Santa Cruz County Continuum of Care

Smart Path to Housing and Health: *Coordinated Assessment and Referral System*

Policies & Procedures Manual
Original Document Approved on December 13, 2017

Revision History

Date	Author	Description
9/19/2018	Habiba Rotter – Smart Path Referral Specialist	Approved: P. 9, 3. a) System Oversight and Roles Transition from HSC to HSD and new staffing structure reflected.
7/12/2018	Habiba Rotter – Smart Path Referral Specialist	Approved: P. 16, 7.e) Updates to Assessments Change in reassessment period from 1 year to 3 months.
8/15/2018	Habiba Rotter – Smart Path Referral Specialist	Approved: P. 16, 8. a) Smart Path Participant List Change in active period from 9 months to 90 days.
9/4/2019	Jessica Scheiner, Senior Analyst, County of Santa Cruz Human Services Department	Approved: P 15 Smart Path Check-in Policy Approved: P. 16 Rapid Re-Housing Programs will take clients with higher VI-SPDAT scores. Approved: P. 18 Referrals of couples or households Approved: P. 20 Dual enrollment in transitional housing and the community queue
9/6/2019	Monica Lippi, Senior Analyst (Smart Path Referral Specialist), County of Santa Cruz Human Services Department	Updated assessment workflow: P.41-42

Contents

1. Background

a) What is a Coordinated Entry System?

A coordinated entry system, also known as coordinated assessment, is an emerging best practice for conducting assessments and referrals that provides a "no wrong door" approach to addressing homelessness. This community-wide system seeks to effectively and efficiently match people experiencing homelessness to available housing and services that best fit their specific needs and situation. In a coordinated entry system, individuals and families (referred to hereafter as "participants") who experience homelessness are assessed with the same tool regardless of where the assessment occurs. Assessment results are used to prioritize participants for scarce resources based on vulnerability and need. Participating projects agree to accept referrals from the system when they have project vacancies, reducing the need for participants to traverse the county seeking assistance from each agency separately. A countywide list of participants experiencing homelessness is retained and prioritized by need and vulnerability for quick referral when agencies have project vacancies.

In Santa Cruz County, the local coordinated entry system, Smart Path to Housing and Health: Coordinated Assessment and Referral System (referred to hereafter as Smart Path), is the responsibility of the Homeless Action Partnership (HAP), which serves as the countywide Continuum of Care (CoC).

b) Federal Department of Housing and Urban Development Requirement

Under the U.S. Department of Housing and Urban Development's (HUD) interim rule[1] 24 CFR 578.7(a)(8), each CoC must establish and operate a centralized or coordinated assessment system. HUD defines a centralized or coordinated assessment system as "a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool" (24 CFR 578.3).

To be eligible for HUD CoC and Emergency Solutions Grant (ESG) funds, communities must participate in a coordinated entry system.

In addition, developing a robust coordinated entry system is one of the primary recommendations of the countywide plan to address homelessness, *All In-Toward a Home for Every County Resident*[2].

[1] https://www.hudexchange.info/resources/documents/CoCProgramInterimRule_FormattedVersion.pdf
[2] http://smartsolutionstohomelessness.org/wp-content/uploads/2012/08/HSP-FullReport-FINAL-Small.pdf

c) Community Vision

The Santa Cruz County community holds firmly to the vision that everyone should have access to stable housing. The vision is to move beyond a fragmented approach to serving persons experiencing or at-risk of homelessness to one that effectively prevents people from becoming homeless and quickly stabilizes people who are already experiencing homelessness.

d) Guiding Principles

Underlying Santa Cruz County's Coordinated Entry System is the conviction that homelessness is preventable and solvable. The system is guided by the following principles:

- Equitable access: Coordinated entry access will be available to all people in all areas of the county.
- Compassionate, caring service: All people will be treated with dignity and respect throughout the process.
- Cultural responsiveness: Coordinated entry will provide services that are linguistically and culturally appropriate throughout the process.
- Trauma-informed services: Coordinated entry will utilize trauma-informed practices while engaging, assessing, and referring participants.
- Housing First[3]: Coordinated entry will provide permanent housing as quickly as possible with low to no barriers.

e) System Goals

The goals of Santa Cruz County's Coordinated Entry System include:

- Create an organized system to improve access to all housing and service types to ensure the experience of homelessness is rare, brief, and nonrecurring.
- Improve and streamline the referral process.
- Create better linkages across projects, including but not limited to establishing warm hand-off referrals to non-housing services and developing coordinated entry committees to regularly discuss strengths and challenges of the project.

[3] See Section 13. Definitions, "Housing First"

- Improve the experience for people to easily and quickly get the assistance they need without having to contact each agency separately.

- Prioritize projects and services for participants who are most in need, utilizing a common assessment tool and community prioritization plan.

- Quickly assess a household's needs and most appropriate intervention, including tailored resources that provide the level of support needed to attain and retain housing.

- Ensure that all people who complete an initial screening are referred to appropriate available resources for immediate needs.

- Diverting those whose housing crisis can be resolved with relatively minimal resources so that they do not require the homeless services system.

- Coordinate outreach countywide to ensure everyone has the same opportunities to receive housing and services regardless of their location.

- Better coordinate emergency shelter referral and placement and connect participants in shelters to permanent housing opportunities.

- Incorporate data-driven metrics to evaluate and strategically develop homeless services and housing resources.

- Develop and implement improved, consistent, and shared training for service agencies in evidence-based practices, for example Trauma-Informed Care and Housing First.

f) Benefits of Coordinated Entry

Benefits of Coordinated Entry to Santa Cruz County include:

- Effective targeting of existing resources by connecting the most vulnerable people to the available housing and resources that best fit their situation.

- Streamlined assessment and application process for all participants, ensuring everyone who completes a Smart Path assessment is included in the pool of participants considered for openings at participating agencies.

- Development of comprehensive data on the number of participants experiencing homelessness and their needs. This data will inform programmatic and policy decisions and support advocacy efforts to leverage additional resources.

2. Smart Path Overview

Ultimately, Smart Path will assist anyone with a housing crisis, including those who are literally homeless[4], at imminent risk of losing housing, or lack adequate or stable housing. Once fully implemented, using a decentralized structure, Smart Path will include all agencies and projects that provide assistance, services, and housing to participants who are homeless or at risk of homelessness. Completed Smart Path Assessments will be used to develop a pool of prioritized participants from which participating projects will fill their vacancies. Participating agencies will accept referrals from Smart Path to fill all project vacancies from the pool of eligible participants who completed a Smart Path Assessment. Referrals will be prioritized based on the household's VI-SPDAT score, length of homelessness, and date of assessment, with participants with the highest VI-SPDAT score (i.e., the greatest vulnerability) receiving priority.

Participants will be able to access the following resources through Smart Path:

- Phase 1: Transitional Housing, Rapid Rehousing, Permanent Supportive Housing, Specialized Housing Choice Vouchers that include case management (e.g., Disabled Medically Vulnerable (DMV) Vouchers), and shelter diversion projects.

- Phase 2: Shelter beds and eviction prevention (rental assistance) projects, in addition to the above.

Once fully implemented, Smart Path will be able to provide immediate information and connections to the following agencies and services:

  - Services unrelated to housing or shelter, such as food and showers
  - Health care agencies
  - Government services such as mainstream benefits programs
  - School-based programs such as those funded through the McKinney-Vento Homeless Assistance Act
  - Faith-based programs

3. Administrative Structure

a) System Oversight and Roles

Oversight of the coordinated entry system, including implementation of the Assessment, Participant List, prioritization and referral matching processes, is provided by the Homeless Action Partnership (HAP). The HAP serves as the Santa Cruz County CoC's collaborative applicant. The CoC Board delegated authority to the HAP, as the collaborative applicant, to approve and implement

[4] See Section 13. Definitions, "Literally Homeless"

operational policies for coordinated assessment (See Delegation of Authority Table approved in April 2015). The Smart Path/Coordinated Entry Steering Committee, a committee of the HAP, leads implementation of coordinated entry and reports back on progress to the HAP.

The Coordinated Entry and Housing Work Group (Housing Workgroup) supports the implementation of Smart Path in a variety of capacities including providing recommendations on policies and procedures, sharing the status and location of referred participants, case conferencing, and identifying other issues that are impacting agencies' ability to effectively serve persons experiencing homelessness . The Housing Work Group meets twice monthly and is comprised of representatives from Smart Path participating agencies and other agencies that serve persons experiencing homelessness.

The Homeless Services Center (HSC) served as the Coordinated Entry Lead Agency from March, 2016 until September, 2018. HSC oversaw the first phase of coordinated entry including planning, launch, and implementation.

The Santa Cruz County Human Services Department (HSD) Community Relations Division began serving as the Coordinated Entry Lead Agency on October 1, 2018. As the Lead Agency, the County Human Services Department is responsible for supervising Smart Path staff, interns, and volunteers including ensuring appropriate performance and addressing issues as needed. A Senior Health Services Manager and two Senior Human Services Analysts staff Smart Path.

b) Grievance Procedures

Any person participating in the coordinated entry process has the right to file a grievance. Resolution of grievances related to a particular service agency (for example, a grievance related to how an assessment was conducted at a particular agency) should be attempted first through that agency's grievance procedure. Grievances specific to the coordinated entry system (for example, a grievance related to the match making process), should be forwarded to the Smart Path Referral Specialist using the Smart Path Grievance Form (see Appendix A). Within five business days, the Referral Specialist will draft an initial recommendation on how to address the grievance, which will be forwarded to the Smart Path System Manager for review and a final determination. The decision will be communicated to the participant within thirty days. Should the participant seek a different resolution, they may appeal the decision by contacting the HAP staff, who will respond within an additional thirty days.

c) Revisions to Policies and Procedures

The Policies and Procedures Manual will be reviewed and, if necessary, updated at least annually by the Smart Path/Coordinated Entry Steering Committee and HAP staff. Operational changes may be

approved by the Smart Path/Coordinated Entry Steering Committee, and any significant policy changes must be approved by the HAP[5].

d) Participating Agencies:

All CoC and ESG funded housing programs must participate in the Coordinated Entry System. The CoC strongly encourages all other housing agencies with housing dedicated to people who are homeless to participate, as well.

4. Smart Path Access Points

Smart Path Access Points refer to any location where participants experiencing or at imminent risk of homelessness (pending) can complete the Smart Path Assessment, as described further below. Initial Access Points will include all HMIS partner agencies, with the goal of incorporating additional projects in the future from throughout the County as appropriate and available. Specific Access Point locations and operating hours will be posted and regularly updated on the Smart Path website at www.SmartPathSCC.org.

To the extent possible, Access Points are located at convenient locations throughout the county and are accessible by public transportation. Access Points are required to be accessible to individuals with disabilities, and participants with a mobility impairment may request a reasonable accommodation in order to complete the Smart Path Assessment at a different location.

Once fully implemented, the following types of locations will either serve as Smart Path Access Points or be able to assist persons in immediately connecting to Access Points:

- Street outreach: mobile case managers/outreach workers
- Homeless service locations: shelters, homeless service and housing agencies, day services projects (such as meals and showers)
- Institutions: schools, hospitals, jails (pending full implementation)
- Public service agencies: clinics, government service agencies, libraries
- Emergency and crisis support agencies: 911, police, first responders, mental health agencies, projects that serve survivors of domestic violence (pending full implementation)
- Events: such as Santa Cruz Connect and Watsonville Connect, the local Project Homeless Connect events

[5] Additional detail on what is considered a "significant policy change" is pending.

- Virtual locations/phone lines such as 211
- Faith-based organizations (pending full implementation)

5. Outreach and Marketing

Outreach and marketing practices ensure that persons throughout Santa Cruz County who are either experiencing or at risk of homelessness (pending) are aware of and able to access Smart Path. Initial targets for distributing information about Smart Path include the Access Points described above, as well as:

- Public websites: such as County and City websites
- Informational flyers at public locations, such as bus stops, laundromats
- Information to the general public, such as public service announcements on the radio and in the newspaper

Smart Path outreach materials will be available in English and Spanish throughout the county, and Access Points with Spanish-speaking Assessment Specialists will be indicated on all Access Point lists. For participants who need additional language translation services, including sign language, interpreters can be made available in-person or via telephone with at least a one-day advance request.

The HAP will affirmatively market housing and supportive services to eligible persons who are least likely to apply in the absence of special outreach, including those who may not realize they are eligible to participate, have recently become homeless, are resistant to receiving services, youth and young adults, location-bound due to physical disabilities, and monolingual Spanish-speaking participants. The outreach methods described above are used to connect people unlikely to access Smart Path on their own.

The marketing campaign will be designed to ensure that people in different populations and subpopulations in the CoC's geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, survivors of domestic violence, and any other protected classes under federal and state law, have fair and equal access to Smart Path.

Similarly, the marketing campaign will be designed to ensure that the Smart Path process is available to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identify, or marital status.

