Before Starting the Special CoC Application

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

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

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

As the Collaborative Applicant, you are responsible for reviewing the following:
1. The Special Notice of Funding Opportunity (Special NOFO) for specific application and program requirements.
2. The Special NOFO Continuum of Care (CoC) Application Detailed Instructions for Collaborative Applicants which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.

CoC Approval is Required before You Submit Your CoC's Special NOFO CoC Consolidated Application
- 24 CFR 578.9 requires you to compile and submit the Special NOFO CoC Consolidated Application on behalf of your CoC.
- 24 CFR 578.9(b) requires you to obtain approval from your CoC before you submit the Consolidated Application into e-snaps.

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

Attachments
Questions requiring attachments to receive points state, "You must upload the [Specific Attachment Name] attachment to the 4A. Attachments Screen." Only upload documents responsive to the questions posed–including other material slows down the review process, which ultimately slows down the funding process. Include a cover page with the attachment name.
- Attachments must match the questions they are associated with–if we do not award points for evidence you upload and associate with the wrong question, this is not a valid reason for you to appeal HUD's funding determination.
- We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).

1A. Continuum of Care (CoC) Identification

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

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

1A-1. CoC Name and Number: OH-503 - Columbus/Franklin County CoC

1A-2. Collaborative Applicant Name: Community Shelter Board

1A-3. CoC Designation: UFA

1A-4. HMIS Lead: Community Shelter Board

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

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

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

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

1B-1.	**Web Posting of Your CoC Local Competition Deadline–Advance Public Notice. (All Applicants)**	
	Special NOFO Section VII.B.1.b.	
	You must upload the Local Competition Deadline attachment to the 4A. Attachments Screen.	
	Enter the date your CoC published the deadline for project application submission for your CoC's local competition.	07/18/2022

1B-2.	**Project Review and Ranking Process Your CoC Used in Its Local Competition. (All Applicants)**	
	Special NOFO Section VII.B.1.a.	
	You must upload the Local Competition Scoring Tool attachment to the 4A. Attachments Screen.	
	Select yes or no in the chart below to indicate how your CoC ranked and selected new project applications during your CoC's local competition:	
1.	**Established total points available for each project application type.**	Yes
2.	**At least 33 percent of the total points were based on objective criteria for the project application (e.g., cost effectiveness, timely draws, utilization rate, match, leverage), performance data, type of population served (e.g., DV, youth, Veterans, chronic homelessness), or type of housing proposed (e.g., PSH, RRH).**	Yes
3.	**At least 20 percent of the total points were based on system performance criteria for the project application (e.g., exits to permanent housing destinations, retention of permanent housing, length of time homeless, returns to homelessness).**	Yes

1B-3.	**Projects Rejected/Reduced–Notification Outside of e-snaps. (All Applicants)**	
	Special NOFO Section VII.B.1.b.	
	You must upload the Notification of Projects Rejected-Reduced attachment to the 4A. Attachments Screen.	
1.	**Did your CoC reject or reduce any project application(s)?**	Yes
2.	**Did your CoC inform the applicants why their projects were rejected or reduced?**	Yes
3.	**If you selected yes, for element 1 of this question, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps. If you notified applicants on various dates, list the latest date of any notification. For example, if you notified applicants on 6/26/22, 6/27/22, and 6/28/22, then you must enter 6/28/22.**	10/04/2022

1B-3a.	Projects Accepted–Notification Outside of e-snaps. (All Applicants)	
	Special NOFO Section VII.B.1.b.	
	You must upload the Notification of Projects Accepted attachment to the 4A. Attachments Screen.	
	Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New Priority Listings in writing, outside of e-snaps. If you notified applicants on various dates, list the latest date of any notification. For example, if you notified applicants on 6/26/22, 6/27/22, and 6/28/22, then you must enter 6/28/22.	10/04/2022

1B-4.	Web Posting of the CoC-Approved Special NOFO CoC Consolidated Application. (All Applicants)	
	Special NOFO Section VII.B.1.b.	
	You must upload the Web Posting–Special NOFO CoC Consolidated Application attachment to the 4A. Attachments Screen.	
	Enter the date your CoC posted its Special NOFO CoC Consolidated Application on the CoC's website or affiliate's website–which included: 1. the CoC Application, and 2. Priority Listings.	10/13/2022

2A. System Performance

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

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

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

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

(limit 2,500 characters)

1) The CoC conducts an annual evaluation of self-reported factors contributing to homelessness to inform and target prevention efforts for persons at risk of becoming homeless for the first time. Reasons for households' homeless crises are captured in HMIS and reported annually, allowing us to identify and analyze risk factors. Weekly system meetings and case conferences add qualitative data on the barriers clients are facing and which risk factors are most common and pervasive. The CoC has determined that higher rents and lack of deeply affordable housing are the primary risk factors for homelessness, which is consistent with a 2015 collaboration with Abt Associates that identified causes of homelessness and housing instability in our community. 2) Reducing the number of first time homeless is a prioritized goal in the CoC's 2022 strategic plan. Prevention resources are prioritized for the most vulnerable populations in our community: Families at risk of becoming homeless that contact the CPoA's homeless hotline are connected to prevention resources to help avoid entering shelter. At-risk pregnant women can access specialized prevention services using TANF, ESG-CV, and local funding. At-risk Veterans can access SSVF prevention resources. Families involved with child protective services can access a prevention program funded by Franklin County Children Services. Community Shelter Board (CSB, the UFA), has developed the Homelessness Prevention Network (HPN) that formalizes collaborations with social service agencies that serve as access points and/or homelessness prevention service providers. CSB trains and certifies HPN partners in housing stabilization best practices. HPN partners provide prioritized access to services for households at highest risk for homelessness as determined by a standardized risk typology and screening protocol. Access points are dispersed in the community and intervene to prevent a household from becoming homeless. These community-based access points identify and assist households before they need to call CPoA's hotline. If households require additional help, access points refer them electronically to homeless prevention service providers for case management and quick financial assistance for housing stabilization. In addition, we focus on legal and other eviction prevention resources, trainings for landlords, property managers, and partners. 3) Community Shelter Board is responsible for this strategy.

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

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

(limit 2,500 characters)

1) Reducing length of time homeless is a key goal in the CoC's 2022 strategic plan. Shelters screen for referral to RRH programs. We work to decrease referral time to RRH by reducing the times between shelter entry and screening and screening and RRH referral and expedite engagement after RRH referral with a Housing First focus. We prioritize for RRH families with children, pregnant women, Veterans, youth, people with disabilities, those fleeing domestic violence, and those with severe service needs and long homeless time. We determine whether it is most appropriate to provide support through RRH or PSH. We increased street outreach capacity to provide re-housing assistance and coordinate with hospitals, corrections, and behavioral health providers to better identify and re-house high system utilizers. We work to expedite processes to acquire a state ID, birth certificate and social security card using an FTE dedicated to this scope. RRH case managers help households develop housing plans, engage landlords, remove barriers and link to assistance and employment, and promote stability. We implemented a landlord recruitment and retention initiative, including marketing, outreach, financial incentives, and risk mitigation funds, to improve access to rental units in our tight housing market. We support community efforts to increase availability of safe, affordable rental housing. We aggressively pursue resources and opportunities to increase the supply of RRH and PSH units and expand re-housing assistance. We partner with the PHA and we secured 94 Mainstreams and all the 304 EHVs allocated for the homeless population. Despite these efforts the average length of time homeless is increasing due to rapid population growth causing an affordable housing crisis. 2) We use HMIS weekly for "by name lists" and monthly "hotlist" reports to review households with the longest homeless time for RRH and PSH referrals. The by name list is embedded in the HMIS and RRH referrals are made through HMIS using scored pools. We use a standardized system-wide needs assessment and case conferencing to engage those with the longest homeless time and most severe service needs. The hotlist is used by the Unified Supportive Housing System, who fills all PSH units according to HUD Notice CPD-16-11 and uses a standardized invitation and application process for those prioritized for PSH based on the "hotlist". 3) Community Shelter Board is responsible for this strategy.

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

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

(limit 2,500 characters)

1) Increasing the rate of positive housing exits is a key goal in the CoC's 2022 strategic plan. Shelters and RRH programs collaborate to quickly house people, link them to resources, and provide aftercare to ensure stability. We work to increase capacity of RRH programs to maximize the number of people they can serve and improve the referral process. Shelters screen people after entry and refer to RRH those who are prioritized for assistance: families with children, pregnant women, Veterans, youth, people with disabilities, those fleeing domestic violence, and people with severe service needs and long homeless time because these populations are less likely to successfully exit without tailored support. Case managers help households develop housing plans, work with landlords, remove barriers, secure housing, and promote stability through linkage to income supports and services. TH programs stabilize veteran and youth households prior to permanent housing placement to increase the likelihood of success at exit. RRH, TH, and shelter providers use financial assistance to pay security deposits and first few months of rent. The assistance is flexible and offered based on household's needs and landlord requirements, with a goal of improving the positive housing rate. Our system-wide landlord recruitment and retention initiative provides outreach, financial incentives, and risk mitigation funds, to improve access to rental units, expand shared living options, and identify strategic landlord partners. We actively support community efforts to increase deeply affordable housing to enhance participants' ability to obtain and retain stable housing. Despite all these efforts the success rate is decreasing due to the rapid growth in population causing an affordable housing crisis, coupled with a staffing shortage systemwide that decreases our ability to provide intensive housing services based on demand. 2) Housing stability for persons in permanent housing is already very high at 97%. PSH providers engage with residents frequently to identify anyone who may become precariously housed and take action to re-stabilize them. PSH residents access a variety of services, including linkage to employment, benefits, and income supports. At least annually, PSH providers assess residents' readiness and willingness to move to independent housing. Residents are not exited from PSH until they feel confident that they can retain housing stability without PSH assistance.

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

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

(limit 2,500 characters)

1) Community Shelter Board (CSB, the UFA) tracks returns via HMIS and issues regular reports at program and system levels, including recidivism rates. CSB examines programs with recidivism rates outside the norm to identify factors contributing to higher or lower rates. Collaboration between emergency shelter and RRH programs via regular case conferencing and system workgroup meetings help inform the CoC of factors that impact returns to homelessness. The Housing Assistance Screening Tool administered by emergency shelters identifies a household's prior use of shelter and re-housing assistance so programs can adjust next-step assistance. 2) Reducing the rate of return to homeless is a prioritized goal in the CoC's 2022 strategic plan. RRH case managers help households develop housing plans and remove barriers. They provide aftercare and resources in case of setbacks and create plans for responding to future crises, through partnerships in the community that support housing stability, with MCOs, Job and Family Services, Office on Aging and peer support organizations. Households can contact their case manager if they encounter a housing crisis, even after services end, to problem-solve. For PSH, programs link participants to community-based supports to improve access to resources and increase resiliency to future setbacks. Linkages may include employment services, education, mental/emotional/physical health services, benefits, Veterans resources, youth services, and child care and parenting resources. We value client expertise and partner guidance and collaboratively develop trainings or resources to address: budgeting to pay rent, navigating conflict with neighbors, housekeeping and cleaning, understanding the lease, how to complete work orders or notify landlord of concerns, interacting with landlords and cooking skills. All RRH and PSH programs have robust eviction prevention procedures. Because we are prioritizing RRH and PSH for those with the highest barriers, we are seeing an increasing rate of recidivism as this is the most vulnerable population being served and most likely to lose housing. Increasing rents (avg 1 bdr rent is 19% over FMR) and the impact of COVID19 on the wellbeing of previously homeless households are factors contributing to this increase. We are also working to reposition our homelessness prevention efforts to prioritize for assistance households with past homeless histories. 3) CSB oversees the strategy.

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

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

(limit 2,500 characters)

1) Increased access to employment is a prioritized goal in the CoC's 2022 strategic plan. We are improving integration with mainstream workforce development and access to employment and skill development resources through a pilot in family emergency shelters started in 2020. The pilot creates incentivized pathways to engage in workforce development. Our approach is to work with Workforce Development Board of Central Ohio and other community-based employment services to integrate workforce specialists, including job coaching, within our CoC programs, where not already present. We support community efforts to increase employment income for low-wage earners and reduce pay disparities. CoC programs encourage participants to include earned income growth in regularly-updated individualized housing stabilization plans. For participants who are underemployed or lack consistent employment, programs help identify higher-paying and more regular work. Linkage to GED, education, skill development, and career development programs is available to help participants access higher-paying jobs. 2) Participants receive help with job searches, applications, resume writing, transportation, and uniforms and professional attire. An increasing number of programs have employment specialists on site to provide more individualized support. Several CoC programs have successful employment and work equity programs that include training, workshops, and collaboration with employers. The CoC has identified private employers who are willing to hire people with histories of criminal behavior, addiction and homelessness. One example is the Right Track Program that consists of classroom experience followed by a paid training position within a PSH provider's housing facilities. More than 50% of participants who complete this program move into traditional jobs in the community. These efforts resulted in a 4-percentage point increase in earned income for CoC program leavers between FY20 and FY21. We are improving integration with the Workforce Development Board of Central Ohio through an employment pilot program that expedites the Ohio Means Jobs referral and acceptance process for families in shelter. 3) Franklin County Department of Job and Family Services, WDB, and CSB oversee this strategy.

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

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

(limit 2,500 characters)

1) Increased access to benefits is a prioritized goal in the CoC's updated 2022 strategic plan. Programs encourage participants to take advantage of all non-employment cash income benefits for which they are eligible, including SSI, SSDI, and TANF. Community Shelter Board (CSB), the UFA, convened a training for providers on the SSA Vulnerable Populations Program to encourage greater applications for SSI for individuals in the crisis response system. CSB regularly provides trainings and disseminates to partners resources and best practices for linking participants to benefits. Case managers help program participants complete applications. The Homeless Hotline (CPoA) screens callers for health insurance to help assess coverage gaps. CSB is working with the Alcohol, Drug, and Mental Health Board, MCOs and others to more effectively leverage Medicaid and other health care resources. 2) As part of our strategic plan, we will continue to utilize the new Social Security Administration Vulnerable Populations program for clients to apply for benefits and will incorporate partner training for this program. We will further expand the use of SOAR system-wide for clients to access benefits, including increasing the number of SOAR certified staff. Franklin County Department of Job and Family Services (JFS) regularly have staff onsite at our CoC's two family shelters to expedite access to benefits. These benefits support RRH efforts. The CoC has SOAR-trained staff who help participants apply for SSI and SSDI benefits. Program staff refer participants to JFS for benefits assistance not available onsite. All Veterans are screened for access to non-employment cash income through a refined coordinated entry system specifically designed for Veterans in partnership with the VA. Those in need of and eligible for both VA and non-VA benefits are linked through this process. Programs provide information to participants about benefits available to them during COVID-19. Programs provided computer access to online portals whenever possible during COVID-19 lockdowns. Annual assessments of PSH clients assess non-employment cash income and individualized housing stabilization plans include goals for increasing these income sources, based on the individual's need and eligibility. Case managers regularly review and update these goals with program participants 3) JFS and CSB oversee this strategy.

2B. Coordination and Engagement–Inclusive Structure and Participation

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

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

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

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

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

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

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

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

(limit 2,500 characters)

1) Each spring, the CoC governing body issues a call for membership nominations via a website post and email to a broad array of stakeholders and community partners. When there is an unexpected vacancy on the CoC or CoC Board, the CoC Chair requests nominations from CoC members for the vacancy. The CoC governing body accepts nominations from any source, including self-nominations. The CoC Board reviews nominations and considers whether additional or different representation would improve the CoC's community perspective and expertise. The CoC considers the CoC Board's membership recommendations during their May/June meeting, discusses any additional suggestions, and votes to determine which individuals or organizations will be invited to join the CoC with a July 1 effective date. 2) The CoC is committed to accommodating the communication needs of individuals with disabilities. Calls for nominations and other announcements are emailed and published on the CoC's website. Meeting materials are distributed to members in PDF format via email and/or mailed as hard copies, depending on individual preference. Materials are both shared visually and explained verbally during meetings. 3) The CoC governing body works closely with the Citizens Advisory Council (CAC), which consists of homeless and formerly homeless individuals, to designate two representatives to serve on the CoC governing body. One of the CAC representatives also serves on the CoC Board. The Youth Action Board also designates a representative to serve on the CoC governing body. This past year, the CoC provided training to select CAC and YAB members on effective board participation to build capacity. This training will continue. 4) The CoC recently added a seat for and recruited an LGBTQ-serving organization. The CoC adopted in 2022 a DEI Plan that sets the goal for the composition of the CoC to be consistent with the composition of the people served by the homelessness system across a range of characteristics, including race, ethnicity, gender, age, LGBTQ+ identity, socio-economic status, disability, and lived experience in the homelessness system and other systems of care. The CoC will pursue this goal over the long-term with an attitude of learning and cultural humility. During this year's CoC membership nomination process, the CoC explicitly requested diverse nominations and CoC members were asked to actively recruit diverse candidates. 57% of the new members this year met the diversity criteria.

