemented two housing challenges in 2019. The challenges engaged shelter and housing partners to quickly and innovatively address housing placements. Both challenges saw an increase in exits to permanent housing. In the Veteran's challenge, eligibility was determined, a voucher issued, and housing applied for within a day. In the Emergency Shelter challenge, a room sharing strategy where two(+) homeless individuals were partnered to make housing cost affordable was initiated. Given this success, the CoC plans to implement these processes across other subpopulations (i.e. youth, families, veterans, and individuals).

MDHA employs a CoC Coordinator who is responsible for monitoring, measuring and encouraging the implementation of this strategy overall by monitoring program performance, HMIS data reviews, and the provision of training and technical assistance for the community. As another layer of oversight, the CoC has the System Performance, the Permanent Housing and the Adult Shelter committees to monitor the ongoing progress of this measurement.

*3A-4. Returns to Homelessness as Reported in HDX.

Applicants must:

	Percentage
1. Report the percentage of individuals and persons in families returning to homelessness over a 6-month period as reported in HDX.	7%
2. Report the percentage of individuals and persons in families returning to homelessness over a 12-month period as reported in HDX.	4%

3A-4a. Returns to Homelessness–CoC Strategy to Reduce Rate.

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

(limit 2,000 characters)

The CoC strategy is conducted on two levels (the CoC System and the Homeless Person) which each consists of three phases: Assess, Prioritize and Implement.
CoC System Level - 1) An annual assessment of the CoC System was done after the FY2019 PIT Count. One of the measures assessed is returns to homelessness. The results of this assessment are shared at the annual State of Homelessness Address in March.; 2) Based on this assessment, the CoC General Assembly and Board determine priorities for the CoC overall for the year; 3) This information is used to determine NOFA decisions, ESG recommendations, and implementation of Consolidated Plans across CoC.
Homeless Person Level - 1 and 2) Individuals are assessed and prioritized using the VI-SPDAT and length of time homeless through our DOPS and HPL process. 3) Providers connect individuals to the appropriate services.

From this analysis, the CoC has brought increased awareness to addressing returns to homelessness. If a formerly homeless client tries to return to an emergency shelter or access point, practices are implemented to prevent the return. Access point staff exhaust all opportunities to prevent clients from returning to homelessness. The CoC has flex funds which can be used for prevention within the first six months that a formerly homeless individual has been housed. For the first six months immediately following an exit to a permanent destination, CoC agencies offer retention services, including support services and case management, to ensure clients do not return to homelessness.

MDHA employs a CoC Coordinator who is responsible for monitoring, measuring and encouraging the implementation of this strategy overall by monitoring program performance, HMIS data reviews, and the provision of training and technical assistance for the community. As another layer of oversight, the CoC has the System Performance, and the Permanent Housing committees to monitor the ongoing progress of this measurement.

*3A-5. Cash Income Changes as Reported in HDX.

Applicants must:

	Percentage
1. Report the percentage of individuals and persons in families in CoC Program-funded Safe Haven, transitional housing, rapid rehousing, and permanent supportive housing projects that increased their employment income from entry to exit as reported in HDX.	7%
2. Report the percentage of individuals and persons in families in CoC Program-funded Safe Haven, transitional housing, rapid rehousing, and permanent supportive housing projects that increased their non-employment cash income from entry to exit as reported in HDX.	26%

3A-5a. Increasing Employment Income.

Applicants must:
1. describe the CoC's strategy to increase employment income;
2. describe the CoC's strategy to increase access to employment;
3. describe how the CoC works with mainstream employment

organizations to help individuals and families increase their cash income; and
4. provide the organization name or position title that is responsible for overseeing the CoC's strategy to increase jobs and income from employment.
(limit 2,000 characters)

The CoC strategy is conducted on two levels (the CoC System and the Homeless Person) which each consists of three phases: Assess, Prioritize and Implement.
CoC System Level - 1) An annual assessment of the CoC System was done after the FY2019 PIT Count. One of the measures assessed is increasing employment income. The results of this assessment are shared at the annual State of Homelessness Address in March.; 2) Based on this assessment, the CoC General Assembly and Board determine priorities for the CoC overall for the year; 3) This information is used to determine NOFA decisions, ESG recommendations, and implementation of Consolidated Plans across CoC.
Homeless Person Level - 1 and 2) Individuals are assessed and prioritized using the VI-SPDAT and length of time homeless through our DOPS and HPL process. 3) Providers connect individuals to the appropriate services.

From this analysis, the CoC has identified a need for an Employment and Income committee that focuses on strategically increasing income of homeless individuals through education and employment. The committee will work to develop MOUs with local Workforce training programs. Such MOUs will strengthen homeless individual's access to Workforce employment coaches and improve communication about job fairs opportunities. The CoC flex fund offers bus passes to ensure individuals can access Workforce centers, particularly the workforce center located on the campus of CitySquare, an ESG and CoC funded agency, as this campus is convenient and welcoming to homeless clients.

MDHA employs a CoC Coordinator who is responsible for monitoring, measuring and encouraging the implementation of this strategy overall by monitoring program performance, HMIS data reviews, and the provision of training and technical assistance for the community. As another layer of oversight, the CoC has the System Performance, committee to monitor the ongoing progress of this measurement.

3A-5b. Increasing Non-employment Cash Income.

Applicants must:
1. describe the CoC's strategy to increase non-employment cash income;
2. describe the CoC's strategy to increase access to non-employment cash sources;
3. provide the organization name or position title that is responsible for overseeing the CoC's strategy to increase non-employment cash income.

The CoC strategy is conducted on two levels (the CoC System and the Homeless Person) which each consists of three phases: Assess, Prioritize and Implement.
CoC System Level - 1) An annual assessment of the CoC System was done after the FY2019 PIT Count. One of the measures assessed is increasing non-employment income. The results of this assessment are shared at the annual

State of Homelessness Address in March.; 2) Based on this assessment, the CoC General Assembly and Board determine priorities for the CoC overall for the year; 3) This information is used to determine NOFA decisions, ESG recommendations, and implementation of Consolidated Plans across CoC. Homeless Person Level - 1 and 2) Individuals are assessed and prioritized using the VI-SPDAT and length of time homeless through our DOPS and HPL process. 3) Providers connect individuals to the appropriate services.

From this analysis, the CoC has identified a need for an Employment and Income committee that focuses on strategically increasing income of homeless individuals through education and employment. This includes ensuring that homeless individuals have access to SOAR processors. Upon initial intake, if a homeless individual is unable to work, the client is referred to a SOAR processor. The CoC utilizes the services of community partners, such as Disability Action Center and North Texas Behavioral Health Alliance, to complete SOAR applications for agencies where a SOAR processor is not employed.

MDHA employs a CoC Coordinator who is responsible for monitoring, measuring and encouraging the implementation of this strategy overall by monitoring program performance, HMIS data reviews, and the provision of training and technical assistance for the community. As another layer of oversight, the CoC has the System Performance, committee to monitor the ongoing progress of this measurement.

3A-5c. Increasing Employment. Attachment Required.

Applicants must describe how the CoC:
1. promoted partnerships and access to employment opportunities with private employers and private employment organizations, such as holding job fairs, outreach to employers, and partnering with staffing agencies; and
2. is working with public and private organizations to provide meaningful, education and training, on-the-job training, internship, and employment opportunities for residents of permanent supportive housing that further their recovery and well-being.
(limit 2,000 characters)

The CoC strategy is conducted on two levels (the CoC System and the Homeless Person) which each consists of three phases: Assess, Prioritize and Implement.
CoC System Level - 1) An annual assessment of the CoC System was done after the FY2019 PIT Count. One of the measures assessed is increasing employment. The results of this assessment are shared at the annual State of Homelessness Address in March.; 2) Based on this assessment, the CoC General Assembly and Board determine priorities for the CoC overall for the year; 3) This information is used to determine NOFA decisions, ESG recommendations, and implementation of Consolidated Plans across CoC. Homeless Person Level - 1 and 2) Individuals are assessed and prioritized using the VI-SPDAT and length of time homeless through our DOPS and HPL process. 3) Providers connect individuals to the appropriate services.

From this analysis, the CoC has identified a need for an Employment and

Income committee that focuses on strategically increasing income of homeless individuals through education and employment. The committee will work to develop MOUs with local Workforce training programs and private entities. Such MOUs will strengthen homeless individual's access to Workforce employment coaches, job openings and improve communication about job fairs opportunities. The CoC flex fund offers bus passes to ensure individuals can access Workforce centers, particularly the workforce center located on the campus of CitySquare, an ESG and CoC funded agency, as this campus is convenient and welcoming to homeless clients.

MDHA employs a CoC Coordinator who is responsible for monitoring, measuring and encouraging the implementation of this strategy overall by monitoring program performance, HMIS data reviews, and the provision of training and technical assistance for the community. As another layer of oversight, the CoC has the System Performance, committee to monitor the ongoing progress of this measurement.

3A-5d. Promoting Employment, Volunteerism, and Community Service.

Applicants must select all the steps the CoC has taken to promote employment, volunteerism and community service among people experiencing homelessness in the CoC's geographic area:

1. The CoC trains provider organization staff on connecting program participants and people experiencing homelessness with education and job training opportunities.	☐
2. The CoC trains provider organization staff on facilitating informal employment opportunities for program participants and people experiencing homelessness (e.g., babysitting, housekeeping, food delivery).	☐
3. The CoC trains provider organization staff on connecting program participants with formal employment opportunities.	☐
4. The CoC trains provider organization staff on volunteer opportunities for program participants and people experiencing homelessness.	☐
5. The CoC works with organizations to create volunteer opportunities for program participants.	☐
6. The CoC works with community organizations to create opportunities for civic participation for people experiencing homelessness (e.g., townhall forums, meeting with public officials).	☐
7. Provider organizations within the CoC have incentives for employment.	☐
8. The CoC trains provider organization staff on helping program participants budget and maximize their income to maintain stability in permanent housing.	☐

3A-6. System Performance Measures Data–HDX Submission Date

05/22/2019

Applicants must enter the date the CoCs submitted its FY 2018 System Performance Measures data in HDX. (mm/dd/yyyy)

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

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources
The FY 2019 CoC Program Competition Notice of Funding Availability at: https://www.hudexchange.info/programs/e-snaps/fy-2019-coc-program-nofa-coc-program-competition/#nofa-and-notices

Warning! The CoC Application score could be affected if information is incomplete on this formlet.

3B-1. Prioritizing Households with Children.

Applicants must check each factor the CoC currently uses to prioritize households with children for assistance during FY 2019.

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

3B-1a. Rapid Rehousing of Families with Children.

Applicants must:
1. describe how the CoC currently rehouses every household of families with children within 30 days of becoming homeless that addresses both housing and service needs;
2. describe how the CoC addresses both housing and service needs to ensure families with children successfully maintain their housing once

assistance ends; and
3. provide the organization name or position title responsible for overseeing the CoC's strategy to rapidly rehouse families with children within 30 days of them becoming homeless.
(limit 2,000 characters)

The CoC strategy is conducted on two levels (the CoC System and the Homeless Person) which each consists of three phases: Assess, Prioritize and Implement.
An annual assessment of the CoC System was done after the FY2019 PIT Count. One of the measures assessed is the number of days to housing of families with children. The results of this assessment are shared at the annual State of Homelessness Address in March. Based on this assessment, the CoC General Assembly and Board determine priorities for the CoC overall for the year. This information is used to determine NOFA decisions, ESG recommendations, and implementation of Consolidated Plans across CoC.

Individuals are assessed and prioritized using the VI-SPDAT and length of time homeless through our DOPS and HPL process. Providers connect individuals to the appropriate services.

From this analysis, the CoC identified the need for more RRH units in order to decrease the length of time families are homeless. With this NOFA, the CoC will add 150 RRH units. To ensure homeless families are housed within 30 days, the CoC partners with Family Gateway which serves as the family access point for the system. Diversion specialists work with the CoC CAS Director to ensure families are diverted from homelessness and, where diversion is not possible, are placed on the housing priority list then housed with next available opportunity. If capacity is reached, families are referred to the CAS Director for placement within other CoC & ESG funded programs.

MDHA employs a CoC Coordinator who is responsible for monitoring, measuring and encouraging the implementation of this strategy overall by monitoring program performance, HMIS data reviews, and the provision of training and technical assistance for the community. As another layer of oversight, the CoC has the System Performance and Family and DV Services committees to monitor the ongoing progress of this measurement.

3B-1b. Antidiscrimination Policies.

Applicants must check all that apply that describe actions the CoC is taking to ensure providers (including emergency shelter, transitional housing, and permanent housing (PSH and RRH)) within the CoC adhere to antidiscrimination policies by not denying admission to or separating any family members from other members of their family or caregivers based on any protected classes under the Fair Housing Act, and consistent with 24 CFR 5.105(a)(2) – Equal Access to HUD-Assisted or -Insured Housing.

1. CoC conducts mandatory training for all CoC- and ESG-funded housing and services providers on these topics.	X

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

3B-1c. Unaccompanied Youth Experiencing Homelessness–Addressing Needs.

Applicants must indicate whether the CoC's strategy to address the unique needs of unaccompanied youth experiencing homelessness who are 24 years of age and younger includes the following:

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

3B-1c.1. Unaccompanied Youth Experiencing Homelessness–Prioritization Based on Needs.

Applicants must check all that apply that describes the CoC's current strategy to prioritize unaccompanied youth based on their needs.

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

3B-1d. Youth Experiencing Homelessness–Housing and Services Strategies.

Applicants must describe how the CoC increased availability of housing and services for:
1. all youth experiencing homelessness, including creating new youth-focused projects or modifying current projects to be more youth-specific

or youth-inclusive; and
2. youth experiencing unsheltered homelessness including creating new youth-focused projects or modifying current projects to be more youth-specific or youth-inclusive.
(limit 3,000 characters)

There are three active groups/committees dedicated to representing and advocating for the needs of homeless youth in our community: The CoC's Youth committee, the Youth Action Board, and the CoC's Youth By Name List (BNL) committee. The Youth committee played a significant role in shaping the youth outreach efforts for the 2019 PIT count including developing a strategy to encourage youth to take the survey independently through a QR code or short URL. The Youth Action Board recently wrote a grant application for the Youth Homeless Demonstration Project and partners with True Colors, a national organization, to advocate for services for homeless youth. The CoC's Youth By Name List (BNL) committee now meets twice monthly as a part of the coordinated assessment system to ensure youth are ranked and placed on the housing priority list (HPL). All youth have equal access to the HPL and are referred to housing programs as their name reaches the top of the list. The Youth BNL meeting allows for case conferencing to identify the best housing solution for the youth.

Over the past year, After8toEducate, Promise House and CitySquare TRAC have been preparing for the opening of a youth drop in center and a transitional housing shelter. This past summer, the drop-in center opened providing evening and daytime resources for homeless youth ages 14-21. The center is still under renovations. Once renovations are complete, an additional 8-bed transitional housing program will be added to the HIC. Youth agencies within the CoC partner with agencies outside the CoC to ensure youth homelessness is rare, brief, and nonrecurring. With the start of the new Employment and Income Committee, youth will benefit from this program as they seek income and employment opportunities for self-sufficiency. This committee will work closely with youth to receive feedback on new project developments.

3B-1d.1. Youth Experiencing Homelessness–Measuring Effectiveness of Housing and Services Strategies.

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

Youth agencies within the CoC partner with local school districts, early childhood providers, and afterschool care providers to address the needs of homeless students under McKinney-Vento. Homeless liaisons from Dallas and Mesquite Independent School Districts serve on the Youth Committee, in addition to early childhood and afterschool providers. The Youth Committee, which meets monthly, for youth count planning activities, and strategic planning events, particularly where youth homelessness is a focus of the meeting. The

CoC regularly shares homeless data as well as training invitations to homeless liaisons within each school district within the CoC geographic area. School districts provide necessary data for consolidated plans on ending homelessness within the Continuum.

3B-1e. Collaboration–Education Services.

Applicants must describe:

1. the formal partnerships with:
a. youth education providers;
b. McKinney-Vento LEA or SEA; and
c. school districts; and

2. how the CoC collaborates with:
a. youth education providers;
b. McKinney-Vento Local LEA or SEA; and
c. school districts.
(limit 2,000 characters)

Youth agencies within the CoC partner with local school districts, early childhood providers, and afterschool care providers to address the needs of homeless students under McKinney-Vento. Homeless liaisons from Dallas and Mesquite Independent School Districts serve on the Youth Committee, in addition to early childhood and afterschool providers. The Youth Committee, which meets monthly, for youth count planning activities, and strategic planning events, particularly where youth homelessness is a focus of the meeting. The CoC regularly shares homeless data as well as training invitations to homeless liaisons within each school district within the CoC geographic area. School districts provide necessary data for consolidated plans on ending homelessness within the Continuum.

3B-1e.1. Informing Individuals and Families Experiencing Homeless about Education Services Eligibility.

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

All CoC agencies that serve families with children are linked to local ISD liaisons through the youth committee efforts. Through this linkage, partner agencies can set up individual training sessions with liaisons to inform staff of eligibility for education services. Agencies then have the responsibility to filter this information to individuals and families within their programs. Agencies inform clients through various methods including informal meetings where the information is provided, flyers and informational one-pagers detailing how to get connected and during regular case management meetings where goal setting, including connection to educational services, is discussed. Dallas ISD student ID badges include the homeless crisis helpline which is managed by the coordinated assessment system. Students and their families are

encouraged to call the 1-800# when experiencing homelessness. Calls are routed based on responses to prompts.

3B-1e.2. Written/Formal Agreements or Partnerships with Early Childhood Services Providers.

Applicant must indicate whether the CoC has an MOU/MOA or other types of agreements with listed providers of early childhood services and supports and may add other providers not listed.

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

3B-2. Active List of Veterans Experiencing Homelessness.

Applicant must indicate whether the CoC uses an active list or by-name list to identify all veterans experiencing homelessness in the CoC. Yes

3B-2a. VA Coordination–Ending Veterans Homelessness.

Applicants must indicate whether the CoC is actively working with the U.S. Department of Veterans Affairs (VA) and VA-funded programs to achieve the benchmarks and criteria for ending veteran homelessness. Yes

3B-2b. Housing First for Veterans.

Applicants must indicate whether the CoC has sufficient resources to ensure each veteran experiencing homelessness is assisted to quickly move into permanent housing using a Housing First approach. Yes

3B-3. Racial Disparity Assessment. Attachment Required.

Applicants must:
1. select all that apply to indicate the findings from the CoC's Racial Disparity Assessment; or
2. select 7 if the CoC did not conduct a Racial Disparity Assessment.

1. People of different races or ethnicities are more likely to receive homeless assistance.	X
2. People of different races or ethnicities are less likely to receive homeless assistance.	
3. People of different races or ethnicities are more likely to receive a positive outcome from homeless assistance.	
4. People of different races or ethnicities are less likely to receive a positive outcome from homeless assistance.	X
5. There are no racial or ethnic disparities in the provision or outcome of homeless assistance.	
6. The results are inconclusive for racial or ethnic disparities in the provision or outcome of homeless assistance.	
7. The CoC did not conduct a racial disparity assessment.	

3B-3a. Addressing Racial Disparities.

Applicants must select all that apply to indicate the CoC's strategy to address any racial disparities identified in its Racial Disparities Assessment:

1. The CoC is ensuring that staff at the project level are representative of the persons accessing homeless services in the CoC.	
2. The CoC has identified the cause(s) of racial disparities in their homeless system.	X
3. The CoC has identified strategies to reduce disparities in their homeless system.	
4. The CoC has implemented strategies to reduce disparities in their homeless system.	
5. The CoC has identified resources available to reduce disparities in their homeless system.	
6: The CoC did not conduct a racial disparity assessment.	

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

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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The FY 2019 CoC Program Competition Notice of Funding Availability at: https://www.hudexchange.info/programs/e-snaps/fy-2019-coc-program-nofa-coc-program-competition/#nofa-and-notices

Warning! The CoC Application score could be affected if information is incomplete on this formlet.

4A-1. Healthcare–Enrollment/Effective Utilization

Applicants must indicate, for each type of healthcare listed below, whether the CoC assists persons experiencing homelessness with enrolling in health insurance and effectively utilizing Medicaid and other benefits.

Type of Health Care	Assist with Enrollment	Assist with Utilization of Benefits?
Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services)	Yes	Yes
Private Insurers:	Yes	Yes
Non-Profit, Philanthropic:	Yes	Yes
Other: (limit 50 characters)		

4A-1a. Mainstream Benefits.

Applicants must:
1. describe how the CoC systematically keeps program staff up to date regarding mainstream resources available for program participants (e.g., Food Stamps, SSI, TANF, substance abuse programs) within the geographic area;
2. describe how the CoC disseminates the availability of mainstream resources and other assistance information to projects and how often;
3. describe how the CoC works with projects to collaborate with healthcare organizations to assist program participants with enrolling in

health insurance;
4. describe how the CoC provides assistance with the effective utilization of Medicaid and other benefits; and
5. provide the name of the organization or position title that is responsible for overseeing the CoC's strategy for mainstream benefits.
(limit 2,000 characters)

All CoC partner agencies are required to participate in the HHSC Community Partner Program through Your Texas Benefits online portal and maintain at least one Your Texas Benefits navigator on staff. This allows CoC agencies to have direct access to HHS and complete online applications directly to expedite Medicaid, TANF and SNAP benefit approval. The Community Partner Program provides ongoing support, training and certification for all partner agencies and their staff, keeping program staff up-to-date regarding resources available. All CoC partner agencies are required to maintain at least one SOAR certified individual on staff. The CoC maintains communication with these SOAR certified staff members and offers regular training opportunities to keep staff up-to-date on SOAR requirements for expedited SSI approvals. As a part of the Parkland Acute Care Network, CoC providers meet monthly with hospital partners to discuss complex cases involving homeless individuals and families to determine the most effective way to get their housing and healthcare needs met. For other mainstream services the CoC hosts monthly round table meetings to keep program staff up-to-date on how to assist individuals' access to services for various needs. Topics for round table meetings last fiscal year included, but were not limited to, immigration services, substance use treatment programs, employment connection agencies, pro-bono legal assistance opportunities, and securing critical documents.

MDHA employs a CoC Coordinator who is responsible for monitoring, measuring and encouraging the implementation of this strategy overall by monitoring program performance, HMIS data reviews, and the provision of training and technical assistance for the community. As another layer of oversight, the CoC has the System Performance committee to monitor the ongoing progress of this measurement.

4A-2. Lowering Barriers to Entry Data:

Applicants must report:

1. Total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in FY 2019 CoC Program Competition.	
2. Total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in FY 2019 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.	
Percentage of new and renewal PSH, RRH, Safe-Haven, SSO non-Coordinated Entry projects the CoC has ranked in its CoC Priority Listing in the FY 2019 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.	0%

4A-3. Street Outreach.

Applicants must:

1. describe the CoC's street outreach efforts, including the methods it uses to ensure all persons experiencing unsheltered homelessness are identified and engaged;
2. state whether the CoC's Street Outreach covers 100 percent of the CoC's geographic area;
3. describe how often the CoC conducts street outreach; and
4. describe how the CoC tailored its street outreach to persons experiencing homelessness who are least likely to request assistance. (limit 2,000 characters)

Across the CoC outreach teams cooperate through the Street Outreach committee which meets at least monthly to coordinate efforts and ensure that teams across the system share the load and cover 100 percent of the CoC's geographic area. During this monthly meeting, teams share centralized data kept by CoC agencies and individual cities within the system regarding new locations of campsites and homeless persons. The committee utilizes collaborative intelligence which includes PIT Count data, reports made directly to agencies in the continuum, police interactions, and 311 complaints, to initiate positive engagements for persons who are least likely to request assistance. The committee is attended by a minimum of 15 outreach workers every month inclusive of subpopulation specific outreach teams (i.e. veterans and youth) as well as teams from outside the urban center of the CoC such as Collin County and the city of Garland. Through this coordinated effort, outreach is conducted daily within the main geographic area of the CoC, in outskirts of the CoC geographic area as the need is identified by the committee, and at least annually for each area within the CoC. The CoC has further collaborated across the system to tailor outreach efforts through coordinated events where multiple services are offered on location at campsites. These events include direct service provision such as ID fairs where state IDs are provided free to any interested homeless and unsheltered persons. These service fairs are often a first link to ongoing positive engagement towards housing or other services for persons experiencing homelessness who would otherwise be unlikely to request assistance.