To the extent possible, Access Points will be accessible to individuals with disabilities, including participants who use wheelchairs. Because they can be completed on mobile devices or on paper, Smart Path Assessments can be conducted in locations that are accessible and comfortable to participants. In addition, Access Points must ensure effective communication with participants, including providing appropriate auxiliary aids and other services necessary to ensure effective communication. Marketing materials will clearly convey that the access sites are accessible to all sub-populations.

6. Non-Discrimination

The HAP does not tolerate discrimination on the basis of any protected class (including actual or perceived race, color, religion, national origin, sex, age, familial status, disability, sexual orientation, gender identity, or marital status) during any phase of the Smart Path process. All agencies participating in Smart Path must comply with applicable equal access and nondiscrimination provisions of federal and state civil rights laws.

Housing programs may have specific eligibility requirements based on their funding sources and/or state or federal law. These programs will be restricted to who they can serve based on their funding requirements. For example, a project funded through the federal Housing Opportunities for Persons With AIDS (HOPWA) may be restricted to only serving persons with HIV/AIDS.

All aspects of the Coordinated Entry System will comply with all Federal, State, and local Fair Housing laws and regulations. Participants will not be "steered" toward any particular housing facility or neighborhood because of race, color, national origin, ancestry, religion, sex, age, familial status, presence of children, disability, actual or perceived sexual orientation, gender identity or expression, marital status, source of income, genetic information, or other arbitrary reasons.

All locations where participants are likely to access or attempt to access Smart Path will include signs or brochures displayed in prominent locations informing participants of their right to file a non-discrimination complaint and containing the contact information needed to file a non-discrimination complaint. The requirements associated with filing a non-discrimination complaint, if any, will be included on the signs or brochures.

See Appendix F for the CoC Written Standards, which includes the Non-Discrimination Policy.

7. Assessments

a) The Smart Path Assessment

Smart Path prohibits screening participants out of the coordinated entry process due to perceived barriers to housing or services, including, but not limited to, little or no income, active or a history of

substance abuse, domestic violence history, resistance to receiving services, the type or extent of disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record.

Prior to conducting Smart Path Assessments, Assessment Specialists will have discussions with persons experiencing or at-risk of homelessness regarding diversion opportunities such as natural supports and potential housing options. If no diversion opportunities are identified, the participant will be invited to complete the common assessment which identifies immediate health and safety needs, potential project eligibility, medical vulnerability, and housing assistance needs. The current Smart Path Assessment utilizes the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) and additional questions to determine participants' immediate needs and project eligibility. Disclosure of specific disabilities or diagnoses is not required to receive assistance or participate in Coordinated Entry. However, specific diagnosis or disability information may be requested for the purposes of determining program eligibility to make appropriate referrals.

Based on demographic information, one of three population-specific VI-SPDAT tools will be used:

- "Single VI-SPDAT" for single adults 25 years old and over and for each individual adult in a couple without minor children
- "Family VI-SPDAT" for one or two adults 18 years old and over with minor children in custody
- "TAY VI-SPDAT" for transition-age youth and young adults (18-24 years old).

See Appendix B for the current Smart Path Assessment tools.

b) Training and Authorization for Conducting the Smart Path Assessment

The Smart Path Assessment can only be conducted by persons who have successfully completed a Smart Path Assessment training. The training will be offered at least twice annually and will provide information on conducting the Assessment including the VI-SPDATs, explaining to others about how the coordinated entry system works, assessing diversion opportunities, and assisting people in crisis. Assessment protocols will be updated and distributed to participating agencies annually or more often as needed, clearly describing the methods by which assessments are to be conducted in adherence to these policies and procedures.

The HAP and Smart Path staff will monitor the quality and consistency of completed Assessments and provide training and adjustments to policies and procedures as necessary. The HAP may revoke the right of any individual or agency to complete Smart Path Assessments if they violate the signed Memorandum of Understanding (MOU) or the policies and procedures described in this document. Please see Appendix C for the current MOU agreement.

c) Confidentiality and Release of Information

The HAP, Smart Path, and its partner agencies recognize the importance of client confidentiality and will inform participants about how, with whom, and for what period of time their information will be shared. Multiple security protections are used to ensure confidentiality of information. The HAP extends the same HMIS data privacy and security protections prescribed by HUD for HMIS practices in the HMIS Data and Technical Standards with respect to Smart Path Assessments and the Participant List, including maintaining a local HMIS security plan. A participant's refusal to consent to share their information does not disqualify the participant for assistance or participation in Smart Path.

All aspects of the Smart Path Assessment are covered under the standard HMIS Release of Information (ROI). The ROI authorizes Smart Path partner agencies to conduct the Smart Path Assessment, enter the information in HMIS, and share participants' information with other participating agencies in order to facilitate the provision of housing and services. The ROI must be completed and uploaded into HMIS before any other participant information can be entered into HMIS. Please see Appendix D for the current Release of Information agreement.

If a participant declines to sign the ROI, the first course of action is to seek to understand the participant's concerns and further explain the purpose of the data sharing. If the participant continues to decline, the trained Assessor may ask the participant to provide an alias of their choice and enter the participant's non-identifying information into HMIS (omitting their Social Security number and date of birth). The Assessor may also enter the participant by "Adding Anonymous Client". The Assessor's agency must keep a record of the participant's alias or anonymous HMIS ID number on file and provide it to the Smart Path Referral Specialist.

If a participant declines to sign the ROI and does not consent to having their information entered into HMIS, the Assessor will ask the participant if they are willing to complete the Smart Path Assessment on paper which will be shared with the Referral Specialist. The Referral Specialist will maintain a separate Participant List outside of HMIS for these participants. No participant data will be entered into HMIS, in order to maintain confidentiality and adhere to the participant's request. When there is an opening in a Permanent Supportive Housing, Rapid Rehousing, or Transitional Housing project, the Referral Specialist will reference both the HMIS Participant List and Participant List outside of HMIS to determine the most highly prioritized eligible participant. Please see Section 10 for information on the confidential process for serving survivors of domestic violence.

d) Conducting the Smart Path Assessment

The Smart Path Assessment may be directly entered into HMIS or completed on paper and then entered into HMIS by an authorized user.

The Assessment should be conducted in a setting that promotes privacy and confidentiality. The Assessment must be completed in accordance with the Smart Path guidelines. See Appendix E for the Smart Path Assessment Process Guide.

The Assessment must be conducted in person and the completed Release of Information entered into HMIS.

Participants may decide what information they provide during the Assessment process, decline to answer Assessment questions, or decline housing and service options without retribution or limiting their access to other forms of assistance. Projects may require participants to provide information necessary to determine project eligibility as required by applicable project regulations.

After completing the Assessment, the Assessor must provide the participant with resource information and assist in direct service connections to meet immediate needs, including emergency shelter, as outlined in the Smart Path Assessment Process Guide (Appendix E.)

Utilization of emergency services such as emergency shelter are not contingent upon Smart Path Access Point assessment operating hours. At minimum, emergency service providers will provide participants with details about the location and operating hours of the nearest Access Point. If possible given staff capacity, providers may call and arrange for the Assessment to take place and/or provide transportation if needed.

e) Updates to Assessments

Participants must complete an Assessment annually to continue being considered active in Smart Path. Participants *may* complete an Assessment after three months since their last Assessment if they have had any changes in their situation. Participants or their designee should contact the Referral Specialist to update the participant's contact or household information when changes occur. HMIS users have the ability to update participants' contact and household information. If participants wish to be reassessed less than 3 months after their previous assessment because they have had significant changes in their circumstance, they or their representative may contact the Referral Specialist to determine whether a new Assessment is warranted. The Referral Specialist may determine that a new Assessment should take place.

8. Participant List and Prioritization

a) Smart Path Participant List

Smart Path will maintain a comprehensive list in HMIS of all participants who have completed an Assessment. VI-SPDAT assessments that were completed prior to Smart Path implementation were transferred into the Smart Path Participant List (Participant List). Participants whom are considered "active" will be included in the Participant List and considered for available housing openings based

on program eligibility and the prioritization policies described below. Participants who have not completed an Assessment with a year will not be considered active.

b) Resource Prioritization

In Santa Cruz County there is a significant gap between the availability of housing and the need. Smart Path uses the VI-SPDAT to help prioritize and determine the type of assistance that best meets the needs of each participant. See Appendix F for the HAP Local CoC/ESG Written Standards.

Prioritization Criteria for Referral to Permanent Supportive Housing[6]:
Smart Path will prioritize active participants who meet the HUD definition of chronically homeless and have the highest VI-SPDAT score for referral to available Permanent Supportive Housing (PSH) program openings. The score range for consideration for a PSH referral for participants who completed a Single or Transition-Aged-Youth (TAY) VI-SPDAT, is 8-17 and 9-22 for participants who completed the Family VI-SPDAT

If multiple participants who are eligible for the same program have the same VI-SPDAT score, the participant with the longest history of homelessness will be prioritized for referral to PSH project openings. Participants who have the same score and length of homelessness, will be prioritized based on the order they completed the Assessment, with participants completing the assessment first receiving priority.

Prioritization Criteria for Referral to Rapid Rehousing Programs[7][8]:
Rapid Rehousing (RRH) programs provide temporary housing and services to individuals and families to facilitate their ability toend their homelessness. Smart Path prioritize participants with the highest VI-SPDAT score within the following ranges for RRH program openings: 4-7 for participants who completed a Single or Transition-Aged-Youth (TAY) VI-SPDAT, and 4-8 for participants who completed the Family VI-SPDAT.

Participants with the same rapid rehousing score will be prioritized based on their length of time homeless, with participants experiencing homelessness the longest receiving priority.
Participants who have the same score and length of homelessness, will be prioritized based on the order they completed the Assessment, with participants completing the assessment first receiving priority.

Please note: on 8/28/19, the HAP voted to increase the VI-SPDAT scores of persons referred to RRH programs through Smart Path. The above prioritization process will continue to be used to prioritize referrals for RRH programs until the new processes and policies have been finalized.

[6] See Section 13. Definitions, “Permanent Supportive Housing”
[7] See Section 13. Definitions, “Rapid Rehousing”
[8] See Section 13. Definitions, “Transitional Housing”

Prioritization Criteria for Referral to Transitional Housing[9]:
Transitional Housing (TH) projects typically serve individuals and families who are anticipated to need only short-term support in order to end their homelessness. Smart Path will prioritize participants with the highest VI-SPDAT score within the following ranges: 4-7 for participants who completed a Single or Transition-Aged-Youth (TAY) VI-SPDAT, and 4-8 for participants who completed the Family VI-SPDAT.

Participants with the same VI-SPDAT score will be prioritized based on their length of time homeless, with participants experiencing homelessness the longest receiving priority. Participants who have the same score and length of homelessness, will be prioritized based on the order they completed the Assessment, with participants completing the assessment first receiving priority.

Other Assistance:
Participants who have a VI-SPDAT scores of 0-3 are not prioritized for housing referrals through Smart Path. Assessors will conduct homeless diversion practices with participants who score in this range and connect them to applicable services such as deposit assistance, and mainstream benefits. Eviction prevention services and emergency shelter services will be included in future phases of Smart Path's implementation.

9. Referrals

a) Matches to Housing Opportunities

Currently, Smart Path provides referrals for Permanent Supportive Housing (PSH), Rapid Re-Housing (RRH), and Transitional Housing (TH) programs. Participating agencies provide the eligibility criteria to Smart Path for participating housing programs The eligibility criteria is used by Smart Path to pre-screen participants on the Participant List for potential project participation. Agencies will update availability of agency-operated housing units and openings in case management/housing navigation projects into HMIS two weeks prior to the assistance becoming available or as soon as possible, and no later than one business day after it becomes available. When a participating program has a vacancy, the Smart Path Referral Specialist uses the HMIS housing match feature, along with non-HMIS participant lists, to prioritize participants from for referral to the project by:

1. Filtering the Participant List based on the appropriate VI-SPDAT scores for the program type as described above;

2. Filtering the Participant List based on the specific eligibility criteria of the available housing project; and

[9] See Section 13. Definitions, "Transitional Housing"

3. Prioritizing the Participant List based on the prioritization methodology for the applicable housing type as described above.

Based on the results of the housing match, the Referral Specialist will make referrals in HMIS to the designated housing project staff.

The Housing Workgroup can be utilized to help housing programs locate referred participants. Smart Path will provide the Housing Workgroup with information on participants who are anticipated to be referred to a housing program to enable Workgroup members can share their knowledge of the future participants' housing and program status and how they might be contacted.