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

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

(limit 2,500 characters)

1) Our CoC's strategic and youth plans are updated via public convenings and focused workgroups that incorporate recommendations and ideas from many partners involved in preventing and ending homelessness. The 2022 update of A Place to Call Home, our strategic framework that articulates our community's vision for making sure everyone has a place to call home, includes goals tailored to all populations facing homelessness served by our system of care. The goals are also aligned with broader community work already underway. CSB facilitated 12 community partner sessions, targeted system level discussions and community listening sessions where almost 150 individuals voiced their thoughts about preventing and ending homelessness in our community. The Citizens Advisory Council, a group comprised of homeless and formerly homeless individuals that meets monthly and advises the CoC participated in these sessions as well. 2. During the sessions organized to gather community input, CSB staff presented the current state of homelessness and the various programming and strategies already in place, to create a baseline understanding of the system and to facilitate development of new ideas. The virtual presentations allowed for targeted discussions of various goals and attendees were able to provide input and come up with new ideas and strategies to improve our system of care. 3) Feedback from these sessions was summarized in overarching goals, and strategies for each goal. Participants were asked to rate the importance of strategies and those that received a high rating were included in the community plan. If a particular goal or strategy was not ranked of 'high value' by the participants, then additional participant suggestions were incorporated into the plan that were deemed to have the highest impact and value toward preventing and ending homelessness. The community plan includes outcomes and outputs for each strategy to measure the progress of our work. The final plan was presented to the CoC for approval. The plan is revisited annually with the intent of updating the goals and strategies regularly to make sure the plan is in line with current developments and the socio-economic environment.

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

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

(limit 2,500 characters)

1) Community Shelter Board (CSB) solicits proposals for new Permanent Housing projects for consideration by the CoC annually. CSB sends the opportunity via email to a wide array of organizations, encouraging further distribution, including organizations that have not previously received CoC funding, and posts the call for proposals on the CoC website. The notification includes instructions for the applications and a deadline. The CoC advertises all NOFOs, along with schedules and instructions, through emails to a wide variety of constituents and asks them for a broad further distribution of the funding opportunities, and on the CoC website. 2) The CoC welcomes participation from entities that have not previously received CoC funds and proactively seeks opportunities to involve new partners. This is stated explicitly in the call for proposals. In 2022 the CoC received and considered two new Concept Papers (local name for pre-applications) for Permanent Housing, from organizations that have not previously received CoC Program funding. One of the projects was approved by the CoC and moved to the Project Application phase of our process. 3) The CoC emails and posts on the website contain instructions for submitting Concept Papers and Project Applications. 4) The CoC determines which new projects to include in the application based on the CoC review process. New projects are required to submit Concept Papers that detail the type of project, target population, percent of units dedicated to the homeless population, provision of supportive services, expected funding sources, and projected results. The CoC Board, Citizens Advisory Council (people with lived experience), and CoC review and evaluate the Concept Papers based on community need using the system gaps analysis and applicants' capacity to operate the project and meet compliance standards, responses included in the application and capacity to administer federal funds. The CoC scores and prioritizes Concept Papers prior to the NOFO's release and determines which project moves to the Project Application phase. The final determination regarding the projects to be included in the competition occurs during the application process, based on available CoC Bonus funding. 5) The CoC is committed to accommodating the communication needs of people with disabilities. Public notices are posted in PDF format on CSB's and the CoC's website. Reasonable accommodations to the application process are made as needed.

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

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

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

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

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

	Entities or Organizations Your CoC Coordinates with for Planning or Operations of Projects	Coordinates with Planning or Operations of Projects
1.	Funding Collaboratives	Yes
2.	Head Start Program	Yes
3.	Housing and services programs funded through Local Government	Yes
4.	Housing and services programs funded through other Federal Resources (non-CoC)	Yes
5.	Housing and services programs funded through private entities, including Foundations	Yes
6.	Housing and services programs funded through State Government	Yes
7.	Housing and services programs funded through U.S. Department of Health and Human Services (HHS)	Yes
8.	Housing and services programs funded through U.S. Department of Justice (DOJ)	Yes
9.	Housing Opportunities for Persons with AIDS (HOPWA)	Yes
10.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	Nonexistent
11.	Organizations led by and serving Black, Brown, Indigenous and other People of Color	Yes
12.	Organizations led by and serving LGBTQ+ persons	Yes
13.	Organizations led by and serving people with disabilities	Yes
14.	Private Foundations	Yes
15.	Public Housing Authorities	Yes
16.	Runaway and Homeless Youth (RHY)	Yes
17.	Temporary Assistance for Needy Families (TANF)	Yes
	Other:(limit 50 characters)	
18.		

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

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

(limit 2,500 characters)

1) City of Columbus and Franklin County (ESG recipients) representatives are members of the CoC Board and the CoC and actively participate in funding allocation conversations in CoC meetings. The City and County grant all ESG allocations to Community Shelter Board (CSB), the UFA. The City, County, and CSB propose ESG allocations to the CoC in accordance with the Consolidated Plan. The CoC also serves on the State Advisory Board on homelessness and provides input on state objectives and proposed ESG funding allocations. CSB is the collaborative applicant and sub-recipient of all State ESG RRH and Emergency Shelter funding in the county, which is allocated in accordance with the State Consolidated Plan. The CoC governing body approves annually all funding allocations. 2) CSB develops annual ESG performance standards for CoC approval. The CoC, City, and County receive quarterly performance evaluations based on these standards, using HMIS data. The performance reports are reviewed during the CoC Board and CoC meetings. These evaluations include program-level reporting of all ESG-funded projects. CSB also provides the City, County and State with the required annual performance reporting using HMIS data and with monthly, quarterly and annual financial reporting on use of funds. The CoC also reviews HIC and PIT data including system capacity by program type, a system gaps analysis, and the System Performance Measures. Funding allocations and performance outcomes determined collaboratively between ESG recipients and the CoC are codified in contracts between the City, County, and State as the ESG recipients and CSB as the ESG sub-recipient. 3) CSB shares HIC and PIT data with the City, County, and State to update the Consolidated Plan and provides descriptive information for the plan on current state, gap in inventory and service provision and projected need. CSB conducts a PIT debrief as an ongoing quality and improvement practice. 4) On behalf of the CoC, CSB regularly shares system updates and reports with the City, County, and State through email, regular meetings, and various workgroups. CSB works with the City, County, and State to update the Consolidated Plan and ensure local homelessness information is accurately incorporated into the Plan's strategies. Information is provided on current state of homelessness, gap in inventory and service provision and projected need. The most recent information provided for the Consolidated Plan update was in July 2021.

2C-3.	Discharge Planning Coordination. (All Applicants)	
	Special NOFO Section VII.B.3.c.	
	Select yes or no in the chart below to indicate whether your CoC actively coordinates with the systems of care listed to ensure persons who have resided in them longer than 90 days are not discharged directly to the streets, emergency shelters, or other homeless assistance programs.	
1.	Foster Care	Yes
2.	Health Care	Yes
3.	Mental Health Care	Yes
4.	Correctional Facilities	Yes

2C-4.	CoC Collaboration Related to Children and Youth–SEAs, LEAs, School Districts. (All Applicants)	
	Special NOFO Section VII.B.3.d.	
	Select yes or no in the chart below to indicate the entities your CoC collaborates with:	
1.	Youth Education Provider	Yes
2.	State Education Agency (SEA)	No
3.	Local Education Agency (LEA)	Yes
4.	School Districts	Yes

2C-4a.	CoC Collaboration Related to Children and Youth–SEAs, LEAs, School Districts–Formal Partnerships. (All Applicants)	
	Special NOFO Section VII.B.3.d.	
	Describe in the field below:	
1.	how your CoC collaborates with the entities checked in Question 2C-4; and	
2.	the formal partnerships your CoC has with the entities checked in Question 2C-4.	

(limit 2,500 characters)

1) The CoC collaborates with Columbus State Community College (CSCC) to assist youth experiencing or at risk of homelessness in continuing educational opportunities. Success-Bridge helps students at risk of dropping out of school due to housing instability with homelessness prevention resources. The CoC collaborates with local high schools and GED providers on educational opportunities for youth. Columbus City Schools Project Connect (the community's largest LEA) attends the CoC's family system operations workgroup meetings to connect with emergency shelter partners regarding services and resources Columbus City Schools actively participates on the CoC Youth Committee. The CoC's Youth System Manager participates in LEA workgroups and forums. The CoC facilitated a streamlined referral process from agencies that provide shelter and housing services for families to Columbus City Schools Project Connect. This process ensures children remain in their school of origin or are immediately enrolled in the school serving the family's temporary address. Project Connect provides daily school transportation for children staying in emergency shelter. Project Connect is also part of the CoC's Homelessness Prevention Network and is trained in housing problem solving, and refers at-risk families to the CoC for additional supports. A partnership with the Franklin County Educational Services Center is being developed as part of the YHDP Coordinated Community Plan and CoC Youth Committee efforts. The CoC provides additional outreach and homelessness prevention information to school districts and suburban schools within Franklin County as opportunities and new relationships are developed. 2) The Columbus State Community College (CSCC) Success Bridge has a formal agreement with CSB and data and outcomes are tracked in HMIS. CSCC has a voting representative on the CoC. Columbus City Schools Project Connect has a formal MOU for the Homelessness Prevention Network. Project Connect has a voting representative on the CoC. Columbus City Schools and South-Western City Schools (two districts with most homeless children) have formal MOUs with the CoC, codifying collaboration on the CoC's plan to prevent and end youth homelessness. The CoC's family emergency shelters also include Head Start program locations under agreements with the respective shelters.

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

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

(limit 2,500 characters)

Each program in the homeless system is required to ensure that children and youth have access to public education and receive assistance exercising their rights as protected by the McKinney-Vento Homeless Assistance Act of 1987. Community Shelter Board (UFA), on behalf of the CoC, monitors all programs annually for evidence that program staff proactively ensure that program participants' rights are not violated regarding public education, including contact with the local Homeless Education Liaison. The relevant excerpt from the P&P manual is: "Education: Programs serving children must ensure that children and youth have access to public education and that their rights are protected in accordance with federal and state requirements. Collaboration opportunities with Columbus City Schools' Project Connect staff are available." The relevant monitoring standard language is: "Children and youth have access to public education and receive assistance exercising their rights as protected by the McKinney-Vento Homeless Assistance Act of 1987, as amended, Title VII, Subtitle B; 42 U.S.C. 11431. Heads of households are advised of their rights as they relate to the public education system."
Each program must demonstrate consistent implementation of processes for advising heads of households of their rights upon entry into any homelessness program through policies and procedures and actual client files. Participant files for households with children must demonstrate collaboration with the Homeless Education Liaison to place children in public school, early childhood programs such as Head Start, Part C services in accordance with the Individuals with Disabilities Education Act, and/or other programs authorized under Subtitle B of Title VII of the McKinney-Vento Homeless Assistance Act of 1987. It is our system's policy that when a family with school-aged children enters emergency shelter, Columbus City Schools Project Connect is informed immediately and the child(ren) will continue to attend school at their school of origin, using the Project Connect busses that pick children up from emergency shelters and transport them to their schools every morning. If a family with children is entering permanent housing, the program staff makes efforts to house the family as close as possible to its school of origin so as not to disrupt children's education.

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

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

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

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

	Describe in the field below how your CoC:
1.	systemically provides up-to-date information on mainstream resources available for program participants (e.g., Food Stamps, SSI, TANF, substance abuse programs) within your CoC's geographic area;
2.	works with project staff to collaborate with healthcare organizations to assist program participants with enrolling in health insurance;
3.	provides assistance to project staff with the effective use of Medicaid and other benefits; and
4.	works with projects to promote SOAR certification of program staff.

(limit 2,500 characters)

1) Community Shelter Board (CSB), the UFA, keeps program staff up-to-date regarding mainstream resources by regularly seeking and disseminating information to partners about cash assistance, non-cash benefits, Food Stamps, meal sites, food programs, mental health and substance abuse treatment services, and other resources. CSB, on behalf of the CoC, monitors all programs annually to ensure that system staff is trained and capable of helping program participants enroll in and utilize mainstream benefits. CSB disseminates resources, best practices, and other assistance information during weekly system operations workgroup meetings with partner agencies and through email communications as updates become available. A newsletter is also emailed out to a large distribution list. The Homeless Hotline, part of our CPoA, screens callers for health insurance to help assess coverage gaps and MCO utilization by those referred to emergency shelter programs. 2) CSB works with organizations that provide mainstream benefits to present information on their programs during system meetings and educate project staff about how to best collaborate with healthcare organizations. The CoC has a pilot partnership with an MCO wherein the CPoA notifies the MCO when one of their customers enters the homeless crisis response system. The MCO can help fully use their healthcare benefits, contributing to regained housing stability. We are working with other MCOs on partnerships to increase collaboration between our systems. 3) CSB is collaborating with the local Alcohol, Drug, and Mental Health Board and MCOs to best leverage Medicaid on behalf of homeless program participants. Some programs use HMIS as a tool for the Medicaid billing process. Majority of PSH providers sub-grant for the provision of supportive services with agencies that are part of the ADAMH system as these agencies are also Medicaid billing agencies and this way Medicaid use is maximized for eligible services. CSB works closely with the VA to ensure that Veterans have access to VA health care resources. 4) As part of the 2022 Community Plan update, multiple partners identified as a significant goal the further use of SOAR throughout the system to assist clients in accessing benefits. CSB is exploring expanded opportunities for SOAR in youth, single adults, veterans, and family systems, will promote SOAR usage and certification to all partners and in late 2022 will determine if there are further expansion opportunities for the program.

3A. New Projects With Rehabilitation/New Construction Costs

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

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

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

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

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

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

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

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

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

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

(limit 2,500 characters)

4A. Attachments Screen For All Application Questions

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

Document Type	Required?	Document Description	Date Attached
1B-1. Local Competition Announcement	Yes	Local Competition...	09/29/2022
1B-2. Local Competition Scoring Tool	Yes	Local Competition...	09/29/2022
1B-3. Notification of Projects Rejected-Reduced	Yes	Notification of P...	10/06/2022
1B-3a. Notification of Projects Accepted	Yes	Notification of P...	10/06/2022
1B-4. Special NOFO CoC Consolidated Application	Yes		
3A-1. CoC Letter Supporting Capital Costs	No		
3B-2. Project List for Other Federal Statutes	No		
P-1. Leveraging Housing Commitment	No	Leveraging Housin...	10/06/2022
P-1a. PHA Commitment	No	PHA Commitment	10/06/2022
P-3. Healthcare Leveraging Commitment	No	Healthcare Levera...	10/07/2022
P-9c. Lived Experience Support Letter	No	Lived Experience ...	09/29/2022
Plan. CoC Plan	Yes	CoC Plan	09/30/2022

Attachment Details

Document Description: Local Competition Deadline

Attachment Details

Document Description: Local Competition Scoring Tool

Attachment Details

Document Description: Notification of Projects Rejected-Reduced

Attachment Details

Document Description: Notification of Projects Accepted

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: Leveraging Housing Commitment

Attachment Details

Document Description: PHA Commitment

Attachment Details

Document Description: Healthcare Leveraging Commitment

Attachment Details

Document Description: Lived Experience Support Letter

Attachment Details

Document Description: CoC Plan

Submission Summary

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

Page	Last Updated
1A. CoC Identification	09/06/2022
1B. Project Review, Ranking and Selection	09/29/2022
2A. System Performance	09/15/2022
2B. Coordination and Engagement	09/06/2022
2C. Coordination and Engagement–Con't.	09/15/2022
3A. New Projects With Rehab/New Construction	No Input Required
3B. Homelessness by Other Federal Statutes	09/15/2022
4A. Attachments Screen	Please Complete
Submission Summary	No Input Required

Local Competition Deadline

In response to question 1B-1, please see the portions highlighted below demonstrating when OH-503 posted its local competition submission deadline for applicants to submit project applications and the submission deadline date stating the deadline is for OH-503's local competition for CoC Program funding. It is common knowledge that local competition applications are submitted to CSB before being submitted to HUD.

.

communityshelterboard

Until everyone has a place to call home

HUD APPLICATION

HUD Continuum of Care Application

FY 2022 Notice of Funding Opportunity

The U.S. Department of Housing and Urban Development (HUD) has released the FY 2022 Continuum of Care (CoC) Program Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants Notice of Funding Availability. The CoC Program is designed to promote a community-wide commitment to the goal of ending homelessness; to provide funding for efforts by nonprofit providers, states, Indian Tribes or tribally designated housing entities, and local governments to quickly rehouse homeless individuals, families, persons fleeing domestic violence, dating violence, sexual assault, and stalking, and youth while minimizing the trauma and dislocation caused by homelessness; to promote access to and effective utilization of mainstream programs by homeless individuals and families; and to optimize self-sufficiency among those experiencing homelessness. The goal of the Youth Homelessness Demonstration Program is to support the development and implementation of a coordinated community approach to preventing and ending youth homelessness and sharing that experience with and mobilizing communities around the country toward the same end. The population to be served by the demonstration program is youth experiencing homelessness, including unaccompanied and pregnant or parenting youth.