4A-4. RRH Beds as Reported in HIC.

Applicants must report the total number of rapid rehousing beds available to serve all household types as reported in the Housing Inventory Count (HIC) for 2018 and 2019.

	2018	2019	Difference
RRH beds available to serve all populations in the HIC	600	373	-227

4A-5. Rehabilitation/Construction Costs–New Projects.

No

Applicants must indicate whether any new project application the CoC ranked and submitted in its CoC Priority Listing in the FY 2019 CoC Program Competition is requesting $200,000 or more in funding for housing

rehabilitation or new construction.

4A-6. Projects Serving Homeless under Other Federal Statutes.	No
Applicants must indicate whether the CoC is requesting to designate one or more of its SSO or TH projects to serve families with children or youth defined as homeless under other federal statutes.	

4B. Attachments

Instructions:

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

Document Type	Required?	Document Description	Date Attached
_FY 2019 CoC Competition Report (HDX Report)	Yes	FY 2019 CoC Compe...	09/25/2019
1C-4.PHA Administration Plan–Moving On Multifamily Assisted Housing Owners' Preference.	No	Moving On Project...	09/25/2019
1C-4. PHA Administrative Plan Homeless Preference.	No		
1C-7. Centralized or Coordinated Assessment System.	Yes	CE Assessment Tool	09/25/2019
1E-1.Public Posting–15-Day Notification Outside e-snaps–Projects Accepted.	Yes	FY2019-CoC-NOFA-P...	09/25/2019
1E-1. Public Posting–15-Day Notification Outside e-snaps–Projects Rejected or Reduced.	Yes		
1E-1.Public Posting–30-Day Local Competition Deadline.	Yes	Continuum-of-Care...	09/25/2019
1E-1. Public Posting–Local Competition Announcement.	Yes	MDHA 2019 NOFA Co...	09/25/2019
1E-4.Public Posting–CoC-Approved Consolidated Application	Yes		
3A. Written Agreement with Local Education or Training Organization.	No		
3A. Written Agreement with State or Local Workforce Development Board.	No		
3B-3. Summary of Racial Disparity Assessment.	Yes	Summary of Racial...	09/25/2019
4A-7a. Project List-Homeless under Other Federal Statutes.	No		
Other	No		
Other	No	FY2019 CoC NOFA A...	09/25/2019

Other	No		

Attachment Details

Document Description: FY 2019 CoC Competition Report

Attachment Details

Document Description: Moving On Project Outline

Attachment Details

Document Description: City of McKinney Housing Authority Admin Plan

Attachment Details

Document Description: CE Assessment Tool

Attachment Details

Document Description: FY2019-CoC-NOFA-Priority-Listing

Attachment Details

Document Description:

Attachment Details

Document Description: Continuum-of-Care-Timeline-FY2019

Attachment Details

Document Description: MDHA 2019 NOFA CoC Program Grant Competition

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: Summary of Racial Disparity Assessment

Attachment Details

Document Description:

Attachment Details

Document Description: DHA Admin Plan

Attachment Details

Document Description: FY2019 CoC NOFA Applicant Scorecards

Attachment Details

Document Description: test

Submission Summary

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

Page	Last Updated
1A. Identification	09/16/2019
1B. Engagement	Please Complete
1C. Coordination	09/25/2019
1D. Discharge Planning	No Input Required
1E. Local CoC Competition	09/25/2019
1F. DV Bonus	09/25/2019
2A. HMIS Implementation	09/25/2019
2B. PIT Count	09/25/2019
3A. System Performance	09/25/2019
3B. Performance and Strategic Planning	09/25/2019
4A. Mainstream Benefits and Additional Policies	09/25/2019
4B. Attachments	Please Complete

Submission Summary	No Input Required

Notes:

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

2019 HDX Competition Report

PIT Count Data for TX-600 - Dallas City & County, Irving CoC

Total Population PIT Count Data

	2016 PIT	2017 PIT	2018 PIT	2019 PIT
Total Sheltered and Unsheltered Count	**3810**	**3789**	**4121**	**4538**
Emergency Shelter Total	1968	1,897	1,972	2044
Safe Haven Total	23	19	23	49
Transitional Housing Total	1080	786	785	993
Total Sheltered Count	**3071**	**2702**	**2780**	**3086**
Total Unsheltered Count	**739**	**1087**	**1341**	**1452**

Chronically Homeless PIT Counts

	2016 PIT	2017 PIT	2018 PIT	2019 PIT
Total Sheltered and Unsheltered Count of Chronically Homeless Persons	**597**	**542**	**587**	**533**
Sheltered Count of Chronically Homeless Persons	464	436	432	407
Unsheltered Count of Chronically Homeless Persons	133	106	155	126

2019 HDX Competition Report

PIT Count Data for TX-600 - Dallas City & County, Irving CoC

Homeless Households with Children PIT Counts

	2016 PIT	2017 PIT	2018 PIT	2019 PIT
Total Sheltered and Unsheltered Count of the Number of Homeless Households with Children	**420**	**258**	**301**	**313**
Sheltered Count of Homeless Households with Children	418	253	299	310
Unsheltered Count of Homeless Households with Children	2	5	2	3

Homeless Veteran PIT Counts

	2011	2016	2017	2018	2019
Total Sheltered and Unsheltered Count of the Number of Homeless Veterans	**555**	**307**	**358**	**320**	**431**
Sheltered Count of Homeless Veterans	521	253	297	254	378
Unsheltered Count of Homeless Veterans	34	54	61	66	53

2019 HDX Competition Report

HIC Data for TX-600 - Dallas City & County, Irving CoC

HMIS Bed Coverage Rate

Project Type	Total Beds in 2019 HIC	Total Beds in 2019 HIC Dedicated for DV	Total Beds in HMIS	HMIS Bed Coverage Rate
Emergency Shelter (ES) Beds	**1871**	**270**	**1279**	**79.89%**
Safe Haven (SH) Beds	**45**	**0**	**45**	**100.00%**
Transitional Housing (TH) Beds	**1311**	**386**	**164**	**17.73%**
Rapid Re-Housing (RRH) Beds	**373**	**15**	**358**	**100.00%**
Permanent Supportive Housing (PSH) Beds	**2191**	**0**	**2191**	**100.00%**
Other Permanent Housing (OPH) Beds	**733**	**0**	**733**	**100.00%**
Total Beds	6,524	671	4770	81.50%

2019 HDX Competition Report

HIC Data for TX-600 - Dallas City & County, Irving CoC

PSH Beds Dedicated to Persons Experiencing Chronic Homelessness

Chronically Homeless Bed Counts	2016 HIC	2017 HIC	2018 HIC	2019 HIC
Number of CoC Program and non-CoC Program funded PSH beds dedicated for use by chronically homeless persons identified on the HIC	1276	1093	961	1096

Rapid Rehousing (RRH) Units Dedicated to Persons in Household with Children

Households with Children	2016 HIC	2017 HIC	2018 HIC	2019 HIC
RRH units available to serve families on the HIC	59	77	132	86

Rapid Rehousing Beds Dedicated to All Persons

All Household Types	2016 HIC	2017 HIC	2018 HIC	2019 HIC
RRH beds available to serve all populations on the HIC	252	422	600	373

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

Summary Report for TX-600 - Dallas City & County, Irving CoC

For each measure enter results in each table from the System Performance Measures report generated out of your CoCs HMIS System. There are seven performance measures. Each measure may have one or more "metrics" used to measure the system performance. Click through each tab above to enter FY2017 data for each measure and associated metrics.

RESUBMITTING FY2018 DATA: If you provided revised FY2018 data, the original FY2018 submissions will be displayed for reference on each of the following screens, but will not be retained for analysis or review by HUD.

ERRORS AND WARNINGS: If data are uploaded that creates selected fatal errors, the HDX will prevent the CoC from submitting the System Performance Measures report. The CoC will need to review and correct the original HMIS data and generate a new HMIS report for submission.

Some validation checks will result in warnings that require explanation, but will not prevent submission. Users should enter a note of explanation for each validation warning received. To enter a note of explanation, move the cursor over the data entry field and click on the note box. Enter a note of explanation and "save" before closing.

Measure 1: Length of Time Persons Remain Homeless

This measures the number of clients active in the report date range across ES, SH (Metric 1.1) and then ES, SH and TH (Metric 1.2) along with their average and median length of time homeless. This includes time homeless during the report date range as well as prior to the report start date, going back no further than October, 1, 2012.

Metric 1.1: Change in the average and median length of time persons are homeless in ES and SH projects.
Metric 1.2: Change in the average and median length of time persons are homeless in ES, SH, and TH projects.

a. This measure is of the client's entry, exit, and bed night dates strictly as entered in the HMIS system.

2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

	Universe (Persons)			Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Submitted FY 2017	Revised FY 2017	FY 2018	Submitted FY 2017	Revised FY 2017	FY 2018	Difference	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
1.1 Persons in ES and SH	9955	4756	8403	105	100	71	-29	88	29	23	-6
1.2 Persons in ES, SH, and TH	10396	5614	9347	111	134	111	-23	178	44	32	-12

b. This measure is based on data element 3.17.

This measure includes data from each client's Living Situation (Data Standards element 3.917) response as well as time spent in permanent housing projects between Project Start and Housing Move-In. This information is added to the client's entry date, effectively extending the client's entry date backward in time. This "adjusted entry date" is then used in the calculations just as if it were the client's actual entry date.

The construction of this measure changed, per HUD's specifications, between FY 2016 and FY 2017. HUD is aware that this may impact the change between these two years.

	Universe (Persons)			Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Submitted FY 2017	Revised FY 2017	FY 2018	Submitted FY 2017	Revised FY 2017	FY 2018	Difference	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
1.1 Persons in ES, SH, and PH (prior to "housing move in")	10466	5687	9553	496	511	515	4	170	113	129	16
1.2 Persons in ES, SH, TH, and PH (prior to "housing move in")	10907	6074	9960	499	508	519	11	268	128	140	12

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

Measure 2: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness

This measures clients who exited SO, ES, TH, SH or PH to a permanent housing destination in the date range two years prior to the report date range.Of those clients, the measure reports on how many of them returned to homelessness as indicated in the HMIS for up to two years after their initial exit.

After entering data, please review and confirm your entries and totals. Some HMIS reports may not list the project types in exactly the same order as they are displayed below.

	Total # of Persons who Exited to a Permanent Housing Destination (2 Years Prior)		Returns to Homelessness in Less than 6 Months			Returns to Homelessness from 6 to 12 Months			Returns to Homelessness from 13 to 24 Months			Number of Returns in 2 Years	
	Revised FY 2017	FY 2018	Revised FY 2017	FY 2018	% of Returns	Revised FY 2017	FY 2018	% of Returns	Revised FY 2017	FY 2018	% of Returns	FY 2018	% of Returns
Exit was from SO	52	21	2	5	24%	4	1	5%	1	5	24%	11	52%
Exit was from ES	1135	1070	91	117	11%	25	77	7%	44	63	6%	257	24%
Exit was from TH	693	609	39	44	7%	20	14	2%	21	34	6%	92	15%
Exit was from SH	3	2	0	0	0%	0	0	0%	2	0	0%	0	0%
Exit was from PH	701	1168	18	48	4%	14	26	2%	23	90	8%	164	14%
TOTAL Returns to Homelessness	2584	2870	150	214	7%	63	118	4%	91	192	7%	524	18%

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts

2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

This measures the change in PIT counts of sheltered and unsheltered homeless person as reported on the PIT (not from HMIS).

	January 2017 PIT Count	January 2018 PIT Count	Difference
Universe: Total PIT Count of sheltered and unsheltered persons	3789	4121	332
Emergency Shelter Total	1897	1972	75
Safe Haven Total	19	23	4
Transitional Housing Total	786	785	-1
Total Sheltered Count	2702	2780	78
Unsheltered Count	1087	1341	254

Metric 3.2 – Change in Annual Counts

This measures the change in annual counts of sheltered homeless persons in HMIS.

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Unduplicated Total sheltered homeless persons	10396	6086	10240	4154
Emergency Shelter Total	9955	5206	9254	4048
Safe Haven Total	30	30	75	45
Transitional Housing Total	632	1110	1185	75

Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

Metric 4.1 – Change in earned income for adult system stayers during the reporting period

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Number of adults (system stayers)	1428	916	1018	102
Number of adults with increased earned income	167	66	76	10
Percentage of adults who increased earned income	12%	7%	7%	0%

Metric 4.2 – Change in non-employment cash income for adult system stayers during the reporting period

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Number of adults (system stayers)	1428	916	1018	102
Number of adults with increased non-employment cash income	505	193	267	74
Percentage of adults who increased non-employment cash income	35%	21%	26%	5%

Metric 4.3 – Change in total income for adult system stayers during the reporting period

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Number of adults (system stayers)	1428	916	1018	102
Number of adults with increased total income	506	240	310	70
Percentage of adults who increased total income	35%	26%	30%	4%

2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

Metric 4.4 – Change in earned income for adult system leavers

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Number of adults who exited (system leavers)	679	205	224	19
Number of adults who exited with increased earned income	113	53	56	3
Percentage of adults who increased earned income	17%	26%	25%	-1%

Metric 4.5 – Change in non-employment cash income for adult system leavers

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Number of adults who exited (system leavers)	679	205	224	19
Number of adults who exited with increased non-employment cash income	244	63	63	0
Percentage of adults who increased non-employment cash income	36%	31%	28%	-3%

Metric 4.6 – Change in total income for adult system leavers

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Number of adults who exited (system leavers)	679	205	224	19
Number of adults who exited with increased total income	248	110	108	-2
Percentage of adults who increased total income	37%	54%	48%	-6%

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

Measure 5: Number of persons who become homeless for the 1st time

Metric 5.1 – Change in the number of persons entering ES, SH, and TH projects with no prior enrollments in HMIS

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Person with entries into ES, SH or TH during the reporting period.	10396	5306	9575	4269
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	2639	2002	3745	1743
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time)	7757	3304	5830	2526

Metric 5.2 – Change in the number of persons entering ES, SH, TH, and PH projects with no prior enrollments in HMIS

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Person with entries into ES, SH, TH or PH during the reporting period.	14634	7158	10853	3695
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	3266	2769	4393	1624
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time.)	11368	4389	6460	2071

Measure 6: Homeless Prevention and Housing Placement of Persons defined by category 3 of HUD's Homeless Definition in CoC Program-funded Projects

This Measure is not applicable to CoCs in FY2018 (Oct 1, 2017 - Sept 30, 2018) reporting period.

Measure 7: Successful Placement from Street Outreach and Successful Placement in or Retention of Permanent Housing

Metric 7a.1 – Change in exits to permanent housing destinations

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Persons who exit Street Outreach	1057	1837	4378	2541
Of persons above, those who exited to temporary & some institutional destinations	154	526	1549	1023
Of the persons above, those who exited to permanent housing destinations	79	135	386	251
% Successful exits	22%	36%	44%	8%

Metric 7b.1 – Change in exits to permanent housing destinations

FY2018 - Performance Measurement Module (Sys PM)

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Persons in ES, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing	8560	4805	9842	5037
Of the persons above, those who exited to permanent housing destinations	1022	1802	2063	261
% Successful exits	12%	38%	21%	-17%

Metric 7b.2 – Change in exit to or retention of permanent housing

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Persons in all PH projects except PH-RRH	3619	4405	4466	61
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	3440	4209	4315	106
% Successful exits/retention	95%	96%	97%	1%

2019 HDX Competition Report

FY2018 - SysPM Data Quality

TX-600 - Dallas City & County, Irving CoC

This is a new tab for FY 2016 submissions only. Submission must be performed manually (data cannot be uploaded). Data coverage and quality will allow HUD to better interpret your Sys PM submissions.

Your bed coverage data has been imported from the HIC module. The remainder of the data quality points should be pulled from data quality reports made available by your vendor according to the specifications provided in the HMIS Standard Reporting Terminology Glossary. You may need to run multiple reports into order to get data for each combination of year and project type.

You may enter a note about any field if you wish to provide an explanation about your data quality results. This is not required.

2019 HDX Competition Report

FY2018 - SysPM Data Quality

	All ES, SH				All TH				All PSH, OPH				All RRH				All Street Outreach			
	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018
1. Number of non-DV Beds on HIC	2135	2085	2141	1910	925	1009	707	624	3138	3182	2973	2517	84	251	269	478				
2. Number of HMIS Beds	117	420	927	1226	621	514	227	188	2126	2367	2109	2517	84	251	260	478				
3. HMIS Participation Rate from HIC (%)	5.48	20.14	43.30	64.19	67.14	50.94	32.11	30.13	67.75	74.39	70.94	100.00	100.00	100.00	96.65	100.00				
4. Unduplicated Persons Served (HMIS)	411	2412	5478	9429	1270	1148	1111	1185	2018	1296	4417	4614	243	1276	1581	1447			3148	5804
5. Total Leavers (HMIS)	273	1995	3666	7806	859	821	481	477	396	288	862	796	84	771	1070	970			1825	3040
6. Destination of Don't Know, Refused, or Missing (HMIS)	15	1506	1065	1998	448	22	34	22	9	2	119	28	1	22	60	48			925	2232
7. Destination Error Rate (%)	5.49	75.49	29.05	25.60	52.15	2.68	7.07	4.61	2.27	0.69	13.81	3.52	1.19	2.85	5.61	4.95			50.68	73.42

2019 HDX Competition Report

Submission and Count Dates for TX-600 - Dallas City & County, Irving CoC

Date of PIT Count

	Date	Received HUD Waiver
Date CoC Conducted 2019 PIT Count	1/24/2019	

Report Submission Date in HDX

	Submitted On	Met Deadline
2019 PIT Count Submittal Date	4/30/2019	Yes
2019 HIC Count Submittal Date	4/30/2019	Yes
2018 System PM Submittal Date	5/22/2019	Yes

DOPS Matrix 2018

Documentation of Priority Status Approved CoC Board of Directors January 12, 2018 Effective February 1, 2018

Housing Intervention	Priority Status	Homeless Category	Length of Stay in Homelessness	Where Experience Homelessness	Severity of Service Needs	Documented Disability
MANDATED: Dedicated or Prioritized Chronic CoC Program Funded PSH ***OPTIONAL: Rapid Rehousing Bridge Housing (HCC)*** ***Other Non-CoC Funded PSH Adopting DOPS*** ***CoC Rapid Rehousing*** **Safe Haven**	**1**	Chronic - Individual or HHLD with Children	> 12 Months Continuous	UN, ES, SH	High = VI-SPDAT Score of 8 or greater	Yes
	2	Chronic - Individual or HHLD with Children	> 12 Months Continuous	UN, ES, SH	Moderate = VI-SPDAT score of 4-7:	Yes
	3	Chronic - Individual or HHLD with Children	Total of at least 4 Episodes Total = > 12 months in 3 years	UN, ES, SH	High = VI-SPDAT Score of 8 or greater	Yes
	4	Chronic - Individual or HHLD with Children	Total of at least 4 Episodes Total = > 12 months in 3 Years	UN, ES, SH	Moderate = VI-SPDAT score of 4-7	Yes
MANDATED MINIMUM Non-Dedicated or Prioritized Chronic CoC Program Funded PSH ***OPTIONAL: CoC Funded Rapid Rehousing*** ***CoC Funded Transitional Housing*** **Safe Haven**	**5**	Category 1 - Individual or HHLD with Children	Any Length of Stay OR = < 90 Days Institution	UN, ES, SH ***OR*** Institution if UN ES SH Prior to entry	High = VI-SPDAT Score of 8 or greater	Yes
OPTIONAL: CoC Funded Transitional Housing ***Safe Haven*** ***RRH for DV Shelter Referred HHLD with Disability***	**6**	Category 1 or 4 - Individual or HHLD with Children	> or = 6 Months Continuous ***OR*** at least 3 episodes in 3 years > = 6 Months ***OR*** = < 90 Days in Institution	UN, ES, SH ***OR*** Institution if UN ES SH Prior to entry	Moderate = VI-SPDAT score of 4-7	Yes
OPTIONAL: CoC Funded Transitional Housing ***Safe Haven***	**7**	Category 1 - Individual or HHLD with Children	Any time > 30 days ***OR*** = < 90 Days Institution	UN, ES, SH ***OR*** Institution if UN ES SH Prior to entry	Moderate VI-SPDAT score of 4-7	Yes

	8	Category 1 - Individual or HHLD with Children	*Any Length of Stay > 14 days*	TH IF previous UN, ES, or SH (*dependent on funding source CoC or ESG*)	Moderate VI-SPDAT score of 4-7	Yes
MANDATED MINIMUM: CoC & ESG Funded Rapid Rehousing for Families ***OPTIONAL: CoC Funded Transitional Housing***	**9**	Category 1 or 4 HHLD with Children	*Any Length of Stay*	UN, ES, SH	Low = VI-SPDAT 0 - 3	Not required. Collect documentation if available
MANDATED MINIMUM: CoC & ESG Funded Rapid Rehousing for Individuals ***OPTIONAL: CoC Funded Transitional Housing***	**10**	Category 1 or 4 Individual	*Length of Stay > 14 days*	UN, ES, SH	Low = VI-SPDAT Score 0 - 3	Not required. Collect documentation if available
Diversion Homeless Prevention Housing Search Assistance ***OPTIONAL CoC Funded Transitional Housing***	**11**	Category 1 or 4 HHLD with Children	*Any Length of Stay*	UN, ES, SH	Required for CoC Funded TH Only Any Score	Not required. Collect documentation if available
	12	Category 1 or 4 Individual	*Length of Stay > 14 days*	UN, ES, SH	Required for CoC Funded TH Only Any Score	Not required. Collect documentation if available
Prevention and Diversion **OPTIONAL: ESG Funded Homeless Prevention**	**NP1**	At-Risk of Homelessness Family / Category 1 or 4 Individual	Primary nighttime residence lost within 14 days OR Category 1 Homeless with Length of Stay < 14 days	No Subsequent residence identified and no social networks to obtain permanent housing OR ES	Not Required	Not required. Collect documentation if available
	NP2	At-Risk of Homelessness Any Household	Primary nighttime residence will be lost within 21 days	Meet any At Risk of Homelessness Criteria	Not Required	Not required. Collect documentation if available

METRO DALLAS HOMELESS ALLIANCE

DOPS

CAS Documentation of Priority Status Form - DOPS

Client Name: _____Client Date of Birth:_____

Client HMIS Identification Number: _____

The Metro Dallas Homeless Alliance verifies that the above named client holds the following priority status documented in the HMIS as of **DATE: _____.**

☐ **P1**	☐ **P6**	☐ **P11**
☐ **P2**	☐ **P7**	☐ **P12**
☐ **P3**	☐ **P8**	☐ **NP 1**
☐ **P4**	☐ **P9**	☐ **NP 2**
☐ **P5**	☐ **P10**	

Additional Documentation Required: _____

_____

_____

VI-SPDAT/SPDAT Score: *(indicate which instrument was used and the score)*

- **VI-SPDAT Individual Adult 2.0: ____**
- **VI-SPDAT Family 2.0: ____**
- **SPDAT Individual Adult 4.0: ____**
- **SPDAT Family 2.0: ____**

Special Conditions or Sub-population Notes:

_____

AUTHORIZED MDHA Staff Name and Signature

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Families

AMERICAN VERSION 2.0

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

COMMUNITY SOLUTIONS

ORG CODE

Administration

Interviewer's Name	**Agency**	☐ Team ☐ Staff ☐ Volunteer
_____	_____	
Survey Date	**Survey Time**	**Survey Location**
MM/DD/YYYY ____/____/_____	__ __ : __ __	_____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

PARENT

First Name	**Nickname**	**Last Name**
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	**Age**	**Social Security Number**	**Consent to participate**
MM/DD/YYYY ____/____/_____	_____	_____	☐ Yes ☐ No

PARENT

☐ No second parent currently part of the household

First Name	**Nickname**	**Last Name**
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	**Age**	**Social Security Number**	**Consent to participate**
MM/DD/YYYY / /			☐ Yes ☐ No