Referrals of couples or households to programs:
Upon request, the second member of a couple or two-person adult household (termed a household for the purposes of the policy revision) can be referred and enrolled into a program when their partner is enrolled, regardless of the second person's assessment score and date, and length of time homeless, conditionally on program eligibility and capacity. The couple or household is defined by the person being referred. In order to prevent abuse of the policy and to ensure that both partners want to be a part of the couple or household, the agency will do individual interviews of each person in the household.

b) Receiving Agency Responsibilities

The following steps will be taken when an agency receives a Smart Path referral:

1. **Contact the participant(s) being referred for assistance**: The agency must make an initial attempt to contact the participant(s) within three business days and a total of 3-5 separate attempts within five business days to find the participant(s) using all of the contact information provided in HMIS, contacting other service agencies that the participant(s) work with, consulting with Housing Workgroup members, and visiting locations that the participant(s) are known to frequent. All attempts to find the participant(s) must be documented in HMIS.

2. **Verify eligibility:** In order to confirm project eligibility, agencies will complete the project's regular eligibility and intake process.

3. **Accept Referral:** If it has been determined that the referred participant(s) are eligible to participate in the project, the agency will accept the referral and complete a program entry for the participant in HMIS.
4. **Decline Referral:** If the referred participant(s) are **not** eligible to participate in the project, the agency will decline the referral in HMIS following the guidelines below. If the agency met with the participant(s) to determine eligibility, the participant must be notified of the decision.

Smart Path participating programs may decline referrals for the following reasons:

- Participating projects may decline Smart Path referrals for the following reasons: The participant does not meet the project's eligibility requirements per the project's funding source or written eligibility requirements;
- Participant(s) cannot be located. capacity to take additional referrals
- The referral includes too many or few people than the project vacancy is designed for
- The agency provides documentation that it lacks the resources needed to effectively or safely serve and support the referred individual or family
- Transitional Housing projects only: participant graduated from a Transitional Housing project within the previous two years
- The participant(s) miss two or more mutually agreed upon initial eligibility intake appointments after the agency has provided all reasonable supports, such as transportation, reminders, and flexible scheduling, to overcome barriers to attend the appointment. Before the agency can decline a referral for this reason, the Referral Specialist would bring the case to the Coordinated Entry and Housing Work Group for case conferencing.
- The agency provides documentation that enrolling a referred participant would create a conflict of interest, as defined in writing by the receiving agency.
- The agency provides documentation that the referred participant has been banned indefinitely from the project per written agency policies. Before the agency can formally decline the referral, the Referral Specialist would need to discuss the reason for the ban with the agency.
- There are significant safety concerns with enrolling the referred participant such as a past history of domestic violence with another participant or agency staff.

Participant(s) may decline a referral to a Smart Path participating program for any reason.

- If the participant(s) are determined eligible for the referred project but declines assistance, their information will be added back to the Participant List according to their current Assessment score and the Referral Specialist will initiate a new match for the vacancy.

- If the participant(s) have expressed a preference not to receive services through particular agencies or projects, the Referral Specialist will contact the participant prior to referring them to those projects.

- There is no limit to the number of resources participants can refuse. Participants may continue to be contacted when a resource they are likely eligible for is available; if they refuse the resource, the Referral Specialist will seek to understand why they are refusing the resource and ensure that the participant(s) are eligible for other resources that they may be

more interested in. If the participant(s) are not interested in resources available through Smart Path they may ask to be inactive.

Agencies must get permission from the Smart Path Coordinated Entry Steering Committee to decline a referral for any reason not listed in this document. Agencies may not decline referrals for the following reasons:

- Participants with psychiatric disabilities refuse to participate in mental health services
- Participants with substance use disorder refuse to participate in substance use treatment services

Agencies must specify in HMIS the reason a participant was declined. If the reason for the denial is not included in the drop-down options in HMIS, the agency must provide a narrative explanation in the allotted space.

The HAP and Smart Path staff will monitor the quality and appropriateness of housing match referrals as outlined in the signed Memorandum of Understanding (MOU) and the policies and procedures described in this document. The HAP and Smart Path staff may provide additional training to participating agencies and adjustments to policies and procedures as necessary.

Please note: if a participant is not enrolled in a program for which they were referred, the Referral Specialist will return the participant to the Community Queue to be considered for future referrals.

Participants who are accepted into a transitional housing shall remain on the community queue and therefore be referred to permanent housing programs.

10. Confidential Process for Domestic Violence Survivors

Smart Path has a separate, confidential process for individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking who are receiving services from designated domestic violence service agencies. This process provides for the confidentiality and safety of participants, while ensuring they receive the same opportunities for accessing housing opportunities as other Smart Path participants.

a) Assessment

When a participating domestic violence agency is working with clients who are experiencing homelessness or are at risk of homelessness, the agency will provide information on Smart Path and ask the client if they would like to complete the Assessment.
If appropriate and available, a trained Assessor will meet with the project client to complete the Assessment. If the participants elects to not have their identifying information included in HMIS, the

Assessor will include the participant as an "Anonymous Client". The Assessor will provide the participant's HMIS ID number to the Referral Specialist to keep on file..

If the participant choses not to have their information entered into HMIS, the participating domestic violence agency will conduct a modified Smart Path Assessment in hard copy format, per regulations that prohibit domestic violence service agencies from entering information on survivors of domestic violence into HMIS. The modified Assessment will include the minimum information necessary to determine eligibility and prioritization for referrals and will specifically exclude personal identifying information, including name, date of birth, Social Security number, and last permanent address.

The domestic violence service agency will include on the modified Assessment the name of the agency, two staff contacts, and an internally generated identification number to be used for all communications regarding the participant. The domestic violence service agency will submit the completed modified assessment to the Smart Path Referral Specialist. All communication related to the participant's Smart Path assessment and referrals will be conducted through the domestic violence service agency using the agency generated identification number.

b) Participant List

The Referral Specialist will maintain a separate DV Participant List outside of HMIS for survivors referred by domestic violence agencies using the modified Assessment form. No client data will be entered into HMIS. in order to maintain confidentiality and safety for survivors and compliance with federal law. The Referral Specialist will use both the Smart Path Participant List in HMIS and the DV Participant List maintained outside of HMIS to prioritize participants for program openings.

c) Housing Support Project Referrals

If the most highly prioritized eligible participant is from the DV Participant List, then the Referral Specialist will provide the referral to the receiving agency via email or phone by providing the participant's identification number and the DV agency's contact information. Smart Path participating agencies that receive referrals for participants with identification numbers will contact the appropriate domestic violence service agency. The domestic violence service agency will be expected to contact the participant and connect them with the applicable project.

11. Other Special Populations

a) Unaccompanied Youth

Santa Cruz County is one of ten communities in 2017 to be awarded funding under HUD's inaugural Youth Homelessness Demonstration Program (YHDP). Smart Path is working closely with the YHDP Youth Advisory Board (YAB) to develop a youth coordinated entry system. This includes developing Access Points to increase easy access for unaccompanied youth and young adults, such as secondary

schools, colleges, as well as developing a street outreach team to connect with youth frequenting downtown corridors, parks, libraries, and other locations as applicable.

Santa Cruz County currently lacks youth-specific housing resources for persons without a history or current involvement in the Foster Care System. However, youth and young adults will be considered for all available housing support programs utilizing the same eligibility criteria and prioritization policies as all populations, which includes vulnerability as indicated by the VI-SPDAT, and in this case the TAY-VI- SPDAT. As youth-specific housing resources are created, the YAB will assist with the development of any specific prioritization policies, taking into account HUD prioritization guidance as well as data gathered from the first phase of coordinated entry.

If an unaccompanied minor is identified through Smart Path, the Assessment Specialist will explain to the minor that they are a mandated reporter and will call the Santa Cruz County Family and Children's Services (CPS) to place a report and receive resources. Unaccompanied minors are not able to complete an Assessment.

b) Veterans

Participants who are currently or at-risk of becoming homeless who have served in the military will be able to access Smart Path through any Access Point. Veteran services agencies also serve as Access Points for all populations. All participants completing an Assessment will be asked if they have served in the military. Persons who have served in the military will be connected to veteran services agencies to ensure they are connected with all assistance for which they are eligible.

12. Evaluation Process

The Metrics and Improvement Work Group, a work group of the Smart Path/Coordinated Entry Steering Committee, and the HAP are responsible for oversight of the coordinated entry system evaluation.

A Participant Survey was conducted countywide in May 2017 to gain an understanding of participants' experience with the homeless services system prior to implementation of the Coordinated Entry System (see Appendix G). The survey focused on ease of access to project locations, feelings of safety and respect at project locations, understanding of application processes, and linkages to community resources. The results of the pre-implementation survey indicate areas for improvement and have informed the planning of Access Points, resource linkage, and other Smart Path policies and procedures.

A post-implementation Participant Survey will be conducted six months after the initial launch of Smart Path, and annually thereafter to solicit feedback on the quality and effectiveness of the entire coordinated entry experience, including the assessment and referral processes (see Appendix H). Similar to the pre-implementation survey, respondents will be selected randomly based on

willingness to participate. The survey results will be analyzed by the Smart Path/Coordinated Entry Steering Committee and the HAP to assess the effectiveness of Smart Path and develop recommendations for improvements.

Each participating agency will be consulted at least annually regarding the assessment and referral process associated with coordinated entry.

System metrics will be evaluated every six months. Data to evaluate these metrics will be generated through the HMIS. The results will be analyzed by the Smart Path/Coordinated Entry Steering Committee and the HAP to assess the effectiveness of Smart Path and develop recommendations for improvements. All participant information collected and used in the evaluation process will be utilized in accordance with privacy and confidentiality protections.

13. Definitions

The definitions below are included for the purposes of better understanding the Policies and Procedures Manual. Some definitions are simplified versions of HUD definitions and are not intended to suggest that the CoC uses definitions that differ from HUD's.

Access Point – Locations where people can complete a Smart Path Assessment to participate in coordinated entry.

Chronically Homeless – A homeless individual, or a family with an adult head of household (of if no adult, a minor head of household) with a disability who:

- Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; AND
-
- Has been homeless in such place for at least 12 months OR on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights.

Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but are included in the 12-month total.

Collaborative Applicant – The Collaborative Applicant is the eligible applicant (state, unit of local government, private, nonprofit organization, or public housing agency) designated by the CoC to:

1. Collect and submit the required CoC Application information for all projects the CoC has selected for funding, and
2. Apply for CoC planning funds on behalf of the CoC.

The CoC may assign additional responsibilities to the Collaborative Applicant so long as these responsibilities are documented in the CoC's governance charter.

Continuum of Care (CoC) – A program of the U.S. Department of Housing and Urban Development (HUD) (regulations at 24 CFR 578) with the expressed goals of promoting communitywide commitment to ending homelessness; providing funding for efforts by nonprofit providers, and state and local governments to quickly rehouse homeless individuals and families; promoting access to and effecting utilization of mainstream programs by homeless individuals and families; and optimizing self-sufficiency among individuals and families experiencing homelessness.

Santa Cruz County's local CoC, Homeless Action Partnership (HAP), is comprised of a broad group of stakeholders dedicated to ending and preventing homelessness. CoC membership is open to all interested parties, and includes representatives from community members, organizations, and jurisdictions within Santa Cruz County. Projects funded by this HUD program are required to participate in the Coordinated Entry System.

Emergency Solutions Grant (ESG) – ESG is a grant program of the U.S. Department of Housing and Urban Development (HUD) that funds emergency assistance for people who are homeless or at-risk of homelessness. ESG funds may be used for street outreach, emergency shelter, homelessness prevention, Rapid Re-housing, and HMIS. ESG grantees are required to participate in the Coordinated Entry System.

Homeless – HUD's definition of homelessness (24 CFR 578.3) has four categories:

o Category 1 – "Literally homeless" individuals/families (see definition above)

o Category 2 – Individuals/families who will imminently lose their primary nighttime residence with no subsequent residence, resources, or support networks.

o Category 3 – Unaccompanied youth or families with children/youth who meet the homeless definition under another federal statute.

o Category 4 – Individuals/families fleeing or attempting to flee domestic violence.

Homeless Action Partnership (HAP) – As Santa Cruz County's Continuum of Care (see definition, above), the HAP is responsible for implementing and overseeing Coordinated Entry. The HAP also is responsible for communitywide planning and ensuring the strategic use of resources to address homelessness; improving coordination and integration between mainstream resources and other programs targeted to people experiencing homelessness; and improving data collection and performance measurement

Homeless Management Information System (HMIS) – A local information technology system used to collect data on the provision of housing and services to homeless individuals and families. Local CoC's are required by HUD to use HMIS for data reporting purposes to retain the ability to receive certain federal funds.

Housing First- An approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements.

HUD – The United States Department of Housing and Urban Development, which funds and administers the Continuum of Care Program nationwide.

Literally Homeless – Persons who are lacking a fixed, regular, and adequate nighttime residence This includes persons who have a primary nighttime residence that is a public or private place not meant for human habitation; a publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by charitable organizations or federal, state, or local government programs); or are staying in an institution for 90 days or less andstayed in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Participant List – A list, primarily within HMIS, of people who have completed a Smart Path Assessment. The list is used to ensure that individuals and families with the greatest need receive priority for referral to housing and related services.