CoCs are required to designate a Collaborative Applicant to submit a consolidated CoC application for funding for the community as a whole, and the Community Shelter Board (CSB) is Columbus and Franklin County's collaborative applicant. Please contact CSB Grants Administrator Gillian Gunawan (ggunawan@csb.org) if you have a new, eligible program that you would like to discuss for this year's CoC application.

Application Schedule

Dates	Activities
8/5/2022	CSB establishes project review & application schedule; releases to applicants via email
8/30/2022	All applications due to CSB by 5pm via e-snaps

8/31/2022 - 9/9/2022	CSB reviews applications and works with applicants to correct technical issues
9/12/2022	CoC Board meeting to consider CoC Consolidated Application and project prioritzation
9/15/2022	Final applications due to CSB via e-snaps
9/16/2022	Notify CoC Applicants of project prioritization
9/20/2022	CoC Meeting to consider CoC Consolidated Application
9/30/2022	Application due to HUD via e-snaps

FY 2022 Notice of Funding Opportunity Applicant Materials

Additional application information will be posted here when available.

2022 Continuum of Care Review, Score, and Ranking Process

2022 Continuum of Care Application Schedule

Continuum of Care Reallocation Policy

2022 Supplemental Notice of Funding Opportunity to address Unsheltered Homelessness

The U.S. Department of Housing and Urban Development (HUD) issued a **CoC Supplemental Notice of Funding Opportunity (NOFO) to address Unsheltered Homelessness**. This is a unique opportunity to apply for NEW funding to address unsheltered homelessness. The CoC Program is designed to promote a community-wide commitment to the goal of ending homelessness; to provide funding for efforts by nonprofit providers, states, Indian Tribes or tribally designated housing entities, and local governments to quickly rehouse homeless individuals, families, persons fleeing domestic violence, dating violence, sexual assault, and stalking, and youth while minimizing the trauma and dislocation caused by homelessness; to promote access to and effective utilization of mainstream programs by homeless individuals and families; and to optimize self-sufficiency among those experiencing homelessness.

Community Shelter Board (CSB) is seeking proposals in response to the Continuum of Care Supplemental Notice of Funding Opportunity to Address Unsheltered Homelessness, (Continuum of Care Supplemental to Address Unsheltered and Rural Homelessness (hud.gov)). **Applications are due to CSB by 5 pm on August 19, 2022.**

Applicants can apply to provide:

- Permanent Housing
  - Rapid Rehousing

- Permanent Supportive Housing (costs for acquisition, new construction or rehab are not allowable)

- Joint Transitional Housing and PH-Rapid Rehousing

- Supportive services only (includes projects providing services to unsheltered)

  - Street Outreach

  - Coordinated Entry

- HMIS

- CoC Planning (limited at 3% of the application)

- CoC UFA (limited at 3% of the application)

The CoC Scoring and Ranking document and the CoC Plan for Serving Individuals and Families Experiencing Homelessness with Severe Service Needs (referenced in the applications) will be issued at a later date but prior to the proposals due date.

CSB is seeking proposals that will demonstrate the ability to create a sustainable program that will achieve all expected outcomes. Review the expected outcomes by project type: Program_Performance_Standards_FY23

Applicants should have experience with providing some or all of the services described in the NOFO. Applicants are expected to implement programs that comply with CSB Partner Agency Standards and the Homeless Crisis Response System Policies and Procedures.

The application is competitive and only the top ranked CoCs will be awarded funding. The application process closely mirrors the annual Continuum of Care Application process. We are expecting to have two concurrent Continuum of Care Applications this year – the regular renewal application expected to be due in September and the new opportunity to address unsheltered homelessness due October 20.

Maximum award for Columbus and Franklin County: $9,123,297 (over 3 years)

Grant term: 3 years, renewable

Grant start date: July 1, 2023

Application Schedule

Dates	Activities
7/18/2022	Request for proposals released
7/29/2022	Notify CSB via email if you would like to receive responses to submitted questions
8/19/2022	Draft applications due to CSB by 5 pm in Word format

8/22/2022 – 8/29/2022	CSB reviews draft applications and works with applicants to finalize
Week of 9/5	CAC meets to review the projects and rank them
9/9/2022	CoC Workgroup meets to review, score projects and rank them
9/13/2022	Draft application due to CSB by 5 pm via email in esnaps format
9/16/2022	Final applications due to CSB by 5 pm in esnaps
10/3/2022	Notify applicants of project prioritization or rejection

2022 SUPPLEMENTAL NOFO APPLICANT MATERIALS

Please make sure to use the correct project type application.

RFP Guidelines

Full Application Schedule

FY22 Match Letter Template

PSH

Street Outreach

RRH

Coordinated Entry

Joint TH-RRH

2022 SUPPLEMENTAL NOFO Q&A

In the question "Applicant is working with HMIS lead to review HMIS data with disaggregation by race, ethnicity, gender identity, and or/age. If not a current HMIS participant, Applicant commits to participate in this review" - is there a report where I can pull this information or is there a plan to provide a report that will help us as an organization see results by race, gender, etc…

CSB reports disaggregate data by race, ethnicity, gender, etc. at the system level in the SPIR. Partners participating in the HMIS can see these similar breakouts for their programs, using the Outcomes Report.

If we apply for the Joint transitional housing and PH RRH, are we required to provide all services directly, or could we partner with another entity to offer RRH?

No, you are not required to provide all services directly. You could subgrant for the provision pf RRH. As a grantor to the subgrantee you will have to make sure that the subgrantee follows all HUD requirements.

Are there any restrictions around what funds can be used as the match requirement? (E.g. if we apply for street outreach we are wondering if PATH funding would count as the match – could both the federal PATH funding and the local match go towards our match requirement for this funding?)

Please check the regulation that governs PATH funding if the funding is allowed to be used as match for other federal programs. If this is allowed then yes, you could use as match. Please see below for guidance specifically for supportive services match:

> **Leveraging Healthcare Resources.** These points are available for CoCs that propose to develop permanent housing projects, including permanent supportive housing and rapid re-housing projects, that utilize health care resources to help individuals and families experiencing homelessness. Sources of healthcare resources include:
>
> - Direct contributions from a public or private health insurance provider to the project; and
> - Provision of health care services, including mental health services, by a private or public organization (including FQHCs and state or local health departments) tailored to the program participants of the project.
> - Direct partnerships with organizations that provide healthcare services, including mental health services to individuals and families (including FQHCs and state or local public health departments) experiencing homelessness who have HIV/AIDS.
> - Eligibility for the project must comply with HUD program and fair housing requirements. Eligibility criteria cannot be restricted by the eligibility requirements of the health care service provider.
>
> CoCs must demonstrate through a written commitment from a health care organization, including organizations that serve people with HIV/AIDS, that the value of assistance being provided by the healthcare organization is at least:
>
> - In the case of a substance abuse treatment or recovery provider, it will provide access to treatment or recovery services for all program participants who qualify and choose those services; or
> - An amount that is equivalent to 50% of the funding being requested for the project(s) will be covered by the healthcare organization.

Acceptable forms of commitment are formal written agreements and must include:

- value of the commitment, and dates the healthcare resources will be provided.
- In-kind resources must be valued at the local rates consistent with the amount paid for services not supported by grant funds. CoCs can receive less than full points for demonstrating commitments less than the threshold described above.

2021 ➖

2020 ➖

2019 ➖

2018 ➖

2017 ➖

2016 ➖

2015 ➖

Local Competition Scoring Tool

In response to question 1B-2, please see the scoring tool OH-503 used in its local competition to score new ranked projects including all project application types.

communityshelterboard

Until everyone has a place to call home

Columbus and Franklin County Continuum of Care (OH-503)
2022 CoC Review, Score, and Ranking Tool

Project Name:					
Organization Name:					
Project Type:					
CoC Funding requested					
Amount of other public funding (federal, state, city, county)					
Amount of private funding					
Total Project Cost	0				

Scoring		Available	Awarded	Max Points per Project Type	Performance Points Ratio
	General Points	35	0		
	PH points	10	0	59	24%
	Joint Points	10	0	59	24%
	SSO CE Points	8	0	57	25%
	SSO non-CE Points	10	0	59	24%
	Performance Points	14	0		
	Total Points Awarded	**N/A**	**0**		

At least 20% percent of total points based on system performance criteria for the project application

At least 33% of total points based on objective criteria for the project application

Please add any comments you have in sthe section below:

Project Outline	Points Available	Points Awarded
Coordinated Entry Participation	1	
Housing First and/or Low Barrier Implementation	1	
All proposed program participants will be eligible for the program component type selected.	1	
Documented, secured minimum match	1	
Project has reasonable costs, as defined locally and proposed activities are eligible and consistent with program requirements	1	
Project is financially feasible	1	
Applicant is active CoC participant	1	
Application is complete and data are consistent; project narrative is fully responsive to the question being asked and meets all criteria for that question as required by the NOFO	1	
Data provided in the application are consistent	1	
Required attachments correspond to the list of attachments in e-snaps that must contain accurate and complete information and are correctly dated.	1	
Acceptable organizational audit/financial review	1	
Project design - Extent to which the Applicant		
Demonstrate understanding of the needs of the clients to be served	2	
Demonstrate type, scale, and location of the housing fit the needs of the clients to be served	2	

Demonstrate type and scale of the supportive services, regardless of funding source, meet the needs of the clients to be served.	2	
Demonstrate how clients will be assisted in obtaining and coordinating the provision of mainstream benefits	2	
Describe the plan to assist clients to rapidly secure and maintain permanent housing that is safe, affordable, accessible, and acceptable to their needs.	2	
Describe how clients will be assisted to increase employment and/or income and to maximize their ability to live independently.	2	
Project leverages housing resources with housing units not funded through the CoC or ESG programs.	2	
Project leverages health resources, including a partnership commitment with a healthcare organization.	2	
Equity		
Applicant has BIPOC individuals in managerial and leadership positions	1	
Applicant’s board of directors includes representation from persons with lived experience	1	
Applicant has individual(s) with lived experience employed on their team	1	
Applicant has process for receiving and incorporating feedback from persons with lived experience	1	
Applicant has reviewed internal policies and procedures with an equity lens and has a plan for updating policies that currently center white dominant culture	1	
Applicant has reviewed agency's program participant outcomes with an equity lens, including the disaggregation of data by race, ethnicity, gender identity, and/or age	1	

Applicant has identified programmatic changes needed to make agency's program participant outcomes more equitable and developed a plan to make those changes	1	
Applicant is working with HMIS lead to review HMIS data with disaggregation by race, ethnicity, gender identity, and or/age. If not a current HMIS participant, Applicant commits to participate in this review	1	
Total Points Available/Awarded	**35**	**0**

Performance Specific - Establish performance measures for housing and income that are objective, measurable, trackable, and meet or exceed any established HUD, HEARTH or CoC benchmarks.	Points Available	Points Awarded
Efficient Number of Households Served (households served in-line with staffing and project need)	2	
Cost per household served in-line with historical information of like-projects	2	
Successful Housing Outcomes Rate meets the CSB/CoC established performance benchmark for project type (Replace with Successful Diversion Rate for SSO - CE)	2	
Recidivism Rate meets the CSB/CoC established performance benchmark for project type	2	
Project Occupancy Rate meets the CSB/CoC established performance benchmark for project type	2	
Average Length of Participation/Housing Stability meets the CSB/CoC established performance benchmark for project type	2	
Increase in Income Rate meets the CSB/CoC established performance benchmark for project type or project proposes and describes an achievable income-related measure	2	
Total Points Available/Awarded	**14**	**0**

PH Specific	Points Available	Points Awarded
The type of housing proposed, including the number and configuration of units, will fit the needs of the program participants.	2	
The type of supportive services that will be offered to program participants will ensure successful retention in or help to obtain permanent housing, including all supportive services regardless of funding source	2	
The proposed project has a specific plan for ensuring program participants will be individually assisted to obtain the benefits of mainstream health, social, and employment programs for which they are eligible to apply and which meet the needs of program participants (e.g., Medicare, Medicaid, SSI, Food Stamps, local Workforce office, early childhood education).	2	
Program participants are assisted to obtain and remain in permanent housing in a manner that fits their needs (e.g., provides the participant with some type of transportation to access needed services, safety planning, case management, housing that meets accessibility related needs, additional assistance to ensure retention of permanent housing)	2	
The proposed project is consistent with the CoC plan described by the CoC	2	
Total Points Available/Awarded	**10**	**0**

Joint TH-RRH Specific	Points Available	Points Awarded
The type of housing proposed, including the number and configuration of units, will fit the needs of the program participants (e.g., ensuring a range of bedroom sizes to assist various family sizes.)	1	
The proposed project will provide enough rapid rehousing assistance to ensure that at any given time a program participant may move from transitional housing to permanent housing. This may be demonstrated by identifying a budget that has twice as many resources for the rapid rehousing portion of the project than the TH portion, by having twice as many PH-RRH units at a point in time as TH units, or by demonstrating that the budget and units are appropriate for the population being served by the project	2	
The type of supportive services that will be offered to program participants will ensure successful retention or help to obtain permanent housing, including all supportive services regardless of funding source	1	
The proposed project has a specific plan for ensuring program participants will be individually assisted to obtain the benefits of mainstream health, social services, and employment programs for which they are eligible to apply and which meet the needs of the program participants (e.g., Medicare, Medicaid, SSI, Food Stamps, local Workforce office, early childhood education).	2	
Program participants are assisted to obtain and remain in permanent housing in a manner that fits their needs (e.g., provides the participant with some type of transportation to access needed services, safety planning, case management, housing that meets accessibility related needs, additional assistance to ensure retention of permanent housing).	2	
The proposed project is consistent with the CoC plan	2	
Total Points Available/Awarded	**10**	**0**

SSO CE Specific	Points Available	Points Awarded
The centralized or coordinated assessment system is easily available/reachable for all persons within the CoC's geographic area who are seeking homeless assistance. The system must also be accessible for persons with disabilities within the CoC's geographic area	2	
There is a strategy for advertising that is designed specifically to reach homeless persons with the highest barriers within the CoC's geographic area.	2	
There is a standardized assessment process	2	
Ensures program participants are directed to appropriate housing and services that fit their needs.	2	
Total Points Available/Awarded	**8**	**0**

SSO non-CE Specific	Points Available	Points Awarded
The proposed project has a strategy for providing supportive services to those with the highest service needs, including those with histories of unsheltered homelessness and those who do not traditionally engage with supportive services	2	
Program participants are assisted to obtain and maintain permanent housing in a manner that fits their needs.	2	
The proposed project has a specific plan for ensuring program participants will be individually assisted to obtain the benefits of mainstream health, social services, and employment programs for which they are eligible to apply and which meet the needs of the program participants (e.g., Medicare, Medicaid, SSI, Food Stamps, local Workforce office, early childhood education).	2	
The project proposed will participate in coordinated entry	2	
The proposed project is consistent with the CoC plan	2	
Total Points Available/Awarded	**10**	**0**

Notification of Projects Rejected-Reduced

In response to question 1B-3, please see the portions highlighted below showing the projects that were rejected and/or reduced and notified 15 days prior to the application submission deadline on 10/4/2022.

communityshelterboard

Until everyone has a place to call home

From:	Lianna Barbu
To:	Wilson, Lauren; Dawnya Underwood
Cc:	Gillian Gunawan; Kirstin Jones
Subject:	FW: Project Scoring and Rankings for the FY22 CoC Supplemental Application
Date:	Tuesday, October 4, 2022 8:49:01 AM
Attachments:	Supplemental Applications Ranking and Scoring.pdf

Good Morning,
Per HUD requirements, this email is to let you know that your LSS/Faith Mission RRH project was reduced due to insufficient available funding.
Please see attached the final recommendation for the ranked position of your project application, including project score and funding amount.
The ranking is posted on the CoC website here: http://www.columbusfranklincountycoc.org/hud-application/. Please let us know if you have any questions.