Children

1. How many children under the age of 18 are currently with you? _____ ☐ Refused
2. How many children under the age of 18 are not currently with your family, but you have reason to believe they will be joining you when you get housed? _____ ☐ Refused
3. *IF HOUSEHOLD INCLUDES A FEMALE:* Is any member of the family currently pregnant? ☐ **Y** ☐ N ☐ Refused
4. Please provide a list of children's names and ages:

First Name	Last Name	Age	Date of Birth

A. History of Housing and Homelessness

5. Where do you and your family sleep most frequently? (check one)

☐ Shelters
☐ Transitional Housing
☐ Safe Haven
☐ **Outdoors**
☐ **Other (specify):** _____
☐ **Refused**

6. How long has it been since you and your family lived in permanent stable housing? _____ ☐ Refused
7. In the last three years, how many times have you and your family been homeless? _____ ☐ Refused

B. Risks

8. In the past six months, how many times have you or anyone in your family...
   a) Received health care at an emergency department/room? ____ ☐ Refused
   b) Taken an ambulance to the hospital? ____ ☐ Refused
   c) Been hospitalized as an inpatient? ____ ☐ Refused
   d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? ____ ☐ Refused
   e) Talked to police because they witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told them that they must move along? ____ ☐ Refused
   f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? ____ ☐ Refused

9. Have you or anyone in your family been attacked or beaten up since they've become homeless? ☐ **Y** ☐ N ☐ Refused

10. Have you or anyone in your family threatened to or tried to harm themself or anyone else in the last year? ☐ **Y** ☐ N ☐ Refused

11. Do you or anyone in your family have any legal stuff going on right now that may result in them being locked up, having to pay fines, or that make it more difficult to rent a place to live? ☐ **Y** ☐ N ☐ Refused

12. Does anybody force or trick you or anyone in your family to do things that you do not want to do? ☐ **Y** ☐ N ☐ Refused

13. Do you or anyone in your family ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone they don't know, share a needle, or anything like that? ☐ **Y** ☐ N ☐ Refused

C. Socialization & Daily Functioning

14. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you or anyone in your family owe them money? ☐ **Y** ☐ N ☐ Refused

15. Do you or anyone in your family get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that? ☐ Y ☐ **N** ☐ Refused

16. Does everyone in your family have planned activities, other than just surviving, that make them feel happy and fulfilled? ☐ Y ☐ **N** ☐ Refused

17. Is everyone in your family currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? ☐ Y ☐ **N** ☐ Refused

18. Is your family's current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because other family or friends caused your family to become evicted? ☐ **Y** ☐ N ☐ Refused

D. Wellness

19. Has your family ever had to leave an apartment, shelter program, or other place you were staying because of the physical health of you or anyone in your family? ☐ **Y** ☐ N ☐ Refused

20. Do you or anyone in your family have any chronic health issues with your liver, kidneys, stomach, lungs or heart? ☐ **Y** ☐ N ☐ Refused

21. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you or anyone in your family? ☐ **Y** ☐ N ☐ Refused

22. Does anyone in your family have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help? ☐ **Y** ☐ N ☐ Refused

23. When someone in your family is sick or not feeling well, does your family avoid getting medical help? ☐ **Y** ☐ N ☐ Refused

24. Has drinking or drug use by you or anyone in your family led your family to being kicked out of an apartment or program where you were staying in the past? ☐ **Y** ☐ N ☐ Refused

25. Will drinking or drug use make it difficult for your family to stay housed or afford your housing? ☐ **Y** ☐ N ☐ Refused

26. Has your family ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:

a) A mental health issue or concern? ☐ **Y** ☐ N ☐ Refused

b) A past head injury? ☐ **Y** ☐ N ☐ Refused

c) A learning disability, developmental disability, or other impairment? ☐ **Y** ☐ N ☐ Refused

27. Do you or anyone in your family have any mental health or brain issues that would make it hard for your family to live independently because help would be needed? ☐ **Y** ☐ N ☐ Refused

28. *IF THE FAMILY SCORED 1 EACH FOR PHYSICAL HEALTH, SUBSTANCE USE, AND MENTAL HEALTH:* Does any single member of your household have a medical condition, mental health concerns, **and** experience with problematic substance use? ☐ **Y** ☐ N ☐ N/A or Refused

29. Are there any medications that a doctor said you or anyone in your family should be taking that, for whatever reason, they are not taking? ☐ **Y** ☐ N ☐ Refused

30. Are there any medications like painkillers that you or anyone in your family don't take the way the doctor prescribed or where they sell the medication? ☐ **Y** ☐ N ☐ Refused

31. *YES OR NO:* Has your family's current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you or anyone in your family have experienced? ☐ **Y** ☐ N ☐ Refused

E. Family Unit

32. Are there any children that have been removed from the family by a child protection service within the last 180 days? ☐ **Y** ☐ N ☐ Refused

33. Do you have any family legal issues that are being resolved in court or need to be resolved in court that would impact your housing or who may live within your housing? ☐ **Y** ☐ N ☐ Refused

34. In the last 180 days have any children lived with family or friends because of your homelessness or housing situation? ☐ **Y** ☐ N ☐ Refused

35. Has any child in the family experienced abuse or trauma in the last 180 days? ☐ **Y** ☐ N ☐ Refused

36. *IF THERE ARE SCHOOL-AGED CHILDREN:* Do your children attend school more often than not each week? ☐ Y ☐ **N** ☐ N/A or Refused

37. Have the members of your family changed in the last 180 days, due to things like divorce, your kids coming back to live with you, someone leaving for military service or incarceration, a relative moving in, or anything like that? ☐ **Y** ☐ N ☐ Refused

38. Do you anticipate any other adults or children coming to live with you within the first 180 days of being housed? ☐ **Y** ☐ N ☐ Refused

39. Do you have two or more planned activities each week as a family such as outings to the park, going to the library, visiting other family, watching a family movie, or anything like that? ☐ Y ☐ **N** ☐ Refused

40. After school, or on weekends or days when there isn't school, is the total time children spend each day where there is no interaction with you or another responsible adult...

a) 3 or more hours per day for children aged 13 or older? ☐ **Y** ☐ N ☐ Refused

b) 2 or more hours per day for children aged 12 or younger? ☐ **Y** ☐ N ☐ Refused

41. *IF THERE ARE CHILDREN BOTH 12 AND UNDER & 13 AND OVER:* Do your older kids spend 2 or more hours on a typical day helping their younger sibling(s) with things like getting ready for school, helping with homework, making them dinner, bathing them, or anything like that? ☐ **Y** ☐ N ☐ N/A or Refused

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : _____ or
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (_____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- ageing out of care
- mobility issues
- legal status in country
- income and source of it
- current restrictions on where a person can legally reside
- children that may reside with the adult at some point in the future
- safety planning

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.01

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

COMMUNITY SOLUTIONS

ORG CODE

Administration

Interviewer's Name	**Agency**	☐ Team ☐ Staff ☐ Volunteer
_____	_____	
Survey Date	**Survey Time**	**Survey Location**
MM/DD/YYYY ____/____/_____	__ __ __ __	_____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question or the assessor does not understand the question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

First Name	**Nickname**	**Last Name**
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	**Age**	**Social Security Number**	**Consent to participate**	
MM/DD/YYYY ____/____/_____	_____	_____	☐ Yes	☐ No

A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)

☐ Shelters
☐ Transitional Housing
☐ Safe Haven
☐ **Outdoors**
☐ **Other (specify):** _____
☐ **Refused**

2. How long has it been since you lived in permanent stable housing? _____ ☐ Refused
3. In the last three years, how many times have you been homeless? _____ ☐ Refused

B. Risks

4. In the past six months, how many times have you...
   a) Received health care at an emergency department/room? ____ ☐ Refused
   b) Taken an ambulance to the hospital? ____ ☐ Refused
   c) Been hospitalized as an inpatient? ____ ☐ Refused
   d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? ____ ☐ Refused
   e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along? ____ ☐ Refused
   f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? ____ ☐ Refused

5. Have you been attacked or beaten up since you've become homeless? ☐ **Y** ☐ N ☐ Refused
6. Have you threatened to or tried to harm yourself or anyone else in the last year? ☐ **Y** ☐ N ☐ Refused

7. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live? ☐ **Y** ☐ N ☐ Refused

8. Does anybody force or trick you to do things that you do not want to do? ☐ **Y** ☐ N ☐ Refused

9. Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that? ☐ **Y** ☐ N ☐ Refused

C. Socialization & Daily Functioning

10. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money? ☐ **Y** ☐ N ☐ Refused

11. Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that? ☐ Y ☐ **N** ☐ Refused

12. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? ☐ Y ☐ **N** ☐ Refused

13. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? ☐ Y ☐ **N** ☐ Refused

14. Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become evicted? ☐ **Y** ☐ N ☐ Refused

D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?	☐ **Y**	☐ N	☐ Refused
16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	☐ **Y**	☐ N	☐ Refused
17. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you?	☐ **Y**	☐ N	☐ Refused
18. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help?	☐ **Y**	☐ N	☐ Refused
19. When you are sick or not feeling well, do you avoid getting help?	☐ **Y**	☐ N	☐ Refused
20. *FOR FEMALE RESPONDENTS ONLY:* Are you currently pregnant?	☐ **Y**	☐ N	☐ N/A or Refused
21. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?	☐ **Y**	☐ N	☐ Refused
22. Will drinking or drug use make it difficult for you to stay housed or afford your housing?	☐ **Y**	☐ N	☐ Refused
23. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:			
a) A mental health issue or concern?	☐ **Y**	☐ N	☐ Refused
b) A past head injury?	☐ **Y**	☐ N	☐ Refused
c) A learning disability, developmental disability, or other impairment?	☐ **Y**	☐ N	☐ Refused
24. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help?	☐ **Y**	☐ N	☐ Refused

25. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking? ☐ **Y** ☐ N ☐ Refused

26. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication? ☐ **Y** ☐ N ☐ Refused

27. *YES OR NO:* Has your current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you have experienced? ☐ **Y** ☐ N ☐ Refused

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : _____ or
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (_____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- ageing out of care
- mobility issues
- legal status in country
- income and source of it
- current restrictions on where a person can legally reside
- children that may reside with the adult at some point in the future
- safety planning

Transition Age Youth -

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(TAY-VI-SPDAT)

"Next Step Tool for Homeless Youth"

AMERICAN VERSION 1.0

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

Eric Rice, PhD

COMMUNITY SOLUTIONS

CSH

USC SCHOOL OF SOCIAL WORK

ORG CODE

Administration

Interviewer's Name	**Agency**	☐ Team ☐ Staff ☐ Volunteer
_____	_____	
Survey Date	**Survey Time**	**Survey Location**
MM/DD/YYYY ____/____/_____	__ __ : __ __	_____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

First Name	**Nickname**	**Last Name**
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	**Age**	**Social Security Number**	**Consent to participate**	
MM/DD/YYYY ____/____/_____	_____	_____	☐ Yes	☐ No

A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)

☐ Shelters	☐ **Couch surfing**	☐ **Other (specify):**
☐ Transitional Housing	☐ **Outdoors**	_____
☐ Safe Haven	☐ **Refused**	

2. How long has it been since you lived in permanent stable housing? _____ ☐ Refused
3. In the last three years, how many times have you been homeless? _____ ☐ Refused

B. Risks

4. In the past six months, how many times have you…
   a) Received health care at an emergency department/room? ____ ☐ Refused
   b) Taken an ambulance to the hospital? ____ ☐ Refused
   c) Been hospitalized as an inpatient? ____ ☐ Refused
   d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? ____ ☐ Refused
   e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along? ____ ☐ Refused
   f) Stayed one or more nights in a holding cell, jail, prison or juvenile detention, whether it was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? ____ ☐ Refused

5. Have you been attacked or beaten up since you've become homeless? ☐ **Y** ☐ N ☐ Refused
6. Have you threatened to or tried to harm yourself or anyone else in the last year? ☐ **Y** ☐ N ☐ Refused

7. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live? ☐ **Y** ☐ N ☐ Refused
8. Were you ever incarcerated when younger than age 18? ☐ **Y** ☐ N ☐ Refused
9. Does anybody force or trick you to do things that you do not want to do? ☐ **Y** ☐ N ☐ Refused
10. Do you ever do things that may be considered to be risky like exchange sex for money, food, drugs, or a place to stay, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that? ☐ **Y** ☐ N ☐ Refused

C. Socialization & Daily Functioning

11. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money? ☐ **Y** ☐ N ☐ Refused
12. Do you get any money from the government, an inheritance, an allowance, working under the table, a regular job, or anything like that? ☐ Y ☐ **N** ☐ Refused
13. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? ☐ Y ☐ **N** ☐ Refused
14. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? ☐ Y ☐ **N** ☐ Refused

15. Is your current lack of stable housing...

a) Because you ran away from your family home, a group home or a foster home?	☐ **Y**	☐ N	☐ Refused
b) Because of a difference in religious or cultural beliefs from your parents, guardians or caregivers?	☐ **Y**	☐ N	☐ Refused
c) Because your family or friends caused you to become homeless?	☐ **Y**	☐ N	☐ Refused
d) Because of conflicts around gender identity or sexual orientation?	☐ **Y**	☐ N	☐ Refused
e) Because of violence at home between family members?	☐ **Y**	☐ N	☐ Refused
f) Because of an unhealthy or abusive relationship, either at home or elsewhere?	☐ **Y**	☐ N	☐ Refused

D. Wellness

16. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?	☐ **Y**	☐ N	☐ Refused
17. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	☐ **Y**	☐ N	☐ Refused
18. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you?	☐ **Y**	☐ N	☐ Refused
19. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help?	☐ **Y**	☐ N	☐ Refused
20. When you are sick or not feeling well, do you avoid getting medical help?	☐ **Y**	☐ N	☐ Refused
21. Are you currently pregnant, have you ever been pregnant, or have you ever gotten someone pregnant?	☐ **Y**	☐ N	☐ Refused

22. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past? ☐ **Y** ☐ N ☐ Refused
23. Will drinking or drug use make it difficult for you to stay housed or afford your housing? ☐ **Y** ☐ N ☐ Refused
24. If you've ever used marijuana, did you ever try it at age 12 or younger? ☐ **Y** ☐ N ☐ Refused

25. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:
    a) A mental health issue or concern? ☐ **Y** ☐ N ☐ Refused
    b) A past head injury? ☐ **Y** ☐ N ☐ Refused
    c) A learning disability, developmental disability, or other impairment? ☐ **Y** ☐ N ☐ Refused
26. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help? ☐ **Y** ☐ N ☐ Refused

27. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking? ☐ **Y** ☐ N ☐ Refused
28. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication? ☐ **Y** ☐ N ☐ Refused

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : ____ or
Is there a phone number and/or email where someone can get in touch with you or leave you a message?	phone: (_____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- ageing out of care
- mobility issues
- legal status in country
- income and source of it
- current restrictions on where a person can legally reside
- children that may reside with the youth at some point in the future
- safety planning

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

DOPS Checklist

Please complete and upload this checklist into IRIS under the documentation section along with all necessary supporting documentation for request.

Homeless and Disability Documentation

□ HMIS Assessment Completed Documents are Uploaded in which Program: _____

□ Homeless History Documentation Complete (Report most recent homeless episode first)

*An episode must be at least 7 days long

Location of episode one: _____

Date Begin: ____ / _____ / _____ Date End: ___ / _____ / _____

□ Homeless Documentation is uploaded. Please specify type: _____

Location of episode Two: _____

Date Begin: ____ / _____ / _____ Date End: ___ / _____ / _____

□ Homeless Documentation is uploaded. Please specify type: _____

Location of episode Three: _____

Date Begin: ____ / _____ / _____ Date End: ___ / _____ / _____

□ Homeless Documentation is uploaded. Please specify type: _____

Location of episode Four: _____

Date Begin: ____ / _____ / _____ Date End: ___ / _____ / _____

□ Homeless Documentation is uploaded. Please specify type: _____

Are there gaps in homelessness? If yes, please explain any gaps:

_____

_____

_____

Are episodes equal or greater than a year Yes No

Does client have disability Yes No

If Yes, what documentation is uploaded in HMIS

□ SSI / SSDI Award Letter □ VA Service Connected □ Disability Certification letter

Client has VI-SPDAT uploaded in system Score: ____

According to above information I am seeking a priority status of: _____

Relevant Sub-Population Categories

□ Veteran □ HIV □ Youth (24 and Under) □ DV

□ Has DD214 Uploaded

□ Self-Report

FY2019 CoC NOFA Priority Listing

Tier	Agency Name	Project Name	New or Renewal	Project Type	Funds Awarded by CoC Board
1	The Bridge	Bridge Steps	New	RRH	$413,683
1	Family Gateway	Rapid Rehousing	New	RRH	$301,439
1	Austin Street Center	Rapid Rehousing	New	RRH	$1,029,300
1	Housing Crisis Center	Permanent Housing (Family) ACE	Renewal	PSH	$349,856
1	Family Gateway	PSH 18	Renewal	PSH	$273,302
1	Housing Crisis Center	Veteran Housing Program (VHP)	Renewal	PSH	$438,641
1	Housing Crisis Center	Permanent Housing Services	Renewal	PSH	$345,358
1	Metrocare Services	Leasing Consolidated	Renewal	PSH	$3,392,305
1	City of McKinney	Rapid Rehousing	New	RRH	$286,650
1	MDHA	CoC Coordinated Assessment System	Renewal	CAS	$332,256
1	MDHA	CoC HMIS	Renewal	HMIS	$500,000
1	Housing Crisis Center	My Residence Program RRH	Renewal	RRH	$384,395
1	Housing Crisis Center	Home Again	Renewal	RRH	$390,126
1	TX Muslim Women New	TH and RRH FY2018	Renewal	TH/RRH	$262,069
1	CitySquare	Destination Home Consolidated	Renewal	PSH	$3,267,861
1	AIDS Services of Dallas	Hillcrest House	Renewal	PSH	$924,916
1	CitySquare	OnTRAC Permanent Housing	Renewal	PSH	$224,129
1	CitySquare	OnTRAC TH-RRH	Renewal	TH/RRH	$181,230
1	Metrocare Services	Safe Haven	Renewal	SH	$404,065
1	Promise House	Promise House EG RRH	Renewal	RRH	$169,778
1	Hope's Door	TH-RHH Hope's Door	Renewal	TH/RRH	$388,412
1	Promise House	Promise House Wesley Inn	Renewal	RRH	$191,440
1	City of Dallas	Shelter Plus Care	Renewal	PSH	$641,812
2	City of Dallas	Shelter Plus Care	Renewal	PSH	$203,202
2	AIDS Services of Dallas	Gateway to PSH	Renewal	PSH	$739,943
CoC Bonus	Metrocare Services	Leasing Expansion	New	PSH	$398,144
CoC Bonus	Shared Housing/Under 1 Roof	Homeless Housing	New	RRH	$491,125
DV Bonus	Family Place New	SSO-CE	New	SSO-CAS	$162,320
DV Bonus	Family Place New	2019 Family Place DV Bonus-RRH	New	TH/RRH	$778,124
DV Bonus	Agape	Rapid Rehousing	New	RRH	$200,000
		Column Total			$18,065,881
		Tier 1 Total			$15,093,023
		Tier 2 Total			$943,145
		Total ARD			$16,036,168
		CoC Bonus Total			$889,269
		DV Bonus Total			$1,140,444
		Collin County Total			$1,137,131

September 13, 2019

FY2019 CoC NOFA Priority Listing

As explained below, the NOFA requires each Continuum to offer a local competition to **review, approve and rank project applicants from eligible agencies**. With the completion of that process, we are pleased, as required, to post this year's priority listing:

FY2019 CoC NOFA Priority Listing

August 2, 2019

Notice of DV Bonus Meeting

MDHA will host a **FY2019 CoC NOFA** – **DV Bonus** meeting on **Monday, August 5, 2019, 11am**, in the **Magnolia Room** of the Meadows Executive Suites, **2904 Floyd Street, Dallas, TX 75204**. Anyone interested in applying for the DV Bonus through this NOFA should plan to attend.

July 26, 2019

Local Application, Revised Timeline, and What's New This Year

Attention NOFA Applicants!

Annually, Metro Dallas Homeless Alliance completes a consolidated application, which includes project applications from homeless service providers within our Continuum, to the Department of Housing and Urban Development (HUD).

On July 3, 2019, HUD released the **Notice of Funding Availability (NOFA) for Fiscal Year 2019**. The notice can be found here: **https://www.hudexchange.info/resource/5842/fy-2019-coc-program-nofa/**

The NOFA requires **each Continuum to offer a local competition** to review, approve and rank project applicants from eligible agencies. The application process consists of the completion of a local narrative

application, project application(s) completion in eSNAPS, and a review of each project application by the Performance Review and Allocations Committee (PRAC). **The full application (narrative and eSNAPS) is due Friday, August 16, 2019 by 8:00 p.m.**

To assist with the completion of the applications, **HUD's priorities, as well as the Continuum's priorities have also been linked** at the end of this email. Priority will be given to applications that demonstrate the ability to meet the Continuum's priorities which are:

- Increasing Rapid Rehousing units
- Removing Supportive Services Only (SSO) Grants
- Increasing assistance to Collin County
- Setting the scoring threshold of 50% of the maximum possible score

HUD's priorities can be found on page 5 of the NOFA guidelines (link above). The FY2019 CoC Local NOFA Application lists the project types available for application.

Applicants looking to consolidate grants, should be mindful that 3 applications must be submitted (a renewal application, a new application and a new combination application consisting of the renewal and the new. For additional changes, please review the link below titled: *What's New for CoC Program New Project Applications*.

Each applicant is asked to attend an applicants' meeting, Thursday, August 1, 2019 at 1:00 p.m. at United Way of Metropolitan Dallas. During this informative meeting, applicants will receive information on the scorecards, which will be used to objectively score each project application, guidance on eSNAPS, and assistance with completing the narrative application.

Please download each of these linked documents:

- **FY2019 CoC Local NOFA Application**
- **HUD Form 2991**
- **FY2019 Continuum of Care Program Competition Timeline – Revised July 26, 2019**
- **What's New for CoC Program New Project Applications**
- **CoC FY2019 Local Priorities**

For additional assistance, please contact Shavon Moore at **shavon.moore@mdhadallas.org** or 214-605-0108.

(Clarification added July 27, 2019: You **do not** need to fill out and submit **HUD Form 2991**, at this time.)

July 18, 2019

FY2019 Continuum of Care Program Competition Timeline – Revised July 18, 2019

July 17, 2019

Revised Timeline

~~FY2019 Continuum of Care Program Competition Timeline – Revised July 17, 2019~~ – Revised above

Your Feedback Requested

As MDHA prepares for the FY 2019 NOFA Application, we are soliciting feedback on this year's **score card** and the Continuum's **priorities** for completing the consolidated application.

The **score card** linked here is similar to last year's score card, with a few minor changes. However, this **score card** does not line up with HUD's priorities, which can be found on pages 5-6 of FY2019 NOFA Guidelines, found here: **https://files.hudexchange.info/resources/documents/FY-2019-CoC-Program-Competition-NOFA.pdf**

As an overview of the **priorities**, MDHA staff are recommending the following **priorities** for this year's NOFA:

- Increase Rapid Rehousing units
- Apply for an HMIS expansion grant to cover user fees
- Reallocate SSO funding
- Increase funding to Collin County
- Setting a threshold for low performing programs

This is just an overview; please read the **full document** before providing feedback.

Please send your feedback on both documents to Shavon Moore at **Shavon.Moore@mdhadallas.org** by close of business Friday, July 19, 2019.

July 15, 2019

~~FY2019 Continuum of Care Program Competition~~ **Timeline** – Revised above

What's New in FY2019 for Project Applications

July 11, 2019

USICH Webinar

USICH staff will provide a high-level overview of HUD's FY 2019 CoC Program NOFA, including policy priorities, scoring, and key changes from the FY 2018 NOFA. They will also offer key considerations and resources for communities as they embark upon the FY 2019 Application Process. **Click through to register.**

Applications Available in e-snaps

The FY 2019 Continuum of Care (CoC) Consolidated Application (CoC Application and CoC Priority Listing) and project applications are now available in ***e-snaps***. You can now access the applications to review, update, and enter information that is required for the application process through the FY 2019 CoC Program Competition NOFA. **For the full HUD announcement click through.**

Timeline

MDHA will endeavor to issue the Continuum of Care (CoC) local competition timeline by the upcoming Monday.