Permanent Supportive Housing (PSH) – Permanent housing is permanent housing with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability to achieve housing stability.

Project - Those projects identified by the CoC as part of its service system, whose primary purpose is to meet the specific needs of people who are experiencing a housing crisis including both 'homeless assistance' and 'homelessness prevention' projects. The term "project" is used here to distinguish an individual agency's project from HUD "programs". A project may or may not be funded by a HUD program.

Rapid Rehousing (RRH) – A Permanent Housing program that emphasizes housing search and relocation services and short-and medium-term rental assistance to move persons experiencing homelessness into permanent housing as rapidly as possible.

Release of Information (ROI) – The consent form that participants complete and sign to grant consent for their personal information to be entered into HMIS and used for Coordinated Entry. Signing the release of information is not required to participate in coordinated entry and receive referrals for housing; however, it is required in order to enter a participants' information into HMIS.

Service Prioritization Decision Assistance Tool (SPDAT) – Assessment tool developed by OrgCode Consulting, Inc., that is designed to help guide case management and improve housing stability outcomes.

Transition Age Youth (TAY) – Young adults ages 18 – 24 years old.

Transitional Housing (TH) – Provides up to 24 months of housing with accompanying support services, providing a period of stability to enable persons experiencing homelessness to transition successfully to and maintain permanent housing.

Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) – Triage tool designed by OrgCode Consulting, Inc. and Community Solutions that can be administered to quickly assess a person's health status and level of risk.

Appendix A: Grievance Form

Smart Path to Housing and Health
Coordinated Assessment and Referral System
Santa Cruz County

Grievance/Complaint Form
Version 9/19/18

Date _____
Your Name _____
Telephone _____
Address _____
_____

People who we can contact to reach you:
Name _____
Telephone _____
Address _____
_____

Name _____
Telephone _____
Address _____
_____

Our intention is to provide accessible, respectful service to assist people in getting connected with programs and services to end their homelessness. We are sorry that you have an unresolved complaint. If your complaint is related to a particular service agency (for example, a complaint related to how a particular agency handled your assessment), please follow the agency's grievance/complaint procedure before completing and submitting this form. If your complaint is related to the Smart Path process including the assessment and housing referral, you will need to put your complaint in writing. You can give your written complaint to any Smart Path Access Point, or you can mail this form to **Santa Cruz County Human Services Department – Smart Path, 1000 Emeline Ave, Santa Cruz, CA 95060.**

Once your written complaint is received, it will be reviewed by the Smart Path Referral Specialist and the Smart Path System Manager. The Referral Specialist will respond in writing to your complaint at the address you listed above, or through a contact person you listed above, within 30 days and will contact you by phone to let you know that the written response has been sent.

You may write your complaint in your own way, or use the other side of this form. If you are unable to complete the written complaint you may ask for assistance from the Smart Path initial assessment specialist or you can have a friend or relative help you complete the complaint.

What is the outcome you want?

_____
_____
_____
_____

Please describe your complaint about Smart Path in your own words.

_____

_____
_____
_____

What action or communication have you already taken to resolve your complaint?

_____
_____
_____
_____

What was the result of the action or communication you took?

_____
_____
_____
_____

Signature _____ **Date** _____

Appendix B: Assessment Tools

For the following assessments, visit https://ctagroup.org/santa-cruz-hmis/santa-cruz-user-central/:

Smart Path Assessments – English:

Smart Path Assessment Packet for Single Adult
Smart Path Assessment Packet for Family
Smart Path Assessment Packet for Transition Age Youth

Smart Path Assessments – Spanish:

Spanish Smart Path Assessment Packet for Single Adult
Spanish Smart Path Assessment Packet for Family
Spanish Smart Path Assessment Packet for Transition Age Youth

Smart Path Assessments – Confidential:

Smart Path Confidential Assessment Packet-Single Adult
Smart Path Confidential Assessment Packet-Family
Smart Path Confidential Assessment Packet- Transition Age Youth

Appendix C: Memorandum of Understanding Agreement

Memorandum of Understanding (MOU) Between

**Agencies Participating in Smart Path to Housing and Health (Smart Path)
and the Santa Cruz County Homeless Action Partnership (HAP)
Version 3/16/18**

Santa Cruz County's vision is to address homelessness using a unified set of efficient interventions that effectively prevent people from becoming homeless and quickly stabilize people who are already experiencing homelessness. This vision can be achieved by better assessing people's needs and barriers, and quickly and seamlessly matching them to the services and housing that they need, regardless of the provider agency or program to which they originally reached out. This is the vision that Smart Path embodies and that agencies signing this MOU support.

Agencies signing this MOU agree to participate in the Smart Path to Housing and Health (Smart Path) Coordinated Assessment and Referral System, comply with the Smart Path Policies and Procedures, and:

- Ensure that participants seeking assistance have prompt access to screenings and assessments as agreed upon in a safe, welcoming, multi-cultural and multi-lingual environment, including collaborating with other Smart Path partners;
- Maintain knowledge of community resources including meal programs, food bank locations, emergency shelters, government benefits, and services for victims of domestic violence, in order to provide every participant who completes the Smart Path assessment with assistance in meeting their immediate needs;
- Ensure clients sign a release of information prior to any information being included in the Smart Path/HMIS database and otherwise shared;
- Ensure agency representation at Smart Path meetings, including the Smart Path/Coordinated Entry Steering Committee, the Coordinated Entry and Housing Work Group, and ad-hoc meetings as needed
    - Please Note: Participation in the Smart Path/Coordinated Entry Steering Committee is only required for agencies that will be receiving referrals;
- Ensure that staff conducting assessments attend a minimum of one Smart Path Assessment training a year, with additional trainings as needed, to maintain consistent adherence to the Smart Path principles and procedures;
- Ensure that only persons trained and authorized to use the Smart Path/HMIS database and the assessment do so; and
- Commit to maintaining current agency information in the countywide 211 system.

Agencies that have agreed to conduct Smart Path assessments further agree to maintain at least one staff person trained and authorized to perform the assessments, including using the Smart Path/HMIS database.

Agencies that have agreed to receive Smart Path referrals further agree to accept and act promptly on all client referrals, as outlined in the Smart Path Policies and Procedures.

In signing this MOU, agencies agree to collaboratively address issues with Smart Path, participants, and other agencies as appropriate to support the success of Smart Path.

Term: the term of this MOU shall be in effect until one of the parties terminates the MOU. Either Party may terminate this agreement by giving the other party sixty (60) day's written notice. Termination of the agreement may be with or without cause.

Evaluation: At least annually, the signatories will evaluate the success of Smart Path and the partnership. Together, the signatories will consider the extent to which each party fulfills their roles and responsibilities as described in this MOU.

Amendments: No amendment or variation of this Agreement shall be effective unless it is in writing and signed by the parties (or their authorized representatives).

Agency's level of participation:

- ☐ Access Point only:
  - ☐ **Comprehensive:** conducts assessments for agency clients and the public throughout operating hours
  - ☐ **Moderate:** conducts assessments for agency clients and the public during designated hours
  - ☐ **Light:** conducts assessments for agency clients only
  - ☐ **Super Light:** staff is not trained to conduct assessments, welcomes mobile outreach staff

- ☐ Access Point and Receiving Referrals
  - Specific Programs:
    _____

I agree to all of the above:

Name: _____

Title: _____

Participating Agency: _____

Date: _____

Name: _____

Title: _____

Homeless Action Partnership

Date: _____

Appendix D: Release of Information Agreement

Santa Cruz County

Homeless Management Information System

CLIENT INFORMED CONSENT & RELEASE OF INFORMATION AUTHORIZATION

_____ is a Partner Agency in the Homeless Management Information System (HMIS). HMIS is a computerized system that can improve programs for homeless persons by allowing information to be shared among partner agencies that provide services such as shelter and health care and/or homelessness research or administrative services. The system is Internet-based and uses many security protections to ensure confidentiality. Partner agencies currently include:

- Association of Faith Communities
- Community Bridges – Mountain Community
- Community Technology Alliance
- Downtown Streets Team
- Families in Transition
- Homeless Garden Project
- Housing Authority of Santa Cruz County
- Homeless Services Center
- Mountain Community Resources
- Pajaro Valley Shelter Services
- Santa Cruz Community Health Center
- Santa Cruz Human Services Department
- Salvation Army
- Veteran Resource Center
- Community Action Board
- City of Santa Cruz
- County of Santa Cruz Homeless Services
- Encompass Community Services
- Front St. Inc.
- Homeless Persons Health Project
- Housing Choices
- Janus Santa Cruz County
- Pajaro Rescue Mission
- Salud Para La Gente
- Santa Cruz Health Services Agency
- Santa Cruz Public Libraries
- Wings Homeless Advocacy

Participation in the HMIS program is important to our community's ability to provide you with the best services and housing possible. As you receive services, information will be collected about you, the services provided to you, and the outcomes these services help you to achieve. Your name and other identifying information will not be shared with any agency not participating in the system (unless required to do so by law.) Authorizing your information to be entered into the HMIS is voluntary. Refusing to do so will not limit your access to shelter or services.

I give authorization for my basic and relevant information to be entered _____ **(please initial)**

and shared _____ **(please initial)** between Partner Agencies in order to help assist me in obtaining permanent housing, employment, financial assistance, vocational services, counseling and medical/mental health treatment and for research and administrative purposes. (Basic information includes intake date, name, social security number, gender, birth date, ethnicity, marital status, number in household, military status, primary language spoken, and non-confidential services requested and received.) I understand that I have the right to receive a copy of all information shared between the Partner Agencies.

I understand that the current list of participating Partner Agencies may change over time to include other agencies who provide housing or services to the homeless population, and I give authorization for my information to be shared with any new Partner Agency._____ **(please initial)**

I understand that I may request a current list of all Partner Agencies at any time. I understand that I may cancel this authorization at any time by written request, but that the cancellation will not be retroactive. I understand that this release is valid for three years from the date of my signature below.

Print Name of Client or Guardian	Signature Of Client Or Guardian	Date

Note: A separate, HIPAA-compliant authorization is required for disclosure of any patient health information, including mental health and drug and alcohol information protected by any State of Federal privacy law including, but not limited to, Health Insurance Portability and Accountability Act ("HIPAA"), 45 C.F.R. parts 160 and 164, California Confidentiality of Medical Information Act ("CMIA"), Civil Code sections 56-56.16, Welfare and Institutions Code section 5328, or 42 C.F.R part 2.1, et seq.

July 2018

Appendix E: Assessment Process Guide

Smart Path Assessment Workflow Steps & Guiding Script

STEP 1: Welcome and Greeting

Introduce yourself and your agency. Inform participant that taking the assessment is the only way they can get on the list for most housing programs in Santa Cruz County. Let them know it can take 15-45 minutes of their time, and their answers will help determine how to best support them with available resources. Be honest with the client that it may take a while for them to be connected to housing assistance. Paraphrase Smart Path context script to provide more detail. Use your own words – don't read to client.

***Guiding Script**:* My name is [interviewer name] and I work with [organization name]. I am trying to connect people with services.

What I'd like to do with you is what's called a Smart Path Assessment. It can take 15-45 minutes. In it, I ask some personal questions about what your situation is like. Then, once we're done, you are on the list for the housing programs in the county.

Smart Path is Santa Cruz County's coordinated entry system that allows us to identify people who are experiencing homeless in Santa Cruz County and determine what programs or forms of assistance they may be eligible for and what may be of most assistance in helping them get back into stable housing. Due to the large number of people who are currently experiencing homelessness in Santa Cruz and the relatively limited services that are available, referral to any particular program is not likely going to happen immediately. In some case, it can several months to over a year.

A couple things to keep in mind while I'm asking the questions: There is no one question that is going to immediately qualify or *dis*qualify you for any form of assistance. We don't share this information with the police, or anyone else who isn't going to provide you services, so you are not going to get in trouble for answering "yes" or "no" to any of the questions. We do not use any of your answers for the purposes of screening you *out* of any program or form of assistance. I only say this because sometimes people think, "I better not say 'yes' to that question, cause then they won't want me." If anything, we are trying to screen you *in*, not screen you *out*.

We can skip any question you like, but the more candid you are with me the more we can make sure to get you into a program that is going to fit what would help you.

Please let me know if you have any questions about the questions. If you're unsure about something, let me know and we can talk through it and figure out which answer is most accurate for you. However, since this is a self-report tool, the final answer does have to come from you; I cannot tell you what the "right" answer is. Do you have any questions before jump in?