Thank you

Lianna Barbu (she/her)
Associate Director

communityshelterboard
Until everyone has a place to call home

Community Shelter Board
355 E. Campus View Blvd., Suite 250
Columbus, OH 43235
Desk: 614-715-2535
Cell: 614-787-7062
www.csb.org

From: Lianna Barbu <lbarbu@csb.org>
Sent: Tuesday, October 4, 2022 8:41 AM
To: cbain@nationalchurchresidences.org; mzimmerman@nationalchurchresidences.org; Mary Price <mprice@chninc.org>; Ryan Cassell <rcassell@chninc.org>; jsharma@chninc.org; Houston, Maria <mnhouston@lssnetworkofhope.org>; Wilson, Lauren <LWilson@lssnetworkofhope.org>; bpierson@mchs.com; Mary Jo Dickinson <mdickinson@mchs.com>; Roxann Payne <rpayne@mchs.com>; kristina.kowatsch-beyer@mchs.com; Pamela J. Mahaney <Pamela.Mahaney@mchs.com>; Sean Arras <Sean.Arras@mchs.com>; Jodi Zellers <Jodi.Zellers@mchs.com>; Quianna Wasler <qwasler@BeaconCommunitiesLLC.com>; Michael Polite <mpolite@BeaconCommunitiesLLC.com>; sdarby@ymcacolumbus.org; Amanda Frankl (afrankl@ymcacolumbus.org) <afrankl@ymcacolumbus.org>; Dawnya Underwood <dunderwood@lssnetworkofhope.org>
Cc: Gillian Gunawan <ggunawan@csb.org>; Kirstin Jones <kjones@csb.org>
Subject: Project Scoring and Rankings for the FY22 CoC Supplemental Application

Good Morning,
Thank you for submitting Project Applications for the FY22 CoC Supplemental competition. The CoC Board met on October 3, 2022 to review the FY22 CoC Supplemental Application and rank new Project Applications, in accordance with the recommendations of the CoC

Workgroup on the Supplemental CoC Application for Unsheltered and Severe Service Needs Population.

Please see attached the CoC Board's recommendations for the ranked position of the project applications, including project scores and funding amounts. The CoC Board accepted all projects. One project was reduced due to insufficient available funding.

The full CoC will meet on October 12 to review and approve the full CoC Supplemental Application.

The ranking is posted on the CoC website here: http://www.columbusfranklincountycoc.org/hud-application/. Please let us know if you have any questions.

Thank you

Lianna Barbu (she/her)
Associate Director

communityshelterboard
Until everyone has a place to call home

Community Shelter Board
355 E. Campus View Blvd., Suite 250
Columbus, OH 43235
Desk: 614-715-2535
Cell: 614-787-7062
www.csb.org

2022 CoC Supplemental Application
Scoring and Ranking

Projects	Type	Total request/ Annual	Total Accepted/ Annual	Total Accepted/3 years	Score	Rank	Match	Total	Match %
CHN Poplar Fen Place	PSH	254,127	254,127	762,381	655.1	1	1,241,220	2,003,601	163%
NCR PSH Expansion	PSH	165,000	165,000	495,000	652.0	2	371,250	866,250	75%
Mount Carmel SSO	Outreach	122,965	122,965	368,894	651.0	3	94,552	463,446	26%
YMCA/Beacon 80 S 6th St	PSH	439,456	439,456	1,318,368	649.5	4	330,900	1,649,268	25%
NCR Berwyn E Place	PSH	338,633	338,633	1,015,899	646.0	5	761,924	1,777,823	75%
LSS/Faith Mission RRH	RRH	**1,461,963**	**1,187,550**	**3,562,650**	642.5	6	1,096,473	4,659,123	31%
LSS/CHOICES RRH	RRH	533,368	533,368	1,600,104	633.5	7	403,326	2,003,430	25%
Total		3,315,512	3,041,099	9,123,296					
Available to apply		3,041,099	3,041,099	9,123,297					
Variance		**274,413**	**(0)**	**(1)**					

Notification of Projects Accepted

In response to question 1B-3a, please see the portions highlighted below showing the projects that were accepted and notified 15 days prior to the application submission deadline on 10/4/2022.

communityshelterboard

Until everyone has a place to call home

From:	Lianna Barbu
To:	cbain@nationalchurchresidences.org; mzimmerman@nationalchurchresidences.org; Mary Price; Ryan Cassell; jsharma@chninc.org; Houston, Maria; Wilson, Lauren; bpierson@mchs.com; Mary Jo Dickinson; Roxann Payne; kristina.kowatsch-beyer@mchs.com; Pamela J. Mahaney; Sean Arras; Jodi Zellers; Quianna Wasler; Michael Polite; sdarby@ymcacolumbus.org; Amanda Frankl (afrankl@ymcacolumbus.org); Dawnya Underwood
Cc:	Gillian Gunawan; Kirstin Jones
Subject:	Project Scoring and Rankings for the FY22 CoC Supplemental Application
Date:	Tuesday, October 4, 2022 8:41:33 AM
Attachments:	Supplemental Applications Ranking and Scoring.pdf

Good Morning,
Thank you for submitting Project Applications for the FY22 CoC Supplemental competition. The CoC Board met on October 3, 2022 to review the FY22 CoC Supplemental Application and rank new Project Applications, in accordance with the recommendations of the CoC Workgroup on the Supplemental CoC Application for Unsheltered and Severe Service Needs Population.

Please see attached the CoC Board's recommendations for the ranked position of the project applications, including project scores and funding amounts. The CoC Board accepted all projects. One project was reduced due to insufficient available funding.

The full CoC will meet on October 12 to review and approve the full CoC Supplemental Application.

The ranking is posted on the CoC website here: http://www.columbusfranklincountycoc.org/hud-application/. Please let us know if you have any questions.

Thank you

Lianna Barbu (she/her)
Associate Director

communityshelterboard
Until everyone has a place to call home

Community Shelter Board
355 E. Campus View Blvd., Suite 250
Columbus, OH 43235
Desk: 614-715-2535
Cell: 614-787-7062
www.csb.org

2022 CoC Supplemental Application
Scoring and Ranking

Projects	Type	Total request/ Annual	Total Accepted/ Annual	Total Accepted/3 years	Score	Rank	Match	Total	Match %
CHN Poplar Fen Place	PSH	254,127	254,127	762,381	655.1	1	1,241,220	2,003,601	163%
NCR PSH Expansion	PSH	165,000	165,000	495,000	652.0	2	371,250	866,250	75%
Mount Carmel SSO	Outreach	122,965	122,965	368,894	651.0	3	94,552	463,446	26%
YMCA/Beacon 80 S 6th St	PSH	439,456	439,456	1,318,368	649.5	4	330,900	1,649,268	25%
NCR Berwyn E Place	PSH	338,633	338,633	1,015,899	646.0	5	761,924	1,777,823	75%
LSS/Faith Mission RRH	RRH	**1,461,963**	**1,187,550**	**3,562,650**	642.5	6	1,096,473	4,659,123	31%
LSS/CHOICES RRH	RRH	533,368	533,368	1,600,104	633.5	7	403,326	2,003,430	25%
Total		3,315,512	3,041,099	9,123,296					
Available to apply		3,041,099	3,041,099	9,123,297					
Variance		**274,413**	**(0)**	**(1)**					

Leveraging Housing Commitment

In response to question P-1, please see the following documents and the table below. Four PSH projects are being submitted and are noted in the attached letter with all units supported by the HCV program. Two RRH projects being submitted do not have a dedicated non-CoC subsidy funding source.

Project Type	Source of Non-CoC Voucher	Rent Subsidy Source	Percent of Units Covered by Subsidy	Date Units Will Be Available
PSH	Columbus Metropolitan Housing Authority	Housing Choice Voucher (HCV) Program	176 of 176 units or 100% covered by non-CoC source	35 units available now, 36 available in Spring 2024, 105 available Fall 2024
RRH	n/a	n/a	0 of 175 persons	n/a
Meet 50% Requirement?			176/(176+175)= 176/351= .5014= 50.14%	

communityshelterboard
Until everyone has a place to call home

COLUMBUS METROPOLITAN HOUSING AUTHORITY
COMMUNITY. COMMITMENT. COLLABORATION.

880 East 11th Avenue
Columbus, Ohio 43211
P: 614-421-6000
cmhanet.com

September 14, 2022

Michelle Heritage
Executive Director
Community Shelter Board
355 E Campus View Blvd Suite 250
Columbus, OH

Dear Michelle Heritage:

The Columbus Metropolitan Housing Authority (CMHA) is a committed partner in the Columbus and Franklin County Continuum of Care and the work to end homelessness in our community. The local goal is to open one new permanent supportive housing project every year and so far, with the support of the Housing Choice Voucher (HCV) program, this goal has been met. For the 2022 Continuum of Care Supplemental Application, several permanent supportive projects are prioritized and have an HCV commitment from CMHA.

Project Name, Type	Project Units/Persons in Supplemental NOFO	HCV Per Project	Anticipated Date of Availability
CHN 2022 SUPL Poplar Fen Place, PSH	35 units	35 units	Fall 2024
YMCA 2022 SUPL Beacon 80 S. 6th St, PSH	70 units	70 units	Fall 2024
NCR 2022 SUPL Berwyn East, PSH	36 units	36 units	Spring 2024
NCR 2022 SUPL PSH Expansion, PSH	35 units	35 units	Currently available

These projects are part of single site developments, and the units will be available for program participants as shown above.

Thank you,

Justin C. Davis
Vice President
Housing Choice Voucher

PHA Commitment

In response to question P-1a, please see the portions highlighted below demonstrating a clear commitment from a PHA to:

1. work with OH-503 to pair vouchers with CoC-funded supportive services; and

2. work with your OH-503 and other stakeholders to develop a prioritization plan for a potential allocation of Stability Vouchers or a preference for general admission to Housing Choice Voucher program through the coordinated entry process for individuals and families experiencing homelessness, at risk of homelessness, or fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking.

COLUMBUS METROPOLITAN HOUSING AUTHORITY
COMMUNITY. COMMITMENT. COLLABORATION.

880 East 11th Avenue
Columbus, Ohio 43211
P: 614-421-6000
cmhanet.com

September 9, 2022

Lianna Barbu
Associate Director
Community Shelter Board
355 E Campus View Blvd Suite 250
Columbus, OH

Dear Lianna Barbu:

Columbus Metropolitan Housing Authority (CMHA) commits to working with Community Shelter Board, the Continuum of Care (CoC) Lead and Unified Funding Agency for OH-503, and other stakeholders, to award any Stability Vouchers received subsequent to an award pursuant to the HUD Notice PIH 2022-24 to eligible families and individuals in Columbus and Franklin County. CMHA and CSB will do this by pairing Stability Vouchers with CoC-funded supportive services.

CMHA will work with the CoC and other stakeholders to develop a prioritization plan for the Stability Vouchers or a preference for general admission to Housing Choice Voucher Program through the Coordinated Entry process for individuals and families experiencing homelessness, at risk of homelessness, or fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking.

Thank you,

Justin C. Davis
Vice President
Housing Choice Voucher

Healthcare Leveraging Commitment

In response to question P-3, please see the portions highlighted below demonstrating the following noted in the table.

Source	Project	Sources of Healthcare Resources	Value of Assistance
Health Center at Faith Mission	LSS CHOICES 2022 SUPL RRH	Mental and behavioral health services, primary care, infectious disease testing and treatment, substance use disorder treatment.	$134,442 annually
Health Center at Faith Mission	LSS FM 2022 SUPL RRH	Mental and behavioral health services, primary care, infectious disease testing and treatment, substance use disorder treatment.	$365,491 annually
Lower Lights	All Awarded Projects	Substance abuse treatment or recovery services	$45,000 annually
Maryhaven	All Awarded Projects	Substance abuse treatment or recovery services	$567,500 annually
Mount Carmel	Mount Carmel Street Medicine and Social Care Project	Mount Carmel Health System Foundation fundraising, grants, and donations	$31,517 annually
National Church Residences	CHN 2022 SUPL Poplar Fen Place	Medicaid/Medicare reimbursements, direct client assistance, lab testing, peer support, etc.	$30,700 annually or $92,100 over three years
National Church Residences	NCR 2022 SUPL Berwyn East	Medicaid/Medicare reimbursements, direct client assistance, lab testing, peer support, etc.	$169,317 annually
National Church Residences	NCR 2022 SUPL PSH Expansion	Medicaid/Medicare reimbursements, direct client assistance, lab testing, peer support, etc.	$82,500 annually
PrimaryOne Health	All Awarded Projects	Substance abuse treatment, recovery, and primary care services	$180,333 annually or $541,000 Over three years
Southeast	All Awarded Projects	Substance abuse treatment, recovery, and primary care services	$75,000 Annually or $225,000 total
YMCA of Central Ohio	YMCA 2022 SUPL Beacon 80 S. 6th St	Revenue generated from Medicaid billing	$17,600 annually
		Total	$1,699,400 annually

August 15, 2022

Maria N. Houston, Psy.D.
Executive Director
CHOICES for Victims of Domestic Violence
1105 Schrock Rd, Ste 100
Columbus, OH 43229

Re: Match Documentation for CHOICES for Victims of Domestic Violence CoC Application

Dr. Houston:

As an authorized representative of The Health Center at Faith Mission, I am pleased to provide this letter of documentation to provide an in-kind match for CHOICES for Victims of Domestic Violence Continuum of Care (CoC) LSS CHOICES 2022 SUPL RRH project.

The Health Center at Faith Mission will provide an in-kind match valued at $403,326 annually through provision of mental health services, behavioral health services, primary care, infectious disease testing and treatment, and substance use disorder treatment to support and ensure the successful implementation of the LSS CHOICES 2022 SUPL RRH project. The funds will be available July 1, 2023 - June 30, 2026.

The Health Center at Faith Mission's services are supported by local, state and federal funding at no charge to individual recipients. It is committed to making every effort to sustain qualified services for this project. Private funding will cover any shortfall.

Sincerely,

Dawnya Underwood, PMP, LMSW
LSS Vice President of Programs
Acting Director at The Health Center at Faith Mission

August 15, 2022

Maria N. Houston, Psy.D.
Executive Director
CHOICES for Victims of Domestic Violence
1105 Schrock Rd, Ste 100
Columbus, OH 43229

Re: Commitment from Health Care Organization for TH/RRH Application

Dr. Houston:

As an authorized representative of The Health Center at Faith Mission, I am pleased to provide this letter of commitment to provide health care services for the proposed Continuum of Care (CoC) Transitional Housing/Rapid Rehousing project.

The Health Center at Faith Mission is a substance abuse treatment or recovery provider. It will provide access to treatment or recovery services for all program participants who qualify and choose those services. The services will be available July 1, 2023 - June 30, 2026.

The Health Center at Faith Mission's services are supported by local, state and federal funding at no charge to individual recipients. It is committed to making every effort to sustain qualified services for this project.

Sincerely,

Dawnya Underwood, PMP, LMSW
LSS Vice President of Programs
Acting Director at The Health Center at Faith Mission

LSS CHOICES
For Victims of Domestic Violence

Memorandum of Understanding
CHOICES for Victims of Domestic Violence
and
The Health Center at Faith Mission
245 N. Grant Ave.
Columbus, OH 43215

This Memorandum of Understanding (MOU), while not a legally binding document, does indicate a voluntary agreement to assist in the implementation of the plans described in the LSS CHOICES 2022 SUPL RRH project. This agreement between CHOICES and The Health Center reflects mutual understanding and commitment by these partnering organizations to enable delivery of the planned activities in accordance with all principles detailed in the Continuum of Care Supplemental Notice of Funding Opportunity to Address Unsheltered Homelessness and related HUD Continuum of Care regulations and policy statements. The grant is expected to have a three-year funding cycle.

Program Goal: To augment Central Ohio's Continuum of Care capabilities through a Transitional Housing and Rapid Rehousing (TH-RRH) program targeting domestic violence (DV) and sexual assault victims.

Lead Agency Roles/Expectation:

- CHOICES will serve as the lead project administrator, overseeing and propelling project forward while managing relationships with the funding agency and across all participating parties working for the greater good of TH-RRH program clients.
- CHOICES will staff a team to effectively carry out the TH-RRH program strategies and activities.
- CHOICES will ensure all program participants will have easy access to TH-RRH, emergency shelter, crisis clinician, community resource services.
- CHOICES will serve as the progress reporter and as the leader in overseeing data collection and analysis of the program.

The Health Center will serve as a key partner offering in-kind contributions to the TH-RRH program:

- Assuring that TH-RRH program clients gain access to the program and services to be delivered on-site at the CHOICES facility during scheduled times.
- Offering to all TH-RRH program clients primary care and behavioral health care and support.
- Offering access to treatment or recovery services for all TH-RRH program clients who qualify and choose those services.

Confidentiality
It is understood by both parties that each participant's records will remain confidential between CHOICES and The Health Center staff. Both parties will abide by HIPAA and FERPA regulations regarding the confidentiality of services provided. Consent is required to participate in the program and for exchanging information between the lead and key partner agencies.

This MOU is non-binding. Upon signature by both parties, it shall be active and shall automatically renew annually unless either party, at any time, provides written notice of intent to terminate.