July 9, 2019

2019 NOFA CoC Program Competition Communications

The FY 2019 CoC Program Competition opened **Wednesday, July 3, 2019**. **This page on the HUD Exchange** contains official HUD releases related to the FY 2019 CoC Program Competition. If you do intend to apply for funding within our CoC, we recommend that you visit that page and read the **FY 2019 CoC Program NOFA** (PDF) itself.

Please bookmark this dedicated page on our website, and make sure you are subscribed to our CoC Constant Contact email list. If you are unsure if you are subscribed, **please fill out this form**.

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SPARC DALLAS

Initial Findings from Quantitative and Qualitative Research

March 16, 2018

This document was prepared by the
Center for Social Innovation (C4) in Needham, MA for
Metro Dallas Homeless Alliance in Dallas, TX

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Background

Racial inequity persists in the United States despite significant attention to this issue over past decades. Recent assessments of the contemporary racial dynamic suggest that racism has not declined but has instead become less overt.[1] One manifestation of the nation's current racial realities is that people of color are disproportionately represented in the homeless population. Black people, in particular, are more likely to become homeless than people of other racial and ethnic backgrounds. Although Black people comprise 13% of the US population and 26% of those living in poverty, they account for more than 40% of the overall homeless population.[2] This suggests that poverty rates alone do not explain the over-representation of Black Americans in the homeless population. Furthermore, Black men remain homeless longer than White or Hispanic men.[3]

Homelessness reflects the failure of our social systems to serve people equally in housing, education, health care, and justice. The Center for Social Innovation (C4) launched Supporting Partnerships for Anti-Racist Communities (SPARC) in 2016 in response to overwhelming evidence that people of color were dramatically overrepresented in the nation's homeless population—across the country and regardless of jurisdiction. The SPARC initiative focuses on using mixed methods research to identify how people are experiencing the accrual of systemic racism and to leverage that knowledge towards systems transformation. The purpose of this report is to present initial findings from our work with Dallas, Texas. A national report is available online and pulls data from across all SPARC communities.[4]

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[1] Bonilla-Silva, E. (2006). *Racism without racists: Color-blind racism and the persistence of racial inequality in the United States*. New York: Rowman & Littlefield Publishers.

[2] US Census Bureau. (2013). Current Population Survey; Carter III, G.R. (2011). From exclusion to destitution: Race, affordable housing, and homelessness. *Cityscape*, 33-70.; US Department of Housing and Urban Development. (2015). *The 2015 Annual Homeless Assessment Report to Congress: Part 1*. Washington, DC.

[3] Carter III, G.R. (2011). From exclusion to destitution: Race, affordable housing, and homelessness. *Cityscape*, 33-70.; Molina-Jackson, E. (2007). Negotiating homelessness through the saliency of family ties: The personal networking practices of Latino and African American men. *J Social Distress and Homeless*, *16*(4), 268-320.

[4] Center for Social Innovation. (2018). *SPARC Phase One Study Findings*. http://center4si.com/wp-content/uploads/2018/03/SPARC-Phase-1-Findings-March-20181.pdf

Glossary of Terms

Racism - A system of advantage/oppression based on race. Racism is exercised by the dominant racial group (Whites) over non-dominant racial groups. Racism is more than just prejudice.

Inequities - Differences in outcomes between population groups that are rooted in unfairness or injustice.

Equity - A situation where all groups have access to the resources and opportunities necessary to eliminate gaps and improve the quality of their lives.

Racial Equity - "Closing the gaps" so that race does not predict one's success, while also improving outcomes for all. Equity is distinct from equality in that it aspires to achieve fair outcomes and considers history and implicit bias, rather than simply providing "equal opportunity" for everyone. Racial equity is not just the absence of overt racial discrimination; it is also the presence of deliberate policies and practices that provide everyone with the support they need to improve the quality of their lives." [5]

Antiracism - "An action-oriented, educational and political strategy for institutional and systemic change that addresses the issues of racism and the interlocking systems of social oppression (sexism, classism, heterosexism, ableism)."[6]

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[5]George J. Sefa Dei, *Power, Knowledge and Antiracism Education*, ed. George Sefa Dei and Agnes Calliste (Halifax: Fernwood, 2000), 13.

[6] Maguire, Angus. "Illustrating Equality vs. Equity." Interaction Institute for Social Change, 13 Jan. 2016, interactioninstitute.org/illustrating-equality-vs-equity/

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1. Executive Summary

Beginning in October 2016, the Center for Social Innovation (C4) partnered with the Metro Dallas Homeless Alliance and other service providers to amplify the issue of racial inequity and homelessness. This partnership included convening a town hall meeting, hosting a provider training, facilitating a planning session of community leaders, and collecting local data.

In the Dallas planning session of community leaders, stakeholders from homeless service organizations identified three "Structural Change Objectives" for our work to address racial inequity in our system, including:

1. **Strengthening opportunities for economic mobility** in communities of color in the Dallas Metro area.
2. **Folding equity measures** into the Continuum of Care's long-term Strategic Plan to End Homelessness.
3. **Diversifying leadership and board membership** in the Continuum of Care and other service providers.

As part of the effort to better understand the intersection of racism and homelessness in Dallas, C4 worked with Metro Dallas Homeless Alliance to collect qualitative and quantitative data that would elucidate the racial dimensions of homelessness in the area. Data collection included:

1. Homeless Management Information System (HMIS) data from fiscal years 2011 to 2016.[7]
2. An online demographic survey of homeless service providers.
3. Qualitative research, including 23 individual interviews with people of color experiencing homelessness and three focus groups comprised of providers, stakeholders, and people experiencing homelessness.

This report presents preliminary findings from this research. In the Discussion, we present promising directions for potential systems change and further research, and in the Recommendations, we outline potential short term and long-term action steps for programs, the Metro Dallas Homeless Alliance, and the City of Dallas. We also explore the links between the data and the objectives identified by the Dallas community leaders.

[7] HMIS includes client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

1.1 Summary of Preliminary Quantitative Findings

- Our analyses of HMIS data from the Dallas Continuum of Care for fiscal years 2011-2016 explored the demographics of people experiencing homelessness compared to people in poverty and the general population, racial/ethnic disparities in location prior to homelessness and destination at exit, and race/ethnicity as a predictor of exit destination. Our findings include:
    - Though the Black population in Dallas constitutes 18.7% of the general population, this group is overrepresented among those living in deep poverty (30.7%) and among people experiencing homelessness (66.7%). The disparity between the percentage in poverty and those experiencing homelessness suggests that poverty alone does not explain the overrepresentation of Black people in the population experiencing homelessness.
    - On the other hand, Whites constitute 63.2% of the general population but are slightly underrepresented in the deep poverty group (49.5%) and drastically underrepresented among the homeless population (29.8%).
    - Looking at prior location of families, Black individuals in households were slightly underrepresented in group entering from "permanent housing, no subsidy." Conversely, White and Hispanic/Latinx[8] individuals were slightly overrepresented in entering from the "permanent housing, no subsidy" location.
    - The most common prior living situation for young adults was "doubled up" (48.3%). Across the "doubled up" experience, race/ethnicity groups were generally proportional, though Hispanic/Latinx were slightly overrepresented. White individuals under 24 disproportionately came from the "institutional care" location.
    - Black individual adults 24 years and older were slightly overrepresented in the population that entered from doubled-up situations.
    - When looking at exit destination, Black families were slightly overrepresented in the population exiting into "permanent housing with a subsidy," while Whites and Hispanic/Latinx families were underrepresented. In fact, logistic regressions showed that, compared to Whites, Blacks were more likely to exit into permanent housing with a subsidy at rates of 57%. Conversely, individuals identifying as Hispanic/Latinx were 32% less likely to exit into permanent housing with a subsidy.

[8] Latinx is a gender neutral term used in lieu of Latino or Latina.

- Compared to White individuals, Blacks and Asians were 26% and over two times (OR=2.47, $p<.01$) more likely, respectively, to exit into permanent housing without a subsidy. Hispanic/Latinx were also 26% more likely to exit into housing without a subsidy.
- Looking at exit destination of individuals under 24 years of age, Whites were considerably overrepresented in the "institutional care" group while Black young adults were underrepresented.
- Across all household type, Blacks were 23% less likely to exit into homelessness and Native Hawaiian and Other Pacific Islanders were almost three times (OR = .34, $p<.05$) less likely to exit into homelessness compared to Whites. Conversely, those reporting Two or More Races were 48% more likely to exit into homelessness.

The findings point to the need for research that examines returns to homelessness, housing stability once exit to housing is documented, and the way age, gender, and other factors interact with race to impact people in intersectional ways.

1.2 Summary of Preliminary Qualitative Findings

Interpretation of qualitative data focused on pathways into homelessness and barriers to exiting homelessness.

1. Pathways into homelessness were often characterized relationally and involve:
    - *Network impoverishment:* It is not just that respondents were experiencing poverty —everyone they know was experiencing poverty too.
    - *Family destabilization:* Strains on social support were often deep, damaging, and exacerbated by systems' involvement.
    - *Intimate partner violence:* Narratives of violence, particularly intimate partner violence (IPV), were common in the narratives of people we interviewed — particularly women.
    - *Health:* Instability and trauma correlated with mental health and substance use issues, while medical health issues were also common in respondents' narratives.

2. Barriers to exiting homelessness are often systemic and include:
    - *Criminal justice involvement:* A criminal record limited housing and employment options for participants.

- *Economic immobility:* People find it difficult to secure employment that pays a housing wage.
- *Lack of quality affordable housing:* People cannot afford the increasing rent and, furthermore, feel less motivated to try due to poor housing quality.
- *Difficulty navigating the system:* People are frustrated with program requirements and find it hard to get what they need from public assistance.

1.3 Provider Survey

To support Dallas with its structural change objective of supporting and developing leadership of color in homeless service agencies, we also conducted research on staff demographics and needs. Through an online survey we collected data on the background of providers working in homelessness response programs and their self-reported desires for professional development. In addition, we sought to understand how people perceive the issue of race in service settings through semi-structured focus groups and interviews. Our analyses of an anonymous online survey of homeless service providers found:

- In the sample of Dallas providers surveyed who reported racial identity (n=63), 60.3% identified as White and 30.2% identified as Black; this is a stark comparison to 66.7% of the homeless population identifying as Black and 29.8% as White.
- Ten of the twelve Executive Directors and seven of the ten Administrators (defined as all administrative roles except Executive Director) identified as White. When asked to report their opinion on how the demographics of leadership reflect the people served, about half (46.9%) agreed that the race/ethnicity of senior managers reflect the race/ethnicity of clients.
- There were some race differences in reported professional development needs that might reflect lack of leadership pathways for people of color. Compared to people of color, White respondents indicated at a greater rate that they needed grant writing and fundraising skills to excel in their current position or advance their careers.
- When asked what barriers might exist when considering professional development opportunities, people of color more often indicated compensation for time and challenges fitting it into busy days. This points to a need for strategies for supporting staff with financial and scheduling concerns.

The entirety of our provider needs analysis can be found in the Appendix (Dallas Homeless Service Providers Diversity & Inclusion – Mixed Methods Findings).

1.4 Recommendations

Based on these data, preliminary recommendations include the following, which are detailed further in the report:

1. Design an equitable Coordinated Entry system.
2. Incorporate racial equity into grantmaking and contracting for homelessness and housing programs.
3. Include racial equity data analysis and benchmarks in strategic planning to end homelessness.
4. Support organizational development to ensure racial equity at the organizational level.
5. Encourage anti-racist program delivery.
6. Promote ongoing anti-racism training for homeless service providers.
7. Collaborate to increase affordable housing availability for all people experiencing homelessness.
8. Utilize innovative upstream interventions to prevent homelessness for people of color.
9. Investigate flexible subsidies to mitigate the effects of network impoverishment.
10. Support innovative health care strategies to meet the health and behavioral health needs of communities of color.

1.5 Implications

This study is grounded in the lived experience of people of color experiencing homelessness, and it offers numerous insights for policy makers, researchers, organizational leaders, and community members as they work to address homelessness in ways that are comprehensive and racially equitable. The demographics alone are shocking—the vast and disproportionate number of people of color in the homeless population in Dallas is a testament to the historic and persistent structural racism that exists in this country. Collective responses to homelessness must take such inequity into account. Equitable strategies to address homelessness must include programmatic and systems level changes, and they must seriously begin to address homelessness prevention. It is not enough to move people of color out of homelessness if the systems in place are simply setting people up for a revolving door of housing instability. Efforts must begin to go upstream into other systems—criminal justice, child welfare, foster care, education, and healthcare—and implement solutions that stem the tide of homelessness at the point of inflow. This report aims to present quantitative and qualitative findings from SPARC's work in Dallas, examine what can be learned from these data, and begin crafting strategies to create a response to the homelessness crisis that is grounded in racial equity.

2. Preliminary Quantitative Research

For the purposes of this report, analysis of Dallas' HMIS data aimed to answer this initial set of research questions:

1. How do the racial demographics of people experiencing homelessness compare to those in poverty and the general population?
2. How do racial demographics of people experiencing homelessness relate to "prior living situation" at program entry?
3. How do racial demographics of people experiencing homelessness relate to "destination" at program exit?

Our team also looked at whether or not race or ethnicity were substantial predictors of destination type upon exiting the HMIS system, for example, whether or not race or ethnicity are predictors of exiting into homelessness, housing without subsidy, or housing with subsidy.

2.1 Preliminary Quantitative Research Findings

The following analyses used HMIS data from the Dallas Continuum of Care for fiscal years 2011-2016. Several slightly different client universes are analyzed in this report, representing a total of 23,334 unique clients with three different household statuses: 1) individuals presenting as part of a household, including heads of households (n=10,403); 2) individuals aged 24 and older (n=10,543); and, 3) individuals under 24 years of age (n=1,820). Univariate and bivariate descriptions below (Tables 1 and 2) represent all household groups. In these tables and descriptions, it is important to note that a variable associated with a head of household may apply to all members of that household, which may skew the data in that characteristics of households with more than one affiliated individual will be given more weight. Tables 3-11, alternatively, describe prior residence and exit destination for all three household groups. Logistic regressions are run on all clients with family group type included in the model as a covariate.

As shown in Table 1, a majority of the study sample (66.7%) were Black, followed by 29.8% White, 0.6% American Indian or Alaska Native (AI/AN), 0.6% Asian, 0.8% Native Hawaiian or Other Pacific Islander, and 1.8% identifying as Two or More Races. Just over eleven percent (11.2%) of clients identified as Hispanic/Latinx. The study sample was 52.5% men, 47.3% women, and 0.2% transgender. The average age was 32 years (Mean=32.32, SD=19.94) ranging from newborn to 90 years. Exactly 12% (12.0%) of individuals reported being a veteran

and 36.8% reported having a disabled condition. Note that the number of valid cases for each variable varies slightly.

Table 1.
Demographics of all individuals in Dallas Continuum of Care, fiscal years 2011-2016. (*N*=23,334)

Characteristic	*N*	*Percentage*
Race		
Black	15,485	66.7
White	6,944	29.8
American Indian or Alaska Native (AI/AN)	141	0.6
Asian	142	0.6
Native Hawaiian or Other Pacific Islander (NHOPI)	119	0.5
Two or More Races	413	1.8
Ethnicity		
Non-Hispanic/Non-Latinx	20,677	88.6
Hispanic/Latinx	2,608	11.2
Doesn't Know/Refused/Missing	48	.2
Gender		
Female	11,027	47.3
Male	12,255	52.5
Transgender (male to female)	46	.2
Transgender (female to male)	4	.0
Age		
Average Years (SD)	32.32	(19.94)
Veterans Status		
Yes	2,793	12.0
Disabling Condition		
Yes	8,577	36.8
No	12,218	52.4

Note: Frequencies of some characteristics may not add up to total n due to missing cases.

How do the racial demographics of people experiencing homelessness compare to those in poverty and the general population?

Table 2 shows a comparison, by race, of ACS general population distribution, poverty threshold distribution, and HMIS and point in time (PIT) homeless counts. Though the Black population in Dallas constitutes only 18.7% of the total population, this group is

overrepresented among people living in poverty (at both the 100% and 50% poverty threshold, at 26.0% and 30.7%, respectively) and among people experiencing homelessness by both the HMIS and PIT counts (66.7% and 60.2%, respectively). On the other hand, Whites constitute 63.2% of the total population but are underrepresented in both poverty groups (53.5% and 49.5%, respectively) and more drastically underrepresented among the homeless population counts, representing only 29.8% of the HMIS sample and 33.1% of the PIT sample. Asians are slightly underrepresented in poverty and homelessness, and individuals identifying as NHOPI (Native Hawaiian or Pacific Islander) and Two or More Races have generally proportionate representation across poverty and homelessness counts.

Individuals identifying as Hispanic/Latinx (of any race) are overrepresented in poverty counts, especially in 100% poverty group, constituting half (49.9%) of this group while only representing 33.0% of the total population. However; Hispanic/Latinx individuals were underrepresented in homelessness counts, constituting only 11.2% of the HMIS sample and 13.2% of the PIT counts.

Table 2.
Total population, poverty distribution, HMIS, and PIT by race.

Race	*ACS [a],%*	*100% poverty[b], %*	*50% poverty[c],%*	*HMIS, %*	*PIT[d],%*
Black	18.7	26.0	30.7	66.7	60.2
White	63.2	53.5	49.5	29.8	33.1
AI/AN	0.4	0.4	0.4	0.6	0.9
Asian	7.5	4.5	5.6	0.6	1.1
NHOPI	0.1	0.0	0.0	0.5	0.7
Two or More Races	2.7	3.2	3.1	1.8	4.0
Hispanic or Latinx	33.0	49.9	40.2	11.2	13.2

[a] ACS 2015 5yr Estimate
[b] ACS 5yr 2015 - 100% poverty line
[c] ACS 5yr 2015 – 50% poverty line (deep poverty)
[d] 2016 Point in Time homelessness count

How do racial demographics of people experiencing homelessness relate to "prior living situation" at program entry?

We sought to understand the locations of clients prior to program entry and at final program exit (if program exit occurred as of the end of FY 2016). For the purposes of this report, "program entry" is defined as the first program entry in the dataset for each individual. "Program exit" is defined by last exit in the dataset for each individual where an exit location was identified. Tables 3-5 show residence prior to program entry by race for the following

three client samples: individuals in households; individuals younger than 24 years of age, and individuals 24 years of age and older.

Table 3 below shows the distribution by race and ethnicity of the prior living situation of individuals in households. Of note, the majority (57.6%) of all cases came from an "other" category,[9] 16.5% came from "permanent housing, no subsidy", and 12.1% came from a homeless situation. Black families were slightly underrepresented in the "permanent housing, no subsidy" location (61.6%). Conversely, White and Hispanic/Latinx individuals were slightly overrepresented in the "permanent housing, no subsidy" location (36.0% and 16.5%, respectively).

Table 3.
*Living situation prior to program entry by race for individuals in households (N=10,447) (percent within location)**

		Race/Ethnicity							
		Black	White	AI/AN	Asian	NHOPI	Two or More Races	Hispanic or Latinx	Percent within prior living situation
Prior living situation	Homeless	74.2%	23.2%	0.7%	0.2%	0.5%	1.2%	10.2%	12.1%
	Permanent housing, subsidy	82.5%	14.7%	1.4%	0.0%	1.4%	0.0%	7.0%	1.4%
	Permanent housing, no subsidy	61.6%	36.0%	0.5%	1.0%	0.5%	0.5%	16.5%	16.5%
	Institutional care	39.0%	51.2%	0.0%	0.0%	9.8%	0.0%	26.8%	0.4%
	Correctional facility	80.0%	0.0%	0.0%	0.0%	20.0%	0.0%	20.0%	0.0%
	Doubled up	79.2%	17.5%	0.3%	0.4%	0.7%	1.9%	10.4%	6.7%
	Transitional setting	75.7%	22.3%	0.2%	0.5%	0.0%	1.3%	10.0%	5.3%
	Other	76.9%	19.1%	0.3%	0.5%	0.5%	2.6%	13.6%	57.6%
Percent within race category		74.1%	22.5%	0.4%	0.5%	0.5%	1.9%	13.2%	100.%

*Percent totals across race and ethnicity will not equal 100% because ethnicity is not mutually exclusive from race.

[9] The high use of "Other" may be due to site-specific, programmatic data entry decisions. More research into how programs use HMIS categories is needed to better understand this finding.

Table 4 below shows the distribution by race and ethnicity of the prior living situation of individuals under 24 years of age. In contrast to individuals in households, only 1.9% came from an "other" living situation. The most common prior living situation for this group was "doubled up" (48.3%), followed by homelessness (21.3%) and institutional care (16.8%). Across the "doubled up" experience, race/ethnicity groups were generally proportional, though Hispanic/Latinx were slightly overrepresented (24.6%). Whites disproportionately came from the "institutional care" location, representing 61.1% compared to only 43.0% of this sample. Whites and Hispanic/Latinx individuals were slightly overrepresented in the homeless category. For those individuals coming from a homeless situation, White and Hispanic/Latinx individuals were underrepresented (35.4%), while Blacks were slightly overrepresented (57.6%).

Table 4.
*Living situation prior to program entry by race for individuals under 24 years of age (N=1,825) (percent within location)**

		Race/Ethnicity							
		Black	White	AI/AN	Asian	NHOPI	Two or More Races	Hispanic or Latinx	Percent within prior living situation
Prior living situation	Homeless	57.6%	35.4%	0.0%	1.3%	0.8%	4.9%	14.7%	21.3%
	Permanent housing, subsidy	68.8%	31.3%	0.0%	0.0%	0.0%	0.0%	12.5%	0.9%
	Permanent housing, no subsidy	60.9%	30.4%	1.4%	5.8%	0.0%	1.4%	18.6%	3.8%
	Institutional care	36.3%	61.1%	0.7%	0.0%	0.7%	1.3%	17.6%	16.8%
	Correctional facility	53.2%	42.6%	0.0%	0.0%	0.0%	4.3%	23.4%	2.6%
	Doubled up	54.0%	43.1%	0.6%	0.3%	0.6%	1.4%	24.6%	48.3%
	Transitional setting	60.5%	34.6%	1.2%	0.0%	0.0%	3.7%	14.8%	4.5%
	Other	71.4%	25.7%	0.0%	0.0%	0.0%	2.9%	16.7%	1.9%
Percent within race category		53.0%	43.0%	0.5%	0.7%	0.5%	2.3%	20.4%	100.0%

* Percent totals across race and ethnicity will not equal 100% because ethnicity is not mutually exclusive from race.

Table 5 below shows the distribution by race and ethnicity of the prior living situation of individuals 24 years of age and older. For this group, the vast majority of individuals came from homelessness (57.4%), followed by "permanent housing, no subsidy" (11.8%) and "doubled up" (11.1%). Across prior living situations, racial and ethnic groups were relatively proportionally represented. The most significant burdens are within the "doubled up" location, where Black individuals were slightly overrepresented (68.8%) and in the "permanent housing, no subsidy" location where Hispanic/Latinx individuals were overrepresented (12.4%).

Table 5.
*Living situation prior to program entry by race for individuals 24 years of age and older (N=10,605) (percent within location)**

		Race/Ethnicity							
		Black	White	AI/AN	Asian	NHOPI	Two or More Races	Hispanic or Latinx	Percent within prior living situation
Prior living situation	Homeless	62.2%	34.5%	0.8%	0.8%	0.4%	1.3%	6.8%	57.4%
	Permanent housing, subsidy	58.0%	38.8%	0.8%	0.0%	0.0%	2.4%	7.4%	2.3%
	Permanent housing, no subsidy	65.5%	31.4%	0.5%	0.5%	0.7%	1.5%	12.4%	11.8%
	Institutional care	46.4%	49.0%	1.4%	0.5%	0.3%	2.4%	6.0%	6.0%
	Correctional facility	53.9%	41.4%	0.7%	0.7%	0.4%	2.9%	12.5%	2.7%
	Doubled up	68.8%	27.6%	1.4%	0.6%	0.3%	1.3%	8.0%	11.1%
	Transitional setting	56.7%	39.0%	0.6%	0.7%	1.0%	2.0%	6.8%	7.6%
	Other	59.2%	32.0%	2.4%	0.8%	1.6%	4.0%	4.0%	1.2%
Percent within race category		61.9%	34.6%	0.8%	0.7%	0.5%	1.6%	7.7%	100.0%

*Percent totals across race and ethnicity will not equal 100% because ethnicity is not mutually exclusive from race.