STEP 2: Determine if the Smart Path Assessment can continue in this format today

Language Considerations: Do not try to do an assessment of a participant you are unable to communicate with due to a language barrier. Instead:

- Ask a bilingual co-worker to assist with the assessment
- Use your agency's interpretation service, if available
- Provide a warm handoff to another staff member or agency to do the assessment

Participant's State: Determine whether the participant is in an appropriate state of mind to proceed with the assessment. Use your best judgment on whether the participant can proceed with the assessment. If the participant is unable to answer questions coherently, is not oriented to person, place, or time, is physically ill, or is otherwise temporarily unable to participate in the assessment process:

- Try to reschedule the assessment; get the participant's contact information to reschedule the assessment at a later date or remind them of the alternative time

- Provide the participant with information on alternative assessment sites

Ask the participant pre-assessment questions to determine whether you should proceed with the Assessment. Answers to these questions do not need to be documented; rather, they are to assist you with determining how to best move forward.

1. <u>Determine whether the participant is homeless:</u>

    a. If the participant is not homeless, provide s/he with resources, but do not proceed with the assessment.
    b. Ask, the participant: *what is your current living situation*? Based on the response:

        1. On the street/in vehicle *(proceed with assessment)*
        2. Emergency shelter *(proceed with assessment)*
        3. Doubled up *(do not proceed with assessment, skip to Step 9 and provide resources)*
        4. Motel *(proceed with assessment **if** motel is paid for by a program, do not proceed if participant is paying for it, skip to Step 9 and provide resources)*
        5. Housed but at risk of losing housing *(do not proceed with assessment, skip to step 9 and provide eviction prevention resources:)*
            - For low-income families with children: Community Action Board Rental Assistance Program
                - Watsonville: (831) 763-2147 x 210
                - Santa Cruz: (831) 547-1741

- For disabled and elderly (60 years of older): Catholic Charities Hope in Home Program (November-February)
    - Watsonville – (831) 722-2675
    - Santa Cruz – (831) 431-6939

6. If the participant identifies as a veteran, proceed with the assessment regardless of their living situation

2. <u>Determine whether the participant is of age to take the assessment:</u>

    a. Ask the participant*: Are you 18 years old or older?*
        - If yes, proceed with the assessment
        - If the participant is younger than 18 and not accompanied by a parent or guardian, explain that you are a mandated reporter and are required to call the Santa Cruz County Family and Children's Services (CPS) to place a report and receive resources. *(Do not proceed with the Assessment.)*

3. <u>Determine whether the participant is in a safe situation:</u>

    a) Ask the participant: *are you currently residing in, or trying to leave, a living situation in which you are threatened or fearful*?
        - If no, proceed with the assessment
        - If yes,
            - If the client is in immediate danger, call 911
            - If the client is not in immediate danger, call Monarch Services (1-888-900-4232) or Walnut Avenue Family and Women's Center (1-866-269-2559)
        - If the participant is over 65 years or a dependent adult also call and report to County Adult Protective Services (831-454-4101)

4. <u>Determine whether the participant has experienced recent sexual assault or human trafficking:</u>
    - If no, proceed with the assessment
    - If yes, refer to Monarch Services (1-888-900-4232)

Please Note: If the participant answered yes to either #3 or #4 above and is not in immediate danger, ask if they would still like to complete the Smart Path Assessment.

- If no, skip to step 9 and provide the participant with resources
- If yes, proceed with the assessment

STEP 3: Diversion Opportunities

Purpose of Diversion

The goal of utilizing homeless diversion practices is to help the participant avoid entering the homeless system. Diversion helps clients think creatively about existing supports and resources that may enable them to stay where they are or move directly into other housing.

Using Diversion to Problem Solve

Because homeless diversion work is a way to engage clients in problem solving, there are no prescribed questions or assessment. However, the following questions are examples of ways to help participants explore potential housing options beyond shelter and the homeless system. Responses to these questions are not to be documented.

1. Where did you sleep last night?
    - If the participant slept somewhere where s/he could potentially safely stay again, explore with the participant under what conditions they might be able to continue to stay at the location

2. What other safe housing options do you have for the next few days or weeks?
    - Even if a housing option is only available for a very short time, it's worth exploring and could give the participant time to identify longer term or other housing options

3. If the participant has been staying in someone else's home, what issues are preventing s/he from staying there?
    - Explore with the participant opportunities for these issues to be resolved. For example,
        i. Could the participant continue to stay there if they contributed to food or utility costs, helped with child care or cleaning, or began receiving case management?
        ii. Could those be resolved with financial assistance, case management or other services?
            - If yes, what services would be of most benefit?

4. If the participant has been staying in their own home, is it possible and safe to stay to continue to stay there?
    - Explore what resources would be needed to continue to stay in the home. For example, would financial assistance, landlord-tenant mediation, or transportation assistance help?

5. Is there anywhere safe outside the immediate area where you can stay? For example, friends or family in other counties or states? If so, what is preventing you from staying with them?
    - If transportation is an issue, the client can be referred to the Homeward Bound program:
        i. Homeless Services Center, Brian Lands, 831-350-1106, blands@santacruzhsc.org
        ii. Salvation Army Community Center, 721 Laurel St, Santa Cruz (see a staff member)

iii. Salvation Army Day Center and Winter Shelter, 104 Grant St, Watsonville (see a staff member)
iv. Salvation Army Winter Shelter, VFW building, 7th Ave, Santa Cruz (see an Intake Manager)

6. Are you working with any agencies that might be able to help you?

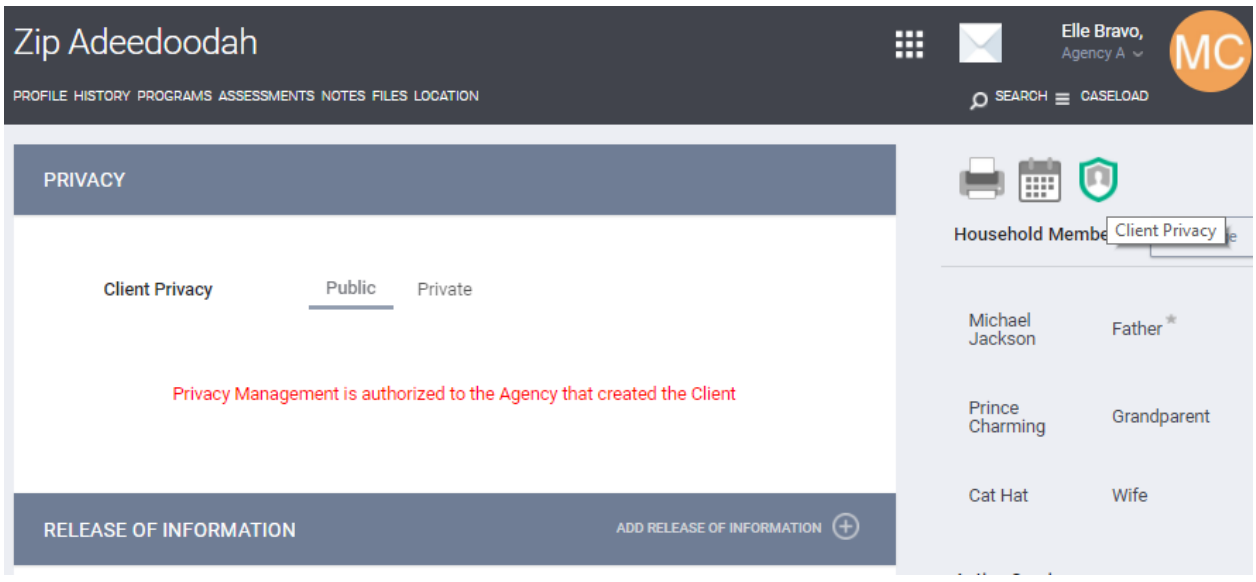
STEP 4: Search for Participant in Clarity HMIS

If available to you, search for the participant's name within Clarity HMIS to see if they have already completed an assessment. If you do not have access to Clarity HMIS, contact someone in your agency who does.

If they have completed an assessment within the past 12 months, then make sure their contact information is up to date and proceed to Step 10. If they have not completed the Smart Path Additional Questions (step 8 questions outside the VI-SPDAT), complete these questions with the client.

If the participant does not have a completed assessment in Clarity HMIS, or it has been longer than one year, you should complete a new assessment. If it has been longer than 3 months, you may complete a new assessment based on the participant's request or your observation.

STEP 5: HMIS Release of Information



Script: In order to be considered for housing assistance provided by homeless services agencies countywide, we need to share some of your information with these agencies with your consent. Signing this Release of

Information and checking the "share with other agencies" option allows us to do that. If you select the "share only with this agency" option, you will not be considered for the full range of housing opportunities.

[If they do not wish to consent]:

Try to find out why they are uncomfortable signing the ROI. Emphasis the security of the data system and that their information will only be shared to help them secure housing or other resources.

If you are uncomfortable with us sharing your name, you can use an Alias instead of your real name on your assessment.

[If they still do not wish to consent]:

We can fill out a paper assessment and keep it outside of the computerized system. The only people who will have access to your assessment will be myself, the Smart Path team, and the staff person at the agency that you may be referred to if you are matched with a program. If you are accepted into a housing program, your information will need to be entered into the computerized system at that point.

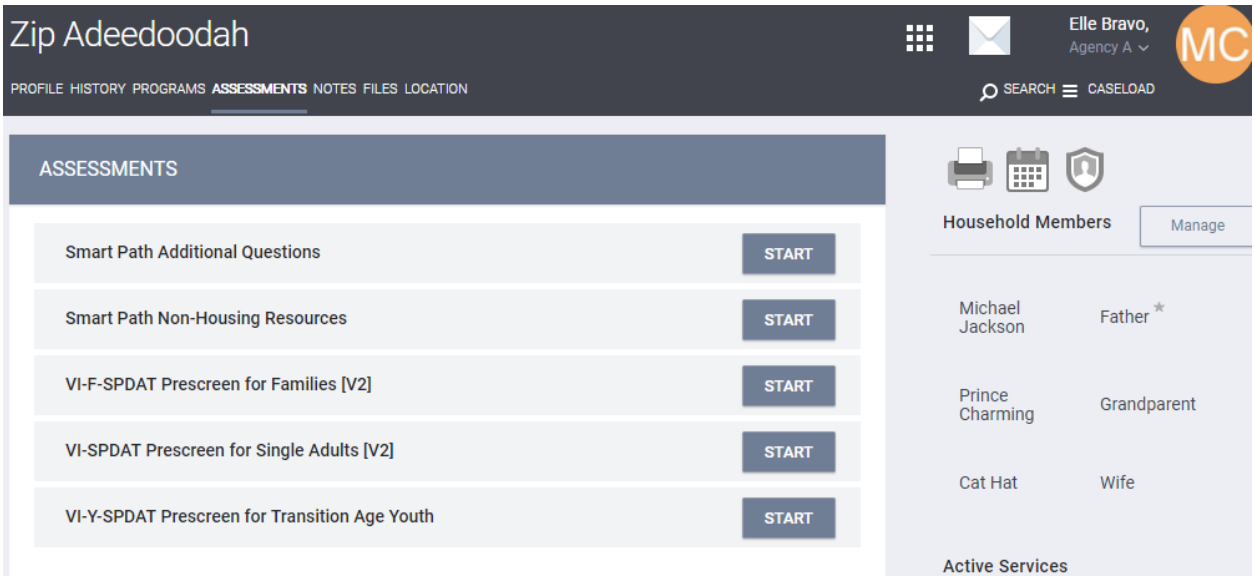
[If they still do not wish to consent]:

We understand your need for confidentiality. We can continue with the assessment, but you will not be considered for housing opportunities. Essentially, you will not be part of the Smart Path Coordinated Entry system.

Note to Assessor: Continue with assessment to determine what kinds of resources are needed. Do not enter the assessment into HMIS and shred all PII documents upon returning to your office.

STEP 6: Conduct the Assessment

The Smart Path Assessment includes several components as described below. If you have access to HMIS,



enter the information directly into the system. If not, ensure that the information is entered as quickly as possible after completion.

Smart Path Assessment Components:

- Smart Path Assessor Information: enter your information so that you can be contacted should their be any questions about the assessment
- Client Informed Consent & Release of Information (see previous step)
- New Client Profile including the client's location information. Please note: at the end of the Assessment you will do a more in-depth exploration of where the participant can be located.
- Smart Path additional questions
- The available versions of the Vulnerability Index – Service Prioritization Assistance Tool (VI-SPDAT)
    - VI-SPDAT for single adults; if two adults are in a couple or a household without children they should each do an assessment. The adults can be linked as a household when they are entered into HMIS.
    - VI-F-SPDAT for adults with minor children
    - VI-TAY-SPDAT for Transition Age Youth (TAY) ages 18-24 who are not part of a family
        - If a Transition Age Youth has a minor child, do the VI-F-SPDAT for families

VI-SPDAT opening script:

In your own words, follow the following script to explain the VI-SDPAT to participants:

The main thing that we use to determine what programs a person may be referred to is the VI-SPDAT, which stands for the Vulnerability Index – Service Prioritization Assessment Tool; people may also refer to it as a

"vulnerability assessment" or "Smart Path test." If someone asks if you are "in Smart Path"; after this you'll be able to say "yes."