We, the undersigned, agree to the roles and responsibilities clarified in this Memorandum.

10/7/2022			10/7/2022
Maria N. Houston, Psy.D.	Date	Dawnya Underwood, LMSW,PMP	Date
CHOICES Director		Acting Director, The Health Center	

LSS FAITH MISSION

August 15, 2022

Lauren Wilson, MSW, LSW
Executive Director
LSS Faith Mission
245 North Grant Avenue
Columbus, OH 43215

Re: Match Documentation for LSS Faith Mission's CoC Application

Lauren:

As an authorized representative of The Health Center at Faith Mission, I am pleased to provide this letter of documentation to provide an in-kind match for LSS Faith Mission's Continuum of Care (CoC) Rapid Rehousing at Faith Mission project.

The Health Center at Faith Mission will provide an in-kind match valued at $365,491 annually through provision of mental health services, behavioral health services, primary care, infectious disease testing and treatment, and substance use disorder treatment to support and ensure the successful implementation of the Rapid Rehousing at Faith Mission project. The services will be available July 1, 2023 - June 30, 2026.

The Health Center at Faith Mission's services are supported by local, state and federal funding at no charge to individual recipients. It is committed to making every effort to sustain qualified services for this project. Private funding will cover any shortfall.

Sincerely,

Dawnya Underwood, PMP, LMSW
LSS Vice President of Programs
Acting Director at The Health Center at Faith Mission

LSS FAITH MISSION

August 15, 2022

Lauren Wilson, MSW, LSW
Executive Director
LSS Faith Mission
245 North Grant Avenue
Columbus, OH 43215

Re: Commitment from Health Care Organization for LSS Faith Mission's CoC Application

Lauren:

As an authorized representative of The Health Center at Faith Mission, I am pleased to provide this letter of commitment to provide health care services for LSS Faith Mission's Continuum of Care (CoC) Rapid Rehousing at Faith Mission project.

The Health Center at Faith Mission is a substance abuse treatment or recovery provider. It will provide access to treatment or recovery services for all program participants who qualify and choose those services to support implementation of the Rapid Rehousing at Faith Mission project. The services will be available July 1, 2023 - June 30, 2026.

The Health Center at Faith Mission's services are supported by local, state and federal funding at no charge to individual recipients. It is committed to making every effort to sustain qualified services for this project.

Sincerely,

Dawnya Underwood, PMP, LMSW
LSS Vice President of Programs
Acting Director at The Health Center at Faith Mission

Lower Lights
Christian Health Center

August 16, 2022

Michelle Heritage Community Shelter Board
355 E. Campus View Blvd., Ste. 150
Columbus, OH 43235

Re: In-kind Match Documentation for Columbus/Franklin County CoC (OH-503) Application

As an authorized representative of Lower Lights Christian Health Center (LLCHC), I am pleased to provide this letter of documentation for in-kind matching funds to Columbus/Franklin County Continuum of Care's (CoC) Unsheltered homeless/severe service needs project.

LLCHC will provide access to substance abuse treatment or recovery services for all program participants who qualify and choose these services. This in-kind match is valued $160 per patient encounter, based on current billing rates consistent with the amount paid for similar services. Estimated $45k/annually based on historical data.

These services will be available July 1, 2023 - June 30, 2026.

LLCHC expects the funds to be available based on 330 Grant funding from the Health Resources Services Administration (HRSA) and Medicaid reimbursement. LLCHC is committed to making every *effort* to ensure funds areavailable for this project.

Sincerely,

Tracy Cloud, CEO
Lower Lights Christian Health Center

MARYHAVEN®
Helping People Restore Their Lives®

Addiction Recovery and Mental Health Services

www.maryhaven.com

LOCATIONS

Maryhaven-Alum Creek
1791 Alum Creek Drive
Columbus, Ohio 43207
614.445.8131

Maryhaven-S High Street
1430 S. High Street
Columbus, Ohio 43207
614.445.8131

Maryhaven-Delaware
88 North Sandusky Street
Delaware, Ohio 43015
740.203.3800

Maryhaven-Mt. Gilead
245 Neal Avenue
Mt. Gilead, Ohio 43338
419.946.6734

Maryhaven-Marion
333 East Center Street
Marion, Ohio 43302
740.375.5550

Maryhaven-Mills Center
715 South Plum Street
Marysville, Ohio 43040
937.644.9192

August 15th, 2022

Michelle Heritage
Community Shelter Board
355 E. Campus View Blvd., Ste. 150
Columbus, OH 43235

Re: In-kind Match Documentation for Columbus/Franklin County CoC (OH-503) Application

As an authorized representative of Maryhaven, I am pleased to provide this letter of documentation for in-kind matching funds to Columbus/ Franklin County Continuum of Care's (CoC) Unsheltered homeless/ severe service needs project.

Maryhaven will provide access to substance abuse treatment or recovery services for all program participants who qualify and choose these services. This in-kind match is valued $567,500 annually based on current billing rates consistent with the amount paid for similar services.

These services will be available July 1, 2023, - June 30, 2026.

Maryhaven expects the funds to be available based on contractual relationships with Managed Care entities, Medicaid, and with various local Mental Health & Recovery Boards. Maryhaven is committed to making every effort to ensure funds are available for this project.

Sincerely,

Oyauma Garrison, MBA, CPCU
President & CEO

Mount Carmel Foundation
6150 East Broad Street | Columbus, Ohio 43213 | T 614-546-4500 | F 614-546-4501

BECAUSE OF YOU MOUNT CARMEL

September 23, 2022

Lianna Barbu
Associate Director
Community Shelter Board
355 E. Campus View Blvd., Suite 250
Columbus, OH 43235

Re: Cash Match Value Documentation for Mount Carmel Health System Foundation CoC Application

As an authorized representative of Mount Carmel Health System Foundation, I am pleased to provide this letter of documentation for matching funds to Mount Carmel's Continuum of Care (CoC) Street Medicine and Social Care project. Mount Carmel Health System Foundation will annually match funds in the amount of 25% of the total funding request or $94,552 from the Mount Carmel Foundation's fund for Community Health and Well-Being. Mount Carmel Health System Foundation will use these funds to ensure the successful implementation of the Mount Carmel Street Medicine and Social Care project. The funds will be available July 1, 2023 - June 30, 2026.

Mount Carmel Health System Foundation expects the funds to be available based on the history of program funding from fundraising, grants and donations. Mount Carmel Health System Foundation is committed to making every effort to ensure funds are available for this project. Private funding will cover any shortfall.

Sincerely,

Deanna Stewart

Deanna Stewart
President
Mount Carmel Health System Foundation

National Church Residences

Permanent Supportive Housing Services

August 18, 2022

Re: Healthcare Commitment for Community Housing Network (CHN)'s new Poplar Fen project Continuum of Care Application.

As an authorized representative of National Church Residences Permanent Supportive Housing Services (NCRPSHS), I am pleased to provide this letter of commitment for the proposed Continuum of Care Poplar Fen project. NCRPSHS' Integrated Primary and Behavioral Healthcare practice will serve as the primary service provider for Poplar Fen, and as such is committed to providing services and support valued at $92,100 over three years from a variety of sources including Medicaid/Medicare reimbursements, direct client assistance for medications and lab testing not covered by insurance, peer support/employment services, and/or other resources as available.

National Church Residences Permanent Supportive Housing Services will use these services and supports to ensure successful implementation of CHN's Poplar Fen permanent supportive housing project.

The committed funding and/or in-kind support will be available July 1, 2023 - June 30, 2026. NCRPSHS expects the funds to be available based on prior year reimbursement, funding, and support provided for facilities similar in size and scope to Poplar Fen. National Church Residences Permanent Supportive Housing Services is committed to making every effort to ensure funds are available for this project, and will work with CHN to help identify alternate funding in the event of any shortfalls.

Sincerely,

Sonya Brown

Sonya Brown
Senior Vice President, Affordable Housing

398 S. Grant Avenue Columbus, OH 43215 Phone: 614.224.2988 Fax: 614.716.0902

National Church Residences' Permanent Supportive Housing is a contract agency of the Alcohol, Drug and Mental Health Board of Franklin County.
National Church Residences' Permanent Supportive Housing Communities are made possible through funding by
the Community Shelter Board and the U.S. Department of Housing and Urban Development.

National Church Residences

Permanent Supportive Housing Services

August 22, 2022

Re: Healthcare Commitment for National Church Residences Permanent Supportive Housing Services (NCRPSHS)' Berwyn East Continuum of Care Application

As an authorized representative of National Church Residences Permanent Supportive Housing Services, I am pleased to provide this letter of commitment for NCRPSHS' new Continuum of Care Berwyn East project. NCRPSHS' Integrated Primary and Behavioral Healthcare practice is committed to providing services and support valued at $507,950 over the course of three years ($169,317 annually), from a variety of sources including Medicaid/Medicare reimbursement, direct client assistance for medications and lab testing not covered by insurance, peer support, employment services, and/or other resources as available.

National Church Residences Permanent Supportive Housing Services will use these funds to ensure the successful implementation of the Berwyn East project. The funds will be available July 1, 2023 - June 30, 2026. NCRPSHS expects the funds to be available based on prior year reimbursement, funding, and support provided for facilities similar in size and scope to Berwyn East. National Church Residences Permanent Supportive Housing Services is committed to making every effort to ensure funds are available for this project, including working to identify alternate funding in to cover any shortfalls.

Sincerely,

Sonya Brown

Sonya Brown,
Senior Vice President, Affordable Housing

398 S. Grant Avenue Columbus, OH 43215 Phone: 614.224.2988 Fax: 614.716.0902

National Church Residences

Permanent Supportive Housing Services

August 22, 2022

Re: Healthcare Commitment for National Church Residences Permanent Supportive Housing Services' Columbus Families and Singles PSH Expansion Continuum of Care Application

As an authorized representative of National Church Residences Permanent Supportive Housing Services, I am pleased to provide this letter of commitment for NCRPSHS' new Continuum of Care PSH Expansion project. NCRPSHS' Integrated Primary and Behavioral Healthcare practice is committed to providing services and support valued at $247,500 over the course of three years ($82,500 annually) from a variety of sources including Medicaid/Medicare reimbursement, direct client assistance for medications and lab testing not covered by insurance, peer support/employment services, and/or other resources as available.

National Church Residences Permanent Supportive Housing Services will use these funds to ensure the successful implementation of the Columbus PSH Expansion project. The funds will be available July 1, 2023 - June 30, 2026. NCRPSHS expects the funds to be available based on prior year reimbursement, funding, and support provided for projects similar in size and scope to this one. National Church Residences Permanent Supportive Housing Services is committed to making every effort to ensure funds are available for this project, including identifying alternate funding in the event of any shortfalls.

Sincerely,

Sonya Brown

Sonya Brown,
Senior Vice President, Affordable Housing

398 S. Grant Avenue Columbus, OH 43215 Phone: 614.224.2988 Fax: 614.716.0902

National Church Residences' Permanent Supportive Housing is a contract agency of the Alcohol, Drug and Mental Health Board of Franklin County.
National Church Residences' Permanent Supportive Housing Communities are made possible through funding by the Community Shelter Board and the U.S. Department of Housing and Urban Development.

PrimaryOne Health

25th ANNIVERSARY

Our mission is to provide access to services that improve the health status of families — including people experiencing financial, social, or cultural barriers to health care.

August 22, 2022

Michelle Heritage
Community Shelter Board
355 E. Campus View Blvd., Ste. 150
Columbus, OH 43235

Re: In-kind Match Documentation for Columbus/Franklin County CoC (OH-503) Application

I am writing this letter of documentation on behalf of PrimaryOne Health as its authorized official. PrimaryOne Health (P1H) is pleased to provide this letter of documentation for in-kind matching funds for services provided to community residents for Columbus/Franklin County's Continuum of Care (CoC) Unsheltered Homeless/Severe Service Needs project.

PrimaryOne Health is the oldest and largest Federally Qualified Health Center (FQHC) in central Ohio and has been serving individuals and families, including those who are unsheltered since 1997. P1H serves over 43,000 patients at twelve (12) locations in Franklin and Pickaway Counties. In addition, we have four (4) mobile health units and Teams who partner with community and faith-based organizations to "Drive Good Health To You!"® This includes going out on the land to reach people who are unsheltered to provide primary care, behavioral health and supportive services.

We will provide access to substance abuse treatment, recovery and primary care services for all program participants who choose our services. This in-kind match is valued at $541,000 based on current billing rates consistent with the amount paid for similar services.

PrimaryOne Health will provide these primary care, substance use and mental health services based on our HHS Health Resources and Services Administration Healthcare for the Homeless (HCH) grant received over the last 20+years and local government funding to assist residents/patients who are uninsured and/or without shelter. PrimaryOne Health is committed to serving this vulnerable population as outlined in our mission and as a FQHC to address the unmet healthcare needs in our community. This letter of documentation includes services for the COC grant period of July 1, 2023 – June 30, 2026.

Should you have any questions or need additional information, please do not hesitate to contact me at 614.859.1946.

Sincerely,

Charleta B. Tavares
Chief Executive Officer

southeast healthcare

Downtown Columbus
P.O. Box 1809, Columbus, OH 43216-1809
614.225.0990
southeasthc.org

Belmont, Harrison & Monroe Counties
St. Clairsville
68353 Bannock Road
St. Clairsville, OH 43950
740.695.9344

Carroll County
Carrollton
783 Jones Avenue
Carrollton, OH 44615
330.627.3954

Delaware County
Delaware Commerce Park
824 Bowtown Road
Delaware, OH 43015
740.695.7795

Franklin County
Clintonville
3770 N. High Street
Columbus, OH 43214
614.294.7117

Downtown Columbus
16 W. Long Street
Columbus, OH 43215
614.225.0990

Franklinton
524 B W. Broad Street
Columbus, OH 43215
614.224.4850

Friends of the Homeless
924 E. Main Street
Columbus, Ohio 43205
614.360.0251

Merion Village
1455 S. 4th Street
Columbus, OH 43207
614.444.0800

Morrow County
The Meadow Center
950 Meadow Drive, Suite A
Mt. Gilead, OH 43338
419.949.2000

Tuscawarus County
New Philadelphia
344 West High Avenue
New Philadelphia, OH 44663
330.339.7850

September 23,2022

Michelle Heritage
Community Shelter Board
355 E. Campus View Blvd. Suite 150
Columbus, OH 43235

Re: In-kind Match Documentation for Columbus and Franklin County CoC (OH-503) Application

Dear Ms. Heritage:

As an authorized representative of Southeast Healthcare, I am pleased to provide this letter as documentation for in-kind matching funds to Columbus and Franklin County's Continuum of Care (CoC) Unsheltered and Severe Service Needs project.

Southeast Healthcare will provide access to substance abuse treatment and recovery services for all program participants who qualify and choose these services. This in-kind match is valued at $225,000 based on current billing rates consistent with the amount paid for similar services.

These services will be available July 1, 2023 - June 30, 2026.

Southeast Healthcare expects the funds to be available based on historical funding levels from the Alcohol, Drug and Mental Health Board of Franklin County (ADAMH) and Medicaid. Southeast is committed to making every effort to ensure funds are available for this project.

Sincerely,

Wendy Williams

Wendy Williams
COO

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

8/22/22

Re: Match Documentation for YMCA Beacon Communities Project

As an authorized representative of YMCA of Central Ohio, I am pleased to provide this letter of documentation for matching funds to YMCA's Continuum of Care (CoC) Beacon Communities Project. YMCA will match funds annually in the amount of $17,600 from revenue generated from Medicaid billing during the three years. The total for three years match is $52,800. Funds will ensure the successful implementation of the Beacon Communities project. The funds will be available July 1, 2023 - June 30, 2026.

YMCA expects the funds to be available based on past years trends. YMCA is committed to making every effort to ensure funds are available for this project. Private funding will cover any shortfall.

Sincerely,

Bradley L. McCain
CFO
YMCA of Central Ohio

YMCA OF CENTRAL OHIO
1907 Leonard Ave, Suite 150, Columbus, Ohio 43219
P 614 224 9622 ymcacolumbus.org

Lived Experience Support Letter

In response to question P-6a, for attachment P-9c, please see the following letter created by the Citizen Advisory Council (CAC). The letter is signed by at least three members involved in the working group that is comprised of individuals with lived experience.