How do racial demographics of people experiencing homelessness relate to "destination" at program exit?

Table 6 shows the distribution by race and ethnicity of the exit destination of individuals in households. The majority exit into "permanent housing, no subsidy" (39.5%) or "other" (35.6%), with 11.5% exiting into "permanent housing with a subsidy" and 10.6% exiting into a "doubled up" situation. Interestingly, very few (1.0%) individuals in this group exited into homelessness. Black individuals were overrepresented in the "permanent housing with a subsidy" group (82.3%) while Whites and Hispanic/Latinx individuals were underrepresented (14.9% and 8.7%, respectively). Race/ethnicity breakdown for "permanent housing, no subsidy" and "doubled up" were relatively proportional to the sample.

Table 6.
*Exit destination by race for individuals in households (N=9,801) (percent within location)**

		Race/Ethnicity							
		Black	White	AI/AN	Asian	NHOPI	Two or More Races	Hispanic or Latinx	Percent within exit destination
Exit desti-nation	Homeless	64.6%	34.4%	0.0%	0.0%	0.0%	1.0%	8.2%	1.0%
	Permanent housing, subsidy	82.3%	14.9%	0.3%	0.1%	0.4%	2.0%	8.7%	11.5%
	Permanent housing, no subsidy	74.4%	22.2%	0.4%	1.1%	0.5%	1.4%	14.0%	39.5%
	Institutional care	65.0%	25.0%	0.0%	0.0%	5.0%	5.0%	30.0%	0.4%
	Correctional facility	64.0%	32.0%	0.0%	0.0%	4.0%	0.0%	8.0%	0.3%
	Doubled up	70.3%	26.6%	0.4%	0.1%	1.3%	1.3%	14.2%	10.6%
	Transitional setting	18.6%	77.0%	0.0%	0.0%	0.0%	4.4%	13.2%	1.2%
	Other	71.8%	25.0%	0.5%	0.3%	0.3%	2.1%	13.7%	35.6%
Percent within race category		74.1%	22.5%	0.4%	0.5%	0.5%	1.9%	13.2%	100.0%

* Percent totals across race and ethnicity will not equal 100% because ethnicity is not mutually exclusive from race.

Table 7 shows the distribution by race and ethnicity of the exit destination of individuals under 24 years of age. The most common exit destinations were "doubled up"(36.1%) followed by "other" (23.5%), "institutional care" (15.2%), and homelessness (11.3%). Compared to 1.0% of individuals in households (see Table 6), more individuals in this household group exited into homelessness. Very few individuals in this household group exited into permanent housing, regardless of whether it was with or without a subsidy (3.3% and 5.7%, respectively), though Black individuals were overrepresented in exiting to permanent housing while Whites were considerably underrepresented (Hispanic/Latinx individuals were also underrepresented though less considerably than Whites). Whites were considerably overrepresented (65.2%) in the "institutional care" group while Black individuals were underrepresented (33.0%).

Table 7. Exit destination by race for individuals under 24 years of age (N=1,786) (percent within location)*

		Race/Ethnicity							
		Black	White	AI/AN	Asian	NHOPI	Two or More Races	Hispanic or Latinx	Percent within exit destination
Exit dest-nation	Homeless	54.7%	39.3%	0.5%	0.5%	0.5%	4.5%	20.2%	11.3%
	Permanent housing, subsidy	70.7%	25.9%	0.0%	0.0%	0.0%	3.4%	17.2%	3.3%
	Permanent housing, no subsidy	69.6%	23.5%	0.0%	2.0%	0.0%	4.9%	16.0%	5.7%
	Institutional care	33.0%	65.2%	0.4%	0.7%	0.0%	0.7%	23.3%	15.2%
	Correctional facility	43.8%	50.0%	0.0%	0.0%	6.3%	0.0%	12.5%	0.9%
	Doubled up	55.5%	40.9%	0.6%	0.3%	0.9%	1.7%	21.3%	36.1%
	Transitional setting	61.1%	34.7%	0.0%	0.0%	1.4%	2.8%	16.7%	4.0%
	Other	53.7%	41.8%	0.5%	1.2%	0.2%	2.6%	20.0%	23.5%
Percent within race category		53.0%	43.0%	0.5%	0.7%	0.5%	2.3%	20.4%	100.0%

* Percent totals across race and ethnicity will not equal 100% because ethnicity is not mutually exclusive from race.

Table 8 shows the distribution by race and ethnicity of the exit destination of individuals. Compared to individuals in households and individuals under the age of 24, considerably more individuals in this household group exited into homelessness, at 22.8%, which was the most common exit destination after "other" (42.0%). Black individuals were slightly underrepresented in exiting into homelessness (57.1%) while Whites were slightly overrepresented (38.3%). Black individuals were slightly overrepresented in exiting into permanent housing (with or without a subsidy, 70.6% and 67.2%, respectively) while White and Hispanic/Latinx individuals were underrepresented.

Table 8.
*Exit destination by race for individuals over 24 years of age (N=9,644) (percent within location)**

		Race/Ethnicity							
		Black	White	AI/AN	Asian	NHOPI	Two or More Races	Hispanic or Latinx	Percent within exit destination
Exit destination	Homeless	57.1%	38.3%	1.2%	0.9%	0.2%	2.3%	8.9%	22.8%
	Permanent housing, subsidy	70.6%	26.4%	0.5%	0.8%	0.5%	1.2%	3.6%	8.1%
	Permanent housing, no subsidy	67.2%	30.9%	0.2%	0.5%	0.5%	0.7%	7.1%	13.1%
	Institutional care	50.2%	46.8%	0.9%	0.4%	0.0%	1.7%	6.4%	2.5%
	Correctional facility	73.4%	25.7%	0.0%	0.0%	0.0%	0.9%	4.6%	1.1%
	Doubled up	58.9%	36.0%	1.4%	0.8%	1.0%	1.9%	8.2%	8.2%
	Transitional setting	58.1%	39.4%	0.5%	1.0%	0.0%	1.0%	5.4%	2.1%
	Other	62.8%	34.0%	0.8%	0.5%	0.5%	1.3%	8.2%	42.0%
Percent within race category		61.9%	34.6%	0.8%	0.7%	0.5%	1.6%	7.7%	100.0%

* Percent totals across race and ethnicity will not equal 100% because ethnicity is not mutually exclusive from race.

2.2 Predictors for Exit Destination

To examine the effect of race, ethnicity, and other factors on exiting into homelessness, multivariate logistic regression was conducted. Results are shown in Table 9. Using Whites as a reference group, some race categories were found to have a statistically significant association with the outcome of exiting into homelessness. Blacks were 23% less likely to exit into homelessness and Native Hawaiian and Other Pacific Islanders were almost three times (OR = .34, $p<.05$) less likely to exit into homelessness compared to Whites. Conversely, those reporting Two or More Races were 48% more likely to exit into homelessness.

Age was statistically significantly associated with the outcome such that for every year older, there was a 3% decreased chance of exiting into homelessness. Using females as a reference group, males and those identifying as transgender or other gender category were less likely to enter into homelessness. Specifically, males were 61% less likely and those identifying as transgender were almost three times less likely (OR = 0.36, $p<.05$) to exit into homelessness. Household status was also examined as a predictor of exiting into homelessness. Compared to individuals over 24 years of age, young adults, as well as individuals in a household, were significantly less likely to exit into homelessness. Specifically, individuals under 24 years of age were over five times less likely to exit into homelessness (OR = 0.18, $p<.01$) and individuals in households were 50 times (OR = .02, $p<.01$) less likely to exit into homelessness.

Table 9.
Predictors of Exiting into Homelessness among Clients in HMIS System

Variables	β	SE	Wald $\chi 2(1)$	OR (95% CI)
Race				
Black	- 0.22	0.05	18.22*	.81 (.73-.89)
American Indian or Alaskan Native	0.26	0.24	1.17	1.29 (.81-2.06)
Asian	0.20	0.27	.56	1.22 (.73-2.05)
NHOPI	-1.08	0.48	5.10**	.34 (.13-.87)
Two or More Races	0.39	0.16	5.88**	1.48 (1.08-2.03)
Ethnicity				
Hispanic/Latinx	0.07	0.08	.65	1.07 (.91-1.26)
Age	-0.30	0.00	202.22*	.97 (.97-.97)
Gender				
Male	-0.46	0.05	88.308	.62 (.56-.68)
Other	-1.02	0.34	8.92*	.36 (.18-.70)
Household Status				
Individual under 24 years	-1.71	0.10	288.22*	.18 (.15-.22)
Individual in a household	-4.22	0.13	1092.92*	.02 (.01-.02)

Note. OR = Odds Ratio. CI = Confidence Interval. *$p<.01$. **$p<.05$

Predictors for Exiting into Permanent Housing/ Renting with Subsidy

A multivariate logistic regression was run to examine the effect of race, ethnicity, and other factors on exiting into permanent housing *with* a subsidy. Results are shown in Table 10. Using White as a reference group, Black individuals and individuals identifying as Two or More Races were more likely to exit into permanent housing with a subsidy at rates of 57% and 45%, respectively. Conversely, individuals identifying as Hispanic/Latinx were 32% less likely to exit into permanent housing with a subsidy. Age was not significant in the model.

Compared with females, individuals identifying as gender non-conforming (e.g. transgender) were over two times (OR=.40, $p<.05$) less likely to exit into permanent housing with a subsidy. Household status was also examined as a predictor of exiting with a subsidy. Compared to individuals over the age of 24, young adults were more than two times less likely (OR=.41, $p<.01$) to exit with a subsidy, yet individuals in households were 46% more likely to exit with a subsidy.

Table 10.
Predictors of Exiting into Permanent Housing *with* a Subsidy among Clients in HMIS System

Variables	β	SE	Wald $\chi 2(1)$	OR (95% CI)
Race				
Black	.45	.07	46.94*	1.57 (1.38-1.78)
American Indian or Alaskan Native	-.17	.39	.19	.84 (.39-1.82)
Asian	-.23	.39	.33	.80 (.37-1.7)
NHOPI	.37	.36	1.07	1.44 (.72-2.90)
Two or More Races	.37	.19	3.90**	1.45 (1.00-2.11)
Ethnicity				
Hispanic/Latinx	-.27	.10	7.18*	.76 (.62-.93)
Age	.001	.00	2.02	1.00 (.99-1.00)
Gender				
Male	.05	.05	.83	.36 (.95-1.16)
Other	-.90	.45	4.0**	.40 (.17-.98)
Household Status				
Individual under 24 years	-.88	.14	38.11*	.41 (.31-.55)
Individual in a household	.38	.06	40.38*	1.46 (1.30-1.65)

Note. OR = Odds Ratio. CI = Confidence Interval.
*$p<.01$. **$p<.05$

Predictors for Exiting into Permanent Housing/Renting without Subsidy

A multivariate logistic regression was also run to examine the effect of race, ethnicity, and other factors on exiting into permanent housing *without* a subsidy. Results are shown in Table 11. Using Whites as a reference group, Blacks and Asians were 26% and over two times, (OR=2.47, $p<.01$), respectively, more likely to exit into permanent housing without a subsidy. Hispanic/Latinx individuals were also 26% more likely to exit into housing without a subsidy. Age was statistically significant in the model, but effect size was minimal. Using females as a reference group, males had a 9% increased likelihood of exiting without a subsidy. Household status was also examined as a predictor of exiting into housing without a subsidy. Compared to individuals over the age of 24, young adults were over two times (OR=0.44, $p<.01$) less likely to exit into permanent housing without a subsidy, whereas individuals in households were over four times (OR=4.59, $p<.01$) more likely to exit into permanent housing without a subsidy.

Table 11.
Predictors of Exiting into Permanent Housing *without* a Subsidy among Clients in HMIS System

Variables	β	SE	Wald $\chi 2(1)$	OR (95% CI)
Race				
Black	.23	.05	26.08*	1.26 (1.15-1.37)
American Indian or Alaskan Native	-.37	.27	1.87	0.69 (0.41-1.17)
Asian	.91	.20	20.21*	2.47 (1.67-3.67)
NHOPI	-.02	.24	.01	0.98 (.61-1.59)
Two or More Races	-.20	.15	1.81	0.82 (.62-1.09)
Ethnicity				
Hispanic/Latinx	.23	.06	14.17*	1.26 (1.12-1.42)
Age	.00	.00	13.68*	1.00 (1.00-1.01)
Gender				
Male	.09	.04	6.05**	1.09 (1.02-1.17)
Other	.92	.73	1.60	2.52 (0.60-10.56)
Household Status				
Individual under 24 years	-.82	.11	51.92*	0.44 (0.35-0.55)
Individual in a household	1.52	.05	855.71*	4.59 (4.14-5.08)

Note. OR = Odds Ratio. CI = Confidence Interval.
*$p<.01$. **$p<.05$

3. Preliminary Findings from Qualitative Data

3.1 Summary

As of March 2018, the SPARC team has launched research in six cities. Across the country, the team has collected 148 oral histories and conducted 18 focus groups. The SPARC team collected 23 oral histories during one week in Dallas in February of 2017. These interviews were conducted entirely with people of color who were currently experiencing homelessness. All respondents were recruited at sites of service delivery in Dallas, although several respondents were unsheltered at the time of their interview. During the same week, the SPARC team also facilitated three focus groups—one for people of color experiencing homelessness, one for direct service providers of color, and one for community leaders in the housing and homeless services systems as well as adjacent systems.

In reviewing the oral history interview data, our approach was to allow themes and concepts to emerge organically from the transcripts, rather than approach the data with any set hypothesis. This method is referred to as a Grounded Theory approach.[10] A team of four reviewers went through each oral history transcript and developed thematic codes. The team used NVIVO software to code the transcripts and run analyses.[11] The majority of our analyses draw on the interviews, but we also include highlights from the focus groups to add additional depth to these findings.

Analyses focused on **pathways into homelessness** and **barriers to exiting homelessness**. We focused on these areas in order to identify potential intervention spaces. Factors that led to homelessness and barriers to exit may be similar depending on the point in time, but we distinguished these factors based on how people answered our questions (e.g., "What led you here?" vs. "What has not been helpful as you try to get housing?").

1. Pathways into homelessness were characterized relationally and involve:
    - *Network impoverishment:* It is not just that respondents were experiencing poverty — everyone they know was experiencing poverty, too.
    - *Family destabilization:* Strains on social support were often deep, damaging, and exacerbated by systems' involvement.

[10] Charmaz, K., & Belgrave, L. (2012). Qualitative interviewing and grounded theory analysis. The SAGE handbook of interview research: The complexity of the craft, 2, 347-365.

[11] QSR International. (2012). NVivo qualitative data analysis software. Retrieved from http://www.qsrinternational.com/product


- *Intimate partner violence:* Narratives of violence, particularly intimate partner violence (IPV), were common in the narratives of people we interviewed — particularly women.
- *Health:* Instability and trauma correlated with mental health and substance use issues, while medical health issues were also common in respondents' narratives.

2. Barriers to exiting homelessness are often systemic and include:
    - *Criminal justice involvement:* A criminal record limited housing and employment options for participants.
    - *Economic immobility:* People find it difficult to secure employment that pays a housing wage.
    - *Lack of quality affordable housing:* People cannot afford the increasing rent and, furthermore, feel less motivated to try due to poor housing quality.
    - *Difficulty navigating the system:* People are frustrated with program requirements and find it hard to get what they need from public assistance.

The following sections document these findings.

3.2 Pathways into Homelessness

Network Impoverishment

A recurring feature of respondents' discussions of their pathways into homelessness was that their narratives demonstrated a striking social dimension. In every SPARC community, people of color had few resources in their networks to draw on should something go wrong. We have begun to refer to this phenomenon as "network impoverishment." People did not come to experience homelessness solely through a lack of capital; they also came to experience homelessness through fragile social networks. The fragility of these networks contained two main, interacting, weak points: lack of capital and lack of emotional support. The following quote from an interview respondent typifies how lack of capital can strain social support:

> INTERVIEWER: Friends can only help so much. Have you found your friends to be helpful at all?
> RESPONDENT: I have. I have really good friends. It's pretty hard to know. Um, I have friends who tell you what you need to hear, instead of what you want to hear. So, that they steered me towards here specifically.
> INTERVIEWER: So, they didn't help you like "hey, come stay here."
> RESPONDENT: No, no because they couldn't afford it. They – they live from paycheck to paycheck like a lot of people do.

This respondent highlights the presence of support in his social network, as his friends offer practical advice and emotional guidance. Financial limitations, however, get in the way of people offering instrumental support. As the quote above reiterates, there are limited resources in social networks to be able to take in people in need. The following quote similarly highlights this chronic lack of resources, which results in the respondent being unable to stay with her family:

> I remember when my sons usually go, "mom you –" "no I am not going to come stay with you, no I am not, no I am not." I will come away and I will baby-sit my grandbabies but no I am not, because after a while I know when I stay with them about three months, "Mom, everybody in here, we got to get us a job."

Both of the above respondents made it clear that it was possible from them to stay with people — provided that they were able to support some of the (increased) costs of the household. This is a consistent pattern in the data: people were not unwilling to double up, to take people in or to live in another person's home — but they did not have the resources to accommodate the additional consumption of resources. There was no extra money anywhere in the respondent's network, and as a result, there was no flexibility in safety nets.

Family Destabilization

In an impoverished social network, family may be present, but they are seen as an unreliable support because members are dealing with their own vulnerability. Family destabilization was another prominent theme in respondents' pathways into homelessness. Family destabilization was often characterized by child welfare and criminal justice systems involvement. The impacts of these systems on the lives of the people we interviewed were often interrelated, so that an experience with one system lead to experience with the other. For example, one respondent recounted her entry into foster care when she was just an infant, due to her mother's involvement with the criminal justice system:

> RESPONDENT: If I walk in my aunty house right now they'll be all fine and good for about three days then one of us got to go. It usually be me, but now I know that it might be because I wasn't raised up in the same home with my family members per se, because I was in a foster home until I was like 21 years old.
> INTERVIEWER: How come?
> RESPONDENT: Because my mom went to jail when I was three months old and she didn't get out until I was nine. And then my mom when she did get a house and everything I started having kids and my sister was living with us and it just been like that all her life.

In the narrative above, the burden of an additional member added to the household eventually strains the family bond so that the respondent has to leave after a few days. Therefore, her aunt's house is not a reliable or permanent form of support, due to a lack of resources within the community network. This social strain is exacerbated by the separation and social isolation this respondent experienced from her family, due to her involvement in the child welfare system from such a young age. Her mother's incarceration exacerbated an already strained familial support system, while her own experiences in foster care further frayed the social ties that may have been able to provide temporary housing.

Intimate Partner Violence

For several of the women of color we interviewed, intimate partner violence (IPV) characterized their experiences of social support collapse and family destabilization. Abuse perpetuated by boyfriends, husbands, and fathers was often brought up in discussions about pathways into homelessness. For instance:

> INTERVIEWER: What do you think are the main factors that led you to be homeless?
> RESPONDENT: Being abused. My ex had me convicted of felonies, two felonies, two misdemeanor which I had all four of them dropped. He was just totally trying to destroy me, totally trying to destroy me.
> INTERVIEWER: So did you live together with him?
> RESPONDENT: Yes, I sold my house, moved in with him, help him got back on his feet, helped him fix up his house, cleaned up his crib, get him a brand new car. And then it was like, "I don't need you no more I got everything I got, you know, I need," so.
> INTERVIEWER: And did you leave?
> RESPONDENT: By him put me in jail, you know, and I learn my lesson. You know, he kept saying that he is the man, he was control and he was the one that was abusive, he took a beer bottle hit it upside his head, I have pictures of it. He strangle me, my sister was on the phone, all this stuff. But when the police came there because he's military trained, he knew how to calm himself down and he made that known to me. I even recorded that to the police didn't matter, I was on his property. So it -- you know, I lost everything behind it.

The above respondent describes physical and financial abuse that left her without the resources to leave the relationship and secure stable housing. In addition, this particular instance of abuse highlights the relationship of IPV to systems involvement and family destabilization. Her partner pressed charges against her, which resulted in her spending time in jail. As she goes on to clarify, being incarcerated significantly hindered her ability to work and gain financial stability:

> INTERVIEWER: And what would you say was the main reason that led to your first experience of homelessness?

RESPONDENT: Like I said, being incarcerated, not working, having an income coming in, being able to get into stable environment.

When women face an increased burden to provide for their families, it can make them particularly vulnerable to homelessness. One participant in our Service Provider Focus Group highlighted this increased risk factor for homelessness for women, specifically in connection to experiences of IPV:

INTERVIEWER: Okay, so my first question to the group is, uh, given your knowledge of homelessness and homeless response programs, who do you feel is at the greatest risk for homelessness?
RESPONDENT: I feel women are. And – and I say that because most women – well with the work that I've done, I kind of have seen how things look from in and out, and I say that because I was working in a program to prevent homelessness, and the reasons why things might have gone left in that program, is because either the woman, who was the head of the household, uh, either was abandoned or abused by her husband or partner, or she lost a job, or there was a illness, or just devastating things. Car repair. Childcare issues. So, those kinds of things. So, I saw that in trying to prevent homelessness, but then women were the ones that were truly affected.

Health

When asked about their pathways into homelessness, people also discussed physical and mental health issues. Descriptions of family destabilization and violence were often deep and damaging, and people described how traumatic experiences exacerbated behavioral and mental health issues. For example, one respondent discussed how the loss of her mother led to substance use which she identified as a factor that contributed to her homelessness:

INTERVIEWER: So, do you know where things started going south? Was it – where do you think it began to go bad?
RESPONDENT: For me? It's probably after my mom died.
INTERVIEWER: Okay, and she died, you said, in '96?
RESPONDENT: Yeah.
INTERVIEWER: Why? Why was that a trigger? You know, like …
RESPONDENT: I didn't – I started using drugs probably like a year later, I started using drugs.
INTERVIEWER: Oh Okay. You didn't have, you didn't know – you didn't have access to mental health care or someone to help you cope?
RESPONDENT: No, not then, but now I do.

People also described a relationship between medical conditions, social network impoverishment, and family destabilization. People with disabling medical and mental health conditions often rely on public safety nets for support when their own social networks are not reliable. For example:

> RESPONDENT: I've been homeless off and on for maybe like five years off and on, because like I used to work but when I used to work before my knees really got bad, see right now I need knee replacements for both of my knees, so it's hard to hold a job and I would get a job because a job was never hard to find but it was hard for me to keep like, you know, lifting things, you know, standing on your feet till I just got to where I gave up on the working part so that made me like homeless because I couldn't have my own place to pay my rent. So, you know, that's why I had to do that, but you know I did get an income you know like Social Security and stuff like that but that took a while too you know.
> INTERVIEWER: Took a while to begin?
> RESPONDENT: Right, right. But then I got that so I had little income and I would try to get me apartment and stuff like that but you got to pay the full amount of rent because for instance, my check would be 700 something a month right okay, but if I paid rent out of that with about $600 or something I didn't have anything to make it through rest of the month till I got tired of that. So that's how I did just to say well I guess I'll just live homeless at least that way I could be able to do something because it was hard, it was almost like impossible but I didn't have no other choice because of my circumstances …
> INTERVIEWER: And you said that you were homeless on and off for five years, so where were you in the times that you weren't homeless?
> RESPONDENT: Well I tried like when I was getting my check first I was getting my apartment since I changed back there like I want to pay the rent, once I pay the rent and stuff, there's hardly no money left, I still had to live for that month, I just didn't have the money to just stay or just do that to get the apartment and the stuff. You don't have any money to do anything, you can't buy clothes and stuff or stuff that you need and you have to have food and stuff like that too you know. So you do not stay...