So, the VI-SPDAT is a questionnaire consisting of about 30-odd questions, mostly yes-or-no except for the first few, that is meant to get an idea of what risks or vulnerabilities a person has faced or may face while experiencing homelessness. This part of the Smart Path assessment typically takes about 10 minutes At the end, you'll get a "vulnerability score" or "VI score" which will allow Smart Path to determine what kinds of programs you may get referred to. The VI-SPDAT is an assessment tool that measures what vulnerabilities a person may face or has faced while experiencing homelessness.

STEP 7: Communicate the Results

The following scripts are examples of how you can communicate the results with participants.

Simple Script (skip if participant scores 0-3): We've reached the end of the Smart Path assessment. Now, we wait. The information you shared with me today will be entered into our Homeless Management Information System, where it can potentially be used later to match you with an appropriate housing program. It's important to note that having done the assessment today does not guarantee you a referral, however, you would not have received one without this step. An agency will contact you if you have been referred and they will conduct an eligibility review.

Score Scripts:

0-3: *If the client scores a 0-3 on the VI-SPDAT focus on doing diversion work with the client.*

Option 1 (Simple): We've reached the end of the Smart Path assessment. At this time, based on your score, you would not be eligible for referral to any of the programs associated with Smart Path, however, there are still several forms of assistance that may be able to help. *[Proceed to step 8 & refer to emergency shelter and other resources if appropriate].*

Script Option 2 (additional detail): This assessment is scored on a scale of 0-17 (singles) or 0-22 (families). People who score a 4 or above are referred to housing programs. Because you scored below a 4, all folks who scored above you are going to get prioritized before you. If you have anyone in your life that you haven't reached out to yet, now is the time. Please contact Smart Path if anything changes for you.

4-17 (Single/TAY) or 4-22 (Family) on the VI-SPDAT

Based on this score, you are potentially eligible for referral into a local housing program. Depending on the housing program, services may include housing location assistance, case management and other services, and

rent assistance. However, it's important to know that all participants that scored higher than you will be prioritized first.

This does not mean a guarantee of these services, but that you will be considered for programs as openings become available. It may take months or longer before a program is ready to contact you. What resources can I help connect you with in the meantime? Are you able to work? Can I refer you to CFET, or another job program?

*Veterans of any score 0-22 are immediately referred to local programs assisting veterans. Please contact Smart Path Referral Specialist, Monica Lippi (831) 454-4108 or Monica.Lippi@SantaCruzCounty.us if you have completed at Veteran VI-SPDAT after it is entered into HMIS. Provide her with the participant's name or Unique Identifier so she can make the referral.

STEP 8: Guiding Questions and Resource Linkage – Ask additional questions not included in VI-SPDAT that will help us locate the participant and provide non-housing resources. See training materials for most current list of additional questions.

The two main resource guides we use are the following, however, agencies are encouraged to use their own as well:

- Stepping up Santa Cruz: steppingupsantacruz.org
- Santa Cruz Free Guide: santacruzfreeguide.org

STEP 9: Closing and Next Steps

- Inform participant that they must reassess every year in order to be referred. Tell them to contact us or visit an Access Point (locations available on the Smart Path website: smartpathscc.org) when it has been a year since they were assessed.
- Inform participant of the importance of continued contact and to let either your agency or the Smart Path Referral Specialist know if their contact information changes or they experience a significant life-changing event. However, make sure they know not to contact to check on their Smart Path status or to inquire into when they will be referred. This will be a waste of their time as this information cannot be predicted!
- Hand out contact cards and outreach materials.
- Thank them for their time.

Appendix F: Local CoC/ESG Written Standards

SANTA CRUZ COUNTY HOMELESS ACTION PARTNERSHIP

Local Continuum of Care Written Standards

For CA-508 Watsonville/Santa Cruz City and County Continuum of Care
Version December 2017

The Homeless Action Partnership (HAP) has developed the following standards for the Santa Cruz County Continuum of Care (CoC). They are intended to govern the provision of assistance for individuals and families. All programs receiving Emergency Solutions Grant (ESG) or Continuum of Care (CoC) funds are required to comply with these standards. Each project may have its own program rules or focus, but they must all align with these standards.

EVALUATING AND DOCUMENTING ELIGIBILITY FOR ASSISTANCE

1. Standard policies and procedures for evaluating individuals' and families' eligibility for assistance consistent with the recording keeping requirements and definitions for "homeless" and "at-risk of homelessness."

The Santa Cruz County Continuum of Care provides funding for the following types of programs: Permanent Supportive Housing (PSH), Rapid Rehousing RRH), Transitional Housing (TH), Emergency Shelter (ES), Street Outreach (SO), Supportive Services Only (including Coordinated Entry), and Planning. As set forth in the HEARTH Act, there are four categories of participant eligibility for CoC funds: 1) Literally Homeless, 2) Imminent Risk of Homelessness, 3) Homeless Under Other Federal Statutes (subject to cap), and (4) Fleeing/Attempting to Flee Domestic Violence.

Documentation must be included in the case file, and/or scanned into the HMIS client record that demonstrates eligibility as follows:

1. Literally Homeless
    a. Eligibility should be documented in the following manner (in order of preference):
        i. Third party verification (HMIS print-out, or written referral/certification by another housing or service provider); or
        ii. Written observation by an outreach worker; or
        iii. Certification by the individual or head of household seeking assistance stating that (s)he was living on the streets or in shelter.
    b. If the provider is using anything other than a Third Party Verification, the case file must include documentation of due diligence to obtain third party verification.

2. Imminent Risk of Homelessness
    a. Eligibility should be documented in the following manner (in order of preference):
        i. A court order resulting from an eviction action notifying the individual or family that they must leave within 14 days; or ii. For individual and families leaving a hotel or motel – evidence that they lack the financial resources to stay; or
        ii. A documented and verified written or oral statement that the individual or family will be literally homeless within 14 days; and
        iii. Certification that no subsequent residence has been identified; and
        iv. Self-certification or other written documentation that the individual lacks the financial resources and support necessary to obtain permanent housing.
3. Homeless Under Other Federal Statute (Not typically used in the Santa Cruz County CoC)
4. Fleeing/Attempting To Flee Domestic Violence (DV)
    a. Eligibility should be documented in the following manner (in order of preference):

i. For victim service providers:
ii. An oral statement by the individual or head of household seeking assistance which states: they are fleeing; they have no subsequent residence; and they lack resources. Statement must be documented by a self-certification or a certification by the intake worker.
iii. For non-victim service providers:
iv. Oral statement by the individual or head of household seeking assistance that they are fleeing. This statement is documented by a self-certification or by the caseworker. Where the safety of the individual or family is not jeopardized, the oral statement must be verified; and
v. Certification by the individual or head of household that no subsequent residence has been identified; and
vi. Self-certification or other written documentation, that the individual or family lacks the financial resources and support networks to obtain other permanent housing.

Additional Eligibility Requirements for the ESG Program Only:
Agencies receiving ESG funds, may, depending upon program type, serve individuals and families who are ”homeless” or “at-risk of homelessness.” All agencies receiving ESG funds will follow state and federal documentation guidelines to demonstrate homelessness, at-risk status, and income eligibility. Agencies will either develop internal documentation forms, or utilize ESG mandated forms as available and appropriate. Agencies will ensure that participant documentation of eligibility is recorded and maintained in accordance with state and federal guidelines.

The applicable standards for the definition of “homeless” in ESG programs are the same as above. The applicable standards for the definition of “at-risk of homelessness” are as follows:

AT RISK OF HOMELESSNESS means:

A. An individual or family who:
    1. Has an annual income below 30 percent of median family income for the area, as determined by HUD;
    2. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or literal homelessness situation; and
    3. Meets one of the following conditions:
        a. Has moved because of economic reasons two or more times during the 60 days immediately preceding the Application for homelessness prevention assistance;
        b. Is living in the home of another because of economic hardship;
        c. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of Application for assistance;
        d. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by Federal, State, or general purpose local government programs for low-income individuals;
        e. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        a. Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        b. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan.

B. A child or youth who does not qualify as homeless under this Section, but qualifies as homeless under Section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), Section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), Section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e–2(6)), Section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), Section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or Section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

C. A child or youth who does not qualify under this section, but qualifies as homeless under Section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

ESG INCOME
Only at risk households who have an income below 30% of area median income will be eligible for services under ESG funding. (This ESG income standard does not apply to CoC or other funding.) Income eligibility will be documented through the collection of pay stubs, benefit statements and third party statements whenever possible. All agencies will follow guidance from federal and state regulations in the development, implementation and monitoring of ESG income eligibility documentation requirements. Agencies will utilize internal, state and/or federal forms for record keeping as available and appropriate.

STREET OUTREACH

2. Standards for targeting and providing essential services related to street outreach.

Providers of street outreach services must target unsheltered homeless individuals and families, meaning those with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station airport or camping ground. Providers may target unique groups within the overall unsheltered homeless population as follows.

Any agency seeking ESG or CoC funds for outreach will be asked to develop detailed written standard for the HAP's review. The agency must design an outreach plan that contains targeting strategies built around both a general outreach plan and one targeted to the unique niches that the partners fill. This plan will include:

1. A listing of the target groups.
2. How you have determined that this target group contains eligible participants.
3. How you will outreach to this target group.
4. What are the challenges of reaching each target group.
5. What minimal information that will be provided including information and referral for housing related needs.

EMERGENCY SHELTER AND DIVERSION

3. Standards for admission, diversion, referral, and discharge by emergency shelters, including standards regarding length of stay, and safeguards to meet the safety and shelter needs of special populations and persons with the highest barriers to housing.

Admission to emergency shelter facilities will be limited to those who meet the definition of "homeless" described above. Additional eligibility requirements (e.g., serving youth or families) may be created at the program level. Any length of stay limitations shall be determined by the individual service provider's policies and clearly communicated to program participants.

Upon initial contact with the point-of-entry, homeless persons will be screened by intake staff to determine appropriate diversion tactics. Diversion tactics may range from immediate case management assistance in determining available and unutilized resources, to referrals for existing homelessness prevention and/or rapid re-housing programs.

If diversion is not possible, the homeless person may be admitted to emergency shelter. The maximum length of stay will be determined by agency policy. No person or persons who are facing or suspect they may face a threat of violence will be discharged into an unsafe condition. Emergency shelter workers will work in collaboration with functional needs

support service providers to arrange safe accommodations for those who are or may be facing a threat of violence. Those who are in danger of a violent crime, or feel they may be, will be entered into a secure database system that is comparable to HMIS. All other emergency shelter admissions will be entered into HMIS.

All persons discharged from emergency shelters will have their exit status entered into either HMIS or a comparable database, and will be provided discharge paperwork as applicable or upon request.

Under the coordinated entry process, homeless persons who are determined through assessment to have the highest barriers to housing – due to a myriad of factors including tri-morbidity, history of chronic homelessness, etc. – will be prioritized for existing housing resources and paired with existing supportive services to increase the likelihood of staying successfully housed.

Per federal requirements, the age and gender of a child under 18 cannot be used as a basis for denying any family's admission to a shelter.

4. Standards for assessing, prioritizing, and reassessing needs for essential services related to emergency shelter.

Under the CoC's coordinated entry system, the VI-SPDAT is the standardized assessment tool that will be used by all ES programs to assess, prioritize, and reassess participants needs for essential services related to ES, as well as for referral to the most appropriate housing and service interventions. The first tier of assessment occurs as they access our area's 2-1-1 program, where qualified advocates will assist those seeking services. In keeping with federal guidelines, our CoC is committed to prioritizing those who are experiencing chronic homelessness, homeless veterans, and families with children who are experiencing a homeless condition.

Upon determination of the appropriate program for referral, the next tier of assessment will involve more complex case management services to be performed by representatives of the program to which the persons were referred.

Under coordinated entry, VI-SPDAT re-assessment will be at least once per year for participants who remain homeless that long. In addition, program participants will meet with case managers throughout their participation in the program, and will have regular progress assessments or evaluations. Participants will also be given the opportunity to provide assessment and feedback of programs as well. Each ES provider ESG funding will be required to have a provable system of program evaluation. Additionally, participating ES providers in our CoC will share their experiences providing clients services, and refine service delivery based on feedback from service providers as well as participants.

PREVENTION AND RAPID REHOUSING

5. Standards for determining and prioritizing which eligible families and individuals will receive homelessness prevention assistance and which eligible families and individuals will receive rapid re-housing assistance.

Households that are assessed to be homeless, and that meet the income standards (where applicable), are eligible for RRH services. Prioritization for RRH referral is based upon the prioritization criteria outlined in the *Smart Path to Housing and Health:*
Coordinated Assessment and Referral System Policies & Procedures Manual.