Columbus and Franklin County, Ohio
Citizens Advisory Council

Resolution for Approval of the CoC Plan
for Serving Individuals and Families Experiencing Homelessness
with Severe Service Needs

September 12, 2022

WHEREAS, the Citizens Advisory Council is a Community Shelter Board sponsored group with membership comprised of homeless and formerly homeless individuals; this group meets monthly and has two seats on the Continuum of Care and one seat on the Continuum of Care Board;

WHEREAS, the Citizens Advisory Council members participated in a focus group on August 8, 2022 and provided feedback on the strategies to be included in the CoC Plan for Serving Individuals and Families Experiencing Homelessness with Severe Service Needs (CoC Plan);

WHEREAS, the Citizens Advisory Council representatives on the Continuum of Care participated in the Workgroup for development of the CoC Plan;

WHEREAS, the Citizens Advisory Council members received all the applications submitted as new projects for implementation under the CoC Plan, reviewed presentations from project applicants and had the opportunity to review and score all the projects submitted;

WHEREAS, the Citizens Advisory Council members received the draft CoC Plan for review and participated in a presentation and discussion of the content of the CoC Plan;

THEREFORE, be it resolved that the Citizens Advisory Council approves the CoC Plan for Serving Individuals and Families Experiencing Homelessness with Severe Service Needs and supports the priorities outlined in the application and the project applications submitted and scored.

Date: Sept 12 '22

Witnessed by:

Cheryl Henderson

Lance Mills

Sharon Hill Simpson

St. Sebastian

Kevin W. Sullivan *

James Brooks

Sheila K. Sullivan

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

P1. Leveraging Housing Resources

P1a-b. Development of new units and creation of housing opportunities

Community Shelter Board (CSB), the Unified Funding Agency, working on behalf of the CoC, solicits new projects annually by requesting Concept Papers – a high level overview of a proposed project. If the CoC approves a Concept Paper, the applicant prepares a comprehensive Project Plan for review, approval and prioritization by the CoC and the Citizens Advisory Council (CAC), a group comprised of people with lived experience of homelessness and expertise on this topic. The Project Plan must demonstrate mobilization of all resources, including state tax credits, Public Housing Authority vouchers, Medicare/Medicaid, healthcare plans, HOME funding, local city and county funding, and CoC funding. Proposing organizations work with Columbus Metropolitan Housing Authority (CMHA) to secure Housing Choice Vouchers.

P1c. Landlord Recruitment

Over the last three years, CSB developed and funded the Home4Good Landlord Initiative to improve our landlord recruitment work, which provides financial assistance to landlords to incentivize them to work with the vulnerable, second-chance renters our system serves. The program has two elements – recruitment and ongoing support – to increase access to market rate and affordable housing for people facing homelessness. The Community Housing Manager is a newly added position that has the exclusive role of recruiting and retaining landlords by visiting apartment complexes and covering both known and new housing complexes that we have not previously worked with, establishing relationships, following up on housing leads and continuously marketing our program to owners and property managers, accounting for geographic areas where people experiencing homelessness want to live but have not been able to find a unit. The Community Housing Manager also manages and updates the list of all available units and landlord contact information for the system.

CSB provides a financial incentive for any new unit that landlords add to our system. New landlords receive a onetime payment of $500 for one- or two-bedroom units and $750 for units with three or more bedrooms. The participating landlord agrees to dedicate the unit to people served by our programs for two years. CSB assists program participants with rent and security deposits, improving stability for both landlord and tenant. Landlords benefit from low vacancy rates, as our system always has tenants ready to move in quickly, and ongoing supportive services available to program participants to help them maintain stability.

CSB manages a Risk Mitigation fund for landlords. The fund reimburses a landlord for lost rent if a client abandons the unit or does not pay their rent and pays for documented unit damages the landlord incurs. The fund helps sustain the landlord relationship and avoid a potential eviction or refusal to rent to future tenants from our system. We have learned that landlords rarely need to access the Risk Mitigation fund, but it gives them peace of mind that encourages them to take on the perceived risk of partnering with homelessness programs. CSB works with Columbus Apartment Association to market Home4Good to landlords and property owners. CSB currently has 659 landlord partners. As a direct result of this strategy, in the past 12 months, we successfully added 48 new landlords in our programs. Without Home4Good we would not be able to reach as many new landlords in such a tight rental market.

As a more recent practice, CSB's Housing Department surveys landlords regularly to identify opportunities for further collaboration. CSB holds a quarterly landlord roundtable meeting based on the needs reflected in the surveys; recent speakers included a Columbus Mediation representative on landlord-conflict resolution resources, a City of Columbus Code Inspection officer and a City of Columbus City Attorney on how to maintain code compliant units. Every six months, CSB conducts face-to-face meetings with landlords with the highest number of units in our system to maintain relationships. We have learned that the roundtable and intensive recruitment and retention strategies helps landlords better understand our system and programs and engages both large and small landlords. These strategies have increased the number of Rapid Re-housing (RRH)

and scattered sites Permanent Supportive Housing (PSH) units that are available to people experiencing homelessness. To further increase the number of housing units, including units in areas where historically we have not been able to secure them, CSB works with Columbus Apartment Association to match our current landlord list with their member list and send out targeted marketing communication to landlords not participating. CSB will work with CMHA to get access to their list of landlords, and will use this list as another outreach mechanism to reach landlords that otherwise are not engaged. A performance measurement system is in place to consistently measure progress on the number of new landlords and units gained as a result of these efforts and the number of landlords retained. The units are mapped to show where we have concentrated units, areas of coverage and areas with lack of coverage for future landlord targeting and expansion. Padmission will be assessed for feasibility as a better real-time tool to connect individuals and families with landlords and as a landlord repository and recruitment tool.

P2. Leveraging Healthcare Resources

All PSH projects partner with community mental health, treatment, and recovery services for program participants who qualify for and choose such services. CSB's new Outreach provider is from Mount Carmel, one of our region's main hospital systems. Mount Carmel has provided street medicine services for many years. As they work to engage and house unsheltered people, they will help our system improve access to healthcare services, including during the transition from unsheltered homelessness to permanent housing.

CSB recently established new Crisis Response Specialist positions for PSH and shelter programs, using ARPA funding provided through the City of Columbus. These Specialists will be embedded in programs to develop supportive relationships with residents and provide immediate mental health crisis services when needed, helping to prevent violence, overdoses, suicides, and responses from emergency services that often are not the most appropriate intervention.

P3. Current Strategy to Identify, Shelter, and House Individuals and Families Experiencing Unsheltered Homelessness.

P3a. Current Street Outreach Strategy

Our system's core Outreach Team consists of six Outreach Specialists and one Outreach Coordinator, funded by local (public and private), and federal funding sources. Our system also has a YHDP-funded Coordinated Access and Rapid Resolution (CARR) Team for transition-age youth that conducts street outreach and outreach at youth drop-in centers. The CARR Team can access all system shelter and housing opportunities, including specialized PSH, RRH, and transitional housing for youth. These Outreach positions are augmented by other community-based outreach, all of which coordinate with each other to cover as much area as possible and prevent duplication of effort, through the Collaborative Outreach Team. This collaborative effort includes the PATH program, Primary One Health and Lutheran Social Services (Healthcare for the Homeless funded agencies), Volunteers of America (SSVF funded program with an Outreach component), Make-A-Day Foundation, warming/cooling centers, food sites, mental health providers, Columbus Coalition for the Homeless, Veterans Administration Outreach program, Franklin County Metro Parks, the local bus system, faith-based partners, Columbus Police Department, the City of Columbus, and Franklin County. Daily, a minimum of 18–20 people provide street outreach services community-wide. Monthly Collaborative Outreach Team meetings and daily informal coordination enable partners to leverage each other's expertise and divide the workload to best serve unsheltered people. Coordination with community partners help identify others who need assistance. Outreach Specialists visit different areas of town and encampments, to ensure maximum coverage of services. The Outreach Team operates Monday through Friday and staggers shifts to engage as many people as possible from 8 a.m. to 8 p.m. at known encampments, and at other places unsheltered people congregate.

In early 2022, CSB issued a Request for Proposals for a new provider for outreach services, to improve our system's capacity to service people experiencing unsheltered homelessness. The CoC selected Mount Carmel,

one of our region's hospital systems, effective August 1, 2022. Since 2001, Mount Carmel's Street Medicine Team has provided direct physical, mental, spiritual, and social care to unsheltered people following evidence-based, housing and health focused best practices. As Mount Carmel adds outreach services to their street medicine services, our system will be able to provide both housing and healthcare resources to those most vulnerable in our community with the same team.

- Mount Carmel's new Housing Outreach Team collaborates with the existing Mount Carmel Street Medicine Team, which includes a Mobile Medical Coach and teams that make daily rounds in the community that are well-known to unsheltered people in the area. These Outreach Teams are multidisciplinary and include medical providers paired with a paramedic/nurse, psychiatric nurse practitioner paired with a paramedic/nurse, case managers paired with paramedic/nurse/peer supporters, and a community paramedic that pairs with community partners for specialty services. The Outreach Team will also collaborate with Mount Carmel's Healthy Living Center, Crime and Trauma Assistance Program, Social Care programs, and Welcome Home program, all of which help people transition from homelessness to stability. Each program supports specific needs of vulnerable populations and provides free services to the community member.
- Mount Carmel will lead the monthly Collaborative Outreach Team meetings and daily coordination and joint work with other community Outreach partners. Their full integration into the Homeless Management Information System (HMIS) and the Unified Supportive Housing System (USHS), the system's coordinated entry into PSH, improves the efficiency of the processes used to refer and house people experiencing unsheltered homelessness.
- Mount Carmel uses a Housing First approach to outreach engagement and prioritizes harm reduction approaches. Their street medicine capabilities mean that healthcare professionals can meet people anywhere in the community and provide direct care without barriers such as billing or insurance issues. Their ability to provide these services builds trust among unsheltered people and helps with housing engagement.
- Mount Carmel's team includes certified Community Health Workers, bilingual caseworkers and certified Peer Recovery Supporters who have lived experience with addiction, recovery, and homelessness. These Peer Supporters build relationships with unsheltered people and help them access addiction treatment and housing services. They maintain the relationship, continue to work on long-term treatment and housing. Once housed, the team continues to provide stability and recovery services to help maintain housing.

Outreach Specialists help connect people to the Homeless Hotline for access to emergency shelter, if desired, where they are screened and prioritized for RRH and PSH programs. The CoC especially targets vulnerable populations, like people experiencing unsheltered homelessness who are survivors of domestic violence, dating violence, stalking, or assault. They can be referred directly to our system's specialized CoC-funded RRH program for survivors without going through the normal shelter-based RRH screening and prioritization process. Unsheltered transition-age youth can be connected directly to specialized youth RRH, PSH, and transitional housing programs without entering shelter. Outreach Specialists can house unsheltered people directly into PSH via USHS, without entering shelter. When Outreach Specialists house people directly from an unsheltered situation, they maintain the relationship and help people transition to housing and access needed services, in collaboration with RRH and PSH program case managers.

Outreach partners also collaborate with the City of Columbus to address encampments of concern to neighborhoods and businesses. CSB is leading a stakeholder group that includes the City of Columbus to develop a shared community response to encampments based on USICH guidance. We encourage the City to only consider camp remediation when all members of an encampment have been engaged and offered re-housing support and there is a re-housing pathway for each individual who is interested. If the City decides to remove an encampment, we request advance notice for Outreach Specialists and community partners to have the opportunity to engage and assist camp residents with housing and other services prior to the camp's disruption. The Columbus Police Department participates in monthly outreach meetings and regular informal coordination, giving us the opportunity to educate law enforcement about constructive approaches to unsheltered homelessness and link people experiencing homelessness to our system's services. During the

COVID-19 pandemic, the community provided access to restrooms and handwashing facilities because the public spaces unsheltered people used were closed. This public health effort sets the stage for a more comprehensive community conversation about public space and access to facilities for people experiencing homelessness. The goal is to develop a consistent approach to encampments that centers the needs and preferences of the people experiencing unsheltered homelessness and provides the most effective and appropriate services focused on low-barrier access to shelter and housing.

CSB measures performance for the Outreach programs by analyzing the number of households served against goals put in place assessing caseload capacity, program occupancy/utilization rate based on capacity, average length of participation, usage and utilization of financial assistance for housing purposes, successful outcomes and successful housing outcomes, rate of exit to PSH, recidivism and cost per household and successful outcome achieved. The USICH Guidance on Core Elements of Effective Street Outreach are utilized to respond to unsheltered homelessness as Outreach employs emerging practices to coordinate for re-housing success. Our system's approach to outreach is effective and will continue to improve with Mount Carmel's leadership and collaboration with community partners, but we need additional resources to hire more Outreach Specialists, which is one of the most demanding jobs in any homelessness system. Larger, multi-disciplinary teams will be able to provide more services and better coverage. Hiring efforts will emphasize recruitment of people with lived experience of unsheltered homelessness. We know that we are missing some unsheltered people and additional Outreach Specialists, especially those with lived experience, would enable our system to engage more people over a larger geographic area and spend more time building the trusting relationships needed to engage and house people experiencing unsheltered homelessness. Our community is growing fast, and our Outreach effort must grow with it to serve everyone.

P3b. Current Strategy to Provide Immediate Access to Low-Barrier Shelter and Temporary Housing for Individuals and Families Experiencing Unsheltered Homelessness

Access to low-barrier shelter is centralized via the Homeless Hotline, part of the CoC's coordinated entry system. The Homeless Hotline is a local phone number that is staffed 24/7/365. It uses HMIS and direct contact with shelters to maintain a comprehensive picture of all available shelter beds and connects individuals and families to the most appropriate option. All families with children and pregnant women experiencing homelessness receive immediate access to shelter. If our system's two family shelters are full, CSB uses hotels to accommodate families and pregnant women. No family is left unsheltered at any point in time. During the past three years, additional resources enabled our system to shelter all single adults who wanted and needed shelter as well. We leased entire motels to provide non-congregate shelter to single adults and we were able to test this model of sheltering. People who were positive for or exposed to COVID-19 received shelter and medical care at a separate hotel site. When COVID-19 funds expire, it is expected that the COVID-19 hotel shelter and additional capacity will close and some single adults will be on a waitlist in the warmer months. If additional sustained funding becomes available, the shelter beds opened during the pandemic for single adults could become permanent, alleviating the warmer months' gap in shelter beds. Even with a gap in shelter beds during the summer, access to a bed occurs within two to three days of the person being placed on a shelter waitlist. Non-congregate sheltering is a viable model, but it is more expensive to implement and maintain. In the colder months, we operate additional overflow capacity by adding beds to existing shelters and use hotels, ensuring everyone who wants and needs shelter receives it, including sex offenders that otherwise are not able to be sheltered in regular shelters due to proximity issues. Outreach Specialists help people experiencing unsheltered homelessness access the Homeless Hotline as part of the engagement effort.

There are no minimum requirements for entering shelter. The Homeless Hotline confirms that callers do not already have a safe, viable alternative to shelter before connecting people to additional resources. If callers have no other safe options, the Hotline reserves a shelter bed for them and helps with transportation to the shelter. Shelter guests are only involuntarily exited from shelter if they present an immediate threat to staff and other guests. Shelter restrictions are analyzed quarterly to make sure restrictions are limited and unbiased. The

decision to restrict someone from shelter for lack of progress is based solely on that person's engagement, not on actual housing outcomes. No one is exited or restricted because they could not secure housing due to the affordable housing crisis in our community. Lack of engagement because of a severe behavioral health barrier is handled via system case conferencing and coordination with behavioral health providers, rather than shelter restrictions. Individuals who are restricted have an appeal process they can access.

The new USICH guidance on working with those experiencing unsheltered homelessness, and an increase in encampments around our community prompted considerations for a different approach for offering immediate accommodations for the unsheltered population. Some unsheltered individuals do not want to access emergency shelters because of the shelter's congregate nature. We are now piloting an approach that provides hotel rooms as non-congregate, temporary accommodations coupled with supportive services until the permanent housing process is completed.

Our system has two low-barrier transitional housing programs for transition-age youth, one of which is a YHDP funded program. Youth can access both programs via Outreach Specialists, the youth-specific coordinated entry, or shelter case managers; year over year we increased the number of transition-age youth we served by 20%. Once youth connect with the coordinated entry, a majority of them immediately begin receiving community referrals to address their mental and physical health, education, employment, mentorship, and life skills (M=0.4 days; n=128). Once exited from the coordinated system, only 2.57% of those who exited have an eviction on record within a year.

Our low-barrier shelters have been effective in quickly connecting people to housing opportunities and RRH programs, based on system-wide standardized screening and prioritization tools that identify the level of support each person needs and wants and the most appropriate program to facilitate quick re-housing. Shelter length of stay continues to rise, but this is a result of the affordable housing crisis, not issues with the shelter or re-housing system. We continue to improve processes and work with community partners and policy makers to address the lack of affordable housing for very low-income people.

P3c. Current Strategy to Provide Immediate Access to Low-Barrier Permanent Housing for Individuals and Families Experiencing Unsheltered Homelessness

For the fiscal year ending on June 30, 2022, 423 unsheltered households were engaged and served by Street Outreach programs participating in HMIS; 93 households were successfully housed (30%) and 41 households opted to enter emergency shelter.