This respondent's narrative highlights the frustrations that come with having the motivation, but not the physical capacity, to engage in employment opportunities that could secure stable housing. It points to a failure in the public safety net to be able to support people with physical disabilities. Although he was receiving public benefits, they were not enough to cover both rent and cost of living.

Another respondent reported a similar experience; she was unable to attain labor work due to a medical condition and was finding it difficult to get other jobs:

> Do you think I ain't been trying to get a job, sweetheart? I mean you know as you get older there are certain things -- well I know I can't stand up long because of my knees. Working at McDonald's, I know I can't do all that either. Lifting up boxes I can't do that either now and I am not going sit on my ass all day long.

Medical health issues that prevent people from working can also exacerbate fraying social ties – as an individual is unable to work, they are unable to sufficiently contribute to the financial needs of their family or community. The following excerpt from a respondent highlights the intersection between these cross-cutting themes, in her own pathway into homelessness:

> INTERVIEWER: What happened?
> RESPONDENT: Well, through this life journey of mine, I came here, me and my husband, and my children. Everything was going fine. My husband was –got ill, sick. So, his sickness began to progress. So, and plus me, of making wrong choices in life, it ended me up in prison. So, I've done prison. I went to prison in 2014. 2013. I got out in 2014…When I got released, basically I was homeless then, in a sense, because like I said, my husband, he was real, just sick. So, he was in a nursing home.
> INTERVIEWER: Okay.
> RESPONDENT: He was in a nursing home, and me being his wife, I couldn't – you know, I couldn't live at the nursing home with him. So, he needed assistance with a person helping taking care of him and I couldn't do that at that time, because I didn't have a stable place to live. I didn't have no job, I didn't have no income. So, I found myself just crying out to the Lord and praying, you know, Lord, what am I to do now?

In the Recommendations section, we propose short and long-term interventions at the system and program level to respond to the needs seen in respondents' pathways into homelessness.

3.3 Barriers to Exiting Homelessness

Factors that lead to homelessness and barriers to exit may be similar depending on the point in time. For example, intergenerational poverty, family destabilization, mental and behavioral health issues, and the impacts of trauma were often raised as barriers to exiting homelessness and features of pathways into homelessness. In our analysis, we made the distinction based on how people answered our questions (e.g., "What led you here?" vs. "What has not been helpful as you try to get housing?"). Based on our conversations with respondents, the burden of a criminal record (in particular a felony status), lack of economic mobility, lack of quality affordable housing, and difficulty navigating the systems in the city, rose to the top as significant barriers for people of color experiencing homelessness in Dallas.

Criminal Justice Involvement

Multiple interview and focus group respondents had been incarcerated and shared the burden of a criminal record. They described difficulties re-entering the community: struggling to find a job, not qualifying for certain types of assistance, rejection by landlords, and strained relationships or fraying of social networks of support.

> Okay, this is what I find is a barrier. Okay, I was here. I've been here, and I had, for my homelessness situation, I had got a Dallas Housing voucher that helps you go out and you find a place, try to find a place to live and you know it's low income. Well, that didn't work for me, because they went back to - It's like you can't live, they won't rent you a place to live because

> you have a felony on your background. So for me, I wasn't able to use that voucher because every place that I went to turned me down, because of the one felony that I have, which I went to prison for on my record.

A focus group participant recounted a similar barrier in accessing housing services due to their felony status:

> RESPONDENT: I got out of prison. Just, I got released from prison. So, . . .
> INTERVIEWER: And would you say that there are a lot of folks who you know who are released from um, uh, carceral institutions or from prisons and jails, um, and come directly to shelter?
> RESPONDENT: I did. Um, I'm a prime example. Um, I did. And, um, I even got the Dallas Housing Voucher – it's called the Dallas Housing Choice Voucher where I couldn't use the voucher because of the felony that I have got charged with. So I'm still homeless.

These respondents' experiences reveal another pattern our team has begun to recognize in our analysis: even those who receive public assistance are often unable to access the benefits for which they are eligible, either due to their felony status or, as seen above, inadequate program funding.

Felony status was seen as a particularly significant obstacle. Respondents with felony statuses reported substantial difficulty attaining jobs that paid a living wage. For instance, although one respondent we interviewed is a skilled tradesman, his previous involvement with the criminal justice system prevented him from accessing employment opportunities:

> I'm a welder by trade. It was a new start for me. I'd just come out here from Atlanta and hoping to start over. When I got here … I started diligently searching for work and did all of the online things when I still had phones and all of that. And it just didn't work out for me because of my past I guess. I had been convicted of a felony in -- years back, you know, back in 2010 I think it was. I found that very hard to get my foot in the door as far as jobs go. You go to a job and they ask you, "Have you ever been convicted of a felony?" All of the sudden, they want to do a background, and then I wasn't considered for work.

Despite his motivation and capacity to find vacancies and initiate applications, his progress is blocked once questions regarding felony status come up. Because he was unable to find work that fit his qualifications and experience, this respondent eventually relied on menial and temporary work. These jobs, however, did not provide an adequate salary to make ends meet. He elaborates:

> So that in itself was a failure -- trying to do the job that I was experienced at, and then eventually started going to these temp services. And these temp services is another thing where they lay

> everything, so you basically gas money to get you from point A to B, and if you don't do that on a daily basis, you find -- you're constantly falling backwards. For me, I started losing things, I started having problems with my car and lost my phone, car broke down and I found myself -- for a long time, I stayed in my car. Then I finally started seeking shelter.

A focus group participant described the feelings of frustration and hopelessness that accompany previously-incarcerated folks as they seek employment and housing:

> We continue to kick Black men out of society … and we arrest Black people in inordinate numbers in our society, and what you're going to see is you're going to see Black men who cannot get in – back into society … When you kick people out of a society, what do you expect from those people? You expect a higher degree of recidivism because you have people who just don't give a damn. No matter what you do, no matter how good you are, you can never get back into society.

Economic Immobility

Regardless of a criminal record, people discussed lack of economic mobility as a significant barrier to exiting homelessness. Respondents often had extensive job histories, but those jobs rarely paid adequately or provided full time hours. Many respondents had degrees or certifications in a variety of fields, but they were still unable to sustain employment with livable wages. The following excerpts from two different interviews summarize these issues:

> INTERVIEWER: So what do you think should or could be done to change the situation and prevent homelessness from happening to people of color?
> RESPONDENT: In my opinion, I think the area of jobs, jobs just not being where people of color can actually get them. It has a lot to do with a lot of people being homeless. I mean, in my opinion, it's just that the job market used to be there and now it's not. It's like we're in this continuum depression or something. It's just-- it's crazy. I mean, you've got lots to work out, you've got lots of people advertising help wanted, but nobody's actually hiring. Why? Were these people not qualified to do backbreaking work or labor or any part of that? I don't understand it.

> INTERVIEWER: And you said you did get a degree in accounting.
> RESPONDENT: Yes … but it's so hard getting a job. That's what I can't understand. I mean we're now like taking -- thinking about going studying something else, you know, something hospitality or something in hotel you know because those -- the hospital is going to always be there and there's always going to be hotel. So there's like I got to re-focus and re-train my mind like, "hey just don't be stuck in accounting and do take whatever comes up." That's where I'm at now.

The first respondent continuously sees potential opportunities for employment, but these do not materialize into tangible jobs. Importantly, he emphasized not only increased availability of

jobs, but increased *access* to jobs for people of color, as a primary space in which change could be made to prevent homelessness. The second respondent touches on another key finding – that despite a college degree and experience in a skilled field, she was unable to secure employment and felt she needed to receive additional training in order to secure dependable employment opportunities. This touches on another important theme that emerged in respondents' conversations regarding employment: job readiness. The employment field is changing significantly, and respondents raised the need to be trained in skills that will prepare them for jobs that are actually available and attainable. Another respondent highlighted this priority as well:

> INTERVIEWER: What kind of education do you think you need?
> RESPONDENT: Well basically to get our high school diploma -- well for number one to get our high school diploma and everything. And maybe -- I know some chicks up in there right now that got high school diplomas and everything, they're still up in the same situation, so.
> INTERVIEWER: What else?
> RESPONDENT: Let's see. Some type of -- instead of just pushing us out there, just have like a job readiness program more or less like, you know for the ones that will be looking for jobs have they be looking for jobs that we want to learn, you know, like basic skills like computers and stuff, you know.

The above respondent recognizes that having a degree is not a guarantee for employment, so he highlights the importance of receiving training in relevant skills to today's economy, such as "computers and stuff." Respondents also identified low wages and poor working conditions in the job opportunities that were available. It is worth noting that a few respondents cited that where they felt the most racial discrimination was in employment. The quote below from two different interview respondents we interviewed is a clear example:

> INTERVIEWER: What led you to becoming homeless?
> RESPONDENT: A lot of things, not trying to save money, spending money, running up my credit cards and I had people harassing me. And that took a toll on me too.
> INTERVIEWER: What do you mean they were harassing you?
> RESPONDENT: It was an organization, the company that I worked for. They were still harassing me. What happened was that they I couldn't do my work they like to play games it was started off as game playing and I just got tired of it they would ---
> INTERVIEWER: This is at your job?
> RESPONDENT: Yeah this was at the job that I worked there and I reported it to the plant manager and he told me, he said "Roxanne, this is not right." I was taking pictures and I was taking 'em and showing them to me, and I was telling him, "I know who did this, this girl name [Redacted Name]." I said, "she is harassing me and she is not leaving me alone." She would spit [inaudible] she would spit on my paperwork, she would take my clipboard that I had paperwork on, she would take it and stump her foot. That's her way of calling me dirty because I was of color.

Respondents repeatedly made it clear that while sometimes in the world of service provision racial bias seemed nuanced or difficult to track, it was more apparent in employment and housing.

Affordable housing

Another barrier to exiting homelessness was the lack of access to affordable housing. People continually spoke of experiences of discrimination when applying for affordable housing, citing bias by landlords or building managers. The following two excerpts highlight two different points in which discrimination can affect people of color's housing outcomes. One respondent describes an environment in which White applicants are given priority over Black applicants for housing vouchers, while another respondent recounts applying for housing through her Dallas Housing Authority (DHA) Voucher but was told that there were no units available once she arrived to look at the apartment:

> INTERVIEWER: Um, have you seen yourself ever affected like in ways that speak to racism or discrimination in terms of accessing services? Like how has that been for you?
> RESPONDENT: With vouchers. You know we get passed by by vouchers. You see certain groups of people getting vouchers than others.
> INTERVIEWER: Oh really?
> RESPONDENT: Yeah, and that happens. I've seen – white – yeah, the white ones get theirs real fast.
> INTERVIEWER: Where do they get them from?
> RESPONDENT: I don't know where they get them from. I try not to be nosey. INTERVIEWER: Didn't you get a voucher?
> [RESPONDENT: I got – I got some -I work through [Redacted Program]. They own their facilities. Their housing stuff. So, I didn't have to go through that voucher thing. But yeah, if you're white you get yours a lot faster.

> I took my housing, DHA voucher, over to like a place where there is mostly Hispanics. They don't want no black people around and they will not rent to you. They will say, "that apartment is already taken," before they let you try to get that apartment. Or, you didn't get approved.

A participant in our service provider focus group also touched on the problem of discrimination in housing, specifically in regard to individuals with felony status:

> I think there should be something in place in systems, especially if they've been incarcerated for a crime unjust or just. It is how do we help them get back and not continue to live a lifestyle of failure and homelessness? And I don't – I don't think that happens, particularly with African-Americans because when we look at some of them are in – just there, and they come out and they get a little bit of money. But then again, here it is they- they've already been marked. And it's difficult to get housing and apartments if you have X-amount of felonies. And you get second

> chance apartments, but those second-chances are not any place where we would want to live. So, they say I choose not to live there. And I might as well live homelessness and hang out on downtown Dallas.

In cases when respondents did obtain vouchers and successfully found housing, they often expressed dissatisfaction with the condition of apartments. As the provider above highlights, many individuals are only given housing options where they are forced to pay the majority of their income for a place in a "bad" neighborhood known for violence and drugs. In some cases, respondents expressed concern that they would relapse into substance use and/or homelessness because of their new housing environment. For example, one respondent had this to say:

> Most places do not have anything available or they do not accept DHA vouchers or the DH voucher is not enough to cover the apartment cost. And it's just been a lot of factor. And I'm trying to get out in an area like a walker target area which is like a more of an area like [Redacted Location] or [Redacted Location] where the crime area -- they try to -- they try to angry the homeless into that type of environment. So really trying to move up in those area, I don't want to be in a area where there is lot of in and out traffic, drugs. I mean you're going to have drugs everywhere and alcohol, but I mean in a more nicer area.

The above excerpt highlights the frustration of only having access to undesirable living environments, but it also touches on the difficulty of finding housing, even with a DHA voucher. Another respondent discussed her difficulty finding a landlord to accept her housing voucher:

> INTERVIEWER: How did you find out?
> RESPONDENT: Go to apartments, they are going to apartments start to find section 8 apartment and seein', and my affordability amount was correct, if it matched, then I can move in they kept asking me, "What kind of voucher do you have?" I'm like, "Section 8 voucher." and I didn't know like what to say and they would have to look at my voucher and be like "Oh no we don't accept that."
> INTERVIEWER: And so what kind did you have you had the regular Mobile Section 8 one?
> RESPONDENT A regular one.
> INTERVIEWER: Yeah regular Section 8.
> RESPONDENT: Yeah regular Section 8 voucher.
> INTERVIEWER: So they didn't take that one?
> RESPONDNENT: No lot of places didn't take it, like it all depends on the apartment.
> INTERVIEWER: Okay, so they wouldn't take Section 8 tenants is what they are saying?
> RESPONDENT: Yeah it all depends on the apartment…A lot of apartments, they wouldn't agree to *your* Section 8 voucher because each voucher is different. I don't have a kid, so my affordability amount will be smaller. And it also depends on zip codes. Zip codes and housing pays what they think apartments are worth, not what the apartment say they are. So a lot of apartments say, "I don't - that affordability amount is too small, it's like me losing, I will be losing

> $200, $300 on rent then I can have somebody that pay the full amount." So lot of apartments say no and because I don't have a kid, my affordability amount will be small.

The above narratives suggest that housing vouchers in and of themselves are not necessarily sufficient to secure housing due to the process that calculates the affordability amount. The following respondent also describes how difficult it can be to receive a voucher in the first place:

> INTERVIEWER: During that time, what services have you accessed? So let's talk a little bit about that and what that experience was like. Accessing, applying for, and getting.
> RESPONDENT: DHA, Dallas Housing Authority. I had applied for that on many occasions. First time, I was at [Redacted Program] and I slipped through the cracks through that and another housing program.
> INTERVIEWER: What do you mean you slipped through the cracks?
> RESPONDENT: For some reason, my name just never came up. Slipped through the cracks. Everybody else was getting their vouchers and whatever, and I am like "Okay, where is my name?" I think on that one, my case manager didn't turn my name in to that for the first time, to DHA. The second time, under my roof, something happened with the vouchers. I had actually talked to them and she said – oh, my file got misplaced. I had talked to them and everything, and we never could get on track with that. So, I slipped through the cracks with them. So, I just said, you know what, forget that then. Then, some years later, I ended up signing back up

The issue of housing stock is especially important in the case of people with prior criminal justice system involvement, living with substance use disorders, or families with children. The ability to live in desirable neighborhoods relates to people's perceived ability to avoid violence, exposure to drugs, and quality educational opportunities. As we look to create opportunities for people to exit homelessness it will be critical to continue to link these strategies with larger efforts to improve low-income housing accessibility and create more mixed-income neighborhoods.

Difficulty Navigating the System

Respondents' reported difficulty obtaining and using housing vouchers is in line with a larger theme that emerged in Dallas. One of the most frequently discussed barriers to exiting homelessness was a general difficulty navigating the service system. Participants felt confronted with burdensome and inequitable qualifications and requirements for services. Individuals with whom we spoke discussed the persistence it took to finally receive services and the frustration felt when waiting lists were long. For example:

> INTERVIEWER: Have you ever had any trouble finding housing or getting services?

> RESPONDENT: With the housing, I had trouble with that. Cause, like I said, I went to [Redacted Program] and I talked to their case workers over there and they said, "You're not eligible because you're not physically, mentally disabled or have some kind of handicap." And I said, "What's that got to do with me being homeless?" Just because I'm not sick and I'm not crazy, I'm still homeless, I need help. He said I don't fit the-- wasn't qualified, I didn't fit the criteria. So I didn't give up. I just said, at some point, somebody's going to have to help me keep going. They're going to help me because I'm not going to give up and be persistent and keep trying.

This quote touches on a particular experience which came up frequently in our interviews: the impression that folks are being tested by programs, and continuously failing to pass. Being turned away from services due to program criteria was a common feature amongst many respondents' narratives across SPARC communities. This pattern was consistent in Dallas as well. This theme was reiterated by a participant in our stakeholder focus group, who described some of the requirements for services in the programs they oversee:

> Well you have to have children. So, we don't have any resources for single people that are experiencing homelessness. You have to have children. Um, you have to be willing and able to work. Um, you have to have legal custody of your children. We have to have proof that you have legal custody of your – of your children. Um, you have to be, um, open and agree to financial literacy training. Um, so those are just some of the initial qualifiers when people call and they want to be a part of our program. And then once a family is accepted, and we don't have like – there's usually a five to seven day move-in process.

As the focus group participant indicated, many programs prioritize clients in a way that leaves others having to fight particularly hard to receive the support they need to exit homelessness. In addition, people felt like program requirements were sometimes a burden that made it harder to succeed. One respondent had this to say:

> RESPONDENT: I went to this other shelter and they wanted to try to entrap me in one of their programs there.
> INTERVIEWER: You said, entrap you in one of their programs?
> RESPONDENT: Yes, because actually some volunteers came through. They found out what my profession was. The man tried to set me up to get a job, because I was under contract with this one shelter, the work to stay program. I was contractually obligated to them to fill out that contract. They sat there and told me I could not go to work.
> INTERVIEWER: Why?
> RESPONDENT: Because I was working for them in their kitchen. I said, "I am not working. I don't get paid to do this. I am a volunteer." They said, "It's paying for your bed." So, really, eight hours a day, I was in that kitchen, working for them and could not go get a regular job, because I was in a work to stay program, which was paying for my bed. So they kept me trapped there.

For the above respondent, a "work to stay" program requirement barred her from finding paid employment, and therefore being able to move towards exiting homelessness. She was put in a position where she had to choose between seeking opportunities for economic mobility and securing shelter. The respondent notes her preference for obtaining a "regular job" and highlights the negative experience she had at the program by framing it as entrapment. When reflecting on the capacity of services to effectively respond to the needs of their clients, a participant in our service provider focus group had this to say:

> So, you know what? What do systems do to help that? And I – I believe, personally, that we don't do enough. We say, "Okay go out here, you have to get this, you have to get this." It's not available." It's just - unfortunately, it's just not there. And then it's not enough. Not enough housing. It's not enough resources.

Both clients and providers feel an acute scarcity in resources available and see how discouraging the process can be — "go out here, you have to get this, you have to get this, this is not available." When people feel like the system is set up to make them jump through hoops rather than support them, overcoming homelessness and sustaining housing is difficult. As Dallas reflects on new strategies to end homelessness, it will be important to incorporate these experiences into the solutions.

4. Discussion: Promising Directions

The sections above report SPARC's initial quantitative and qualitative findings on the experiences of homelessness of people of color in Dallas. The qualitative themes emerged from the data independent of the Structural Change Objectives selected by Dallas' SPARC working group. As mentioned in the executive summary, Dallas chose to focus on three areas of structural change:

1. Strengthening opportunities for economic mobility in communities of color in the Dallas Metro area.
2. Folding equity measures into the Continuum of Care's long-term Strategic Plan to end homelessness.
3. Diversifying leadership and board membership in the Continuum of Care and other service providers.

The research summarized in this report helps guide this work and suggests additional areas for short and long-term action. The stories we heard repeatedly demonstrated that the network impoverishment of communities make homelessness seem inevitable. In this context, how does the community strengthen these networks? What are the necessary investments to build assets in communities of color? How do the city and county return economic mobility to some of its most disenfranchised citizens? How does that work flow through an anti-racist lens so that it is strengths-focused and empowerment-based rather than paternalistic? How do systems interact to effectively serve people with medical and mental illness?

As we continue to explore the data from this initiative, we are aware that a number of research questions deserve additional attention. In the next section, we discuss the implications of our findings and highlight potential areas of future research on race and homelessness. In the final section, we identify a concrete list of recommendations.

4.1 Economic Mobility for Communities of Color

Economic mobility is clearly a pillar of ending homelessness but remains elusive in many communities. As was detailed in the qualitative section of this report, respondents often had a rich job history, but had a great deal of difficulty securing employment that would pay a living or housing wage. Barring a significant shift in federal or state policies regarding minimum wage, it is unlikely that our current workforce development approach will be sufficient to end homelessness. Simply put, if someone comes to experience homelessness while working for

minimum wage, transitioning to a different minimum wage job will not make a substantial difference in their life.

The SPARC team has begun to examine in greater detail what respondents had to say about their employment history and employment search. One area requiring more analysis is employment discrimination. Unsurprisingly, respondents have repeatedly reported experiencing interpersonal racism over the course of their job searches. They have also discussed the role of systemic racism in preventing them from attaining career-track jobs, reporting, for example, inequitable access to education or skill development (including vocational training).

As we continue to investigate concrete and immediate steps that we could take in order to drive change in our communities, the SPARC team has begun to look more closely at the way communities spend workforce development dollars. A potential direction to take workforce development would be to reduce the size of cohorts moving through programs and intensify the skills being acquired. For example, rather than moving 150 people through a soft skills development program it might be more beneficial to move 20 people through a UX (user experience) design code academy that is connected to a job placement possibility at several design or technology firms.

Additionally, as mentioned above, it will be important to think about what economic stabilization looks like. Our findings point to upstream intervention sites that are community-based and focused on stabilizing fragile networks through necessary infusions of capital—either through targeted subsidies, flexible emergency funding, or policies that better facilitate pooling income.

Finally, we should consider how soft skill development programs are frequently constructed around behavioral norms for professional conduct that have been established and advanced by White people. What does it mean to engage a 17-year-old Black person in a program that essentially tells them that their way of interacting the world is the wrong way?

These kinds of questions are important to consider in the construction of workforce development programs but also with regard to the ways in which we consider advancing staff of color on our teams. As we examine why certain staff members do or do not advance, an important consideration must be whether or not they are being passed over because they are not cultural matches with senior leadership. As one respondent stated, “Senior managers want to know that the people around them will think like them and respond to situations the same

way that they would. Sometimes it seems like they don't choose Black staff or staff of color to advance because they don't think we're enough like them culturally."

As we continue to break down the ways in which interpersonal and structural racism exacerbate each other, it could be helpful for programs to engage in honest dialogue about how personal bias might be enabled by structural factors. In the case of supporting people of color in their job search, it might be understanding a person's context and giving second chances, rather than saying, "They've had three weeks to get an interview and they still haven't." With regard to staff of color, it might mean re-working job descriptions rather than saying, "I'm not promoting them because they don't have a B.A.—not because they're Black."

4.2 Upstream and Downstream Stabilization

Our qualitative data suggest that destabilizing factors often occur well before people come to experience homelessness. Upstream stabilization may be best achieved through the development of short-term flexible subsidies. People do not always need large amounts of money, or even money that is dedicated specifically towards housing or utilities. Many respondents expressed having initial difficulty with a non-rent related financial burden. Common examples have been car repairs or food. However, without the money to pay for these non-housing areas, a crisis can rapidly develop. Respondents who cannot pay for their car repairs may be unable to get to work and subsequently lose their jobs, or those who cannot afford food for the whole household may kick adolescents or emerging adults out of the house in order to free up resources for the very young or very old.

Stabilizing these households who are on the precipice requires immediate infusions of capital. However, these subsidies have to be uniquely flexible to cover a wide range of one-time needs. This might represent expanding discretionary spending so that community members at risk of becoming homeless have access to it. Moreover, prevention approaches need to be shared among all sectors working with low income folk, so that everyone is preventing crises that lead to housing loss.