Households that are assessed to be at risk of homelessness, and that meet the income standards (if applicable), are eligible for homelessness prevention services. Additional risk factors for prioritizing limited assistance include: Seniors, families with dependent children, former foster youth, chronically homeless, veterans, victims of domestic violence, and medically vulnerable individuals.

Each prevention or RRH provider will be responsible for serving potential participants that are referred through the coordinated entry system in order of referral, with provisions for priority service for eligible households prioritized through coordinated entry by the CoC.

RRH households will be re-certified at least annually; prevention households will be re-certified at least quarterly.

6. Standards for determining what percentage or amount, of rent and utilities costs each program participant must pay while receiving homelessness prevention or rapid re-housing assistance.

Each ESG or CoC-funded agency will be responsible for determining income as a basis of eligibility for or determining the amount or type of services. (Note: There are no firm income limitations for RRH or prevention programs except for those that may be required by a funding source.) As part of this income determination the relevant staff person will ascertain the amount that the household is able to contribute towards rental payments. Factors to consider may include: Potential upcoming income increases / decreases, family size, availability of other resources to meet costs and other factors as determined by the agency staff in consultation with the household.

Due to the great variety of circumstances among homeless and at risk families and individuals in Santa Cruz County, the CoC has determined that each individual prevention or RRH program may (within CoC, ESG, or other funder requirements) decide internally if they will charge participants a set percentage of income, a set percentage of actual rent, or a set dollar amount while receiving RRH or prevention services, or if they will provide a phased payment plan dependent on individual household circumstances. Individual agencies may also decide to not have participants pay any rental costs while receiving services. Each program should use a progressive engagement and assistance approach.

Each participant and landlord will receive written verification of the amount and duration of assistance provided by the agency and rent to be paid by the participant. Income to be calculated includes: wages of adults in household, cash benefits, child support and self-employment income. Employment income of children, non-cash benefits and sporadic gifts will not be counted as available income in determining rental payments.

As the overall goal of the CoC is to ensure that households are able to maintain housing independently, it is important that each agency properly assess potential households to ensure that they are a good match for the program, and to refer them to more extensive supports as available if the household is not likely to be able to maintain housing costs independently.

7. Standards for determining how long a particular program participant will be provided with rental assistance and whether and how the amount of that assistance will be adjusted over time, lease requirements, and participant re-evaluations.

Again, due to the great variety of circumstances among homeless and at risk families and individuals in Santa Cruz County, the CoC has determined that each individual prevention or RRH program may set a maximum number of months that a program participant may receive rental assistance, or a maximum number of times that a Program participant may receive rental assistance. The total period for which any participant may receive services must not exceed 24 months in three years. However, no individual or family may receive more than a cumulative total of eighteen months of rental assistance, including any rental assistance paid in arrears.

Each agency will perform initial screening to determine the number of months that a client will initially receive a commitment of rent assistance, including payments in arrears. This initial commitment will be in writing and verified by the agency representative and the participant. Factors to take into consideration during the initial commitment are the participant's ability to pay rent in the immediate month and subsequent months such as anticipated change in income, time necessary to recover from unexpected expenses, etc. Short-term rental assistance may begin as soon as an applicant and a unit have been approved.

As the program participant is nearing the end of their initial commitment of assistance, the caseworker will contact the household to assess their need for continued assistance. After a review of the participant's continued eligibility, the caseworker will make a recommendation regarding the receipt of additional rental assistance, and this recommendation will be forwarded to the supervisor for review and approval. In addition to this analysis of additional assistance requirements, each participant will need to recertify each three month period providing the required, completed sections of the application forms and back-up verification documents.

Over the course of program participation, the caseworker will continue to meet with the household on an as needed basis, and will re-determine the eligibility of the household at least every three months. In the event that a program participant reaches 12 months of rental assistance, their unit will be re-inspected for continued compliance with rent reasonableness and habitability standards.

Rent may be paid in arrears as long as it allows the client to remain in their unit or move to another unit. Rental months paid in arrears are included in the maximum number of assistance months.

8. Standards for determining the type, amount, and duration of housing stabilization and/or relation services to provide to a program participant, including the limits, on the homelessness prevention or rapid rehousing assistance that each program participant may receive, such as the maximum amount of assistance, maximum number of months the program participant receive assistance; or the maximum number of times the program participant may receive assistance.

Each agency will perform initial screening to determine the number of months that a client may initially receive a commitment of stabilization services. This initial commitment will be in writing and verified by the agency representative and the participant.

Consistent with funding source limits, prevention or RRH programs may determine the type, maximum amount and duration of housing stabilization and relocation services for individuals and families who are in need of homelessness prevention or rapid re-housing assistance through the initial evaluation, re-evaluation and ongoing case management processes

Additional requirements:

1. Program participants must meet with a case manager at least once a month for the duration of assistance, except where prohibited by requirements under Violence Against Women Act (VAWA) or Family Violence Prevention and Services Act (FVSP).
2. Program participants must be assisted, as needed, in obtaining appropriate supportive services, like mediation or mental health treatment or services essential for independent living; and mainstream benefits like Medicaid, SSI, or TANF.
3. Except for housing stability case management, the total period for which any program participant may receive service costs must not exceed 24 months during any three-year period. The limits on the assistance under this section apply to the total assistance an individual receives, either as an individual or as part of a family.
4. Security Deposits: ESG or CoC funds may pay for a security deposit that is equal to no more than two months' rent.
5. Last Month's Rent: If necessary to obtain housing for a program participant, the last month's rent may be paid from ESG or CoC funds to the owner of that housing at the time the owner is paid the security deposit and the first month's rent. This assistance must not exceed one month's rent and must be included in calculating the program participant's total rental assistance, which cannot exceed 24 months during any three-year period.
6. Utility Payments: ESG or CoC funds may pay for up to 24 months of utility payments per program participant, per service, including up to six months of utility payments in arrears, per service. A partial payment of a utility bill counts as one month. This assistance may only be provided if the program participant or a member of the same household has an account in his or her name with a utility company or proof of responsibility to make utility payments. Eligible

utility services are gas, electric, water, and sewage. No program participant shall receive more than 24 months of utility assistance within any three-year period.

7. Housing Stability Case Management: ESG or CoC funds may be used to pay cost of assessing, arranging, coordinating, and monitoring the delivery of individualized services to facilitate housing stability for a program participant who resides in permanent housing or to assist a program participant in overcoming immediate barriers to obtaining housing. This assistance cannot exceed thirty days during the period the program participant is seeking permanent housing and cannot exceed 24 months during the period the program participant is living in permanent housing.
8. Maximum Amounts and Periods of Assistance: Prevention and RRH providers may set a maximum dollar amount that a program participant may receive for each type of financial assistance. Each provider may also set a maximum period for which a program participant may receive any of the types of assistance or services under this section. However, except for housing stability case management, the total period for which any program participant may receive the services under paragraph (b) of this section must not exceed 24 months during any three-year period. The limits on the assistance under this section apply to the total assistance an individual receives, either as an individual or as part of a family. The agency may set a maximum number of months that a program participant may receive rental assistance, or a maximum number of times that a program participant may receive rental assistance. The total period for which any participant may receive services must not exceed 24 months in three years. However, no family may receive more than a cumulative total of eighteen months of rental assistance, including any rental assistance paid in arrears.
9. Short-term and medium-term rental assistance must follow applicable HUD definitions and requirements.
10. Compliance with Fair Market Rent (FMR) Limits and Rent Reasonableness: Rental assistance is prohibited from being provided for a housing unit, unless the total rent for the unit does not exceed the fair market rent established by HUD.
11. Compliance with Minimum Habitability Standards: The revised habitability standards (shelter and housing standards) incorporate lead-based paint remediation and disclosure requirements. If ESG funds are used to help a Program Participant remain in or move into permanent housing, that housing must meet habitability standards.
12. Rental Assistance Agreement and Lease Standards: The rental assistance agreement must set forth the terms under which rental assistance will be provided.
13. Each program participant receiving rental assistance must have a legally binding, written lease between program participant and the owner) for the rental unit, unless the assistance is solely for rental arrears. Project-based rental assistance leases must have an initial term of one year.
14. No rental assistance can be provided to a household receiving rental assistance from another public source for same time period (except 6 months of arrears).

TRANSITIONAL HOUSING

Transitional Housing (TH) is designed to provide homeless individuals and families with interim stability and support to successfully move to and maintain permanent housing.

9. Standards regarding eligibility criteria and targeting for transitional housing.

Households are eligible for TH if they meet the following eligibility standards:

- Must meet the HUD definition of homeless.
- Must meet any additional eligibility criteria set forth in the NOFA through which a project was funded and the grant agreement (e.g. households fleeing domestic violence).
- Programs may establish additional eligibility requirements (e.g., serving youth or families) beyond those specified here in line with applicable legal requirements.

All referrals to TH and assessment for type and level of services must come through the coordinated entry system. Prioritization for TH referral is based upon the prioritization criteria outlined in the *Smart Path to Housing and Health: Coordinated Assessment and Referral System Policies & Procedures Manual.*

Chronically homeless households being referred to TH must be informed that by entering a TH project, they may lose eligibility for PSH project dedicated to serving chronically homeless households.

10. Standards regarding length of stay, supportive services, and assistance for transitional housing.

The following minimum standards will be applied to all TH programs:

- Maximum length of stay cannot exceed 24 months.
- Assistance in transitioning to permanent housing must be provided.
- Supportive services must be provided throughout the duration of stay in TH.
- Program participants in transitional housing must enter into a lease, sublease or occupancy agreement for a term of at least one month. The lease, sublease or occupancy agreement must be automatically renewable upon expiration, except on prior notice by either party, up to a maximum term of 24 months.

PERMANENT SUPPORTIVE HOUSING

Permanent Supportive Housing (PSH) for persons with disabilities is permanent housing with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability.

11. Standards regarding eligibility criteria, prioritizing, and targeting for permanent supportive housing.

Households are eligible for PSH if they meet the following eligibility standards:

- Households must meet the HUD definition of homelessness.
- One adult or child member of the household must have a disability.
- Must follow any additional eligibility criteria set forth in the NOFA through which a project was funded and the grant agreement (e.g. Projects originally funded under the Samaritan Housing Initiative must continue to serve chronically homeless individuals and families; projects funded under the Permanent Supportive Housing Bonus must continue to serve the homeless population outlined in the NOFA under which the project was originally awarded).
- Programs may establish additional eligibility requirements (e.g., serving youth or families) beyond those specified here in line with applicable legal requirements.

All referrals to PSH and assessment for type and level of services must come through the coordinated entry system. Prioritization for TH referral is based upon the prioritization criteria outlined in the *Smart Path to Housing and Health: Coordinated Assessment and Referral System Policies & Procedures Manual.*

<u>Adoption of HUD Notice CPD-16-11</u>:
The CoC has adopted the orders of priority for CoC-funded PSH as established in Notice CPD-16-11: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing. As such, all PSH eligible households will be prioritized in the following order of priority:

1. Chronically Homeless Individuals and Families with the Longest History of Homelessness and with the Most Severe Service Needs.
2. Chronically Homeless Individuals and Families with the Longest History of Homelessness.
3. Chronically Homeless Individuals and Families with the Most Severe Service Needs.
4. Other Chronically Homeless Individuals and Families.

The Smart Path/CES Steering Committee will develop appropriate prioritization policies for youth-only housing projects.

12. Standards regarding length of stay, supportive services, and assistance in permanent supportive housing.

- There can be no predetermined length of stay in PSH.
- Supportive services designed to meet the needs of the project participants must be made available to the project participants throughout the duration of stay in PSH.
- Project participants in PSH must enter into a lease (or sublease) agreement for an initial term of at least one year that is renewable and is terminable only for cause. Leases (or subleases) must be renewable for a minimum term of one month.

ADDITIONAL STANDARDS APPLICABLE TO ALL PROGRAM TYPES

13. Participation in HMIS.

All ESG and CoC funded programs must participate in the Santa Cruz County Homeless Management Information System (HMIS) by collecting and entering required data on all participants served. Each agency receiving ESG or CoC funds will ensure that data on all persons served and all activities assisted are entered into the Santa Cruz County HMIS, in accordance with HUD's standards on participation, data collection, and reporting, and in accordance with locally approved HMIS policies and procedures. Such agencies must also participate in CoC HMIS Technology Committee meetings.

If the ESG or CoC funding recipient is a domestic violence agency, or other Victim Services Provider as defined in VAWA and related federal law, the recipient is prohibiting from entering client data into HMIS, but must instead entered such data into a comparable data system as defined in applicable HUD guidance.

The HAP actively encourages non-ESG or CoC-funded programs to participate in the Santa Cruz County HMIS.

14. Participation in Coordinated Entry.

All ESG and CoC funded programs are required to participate in the CoC's coordinated entry system and comply with all federal CoC and ESG coordinated entry requirements. In addition, all ESG-funded programs are required to comply with state ESG coordinated entry requirements.