For RRH, over the past three years our CoC has expanded family RRH programs; added RRH, transitional housing, and PSH for transition-age youth via the YHDP; and added a CoC-funded RRH program for survivors of domestic violence, dating violence, sexual assault and stalking, to increase capacity to serve people experiencing both unsheltered and sheltered homelessness. This year CSB adjusted the referral system so that Outreach Specialists could refer unsheltered people directly to the RRH program for survivors without entering shelter. The Housing Assessment Screening Tool (HAST) prioritizes and expedites referrals of families and single adults to RRH programs based on vulnerability. Our new HMIS system, implemented in 2021, includes separate scored HAST "pools" for single adults and families that keeps track of each person's priority (score) – this implementation in HMIS significantly improved the efficiency of the referral process to RRH programs, moving to a seamless process that also incorporates our coordinated entry requirements. However, even with the added RRH capacity we are still unable to meet demand for single adults in need of RRH services based on vulnerability, which is why we are looking to further expand the CoC's RRH programming.

For PSH, our CoC manages vacancies and prioritizes program participants for PSH using the centralized Unified Supportive Housing System (USHS). USHS was established in 2008 by CSB, CMHA, and the Franklin County Alcohol, Drug and Mental Health (ADAMH) Board, as the coordinated entry into PSH. USHS and PSH

programs are based on Housing First principles. Originally, Outreach Specialists and shelter case managers submitted applications to USHS on behalf of clients. Through analysis of HMIS data, CSB learned that the practice did not always result in the people with the most severe service needs accessing PSH. Instead, the system sometimes prioritized qualified clients who were best able to complete the needs assessment and obtain documentation, which could miss people experiencing unsheltered homelessness who could be more difficult to engage. Due to this, we moved to a process where USHS continuously screens active system Outreach and shelter clients for PSH using HMIS data. Monthly, CSB prepares a "hotlist" of prioritized clients based on their homeless status, history of homelessness, and self-declared disability. For the households prioritized by USHS as chronic or long-term homeless, the household's case manager is asked to submit a standardized service needs assessment. USHS uses this assessment to prioritize households for PSH based on vulnerability and match them to open units according to their needs and preferences. Case conferencing identifies those who need immediate assistance but may not rise to the top of the hotlist. USHS adheres to HUD CPD-16-11, prioritizing chronically homeless households first, then long-term homeless households with severe service needs. We found this process more effectively targets those with the longest homeless time and the most severe service needs, including more people experiencing unsheltered homelessness. With the addition of the Emergency Housing Vouchers in our community, with agreement from the PHA, we dedicated all the vouchers to the homeless and disabled population. Due to the immediate availability of this significant number of vouchers we were able to temporarily open up PSH applications to not only those that are on our hotlist but also to families and individuals with a disability that do not have the longest histories of homelessness, in an effort to prevent households from reaching a chronicity state. As the chart in section P4 shows, through this intervention we managed to keep the chronic homeless numbers stable throughout the COVID-19 pandemic, even though housing activities became extremely difficult during this timeframe. PSH is the most effective intervention for Outreach clients who have long histories of homelessness and disability. PSH programs are required to have processes that expedite the housing process so that vacancies are filled quickly, and people spend as little time as possible in an unsheltered situation or in an emergency shelter. Our system's PSH programs have an overall 99% success rate. People entering PSH from an unsheltered situation have an over 90% success rate. Continuously adding PSH units – including the PSH programs identified below – is a critical component of our CoC's strategy to reduce unsheltered homelessness. Our system has a good, coordinated effort to quickly house people who are in an unsheltered situation and additional PSH and Outreach capacity is essential to identify and house more.

Our CoC has the following site-based PSH projects in the development pipeline: (1) National Church Residences Permanent Supportive Housing, Berwyn East Place: 36 units designated for seniors (aged 55 and older) with advanced geriatric conditions who are experiencing chronic homelessness. Tailoring PSH to this older population is important in our community, where 54% of people experiencing unsheltered homelessness are aged 40–64 and 4% are over age 65. CMHA committed to providing HCVs. The project is projected to open in spring 2024. (2) Community Housing Network, Poplar Fen Place: 35 units dedicated to chronically homeless individuals aged 55 and older. CMHA committed to providing HCVs. The project is projected to open in fall 2024. (3) Beacon Communities, PSH: 70 units, all dedicated to people experiencing chronic homelessness. CMHA committed to providing HCVs. The project is projected to open fall/winter 2024. (4) National Church Residences Permanent Supportive Housing, Expansion: Adds 35 units in exiting supportive housing projects that are currently not dedicated as PSH units. The units will be occupied by chronic homeless individuals through unit turnovers. CMHA is already providing HCVs.

P4. Updating the CoCs Strategy to Identify, Shelter, and House Individuals Experiencing Unsheltered Homelessness with Data and Performance

1. Our system's Street Outreach program participates in the CoC's HMIS, collecting data on services and referrals for people experiencing unsheltered homelessness. Inclusion in HMIS gives our CoC the ability to use data to analyze the needs of the unsheltered population and identify those who meet chronic and long-term homelessness criteria to prioritize for housing. CSB analyzes demographics and trends over time and focuses on

continuous performance improvement. Street Outreach programs adhere to performance metrics that set standards for successful outcomes (75%), successful housing outcomes (55%), six months recidivism (< 10%) and average length of participation (90 days), among other output-based metrics that set goals for number served, exits to permanent supportive housing, full utilization of program capacity and efficient utilization of funds available per person served and per successful outcome achieved. A renewed focus will be to track time to housing for the unsheltered population with the goal of reducing the overall time by reducing the time for the components of the housing process – time to housing referral, time for eligibility determination and submission of housing documentation, and time to lease signing.

CSB tracks time to housing via USHS, as shown in the table below. This work will be refined going forward to assess metrics by subpopulations (e.g., unsheltered population vs. severe service needs sheltered population). Continuous data-informed system and process improvements enabled us to prioritize people with the longest homeless time and most severe service needs for PSH. The difficult affordable housing market is a serious problem, as evidenced by the current time to housing. Our system strives to optimize the elements of the housing system we can control, to speed the process. The numbers below reflect time to housing in 2022, an average of 160 days. In contrast, in 2020 the time to housing ranged between 74 and 181 days, and we had an average of 122 days to housing. The deepening affordable housing crisis impacted our ability to house by a 31% increase in our time to housing.

Average Days for USHS Processes								
	January	February	March	April	May	June	July	August
Invite to Assessment Submission	14	1	22	-3	-2	-1	4	2
Invite to File Submission	18	7	19	3	10	6	8	13
File Submission to Pool Entry	6	1	2	0	2	1	2	1
Pool Entry to Housing Referrals	64	70	46	36	45	46	27	76
Referral to Housed	71	83	92	93	104	98	125	80
ID Date to Housed Date	148	157	159	155	186	146	183	143

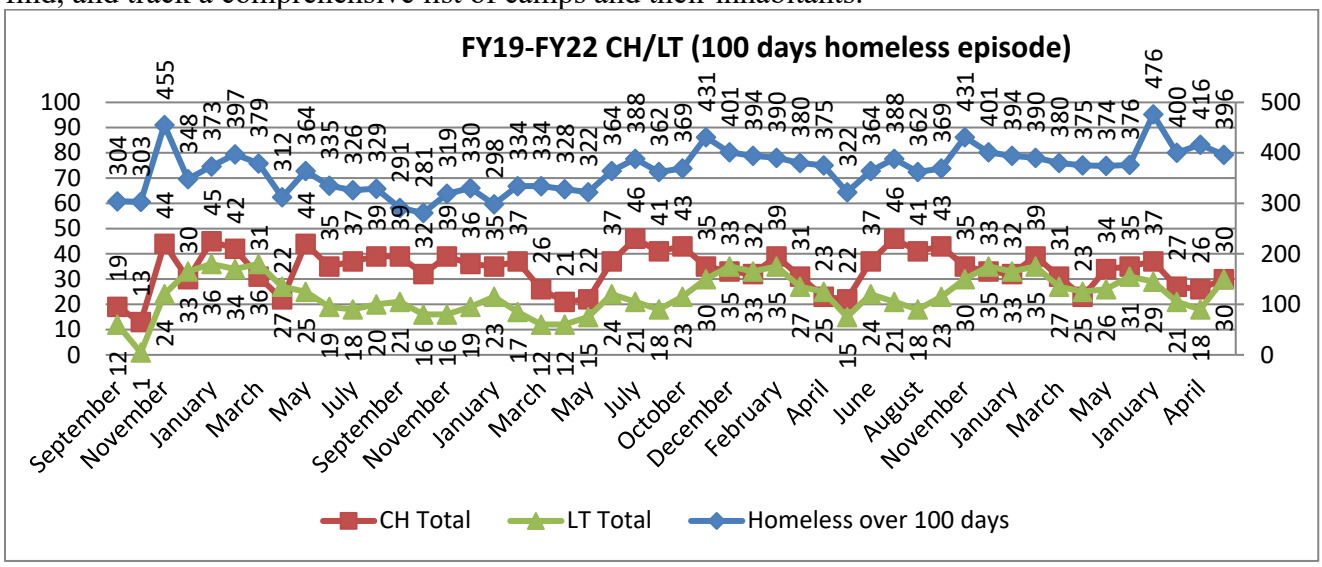
Adding capacity to our Street Outreach program will allow us to broaden the team's reach and collaborations by working with mainstream healthcare providers, social service, and employment agencies to bring more services to those unsheltered. They will help with a housing focused engagement, while sharing information about the other needs people have and improving our ability to identify and address trends and best practices.

CSB's data indicates the demographics of people experiencing unsheltered homelessness differ from the general homeless population in our community. Understanding these demographics ensure our Outreach efforts and teams are inclusive and representative of the people we serve and services are culturally appropriate. Better understanding the unsheltered population will also help us improve access to low-barrier shelter.

- Men are overrepresented among people experiencing unsheltered homelessness; 63% are male and 36% are female, while the sheltered homeless population is 55% male and 44% female.
- Unsheltered people tend to be older than the sheltered population, with 54% aged 40–64 years and 4% over 65 years.
- 36% of people experiencing unsheltered homelessness are African American, 55% are White, and 9% are Multiracial or Other. The sheltered homeless population in our community is 61% African American, 32% White, and 7% Multiracial or Other.
- Almost everyone experiencing unsheltered homelessness self-reports a disability (96%), while only 59% of the sheltered population do so. 84% report a mental health disorder, 61% a substance use disorder and 62% a chronic health condition.

Data over the past three years indicates that the number of people with over 100 days of continued homelessness is increasing. A more robust Outreach Team will help to understand this trend, more comprehensively identifying where unsheltered people are living and what engagement strategies are most effective to help them access low-barrier shelter and permanent housing. Our current outreach effort is strengthened by leveraging community partners. A larger structured team is needed to fully engage unsheltered

people over time, better identify encampments, especially camp locations in wooded areas that are difficult to find, and track a comprehensive list of camps and their inhabitants.



Under this plan, CSB will lead the creation of an "active list" to help identify people on the street regardless of the unsheltered individual's use of services. This active list of everyone who is unsheltered will be updated regularly by all Street Outreach providers in the community. Outreach Specialists will be provided with mobile technology that will expedite the housing process and provision of services by working with unsheltered individuals where they are located. CSB will improve the collaboration between the Outreach Team and RRH services to help facilitate the housing process of unsheltered and severe service needs individuals.

There is community consensus that a combined system of data and information for Street Outreach and medical teams is needed, one that can potentially track individuals before their information is available for HMIS purposes and/or a system where the healthcare and homelessness systems can safely collaborate and share information about people that need assistance. For example, emergency rooms often serve unsheltered and severe service needs individuals who are unknown to the Outreach Teams and who are not appropriately engaged for housing purposes. The ability to share information will not only improve the service provision to this population but will also increase the healthcare participation in the care of vulnerable individuals. Access of the Outreach Team to a system used by hospitals, like EPIC, will significantly increase the quick identification and appropriate service provision for individuals that otherwise may not be identified as needing services or whose identification would be delayed. This is a long-term strategy that will be developed by a multi-stakeholder workgroup.

Considering the challenges inherent to the online environment, CSB will assess its current system to find opportunities to reduce duplicative data collection and entry processes, so an individual does not have to provide the same data multiple times.

2. For low-barrier shelter and temporary accommodations during the COVID-19 pandemic, additional resources enabled our system to shelter all single adults who wanted and needed shelter. CSB leased entire motels to provide non-congregate shelter to single adults which allowed us to test this model of sheltering. If additional sustained funds become available the shelter beds opened during the pandemic for single adults could become permanent, alleviating the warmer months' gap in shelter beds. Non-congregate sheltering is a viable model, but it is more expensive to maintain and implement.

The Homeless Hotline, which is our first step in accessing emergency shelter, is monitored continuously by CSB staff with "mock calls" that follow prescribed scenarios to test and ensure that no person is denied shelter unless they have other safe accommodations in place. The scenarios tested cover a wide range of callers,

including but not limited to people who are inebriated, sex offenders, non-English language speakers, and people with various criminal backgrounds. Results of the calls are shared with the Homeless Hotline leadership as part of our continuous training and improvement efforts. We also monitor the Hotline for their phone wait time, and call reports are analyzed monthly and quarterly.

We already operate low-barrier shelters, and as a best practice, shelter guests are only involuntarily exited from shelter if they present an immediate threat to staff and other guests – individuals who are restricted can appeal the decision. CSB will continue to review and analyze quarterly the list of those individuals who are service restricted from shelters to ensure that the restrictions are not excessive, are valid and not biased, and to address inadequate restrictions. CSB will continue to refine use of data and examine how many clients are restricted from each shelter for use of drugs/alcohol inside the shelter and initiate community conversations around advancing harm reduction options by involving the local Alcohol, Drug and Mental Health Board. With greater emphasis on harm reduction, we will expand harm reduction coordination and training for Outreach and system partners.

CSB continuously works with emergency shelters and transitional housing programs to address the average length of stay and participant success rate. By decreasing the average length of shelter/transitional housing stays and increasing success rates, the positive bed turnover creates more availability for beds and low-barrier shelter and temporary accommodations expand without increasing the bed capacity of these programs.

3. For permanent housing, CSB's Housing Department, established in 2020, serves as a central point of contact for landlords and program participants to help resolve any challenges early, preventing evictions and returns to homelessness. The Housing Department focuses on expediting the housing process for both RRH and PSH programs. For RRH, CSB issues the first iteration of financial assistance on behalf of the client, usually the first month's rent, security deposit, and/or utility assistance. By handling these initial payments, CSB ensures quick payment and compliance with all funder requirements. For PSH, CSB operates the USHS, a centralized system for managing PSH vacancies and prioritizing program participants for PSH, depending on their needs and preferences. USHS continuously screens active system clients for PSH using HMIS data and case conferencing, including people experiencing unsheltered homelessness. Monthly, a hotlist is prepared with prioritized clients based on their homeless status, history of homelessness, and self-declared disability. For the households prioritized by USHS as chronic or long-term homeless, the household's case manager submits a standardized service needs assessment. USHS uses this assessment to prioritize households for PSH based on vulnerability and matches them to open units according to their needs and preferences. USHS adheres to HUD CPD-16-11, prioritizing chronically homeless households first, then long-term homeless households with severe service needs. All system PSH programs are contractually required to participate in USHS. USHS housing activities are tracked rigorously, with time to housing being the most important metric utilized. By reducing the time it takes to complete each of the housing components we will also improve the overall time to housing and the performance of the housing system (please see the table under section P4.1).

The Housing Department also manages our system's Rental Assistance programs. A dedicated Housing Inspector conducts inspections quickly, reducing the time to housing for program participants and vacancy time for landlords. In the past two years, 1,400+ inspections were completed and the average time to complete a new unit inspection is four days. A Community Housing Manager focuses on recruiting and retaining landlords in our very tight affordable housing market, aided by the Home4Good program. A Housing Administrator works with system programs to administer the technical aspects and requirements for rental assistance programs. CSB's problem-solving interventions and timely responses to landlords' needs have improved and expanded our housing abilities. A newly hired Client Housing Manager helps program participants gather necessary documentation for housing, a task that has become increasingly difficult during the COVID-19 pandemic. Identification documents, social security benefits, and certificates of disability are extremely difficult to obtain. The Client Housing Manager works with public entities to improve access for our system's clients and acquire

the needed documentation more quickly. Recently, CSB contracted with a LISW to conduct disability assessments for people who are otherwise eligible for PSH but who are unable to get a disability assessment due to long wait times or because the individual needs a specialized person to conduct the assessment. The LISW has extensive experience working with the homeless and disabled population with severe mental illness, addiction, or HIV/AIDS. This contract greatly expedites the eligibility determination process for severe service needs individuals. These new initiatives that address basic eligibility determination for PSH will also expand our ability to house those most vulnerable, unsheltered individuals who are unable to gather the necessary housing paperwork because of their vulnerabilities. The goal of the Housing Department is to expedite the housing process for individuals and families experiencing homelessness. The activities of the Housing Department are performance-focused on rapidly housing unsheltered and severe service needs individuals and families.