Spending models of this kind have existed for many years in the faith community. It is not uncommon for churches to step into exactly the need that is being described. Unfortunately, network impoverishment affects faith communities as well. As the broader community has less extra money, there is less ability to 'take up the collection plate' in order to meet someone's needs in crisis. In order to address the hemorrhaging of people of color into the population

experiencing homelessness it will be necessary to replenish (or establish) these kinds of community level safety-nets.

Downstream stabilization focuses on securing families or individuals in housing units that they move into after exiting the homelessness response system. In these cases, two things need to be evaluated:

1. Does doubling up make sense?
2. What supports would be necessary in order to facilitate successful family reunification (for people of all ages)?

With regard to doubling-up, we need to begin to ask whether or not (middle class, White) norms of how housing needs to function make sense for all. Communities of color that have a history of living inter-generationally or with other close family or friends may protect against homelessness. Frequently, respondents would discuss being moved into housing on a time limited subsidy knowing that they would not be able to afford the housing once the subsidy ended. We believe this situation to be one of the key drivers of the rapid cycling phenomenon seen within family homelessness. The young women of color typically heading these households are not able to secure an income that will offset the loss of the subsidy, so they rapidly come to experience homelessness again. It is possible that this process may be improved by encouraging providers to let clients direct the housing outcomes. Additionally, if subsidies were adjusted to be shallower, but longer, and families exiting the shelter were encouraged to pool their subsidies and live together, this may provide enough time to stabilize and locate employment. As these options are explored, it will be important to advocate against the "cliff effect," or policies that cut or lessen benefits as incomes increase, so that despite new income, families end up further behind.

In addition to economic stabilization, encouraging living together allows for new networks of social support to be entrenched. Moving in this direction may help encourage supportive relationships within communities that are very frequently missing large numbers of people due to the continued predatory involvement of the criminal justice system.

This method could also assist with stabilizing youth, who could potentially return home but had not (and had no plans to) because they had been thrown out for being unable to contribute to household expenses. When subsidies can assist with rent payments or food in a meaningful way, it may be possible to negotiate their return to a stable living situation.

Finally, many respondents also expressed that family reunification was not possible for a variety of reasons, not all economic. Frequently these reasons involved significant social stress that may have begun with money, but these problems are not solved simply by subsidizing the return; the mistrust and anger that developed was real and often overwhelmed any desire to return to a stable living situation. In order to successfully facilitate reunification (and stabilize people downstream, e.g. after they had been re-housed) it will be important to provide ongoing services in the form of family therapy and other counseling in order to help heal social ruptures. While people are often able to mend these bridges on their own, the support to do so is often lacking. In order to re-house people (especially youth), we must treat their grievances not as temper tantrums but as real obstacles standing between them and a home.

4.3 Hispanic/Latinx

Existing literature frequently refers to the "Latino paradox" with regard to the idea that the Hispanic/Latinx population in the U.S. shares risk factors for homelessness with the Black population, but they are underrepresented, not overrepresented, among people experiencing homelessness. Despite this discussion in the literature, we have increasing reason to suspect that these theories are based on inaccurate reporting and weak methodology for counting people experiencing homelessness and/or Hispanic/Latinx people not accessing homeless services. Emerging from our research is the finding that in communities that have more intentional outreach to Hispanic/Latinx communities, numbers tend to trend upwards towards overrepresentation.

Our preliminary research suggests the need to focus our attention in meaningful and immediate ways on reaching out to Latinx communities. This will require deliberate cultivation of Spanish-speaking outreach teams made up of members of the communities that they hope to engage. Ideally, these teams would have preexisting relationships that they can leverage to build trust. Additionally, programs might begin to take steps to segregate documentation and immigration status from other components of a client's file and hold it on a "need-to-know" basis, similarly to how HIV/AIDS information is managed under HIPPA. While this policy change would not have a legally enforceable edge, it would be a step towards building trust with clients regarding whether or not their immigration status will be shared with other staff—and to what extent the circulation of that information puts them at potential risk. Moreover, we might begin to more carefully identify what services we actually require immigration or citizenship information in order to activate. A number of services that may currently request this information may in fact not actually require it to report to funders or screen individuals in or out of services.

By limiting requests for information regarding documentation status to only those services that absolutely require it and putting strict firewalls around that information, we may begin to have better engagement with Hispanic/Latinx communities experiencing homelessness. With better engagement will come a more accurate understanding of rates of homelessness, characteristics, and needs.

4.4 Trans* People of Color

Our current understanding of the needs of trans* (used here to refer to all trans, gender-expansive, gender-fluid, or non-binary individuals) people experiencing homelessness is similarly limited. While the SPARC team has been lucky enough to engage a number of trans* youth and some trans* adults in our research, we are very far from being able to characterize patterns in trans* experiences of homelessness. While we expect that social rejection and stigma play a role in pathways into homelessness, we do not yet have enough information to suggest appropriate structural interventions.

One obstacle in the way of researching trans* experiences of homelessness is inconsistent administrative data. While there is a great deal of anecdotal evidence around trans* people experiencing homelessness at greater rates, there is still a dearth of data on trans* individuals in service systems. Because of this, we are left with an inaccurate understanding of how many trans* individuals are in need of service, and we are not able to estimate rates of disproportionality across race and gender identity. We advise programs to work diligently to capture sexual orientation and gender identity/expression (SOGIE) data so that policy decisions can be more informed.

Finally, it is important to track requests that trans* clients are making of systems. While the SPARC team will continue to analyze the available data, we believe that the best resource available to programs and systems leaders are the voices of people who are currently utilizing services. By creating a way to track (and document responses to) requests or complaints that come from trans* clients, systems can use the knowledge that is already there while waiting for better research to emerge.

5. Recommendations

There are numerous actions Metro Dallas Homeless Alliance (MDHA) and the City of Dallas can take now and plan to take in the future. SPARC's recommendations include:

1. **Design an equitable Coordinated Entry system**. Coordinated Entry organizes the Homelessness Response System with a common assessment and a prioritization method. This directs clients to the appropriate resources and allows for data-driven decision making and performance-based accountability. Continual review of data from this process for racial disparities can assess whether housing interventions are sufficiently provided to people of color who come into contact with the system. Examination of the data can also help pinpoint additional intervention need. Coordinated Entry is at the root of MDHA's response to homelessness, and racial equity should be integrated into Coordinated Entry.
2. **Incorporate racial equity into funding and contracting for homelessness and housing programs.** Funders should consider how to infuse a race explicit lens into its contracting, requiring that programs report how their work will address issues of racial equity. Specifically, it is useful to develop criteria in which racial equity is part of the evaluative process for scoring funding proposals. Funders can also play a role by evaluating the racial diversity of agency leadership. Finally, they should encourage agencies to periodically conduct internal program and policy reviews that examine disparities in outcomes based on race.
3. **Include racial equity data analysis and benchmarks in strategic planning to end homelessness.** As Dallas sets goals around program development, expanding housing capacity, and creating more housing placements, the system should be measuring impact by race and ethnicity. It will be vital to look at how race and ethnicity relate to returns to homelessness. Additionally, it may be helpful to use a formal racial equity tool in organizational decision making. All major organizational decisions, whether explicitly about race or not, should be analyzed through an internal racial equity tool that will highlight potential negative consequences to communities of color.
4. **Support organizational development to ensure racial equity at the organizational level.** Many agencies that provide human services are at a critical point of self-examination. As we continue to unpack the impact of systemic inequity on the populations we serve, the time has also come to investigate the organizational practices, structures, and cultures of serve settings that unconsciously perpetuate inequity for those same communities. Despite agencies' best intentions to promote equity and justice, many have a long way to go before their internal practices, staff and

leadership teams, resource allocation, facilities, and strategic planning reflect and advance these goals. However, promising practices exist and can be leveraged and tailored to organizations that are ready to do the work. MDHA can support agencies by providing resources to do this work and by disseminating tools and strategies.

5. **Encourage anti-racist program delivery.** SPARC's findings suggest that programs that are strengths-focused, empowerment-based, and trauma-informed, rather than paternalistic, will best serve people of color experiencing homelessness. Programs will need to look internally to answer questions about whether or not they are inadvertently replicating systems of disenfranchisement. Performing internal systems audits and looking at program output data by race and ethnicity for disproportionality can help target the work. These philosophies might also play a key role in inter- and intra-agency equity plans.
6. **Promote ongoing anti-racism training for homeless service providers.** Government and nonprofit staff will benefit from continuous training on the intersection of race and homelessness, on bias, and on strategies to confront racism within their work. Building off of Recommendation 2 (Support Organizational Development), MDHA can host inter-agency trainings and support trainings for individual agencies. While organizational development focuses on structural change to organizations, training can focus on interpersonal skills—both for working with clients and for working with our colleagues.
7. **Collaborate to increase affordable housing availability for all people experiencing homelessness.** People in Dallas described frustration not only in the wait to receive a voucher but also in the difficult process of trying to find a landlord or apartment complex that would accept it. As the community begins to discuss how best to address homelessness through a racial equity lens, it will be necessary to discuss how people experiencing homelessness could be moved into desirable units and neighborhoods by working with landlords and developers to address issues with accepting housing vouchers.
8. **Utilize innovative upstream interventions to prevent homelessness for people of color.** Homelessness is not inevitable. The data in this report suggest that it may be possible to stabilize people well before they become homeless by identifying pathways and providing support early. Preventing homelessness is a key component of achieving the county's goals, and the community is making efforts to improve its upstream services and homelessness prevention efforts. MDHA should continue focusing on areas where it can have the biggest impact, including targeted eviction prevention for people at risk of homelessness. Prevention also means working with the criminal justice, child welfare, and public health systems to reduce the number of people exiting into homelessness from programs and institutions within those systems.

9. **Investigate flexible subsidies to mitigate the effects of network impoverishment.** Many financial crises start as non-rent related. For many of our research participants, initial needs were for food, car repair, or bills. This suggests that for some people, flexible subsidies could be used to avert crises that spiral into homelessness. Short-term interventions of this kind can prevent or end homelessness quickly and connect people to other systems and resources, such as employment, health care, child care, and a range of services to support greater stability. It may offer a range of one-time assistance, including eviction prevention, legal services, relocation programs, family reunification, mediation, move-in assistance, and flexible grants to address issues related to housing and employment.
10. **Support innovative health care strategies to meet the needs of communities of color.** Low-income individuals may have more difficulty accessing and paying for health care in states like Texas where lawmakers have thus far declined to expand Medicaid eligibility to all families and individuals with incomes up to 138 percent of the federal poverty level. Medical and mental health needs emerged as an important feature of people's pathways into homelessness, experience of the system, and barriers to exit. The homelessness response system should collaborate with health providers to increase people's ability to access care with or without insurance.

6. Conclusion

We recognize that equity-based work should not be confined to specific initiatives, but rather should be the lens through which all of the work flows. As communities develop equity approaches, they do not happen in isolation, limited to one program or one response. Instead, racial equity models need to be widely spread across systems and sectors.

We look forward to working with community leaders across the cities engaged in SPARC to continue to develop and hone the skills of equity implementation. Our hope continues to be that we will someday be a nation that does not strive towards equity but has realized the vision of having these values sit at the core of what we do.

7. Appendix

7.1 Dallas Homeless Service Providers Diversity & Inclusion – Mixed Methods Findings

Every day, our nation puts the complex problem of solving homelessness into the hands of individual providers doing the work. Successfully recruiting, hiring, training, and supporting the homeless service workforce is key to ending homelessness.[12] Because the goal of SPARC is to fight homelessness by improving outcomes for people of color, an important question is: What are the characteristics of a workforce that best serves people of color? Advancing racial equity in programs may mean ensuring that people working in agencies, from the front desk to the boardroom, reflect the race and ethnicity of the people they serve. Through an online survey, SPARC and our Dallas partners set out to learn more about the background of providers working in homelessness response programs and their self-reported desires for professional development. In addition, we sought to better understand how people perceive the issue of race in service settings through qualitative research.

Methods

To learn more about the race and ethnicity of people working in housing and homeless service programs in Dallas, SPARC and the Metro Dallas Homeless Alliance administered an online survey. The survey was sent through e-mail and was open to respondents for approximately one month. Participation was voluntary, and we received 64 responses. Results of the survey are described below and suggest a preliminary picture of how the race and ethnicity of staff relate to their experience, job categories, and professional development goals. The summary of the survey results are followed by a few quotes from qualitative interview and focus group participants that shed additional light on the subject of provider race and ethnicity.

Results

In the sample of Dallas providers surveyed who reported racial identity (n=63), 60.3% identified as White, 30.2% identified as Black, 6.3% identified as Two or More Races, and 3.2% identified as Asian. No respondents identified as Native Hawaiian or Pacific Islander (NH/PI) or as Alaskan Native or American Indian (AN/AI). In a separate question on ethnicity, 14.1% identified as Hispanic or Latinx. Results that compare responses by race are extremely limited by the small

[12] Mullen, J., & Leginski, W. (2010). Building the capacity of the homeless service workforce. *Open Health Services and Policy Journal, 3*, 101–110.

sample size, but including this information is important for a comprehensive discussion about provider race and ethnicity.

Race	Percent	Frequency
Alaskan Native or American Indian	0.0%	0
Asian	3.2%	2
Native Hawaiian or Other Pacific Islander	0.0%	0
Black	6.3%	19
White	60.3%	38
Two or More Races	6.3%	4
Ethnicity		
Hispanic or Latinx	14.1%	9
Non-Hispanic or Latinx	84.4%	54

Almost two-thirds (62.3%) identified as female and 34.4% as male; 3.1% declined to answer. The mean age of respondents was 46 (SD=12.5) years old and ranged from 24 to 69. The majority (76.6%) identified as straight or heterosexual, while 14.1% identified as lesbian, gay, bisexual; 9.4% declined to answer).

Respondents worked in emergency shelter, transitional housing, permanent housing, outreach, drop-in centers, advocacy organizations, and other specialized services. These organizations were categorized as mostly nonprofit (85.9%), as opposed to government agency (9.4%). Over a third (34.9%) of respondents were either an Administrator or Executive Director. Ten of the 12 (83.3%) Executive Directors and seven (70%) of the ten Administrators (defined as all administrative roles except Executive Director) were White. Similarly, senior managers were only 22.7% people of color compared to 77.3% White, while front line staff were only 46.3% people of color compared to 51.2% White.

Educational backgrounds were not comparable between race groups: only 15.8% of Black individuals reported holding a master's degree compared to 47.4% of White individuals. Over twenty percent (24.2%) of respondents reported having personally experienced homelessness. In order to protect anonymity on this sensitive question, results are not presented by race.

Experienced homelessness (answered: n=62)	Percent	Frequency
Yes	24.2%	15
No	75.8%	47

We asked respondents to reflect on their current organization and report how well the race and ethnicity of frontline staff and senior managers reflect the race and ethnicity of the people they serve. Overall, the majority (84.4%) of respondents agreed or strongly agreed that the race/ethnicity of frontline staff reflect the race/ethnicity of clients. Almost half (46.9%) agreed or strongly agreed that the race/ethnicity of senior managers reflect the race/ethnicity of clients.

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Sure
The race and ethnicity of frontline staff at my organization reflects the race and ethnicity of the people we serve.	39.1%	45.3%	7.8%	7.8%	0.0%
The race and ethnicity of senior managers at my organization reflects the race and ethnicity of the people we serve.	15.6%	31.3%	28.1%	17.2%	4.7%

We asked survey respondents to think about what kinds of skills they would need to 1) excel in their current position, and 2) take their career where they wanted it to go.

Overall, respondents most frequently indicated that they needed skills in written communication, financial management, time management, and data management. There was some variation despite the small sample size. Only 40.0% of people of color indicated needing grant writing compared to 84.2% of White respondents. Similarly, only 56.0% of people of color indicated needing fundraising skills compared to 89.5% of White respondents.

Skills needed to excel in current position	Total	White (n=38)	Combined PoC group (n=25)
Mental health counseling	64.1%	68.4%	56.0%
Time management	84.4%	86.8%	80.0%
Financial management	87.5%	92.1%	84.0%
Written communication	92.2%	89.5%	96.0%
Technology skills	73.4%	71.1%	76.0%
Grant writing	65.6%	84.2%	40.0%
Data management	78.1%	73.7%	84.0%
Fundraising	76.6%	89.5%	56.0%
Supervisory skills	71.9%	68.4%	76.0%
Note: Percentages are calculated with race totals as the denominator. **Participants could select all that apply.**			

We also asked respondents what skills they needed to take their career where they wanted it to go. Overall, people most frequently indicated that they need skills in time management, written communication, financial management, technology skills, and data management. While conclusions are limited based on the small sample size, there was some variation. For example, of the 92.0% of people of color indicated they needed skills in written communication compared to 84.2% of White staff. Almost three-quarters (73.7%) of White staff indicated a need for fundraising while only 52.0% of people of color indicated they needed that skill.

Skills needed to advance to career goals	Total	White (n=38)	Combined POC group (n=25)
Mental health counseling	73.4%	76.3%	68.0%
Time management	89.1%	92.1%	84.0%
Financial management	82.8%	81.6%	84.0%
Written communication	87.5%	84.2%	92.0%
Technology skills	78.1%	78.9%	76.0%
Grant writing	64.1%	71.1%	56.0%
Data management	78.1%	76.3%	80.0%
Fundraising	65.6%	73.7%	52.0%
Supervisory skills	65.6%	63.2%	68.0%
Other			
Note: Percentages are calculated with race totals as the denominator. **Participants could select all that apply.**			

The final set of questions asked providers to consider the barriers/facilitators to professional growth by answering the question, "If training or classes were offered to help you develop the skills you selected above, how important (Not a Concern, Somewhat Important, Very Important) would the below factors be to you, as you considered taking part?" The factors listed were 1) fitting it into my busy day, 2) compensation for my time, 3) support from my manager, and 4) topic relevance.

Most important to all providers was "topic relevance" (82.3% selected "very important"). To follow, two-thirds felt that "fitting it into my busy day" was also important (66.1% selected "very important"). Keeping the small sample size in mind, the importance of topic relevance and fitting trainings or classes into one's day was fairly consistent across racial groups. There was some difference between people of color and White respondents: 80.0% of people of color compared to 52.6% of White respondents indicated that "fitting into busy days" was "very important"; 32.0% of people of color compared to 7.9% of White respondents indicated that compensation was "very important"; 72.0% of people of color indicated that support from

management was "very important" compared to only 39.5% of White staff; and 72.0% of people of color compared to only 39.% of white staff indicated that topic relevance was "very important".

Conclusions from this survey are limited by a small sample size. The complete dataset will be made available to our Dallas partners. Despite the small sample size, the most striking finding from this survey is the underrepresentation of people of color in senior level positions. It is difficult to generalize this finding because higher level staff may have been more likely to respond to the survey. However, given the substantial number of Administrators and Executive Directors who did respond, the finding that the overwhelming majority were White is notable. Additionally, respondents reported directly through a survey item that race and ethnicity of senior management, in their opinion, does not reflect the people they serve.

Qualitative Data

The data described above come from a non-systematic, voluntary survey of people working in housing and homelessness programs in Dallas. The sample was small, and the response rate overall or across racial and ethnic groups is unknown. However, our qualitative findings can help guide interpretation and clarify potential recommendations.

Lack of diversity in the homeless service workforce may have a negative impact on client's experiences of services and outcomes. A few people talked about experiences of racism within programs. One respondent shared:

> INTERVIEWER: Do people of color get treated differently by staff here?
> RESPONDENT: It depends. I – I'm not saying all white folks. But white folks act like they're just afraid to talk to anybody who's Black. Just afraid of them. You get the biggest impression they're afraid to say anything. Or deal with it. You know. They'll say kind of feel like I can't help you.
> INTERVIEWER: They say what?
> RESPONDENT: They say have him help you.
> INTERVIEWER: Have him help you.
> RESPONDENT: They point towards an employee that's of color. Yeah. They don't want to deal with you. Usually the new ones.
> INTERVIEWER: The new what? New who's?
> RESPONDENT: You can tell where they just are afraid. They watch a lot of television. They watch a lot of movies.

This respondent shared a negative experience where his needs were not met by a White staff, who instead ushered him to go to an employee of color. His narrative suggests that he has observed this as a pattern and internalizes that some White staff, especially new employees, are afraid of Black people. People also noticed subtle differences in access to resources:

> INTERVIEWER: I see what you are saying. Do you think people of color get treated differently by staff members? In any homeless service center, not necessarily here.
> RESPONDENT: Yeah. One situation, my first day here I was greeted, welcomed in and my paperwork processed I was given a bunk. Okay two months down the line I sat right there. I am a volunteer in the kitchen as well so I watched two individuals come in, one is a man, one is a lady, they're not of color. They were greeted by the same individual. They were provided with food, upon entering, water, access to the clothes, and I sat there and I watched that and I said damn I wasn't given that opportunity. So I just looked at it. Even though it was not something – it was nothing serious but because I mean eventually I had access [it, but it was like they had me finish the intake process and they were like at distance and stuff, so I was like wow how did I miss that. It was that situation. There was another situation where I didn't have blankets and stuff like that. I accumulated it. Certain people not of color that come through, it's like magic, this shit just appears and I sit and I mean like where did the hell did this come from, how come I didn't get?

A few qualitative interviews with service users explored the Whiteness of agency leadership.

> INTERVIEWER: Do you feel people of color get treated differently by staff?
> RESPONDENT: You know what, that's difficult to say, because I think staff has different expectations and since staff is -- all of the upper staff in every homeless shelter in Dallas is all white, every bit of it. And most of the clients are black. Now you tell me how the white staff is going to relate to white people when they come in. Yeah, they get treated -- white people are treated differently. But then the whole bureaucracy is, I call it, the Tarzan of the ape -- Tarzan and the ape-man bureaucracy, because we have a bureaucracy where we have people -- where we have all these blacks and there's always a white person who's leading it, at the head of it, as if there's not a black person intellectually capable of doing that.

This respondent above suggests that homeless service agencies are always led by White people, while all of the clients and many of the providers are Black. His comments are striking, and resonate with the data of our survey, despite its limited sample size.

Discussion

Our online survey of providers, focus groups, and interviews shed light on the diversity of the homeless service workforce in Dallas. Our findings describe a need for leadership to commit to racial equity, both as a lens to view client outcomes and a framework for managing and supporting the people who work for their agency. Because one of Dallas' structural change goals is professional development and leadership training for people of color, paying close attention to the real challenges providers of color face is vital. This research suggests practice and policy implications in the following areas:

- **Hiring.** If requiring a master's degree is getting in the way of hiring leadership of color, particularly Black leaders, programs should think critically about whether such a requirement is necessary.

- **Training.** Everyone in the U.S. is exposed to racism and has work to do to unlearn implicit biases. Anti-racism and diversity training should be ongoing and an understanding of microagressions, not just for White providers but for all staff.

- **Promoting.** Continued and ongoing analysis of how staff are promoted, what salary grades they are assigned, and what opportunities for professional development they are offered should be a robust part of every program. By routinely collecting this data and analyzing it by race/ethnicity, gender identity/expression, and sexual orientation, programs can continue to drive themselves towards equitable practices.