Participation on coordinated entry requires using the applicable VI-SPDAT assessment tool, and following established policies procedures outlined in *Smart Path to Housing and Health: Coordinated Assessment and Referral System Policies & Procedures Manual.* It also requires attendance at Smart Path/Coordinated Entry System Steering Committee meetings.

15. Emphasis on Housing First.

All ESG or CoC funded programs must use Housing First (and progressive engagement practices), including the following:

- Ensuring low-barrier, easily accessible assistance to all people, including, but not limited to, people with no income or income history, and people with active substance abuse or mental health issues;
- Helping participants quickly identify and resolve barriers to obtaining and maintaining housing;
- Seeking to quickly resolve the housing crisis before focusing on other non-housing related services;
- Allowing participants to choose the services and housing that meets their need, as practical;
- Connecting participants to services available in the community that foster long-term housing stability;
- Offering financial assistance and supportive services in a manner that offers a minimum amount of assistance initially, adding more assistance over time if needed to quickly resolve the housing crisis. The type, duration, and

amount of assistance offered shall be based on an individual assessment of the household, and the availability of other resources or support systems to resolve their housing crisis.

16. Participation in the HAP and coordination with other service providers,

All CoC and ESG funded providers are expected to participate in our area's CoC, known as the Homeless Action Partnership (HAP), and will work collaboratively to coordinate funding that addresses the needs of the entire CoC. To meet these goals, the CoC requires that all ESG and CoC funded providers not only participate in HMIS and coordinated entry, but also

- Attend HAP meetings and work groups.
- Ensure that staff members coordinate as needed regarding referrals and service delivery with staff members from other CoC agencies in order to ensure that services are not duplicated and clients can easily and efficiency access the services they need.
- Ensure that staff members participate in any CoC trainings related to improving coordination among HAP members.

17. Educational policies and liaison.

All programs that serve households with children or unaccompanied youth, must:

- Take the educational needs of children into account when placing families in housing and will, to the maximum extent practicable, place families with children as close as possible to their school of origin so as not to disrupt such children's education
- Inform families with children and unaccompanied youth of their educational rights, including providing written materials, help with enrollment, and linkage to McKinney Vento Liaisons as part of intake procedures.
- Not require children and unaccompanied youth to enroll in a new school as a condition of receiving services.
- Allow parents or the youth (if unaccompanied) to make decisions about school placement.
- Not require children and unaccompanied youth to attend after-school or educational programs that would replace/interfere with regular day school or prohibit them from staying enrolled in their original school.
- Post notices of student's rights at each program site that serves homeless children and families in appropriate languages.
- Designate staff that will be responsible for:
    - ensuring that homeless children and youth in their programs are in school and are receiving all educational services they are entitled to.
    - coordinating with the CoC, the Department of Social Services, the County Office of Education, the McKinney Vento Coordinator, the McKinney Vento Educational Liaisons, and other mainstream providers as needed.

18. Equal Access and non-discrimination.

<u>General HAP Anti-Discrimination Policy</u>

The HAP does not tolerate discrimination on the basis of any protected class, including actual or perceived race, color, religion, national origin, sex, age, familial status, disability, sexual orientation, gender identity, or marital status. All CoC programs must comply with applicable equal access and nondiscrimination provisions of federal and state civil rights laws. Any programs that are required by a funding source to limit participants (e.g., HOPWA agencies may only serve persons living with HIV/AIDS) will avoid discrimination to the maximum extent allowed by their funding sources and their authorizing legislation.

Program Requirements Regarding Equal Access and Non-Discrimination

- Providers must have non-discrimination policies in place and assertively outreach to people least likely to engage in the homeless system.
- Providers must comply with all federal statutes and rules including the Fair Housing Act, the Americans with Disabilities Act, and Equal Access to Housing Final Rule.
- The people who present together for assistance, regardless of age or relationship, are considered a household and are eligible for assistance as a household.
- Projects that serve families with children must serve all types of families with children; if a project targets a specific population (e.g., women with children), these projects must serve all families with children that are otherwise eligible for assistance, including families with children that are headed by a single adult or consist of multiple adults that reside together.
- The age and gender of a child under 18 must not be used as a basis for denying any family's admission to a project.
- Providers must abide by the *Equal Access to Housing in HUD Programs – Regardless of Sexual Orientation or Gender Identity* Final Rule published in 2012 and the subsequent Final Rule under 24 CFR 5 General HUD Program Requirements; Waivers, September 2016.
- The HAP encourages providers to practice a person-centered model that strongly incorporates participant choice and inclusion of subpopulations present in the Santa Cruz County service area, including homeless veterans, youth, families with children, and victims of domestic violence.

Appendix G: Pre-Implementation Participant Survey

Smart Path Consumer Pre-Launch Survey
Version: 5/8/17

Date: _____

Location: _____

Name of Survey Administrator: _____

1. What is your age?_____

2. Are you:
   - ☐ Single adult
   - ☐ Family with children
   - ☐ Veteran
   - ☐ Foster youth

3. Which racial group do you identify with most?
   - ☐ White
   - ☐ Black or African American
   - ☐ American Indian or Alaska Native
   - ☐ Native Hawaiian or Pacific Islander
   - ☐ Asian
   - ☐ Other: _____

4. Which ethnicity do you identify with most?
   - ☐ Hispanic or Latino
   - ☐ Not Hispanic or Latino

5. Where do you sleep most frequently (check one)?
   - ☐ Shelters
   - ☐ Transitional Housing
   - ☐ Permanent Housing
   - ☐ Outdoors
   - ☐ Vehicle
   - ☐ Other: _____

6. Have you done the VI-SPDAT or VI or 180 survey? Yes / No
   If Yes, How did you find out about doing the VI-SPDAT or VI or 180 survey?
   - ☐ Referred by someone:
     - ☐ Friend/someone I know
     - ☐ Another service provider
     - ☐ Other: _____
   - ☐ Advertisement
   - ☐ 2-1-1
   - ☐ Other: _____

7. Have you received services or applied for services at homeless services or housing programs? Yes / No
   If Yes, how did you hear about the programs? (you can mark more than one)
   - ☐ Referred by someone:
     - ☐ Friend/someone I know
     - ☐ Another service provider
     - ☐ Other: _____
   - ☐ Advertisement
   - ☐ 2-1-1
   - ☐ Other: _____

8. Was it easy to know where to go to apply for homeless services and housing programs you might be eligible for? Yes / No

9. Were there any challenges in reaching places to apply for homeless services and housing programs? Yes / No
   - ☐ If Yes, what where they:
     - ☐ Transportation
     - ☐ Hours of operation
     - ☐ Location
     - ☐ Other: _____

   If Yes, how can we make it easier for you? _____

10. Did you know what to expect from the process when you were first referred to do the VI-SDAT survey or other homeless services and housing programs? Yes / No

11. Was the process clearly explained to you when you met with program staff? Yes / No

12. In your interactions with program staff, did you usually feel welcomed, safe, and put at ease?
    Yes / No
    If Yes, what made you feel welcome?_____
    _____
    If No, how could we make you feel more welcome?_____
    _____

13. Were you able to get services in your primary language?
    Yes / No
    If No, what is your primary language? _____

14. As you were searching for services, did you feel your wishes were respected and that you were treated with dignity?
    Yes / No
    If No, what can we do to improve?_____
    _____

15. As you were searching for services, did you feel like all the things about you (like your culture, ethnicity, age, sexual orientation, gender) were respected and treated with dignity?
    Yes / No

If No, what can we do to improve?_____

_____

16. Since applying for homeless services and/or housing programs, have you attempted to contact program staff for information? Yes / No

    If Yes, was it easy to access? Yes / No

    If No, what can we do to improve?_____

    _____

    Did you get the information you were looking for? Yes / No

    If No, what can we do to improve?_____

    _____

17. As you were searching for services, did staff at any of the programs connect you to resources that were helpful to you?

    Yes / No

    If Yes, which ones were most helpful?

    - ☐ Showers? Yes / No / Didn't need
    - ☐ Meals? Yes / No / Didn't need
    - ☐ CalFresh (Food Stamps)? Yes / No / Didn't need
    - ☐ County Benefits (GA, SSI, CalWorks)? Yes / No / Didn't need
    - ☐ Health care services? Yes / No / Didn't need
    - ☐ Shelter? Yes / No / Didn't need
    - ☐ Other: _____

    If No, why weren't those resources helpful?

    - ☐ I already tried the resource, not for me
    - ☐ It took too long to get
    - ☐ I wasn't interested
    - ☐ I wasn't eligible
    - ☐ Other: _____

16. Did program staff connect you to resources that you didn't know about before? Yes / No

17. Did program staff connect you to resources that you knew about but had trouble accessing? Yes / No

18. What other resources do you need that you wish you could get?

    _____

    _____

    _____

    _____

19. Is there anything else you would like us to know about your experience?

    _____

    _____

    _____

    _____

THANK YOU FOR COMPLETING THE SURVEY!

Appendix H: Post-Implementation Participant Survey

Smart Path Consumer Post-Launch Survey
Version: 5/8/17

Date: _____

Location: _____

Name of Survey Administrator: _____

1. What is your age? _____

2. Are you:
   - ☐ Single adult
   - ☐ Family with children
   - ☐ Veteran
   - ☐ Foster youth

3. Which racial group do you identify with most?
   - ☐ White
   - ☐ Black or African American
   - ☐ American Indian or Alaska Native
   - ☐ Native Hawaiian or Pacific Islander
   - ☐ Asian
   - ☐ Other: _____

4. Which ethnicity do you identify with most?
   - ☐ Hispanic or Latino
   - ☐ Not Hispanic or Latino

5. Where do you sleep most frequently (check one)?
   - ☐ Shelters
   - ☐ Transitional Housing
   - ☐ Permanent Housing
   - ☐ Outdoors
   - ☐ Vehicle
   - ☐ Other: _____

6. Have you done a Smart Path Initial Assessment? Yes / No
   If Yes, How did you find out about Smart Path?
   - ☐ Referred by someone:
     - ☐ Friend/someone I know
     - ☐ Another service provider
     - ☐ Other: _____
   - ☐ Advertisement
   - ☐ 2-1-1
   - ☐ Other: _____

7. Was it easy to know where to go for Smart Path? Yes / No

8. Were there any challenges in reaching a Smart Path location? Yes / No
   - If Yes, what where they:
     - Transportation
     - Hours of operation
     - Location
     - Other: _____

   If Yes, how can we make it easier for you?_____

9. Did you know what to expect from the process when you were first referred to Smart Path? Yes / No

10. Was the Smart Path process clearly explained to you when you met with staff? Yes / No

11. In your interactions with the staff you met with for the Smart Path Initial Assessment, did you usually feel welcomed, safe, and put at ease?
    Yes / No
    If Yes, what made you feel welcome?_____
    _____
    If No, how could we make you feel more welcome?_____
    _____

12. Were you able to get services in your primary language?
    Yes / No
    If No, what is your primary language? _____

13. In your interactions with the staff you met with for the Smart Path Initial Assessment, did you feel your wishes were respected and that you were treated with dignity?
    Yes / No
    If No, what can we do to improve?_____
    _____

14. In your interactions with the staff you met with for the Smart Path Initial Assessment, did you feel like all the things
    about you (like your culture, ethnicity, age, sexual orientation,
    gender) were respected and treated with dignity?
    Yes / No
    If No, what can we do to improve?_____
    _____

15. Since doing the Initial Assessment, have you attempted to contact Smart Path for information? Yes / No
    If Yes, was it easy to access? Yes / No
    If No, what can we do to improve?_____
    _____
    Did you get the information you were looking for? Yes / No
    If No, what can we do to improve?_____
    _____

16. Did Smart Path connect you to resources that were helpful to you?
    Yes / No
    If Yes, which ones were most helpful?

- ☐ Showers? Yes / No / Didn't need
- ☐ Meals? Yes / No / Didn't need
- ☐ CalFresh (Food Stamps)? Yes / No / Didn't need
- ☐ County Benefits (GA, SSI, CalWorks)? Yes / No / Didn't need
- ☐ Health care services? Yes / No / Didn't need
- ☐ Shelter? Yes / No / Didn't need
- ☐ Other:_____

If No, why weren't those resources helpful?

- ☐ I already tried the resource, not for me
- ☐ It took too long to get
- ☐ I wasn't interested
- ☐ I wasn't eligible
- ☐ Other:_____

17. Did Smart Path connect you to resources that you didn't know about before? Yes / No

18. Did Smart Path connect you to resources that you knew about but had trouble accessing? Yes / No

19. What other resources do you need that you wish you could get?

_____
_____
_____
_____

20. If there is one thing you would like to be improved with Smart Path, what would it be?

_____
_____
_____
_____

THANK YOU FOR COMPLETING THE SURVEY!