7.2 Entry and Exit Location Groupings

We grouped HMIS data fields for situations at entry into the following categories for our analyses:

1. **Homeless (Shelter + Street)**
    a. Place not meant for human habitation
    b. Emergency Shelter (including motel/hotel with voucher)
2. **Permanent Housing/Renting w/ subsidy**
    a. Rental by client with VASH subsidy
    b. Rental by client with other ongoing subsidy
    c. Permanent housing for formerly homeless persons
    d. Owned by client with ongoing subsidy
3. **Permanent Housing/Renting w/o subsidy**
    a. Rental by client with no ongoing housing subsidy
    b. Residential project/halfway house with no homeless criteria
    c. Owned by client with no ongoing subsidy
4. **Institutionalized Care**
    a. Long-term care facility or nursing home
    b. Substance abuse treatment facility or detox center
    c. Foster care home or foster care group home
    d. Hospital or other residential non-psychiatric medical facility
    e. Psychiatric hospital or other psychiatric facility
    f. Mental health/psychiatric, physical health, substance use treatment, foster care
5. **Jail, prison or juvenile detention facility**
6. **Doubled Up**
    a. Staying or living with friends
    b. Staying or living with family
7. **Transitional setting**
    a. Transitional Housing for homeless persons (including youth)
    b. Safe Haven
    c. Hotel/Motel (no voucher)
8. **Other**
    a. Other (True Other; i.e., response option was labeled "Other")
9. **Missing data** (not included in analysis)
    a. Client does not know
    b. Client refused

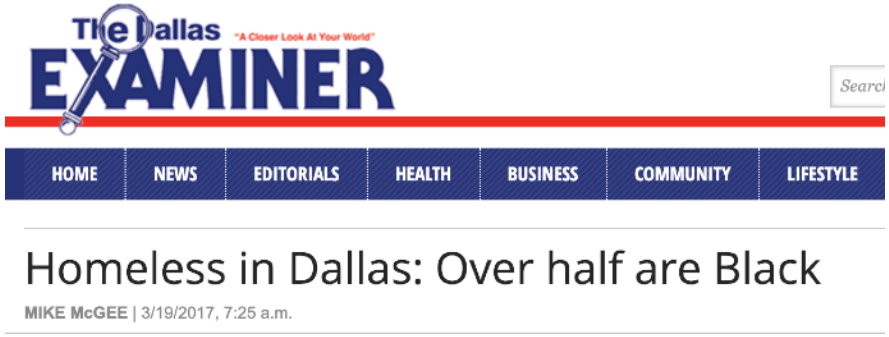
We grouped HMIS data fields for destination at project exit into the following categories for our analyses:

1. **Homeless (Shelter + Street)**
    a. Place not meant for human habitation
    b. Emergency Shelter (including motel/ hotel with voucher)
2. **Permanent Housing/Renting w/ subsidy**
    a. Rental by client with VASH subsidy
    b. Rental by client with other ongoing subsidy
    c. Permanent housing for formerly homeless persons
    d. Owned by client with ongoing subsidy
3. **Permanent Housing/Renting w/o subsidy**
    a. Rental by client with no ongoing housing subsidy
    b. Residential project/halfway house with no homeless criteria
    c. Owned by client with no ongoing subsidy
4. **Institutionalized Care**
    a. Long-term care facility or nursing home
    b. Substance abuse treatment facility or detox center
    c. Foster care home or foster care group home
    d. Hospital or other residential non-psychiatric medical facility
    e. Psychiatric hospital or other psychiatric facility
    f. Mental health/psychiatric, physical health, substance use treatment, foster care
5. **Jail, prison or juvenile detention facility**
6. **Doubled Up**
    a. Staying or living with friends (permanent)
    b. Staying or living with family (permanent)
    c. Staying or living with friends (temporary) (option at exit only)
    d. Staying or living with family (temporary) (option at exit only)
7. **Transitional setting**
    a. Transitional Housing for homeless persons (including youth)
    b. Safe Haven
    c. Hotel/Motel (no voucher)
8. **Other**
    a. Other (True Other; i.e., response option was labeled "Other")
    b. Deceased
9. **Missing data (not included in analysis)**
    a. Client refused
    b. Data not collected
    c. No exit interview completed

MDHA
METRO DALLAS HOMELESS ALLIANCE

Racial Equity and Homelessness 2.0: Considerations for Next Steps

Racial Equity and Homelessness
DFW Press highlights Racial Inequity in Homelessness



Racial Equity and Homelessness
Previous Programming

HARD CONVERSATIONS: RACISM AND HOMELESSNESS

WHEN: November 18, 2016 @ 12:30 pm – 2:00 pm America/Chicago Timezone

WHERE: Auditorium (1st Floor) of the J. Erik Jonsson Central Library
1515 Young St
Dallas, TX 75201
USA

COST: Free

CONTACT: David Gruber, MDHA
469-222-0047
Email
Event website

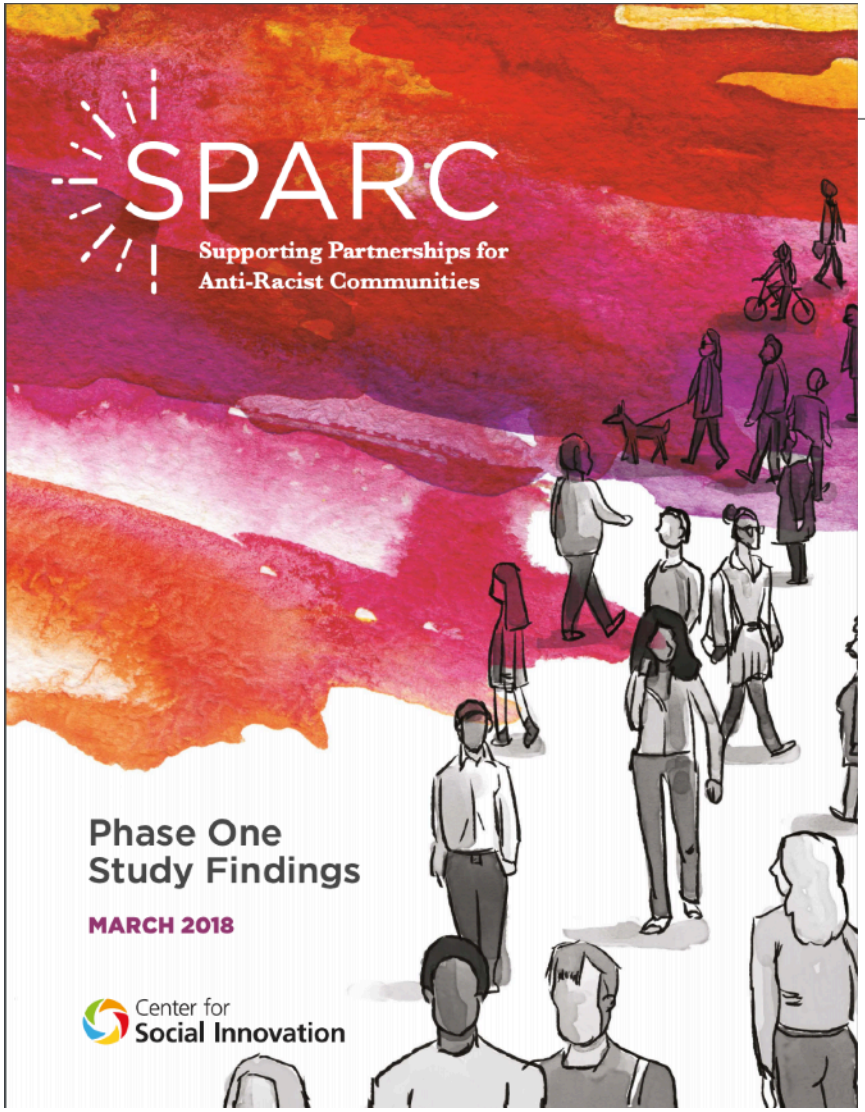
Calendar

Add to Calendar

Hard Conversations: Racism and Homelessness

What: **MDHA**, and the **Dallas Public Library** invite the public to take part in the next installment of **Hard Conversations**, this time on **Racism and Homelessness**. Persistent racial inequality stands out in the area of homelessness, particularly in Dallas. **Fulfilling the vision of making homelessness rare, brief and nonrecurring, in Dallas and Collin Counties, will only be possible by addressing the disproportionality of homelessness among African Americans.** MDHA is committed to the realization of full racial equity, as a proud partner of **Dallas Faces Race**.

Racial Equity and Homelessness
Research (SPARC-Center for Social Innovation)



SPARC
an initiative of
Center for Social Innovation

SPARC DALLAS

Initial Findings from Quantitative and Qualitative Research

March 16, 2018

This document was prepared by the
Center for Social Innovation (C4) in Needham, MA for
Metro Dallas Homeless Alliance in Dallas, TX

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Center for Social Innovation

Racial Healing and Homelessness 2.0
Planning

WHAT

Creation of a racial equity plan of action for ending homelessness in Dallas with Metro Dallas Homeless Alliance, Dallas Truth, Racial Healing & Transformation, United Way of Metropolitan Dallas, SPARC, Faith Forward Dallas as lead community partners and other organizations as participating/ supporting community partners

WHY

Homelessness in Dallas is a racial equity issue. According to the initial research findings of the March 2018 SPARC Dallas report, "Though the Black population in Dallas constitutes 18.7% of the general population, this group is overrepresented…among people experiencing homelessness (66.7%)." There's no current effort in DFW to address homelessness as an equity issue.

WHERE

Racial Equity and Homelessness 2.0 is focused on the Dallas Metro area, and may extend to Dallas County. Dallas is one of six cities (Atlanta, GA., Columbus, OH., San Fransisco, CA., Syracuse, NY., and Pierce County, Washington) involved in a national quantitative and qualitative study of race and homelessness by SPARC (Supporting Partnerships for Anti-Racist Communities), an initiative of the Center for Social Innovation.

Racial Equity and Homelessness 2.0
Initial Partners

United Way of Metropolitan Dallas

MDHA
METRO DALLAS HOMELESS ALLIANCE

SPARC
an initiative of
Center for Social Innovation

TRUTH, RACIAL HEALING & TRANSFORMATION™
Dallas

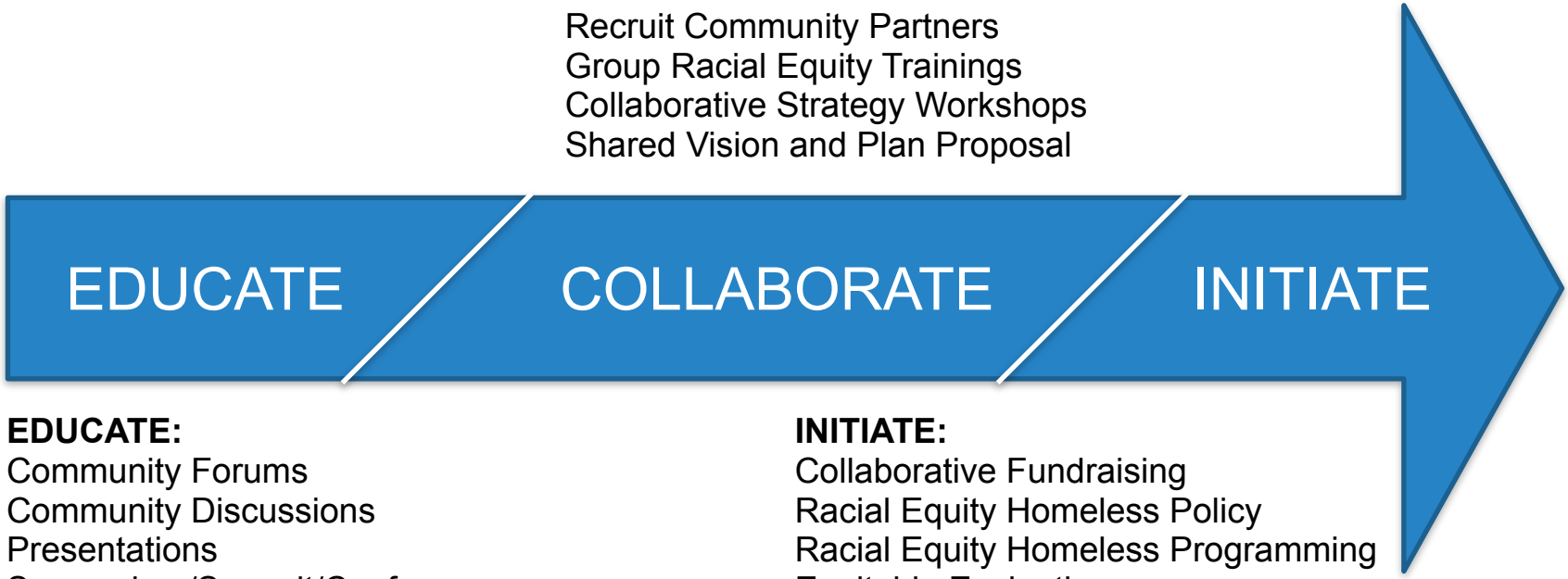
FAITH FORWARD DALLAS

Racial Equity and Homelessness 2.0
Potential Local Partners

AND MANY MORE…

Racial Equity and Homelessness 2.0
Engagement Strategy

COLLABORATE:
Recruit Community Partners
Group Racial Equity Trainings
Collaborative Strategy Workshops
Shared Vision and Plan Proposal



EDUCATE:
Community Forums
Community Discussions
Presentations
Symposium/Summit/Conference

INITIATE:
Collaborative Fundraising
Racial Equity Homeless Policy
Racial Equity Homeless Programming
Equitable Evaluation

2019-20 Racial Equity and Homelessness 2.0 Timeline

Dallas Truth, Racial Healing and Transformation
Community-Driven, Community Informed

HOW

1. EDUCATE
2. COLLABORATE
3. INITIATE

(See Engagement Strategy Diagram)

DRAFT BUDGET

PLANNING:	
MDHA	**5,000**
DALLAS TRHT	**5,000**
EDUCATE:	
Community Programming, Etc.	**10,000**
COLLABORATE:	
Collaborative Workshops, Etc	**10,000**
TOTAL:	**30,000**
Future Funding	
INITIATE:	**TBD**

Racial Equity and Homelessness 2.0
First Draft Plan by Dallas THRT Director, Jerry Hawkins

WHO

Jerry Hawkins is the Director of Dallas Truth, Racial Healing, and Transformation (DTRHT), part of a national 14-city initiative by The W.K. Kellogg Foundation. Jerry was formerly the Project Director of Bachman Lake Together, an early childhood collective impact initiative in Dallas, and Director of Children's Services at the Wilkinson Center in East Dallas/Southeast Dallas. Jerry is also a co-founder of The Imagining Freedom Institute (The IF Institute), a thought leadership group that works with organizations and institutions to build their capacity for internal and external equity and social justice efforts, and a co-creator of the Race to Equity DFW conversation series. He is a current Leadership Arts Institute Fellow with the Business Council for the Arts, a Trustee appointed member of Dallas ISD's Racial Equity Advisory Council, a past Fellow with Leadership ISD, and a past Leadership Fellow with D Academy/ D Magazine. Jerry Hawkins served as an Advisory Board member at Children's Medical Center, and on Dallas ISD's African American Student Success Task Force. Jerry is also a highly trained consultant of social justice, inclusion and racial equity work, with a concentration on the intersection of race, education and the history of cities. While living in Chicago, Jerry previously worked for the Chicago Urban League and Chicago Public Schools.

2019 Scorecard Continuum of Care (CoC) Renewal Projects

The results of this CoC Renewal Project Scorecard will be used by the Performance Review and Allocations Committee (PRAC) as a baseline evaluation tool for prioritization and allocation decisions for CoC program funds for renewal projects. The score will be a starting point for PRAC discussion regarding ranking and projects to be included in the final CoC Collaborative Application to HUD. The Renewal Projects will also be evaluated based on the MDHA RFP which will include new performance evaluation items reflecting the HUD Notice of Funding Availability.

Agency Recipient Name:
Subrecipient:
Project Name:
CoC Performance Period:
Project Grant Number:
Component Type (PSH, RRH, TH, SH, Joint TH-RRH):

Objective 1
Ending Homelessness
Maximum Points Available: 40 Points

Capacity Rate: Maintain Efficient Unit Capacity

1.1 What is the quarterly PIT unit capacity rate? (APR Q7b)

Proposed	Actual	Computation	Point Distribution Scale	Possible Score	Project Score
	Q1:		0 quarters ≥ 90%	0	
	Q2:		1 quarter ≥ 90%	5	
	Q3:		2 quarters ≥ 90%	10	
	Q4:		3 quarters ≥ 90%	15	
			4 quarters ≥ 90%	20	

Organization is Active Participant in the Continuum of Care

1.2 Applicant participated in the 2019 point in time count.

Point Distribution Scale	Possible Score	Project Score
Yes	10	
No	0	

1.3 What % of MDHA CoC Assembly and CoC round table meetings did the applicant attend July 1, 2018 - June 30, 2019? (All Round Tables, Assembly Meetings, Motivational Interviewing, and RRH training attendance included)

Total # Meetings	Total # of Meetings Attended	Computation	Point Distribution Scale	Possible Score	Project Score
		#DIV/0!	< 50%	0	
			51% - 74%	5	
			75% - 100%	10	
			Total Points Available for Objective 1:	**40**	0

Objective 2
Creating a Systemic Response to Homelessness
Maximum Points Available: 40 Points PSH and SH / 40 Points RRH and TH-RRH

Rapidly Rehouse

2.1 What was the average Length of Time between Project Entry Date and Residential Move-In Date? (Q5a and Q22c)

Total Households Moved in	LOT	Computation	Point Distribution Scale	**RRH/TH-RRH Possible Score**	**Project Score**
			Avg LOT was over 90 days	0	
			Avg LOT was 61-89 days	5	
			Avg LOT was 31-60 days	10	
			Avg LOT was 30 days or less	20	

Chronically Homeless: Percentage Served

2.2 What percentage of the individuals (Head of Households) served by the project were chronically homeless (CH) at time of enrollment? (APR Q26b)

Total Head of Households Served	CH Served	Computation	Point Distribution Scale	**PSH/SH Possible Score**	**Project Score**
		#DIV/0!	Less than 20%	0	
			Between 21% and 39%	5	
			Between 40% and 59%	10	
			Between 60% and 79%	15	
			Between 80% and 100%	20	

Homeless Identified through CAS DOPS Prioritization

2.3 What percentage of households newly enrolled in the program between July 1, 2018 - June 30, 2019 are from the Housing Priority List? (Q5a Detail and HPL)

Total Households Enrolled	Number that were from HPL	Computation	Point Distribution Scale	**Possible Score**	**Project Score**
		#DIV/0!	Less than 20%	0	
			Between 21% and 39%	5	
			Between 40% and 59%	10	
			Between 60% and 79%	15	
			Between 80% and 100%	20	
			Total Points for Objective 2:	**40/40**	0

Objective 3
Strategically Allocating and Using Resources
Maximum Points Available: 30 Points

Ensure that Programs are Utilizing all Funding Allocated for Project

3.1 What percentage of total grant funds did the applicant leave unspent after 90 days from last grant term end? (LOCCS draw report)

Total Funding Allocated	Total Funding Recaptured	Computation	Point Distribution Scale	**Possible Score**	**Project Score**
		#DIV/0!	> 10%	0	
			Between 6.01% and 9%	5	
			Between 3.01% and 6%	10	
			Between 0.01% and 3%	15	
			No funds recaptured	20	

3.2 Applicant designates at least one staff member who is SOAR certified. (Please provide documentation)

Point Distribution Scale	**Possible Score**	**Project Score**
Yes	10	
No	0	
Total Points Available for Objective 3:	**30**	0

Objective 4
Using an Evidence-Based Approach
Maximum Points Available: 40 Points

Housing Retention: Ensure Participants are Stably Housed in Program

4.1 What percentage of program participants (leavers and stayers) maintained program housing for 6 months or longer? (APR Q22a1 for TH; Q5a Detail for PSH and RRH)

Total Households Moved In	Total 181 days+	Computation	Point Distribution Scale	Possible Score	Project Score
		#DIV/0!	≤ 79%	0	
			Between 80% - 84%	5	
			Between 85% - 90%	10	
			Between 91% - 94%	15	
			Between 95%-100%	20	

Housing Stability: Ensure Participants are Stably Housed Upon Exit

4.2 What % of leavers households exited into permanent housing destinations? (Q23a & Q23b).

Total Leavers	Total Leavers to PH	Computation	Point Distribution Scale	Possible Score	Project Score
		#DIV/0!	< 73%	0	
			Between 73%-86%	5	
			Between 87%-90%	10	
			Between 91% - 95%	15	
			Between 96%-100%	20	
			Total Points Available for Objective 4:	**40**	0

Objective 5: Financial Management
Increased Income / Employment
Maximum Points Available: 40 Points

Increase in Earned Income

5.1 What percentage of adults had an increase in earned income at exit or annual assessment? (Q19a3)

Total Adult Leavers/Stayers	Total Adults with income gain	Computation	Point Distribution Scale	Possible Score	Project Score
		#DIV/0!	< 19%	0	
			Between 20% - 39%	5	
			Between 40% -59%	10	
			Between 60% - 79%	15	
			≤ 80%	20	

Increase in Non-Employment Cash Income

5.2 What percentage of adults had an increase in non-employment cash income at exit or annual assessment? (Q19a3)

Total Adult Leavers/Stayers	Total Adults with income gain	Computation	Point Distribution Scale	Possible Score	Project Score
		#DIV/0!	< 19%	0	
			Between 20% - 39%	5	
			Between 40% -59%	10	
			Between 60% - 79%	15	
			≤ 80%	20	
			Total Points Available for Objective 5:	**40**	0

Objective 6
Providing Flexibility for Housing First with Service Participation Requirements
Maximum Points Available: 10 Points

Housing First Approach					
6.1 Based on monitoring, does the project follow a housing first model?					
Point Distribution Scale				**Possible Score**	**Project Score**
			Yes	10	
			No	0	
			Total Points Available for Objective 6:	**10**	0

Objective 7 **HMIS** **Maximum Points Available: 20 Points**		
7.1 Program users are accessing the HMIS (User Login Report)		
Point Distribution Scale	**Possible Score**	**Project Score**
Yes	10	
No	0	
7.2 Agencies have taken required training on time (New User and Privacy, Security, and Ethics Training)		
Point Distribution Scale	**Possible Score**	**Project Score**
Yes	10	
No	0	
Total Points Available for Objective 7:	**20**	0

Overall Score for the Project

Maximum Points Possible: 220 for PSH and SH/ 220 for RRH and TH-RRH

SECTION	OBJECTIVE	SECTION SCORE	TOTAL SCORE
Section 1	Ending Homelessness	0	0
Section 2	Creating a Systemic Response to Homelessness	0	
Section 3	Strategically Allocating and Using Resources	0	
Section 4	Using an Evidence-Based Approach	0	
Section 5	Financial Management	0	
Section 6	Providing Flexibility for Housing First with Service	0	
Section 7	HMIS	0	

Agency Comment: Use this section to respond to any metric above with any unusual circumstances that may have abnormally lowered a performance category for your agency.

V2

Applicant Name:		***Project Name:***		
Renewal CoC Application Scoring Rubric FY2019			**POINTS POSSIBLE**	**SCORE**
Application Completeness and On Time				
			yes	
Submitted complete with all attachments on time		Yes, completed and on time		
- All attachments in eSNAPs including applicant attachments		No, application not on time. **Application will not be scored.**		
- All Match with correct date and amount				
- eLOCCS history				
- Program intake and participant forms				
eSNAPS Application Part	**eSNAPS Question #**	**Scored Response**		
Part 3A Project Detail	5a. Does the PH project provide PSH or RRH?	RRH 8 Points, PSH 4 Points, SSO 0 Points	**8**	
Part 3B Project Description	1. Description	PRAC Scoring Range 0-10	**10**	
	3a. & 3d. Housing First	Yes & Yes	**2**	
	3b. Housing First	check all 4	**2**	
	3c. Housing first	check all 4	**2**	
Part 4A Supportive Services	1. Total services provided by Applicant Partner or Non Partner	Applicant/Partner/Non-Partner 0-5 services - 0 Points	**5**	
	0, 2 or 5 points	Applicant/Partner/Non-Partner 6-11 services - 2 points		
		Applicant/Partner/NonPartner 12-16 services - 4 points		
	2a.	Yes	**2**	
	2b.	Yes	**2**	
	3.	Yes	**2**	
Part 6 Budget	Budget presentation, housing to services ratio no less than 70:30, housing is leasing or rental assistance line items including match for rental assistance	PRAC Scoring Range 0-5 points	**5**	
CoC Local Application Narratives	**Question #**	**Scored Response**		
Response to Performance	1	PRAC Scoring Range 0-10	**10**	
Evidence-Based Approach	2	PRAC Scoring Range 0-10	**10**	
Housing First and Vulnerability Allowance	3	PRAC Scoring Range 0-10	**10**	
Cost Effectiveness	4	PRAC Scoring Range 0-10	**10**	
		TOTAL:	**80**	0