Establishment of CSB's Housing Department in 2020 allowed us to expedite inspections, vacancy processing, and landlord recruitment for scattered sites units. For PSH units that have HCVs, EHVs and other subsidies, the Housing Department meets weekly with CMHA to help move application packets and inspections forward quickly and address any barriers, including missing documentation. We continue to evaluate strategies to improve housing outcomes for people experiencing unsheltered homelessness, using robust data analysis. This coordination is just the start of our work to expand the CoC's ability to rapidly house individual and families with histories of unsheltered homelessness and severe service needs. As this coordinated system reaches its optimal operations it will expand to service more households. CSB measures performance for the permanent housing programs quarterly by looking at performance metrics that set standards for the volume of households served against the goals established based on their capacity (capacity multiplied by expected turnover rate), program utilization rate (95%), successful housing outcomes (90%), recidivism (<10%), rate of involuntary exits (<20%), housing stability (24 months), increases in income from employment (15%) and other sources (30%) and positive unit turnovers (20%). Programs that fail to meet goals are provided technical assistance and are required to establish quality improvement plans.

P5. Identify and Prioritize Households Experiencing or with Histories of Unsheltered Homelessness

The Columbus and Franklin County CoC, in contrast with other larger communities with a significant number of unsheltered individuals, has less than 1,000 unsheltered people at any point in time. However, this number continues to grow despite our efforts to implement a systemic response to unsheltered homelessness. This plan addresses improvements to our systemic approach that we believe, if implemented, can provide a model of how to implement a community-wide strategy to decrease the number of unsheltered individuals and house the most vulnerable, despite the affordable housing pressures felt nationwide.

Coordinated Entry Improvements

To make sure that people who are unsheltered are able to access housing or resources in the community, the coordinated entry process will include Outreach Teams with a presence at Drop-in Centers as another means of engaging unsheltered individuals. The consistent practice for the intake and re-housing process will happen at the location where the unsheltered person is at or is currently residing. This includes assisting someone with paperwork for services and housing. Drop-in and Warming Centers will be utilized for appointments and meetings, particularly in the colder months. This will allow for people, who otherwise would not engage, to access housing and services in an alternative way. The Housing Assessment Screening Tool (HAST) will be administered at intake but also after the person has been more deeply engaged. Often, once a relationship has been established, the HAST is able to provide a better reflection of the needs of an individual. Identification is a significant problem for housing purposes as individuals are missing basic documentation needed for housing. Acquiring this documentation can sometimes take a significant amount of time due to delays in processing by federal agencies or cross-state bureaucracies. Use of the CSB contracted LISW to expedite documentation and the Franklin County Recorder's Office to store birth certificates and use of the HMIS as a repository for identification documents is essential to move the housing process further.

Street Outreach Expansion and Coordination Improvements
Additional Outreach will improve consistent engagement with unsheltered people and allow us to cover a wider geographic area. We will also be able to link and coordinate more effectively with unsheltered individuals being discharged from hospitals and jail and help us better integrate community services and partners into outreach efforts. It will also improve staff recruitment and retention for these challenging roles.

The CoC will support projects that connect unsheltered people with housing resources. Additional Outreach Specialists are needed in the community, especially considering that the average current caseload per caseworker is 40 individuals. We will support projects that include cross-disciplinary team members to address various needs. We will adopt a zonal approach where each organization's members cover a specific sector of the community. This zonal approach allows Outreach Teams to become familiar with neighborhoods and develop trust with unsheltered individuals who are hesitant to utilize services. Agencies providing street outreach services will be expected to work together and standardize their teams following a set of best practices. The Collaborative Outreach Team will implement this coordinated approach. Outreach Specialists will be trained on a culturally sensitive response approach that is mindful of race and ethnicity, LGBTQ+ issues and trauma and additional complexities that individuals present. Establishing a coordinated approach between partners will be key to providing services. The CoC will support projects that provide survival services to unsheltered individuals including providing lanterns, blankets, insulin, or other resources that assist unsheltered persons at the time of engagement. The goal of these efforts is to promote familiarity and trust with Outreach Specialists and build a bridge to connect with housing services.

Street Outreach programs will target individuals who are often hard to reach, such as unsheltered individuals living in cars or families who fear separation. To further ensure unsheltered individuals' access to resources, the CoC will support partners that provide street outreach services during non-business hours. The CoC strategy will include reaching out to faith-based providers who have effective Outreach Teams and drop-in centers to establish collaborative partnerships that will aid in the identification of those who do not currently engage but need housing and services.

To further engage unsheltered individuals with severe service needs who are reluctant to use services, support will be given to programs designed to address fear of using the services – empowering people to embrace healthy change. To minimize fear associated with accessing services, programs that promote the concept of 'communities who are already together stay together' will be supported, such that they allow unmarried couples or groups of campers to stay together during the transition into housing. Projects are encouraged to incorporate the care of pets, whether a provider proposes to add to their outreach partnerships a veterinarian that visits encampments (this service currently exists but needs formalizing) or facilitation of a pet foster care program.

The City of Columbus commits to increasing the number of 24/7 drop-in centers and safe centers of support to be outreach hubs to accommodate the increase in Outreach Specialists and engagement goals outlined in this Plan. The outreach 'hubs' provide access for immediate/urgent needs and will be open during non-traditional hours. The Citizens Advisory Council will expand its presence to more sites frequented by unsheltered or previously unsheltered individuals, like the drop-in centers, for better engagement and peer support. The Columbus Coalition for the Homeless will continue to operate a warming/cooling center with the goal of adding more warming centers/drop-in centers that provide healthcare and behavioral healthcare services.

As part of leveraging behavioral health resources, we will explore a peer-supported warmline that focuses on severe mental health and addiction services. Additionally, we will consider funding peer-support centers that are open throughout the day, across the city. The programs that will be developed will increase access to housing navigation services, health care, and other supportive services. We will support a coordinated care plan, in which behavioral health, physical health, street outreach case management, and housing providers work

together in a coordinated manner to meet the needs of the person. The coordinated care will be managed by the Outreach Specialist to ensure the care pathways are meeting the person's needs through one consistent contact. The CoC will continue to leverage healthcare services by increasing awareness of the services that Managed Care Organizations provide. Our revamped Street Outreach program embeds a healthcare partner in the provision of their services, who can work alongside the team and follow unsheltered individuals into housing – maintaining the individual's trust along the way. Another goal will be to expand the use of healthcare navigators to provide services and help unsheltered individuals navigate health insurance options.

Prioritizing the Needs of Unsheltered Individuals and Needed Improvements: Local Voices

Stemming from the working groups and focus groups with unsheltered individuals (further described in section P6), *empowerment* was commonly cited as a necessity within the community for unsheltered individuals. To facilitate empowerment, partners will provide learning opportunities for unsheltered individuals and for those with a history of homelessness. The CoC funded projects will embed in their supportive services provision employment and job training services that will also help unsheltered individuals learn how to use computers and navigate websites. This is an essential skill as most applications to access benefits, housing, employment and other supportive services are online, and in general, unsheltered individuals and people with severe service needs are unskilled with this technology. Focus group respondents report that they would feel more comfortable completing the application processes alone because it would eliminate the discomfort of sharing personal identifiers with strangers. Teaching computer and navigation skills empowers people to be self-sufficient and independent in navigating services, including permanent housing.

Economic barriers hinder individuals from obtaining and retaining permanent housing. Because individuals with criminal backgrounds remain unhired despite an abundance of available jobs, support will be given to partners that work with companies to hire an unsheltered individual with skills, despite their criminal record. To prevent discouragement resulting from possible multiple unsuccessful interviews, support will be given to programs that help to line up jobs for unsheltered individuals. Peer support interventions are also encouraged. Hiring individuals who have themselves experienced homelessness as service providers offers jobs that help them maintain permanent housing and encourages those who are distrustful of accessing resources to engage and participate in services.

Another common theme that emerged from the focus groups is protection of self/personal belongings. Focus group informants made it clear that storage space is needed to protect their personal belongings, and this will be incorporated in the 24/7 drop-in centers. Partnerships with organizations that provide legal aid to protect individuals' employment status and housing/eviction status are encouraged, along with support to expunge criminal records. With respect to protection of self, programs and organizations that extend their assistance beyond typical business hours will be supported, along with shelters/soup kitchens that offer high-nutrition and a variety of foods, along with safe spaces.

The CoC will support Outreach programs that expand their information dissemination processes. Based on recommendations from the focus groups, further advertising via fliers and marketing materials will be incorporated, and the distributed information will include additional information such as upcoming weather reports. Use of social media to get information about housing, shelter availability and access to essential services is encouraged. Much information is spread via word-of-mouth between unsheltered individuals, and thus Street Outreach programs should take advantage of that knowledge to spread information in a way that is easy to pass along. To support existing social networks of care, the CoC plans to expand existing transportation programs to include transportation services that connect individuals to their families.

Permanent Housing Approach and Prioritization

For PSH programs, participants are prioritized via the USHS. Using HMIS data, all clients with long periods of continuous or episodic homelessness are identified and compiled into a monthly hotlist. Regular system case

conferencing and recommendations from Outreach Specialists help identify and add people who need PSH, including those who do not appear on the HMIS hotlist due to incomplete data. For the identified people, shelter or RRH case managers, or Outreach Specialists are invited to submit a Severity of Service Needs Assessment that covers physical, mental, behavioral, and developmental health, substance use, utilization of crisis or emergency services to meet basic needs (e.g., emergency rooms, jails), vulnerability to victimization, vulnerability to illness or death, and barriers to housing/risk of continued homelessness. Clients are prioritized for open PSH vacancies based on their Assessment scores. The Assessment automatically prioritizes people experiencing unsheltered homelessness – often extremely vulnerable with serious health challenges. Specifically, people experiencing chronic homelessness receive the highest priority; those with the highest scores, and therefore the highest need, are offered PSH first.

The case manager or Outreach Specialist for a prioritized client is notified when an appropriate PSH vacancy opens, so they can discuss the opportunity with the client. Prioritized clients can view the unit and learn about the PSH programs and can decline up to two PSH offers if they do not think it is a good fit for them. When a client accepts entry into a PSH program, CSB's Housing Department works with the organization operating the PSH program and CMHA (if applicable) to house the person as quickly as possible. If a client declines the PSH unit, the opportunity moves to the next highest prioritized household that fits the vacant unit configuration. When unsheltered clients decline housing, they stay on the hotlist and Outreach Specialists continue to engage with them, provide services, and help them access housing opportunities.

For RRH programs, our system uses the Housing Assistance Screening Tool (HAST), an assessment administered by shelter staff when people enter shelter or are engaged in Outreach programs. HMIS data and the results of the HAST are used to prioritize people for RRH. The HAST assesses homeless time, healthcare and other service needs, and housing barriers. The HAST also collects information needed to identify people who would benefit from specialized RRH programs for transition-age youth and survivors of domestic violence, dating violence, sexual assault, and stalking. People in an unsheltered situation often score higher on the HAST because of longer homeless time, higher service needs, and higher vulnerability. Unsheltered people who are survivors of domestic violence can enter the specialized DV RRH program without entering shelter, via referral from their Outreach Specialist.

CSB's prioritization system prioritizes people with the longest homeless time and most severe service needs which often are those who are unsheltered. Additional resources for Outreach and PSH will allow us to engage and house more unsheltered people, reducing unsheltered homelessness in our community. With additional Outreach funding, Outreach Specialists can reduce caseloads – the average is currently 40 – to better engage and gain trust with unsheltered individuals to more quickly establish a housing path. Additional funding for 176 homeless units in the four PSH programs in development would help provide supportive services and health care needed by people with severe service needs who have experienced long-term homelessness and disability.

Our CoC aggressively pursues development of new PSH programs, building partnerships and leveraging all available resources to develop new units. We have expanded existing RRH programs and created new programs tailored to specialized vulnerable populations, and implemented creative strategies for landlord engagement, building a community of partners willing to give people a second chance. Using data and analysis, CSB continually adjusts system procedures to help people move more efficiently and effectively from homelessness to housing, despite the severe challenges imposed by the deepening affordable housing crisis. With additional resources for Outreach and PSH programs, we will be able to do more.

The CoC will encourage and support housing projects to take advantage of their communities and create centers of support for the severe service needs population. For example, site-based PSH should incorporate the recommendations from the Plan related to engaging severe service needs individuals by routinely inviting healthcare providers to their sites. This will allow healthcare providers to more easily connect with individuals

who need services because they can serve one locale rather than track down individuals living in different areas. This strategy will increase recruitment of healthcare providers and help ensure that high service needs are met.

To ensure individuals retain access to housing and healthcare services, the CoC will continue to work with partners to have low-entry barriers to housing with high tolerance for behavioral non-compliance. In addition, programs that teach housekeeping/lifestyle skills will facilitate individuals' ability to maintain permanent housing. Efforts to improve the quality of housing and safety of the neighborhoods where PSH units are located is recommended by unsheltered individuals. Moreover, quick time to housing into deeply affordable, high-quality housing will prevent individuals from losing hope in the system.

P6. Involving Individuals with Lived Experience of Homelessness in Decision-Making

In preparation of this plan, 10 unsheltered individuals were interviewed in two focus groups at The Open Shelter drop-in center. The 10 individuals were recruited working with center staff and the Outreach Team. A third focus group of eight members of the Citizens Advisory Council (CAC) was held at a public library. The groups were asked about the types of resources/services they have used, what would make those services better, what barriers they faced accessing those services, and recommendations for how the CoC should spend these funds. Their input was notated, and thematic analysis was used to identify common ideas/recommendations. The results were used to inform the programs and services proposed in this plan and described in section P5 above. While not all recommendations from the focus groups can be directly funded through CoC funding or relate to this plan, partners will consider the input as they move forward with their projects. Four common themes emerged from participants' reported barriers and recommendations: (1) empowerment; (2) economic assistance/employment; (3) protection of self and personal belongings; and (4) Outreach programs. These themes were translated into the strategies in section P5.

The CAC is comprised of people with lived experience and expertise of homelessness. The Youth Action Board (YAB) is comprised of youth with lived experience and expertise. The CAC has two representatives with voting rights on the CoC governing body, one of whom also serves on the CoC Board. The YAB has one representative with voting rights on the CoC governing body. These representatives attend meetings and actively participate in CoC decision-making. The CAC and YAB meet monthly to discuss system programs, identify challenges, and propose solutions. The CAC and YAB consistently provide unique value to our system, alerting us to emerging issues and barriers and helping the system develop more effective strategies and procedures. In addition, persons with lived experience are providing feedback and are involved in decision-making at all levels of an organization serving them:

- Every organization that operates homelessness programs in our system is required to have at least one person with lived experience of homelessness on their governing board. The CAC helps identify candidates for board positions. This is not a check-the-box exercise. Agencies are required to ensure board members attend meetings, including adjusting dates and times when needed and helping with transportation. Agencies also ensure board members are empowered to fully participate and provide meaningful feedback on agency programs by providing board orientation and mentorship. CSB monitors agencies annually to ensure compliance with this requirement, including reviewing board meeting notes to confirm participation.
- All homelessness programs in our system are required to survey their program participants regularly and incorporate feedback to improve services. Programs are also required to involve program participants in program operations when possible and most programs employ peer support specialists with lived experience. CSB monitors agencies annually to ensure requirement compliance.
- Organizations proposing new PSH projects must present the Project Plan to the CAC in writing and via a prerecorded video. CAC members provide feedback on PSH Project Plans, ensuring that the proposing organization has the physical space and service plans that will best stabilize people with disabilities exiting homelessness to housing. CSB staff capture this feedback in writing for the CoC, so they can take it into account and require any needed adjustments prior to approving a PSH project. The CAC and YAB

representatives on the CoC also provide input during the CoC's discussion of each project. Feedback from people with lived experience improves our system's PSH programming.

- People with lived experience and expertise from the CAC reviewed the responses to the results of the Request for Proposals for Outreach Services that CSB issued earlier this year. They discussed each proposal and provided feedback that informed CSB's decision-making and helped make the best possible choice for people experiencing unsheltered homelessness.
- The voting representatives from the CAC on the CoC governing body participated in the Workgroup to develop this CoC Plan and contributed to the CoC's review and approval process for this Plan and the accompanying project applications for funding.

P7. Supporting Underserved Communities and Supporting Equitable Community Development

Throughout the past three years the CoC expanded its work with Outreach partners that serve individuals experiencing unsheltered homelessness who do not traditionally access programs. The goal is to expand services to locations unsheltered individuals frequent. The Collaborative Outreach Team (COT) is the group that incorporates all the entities included below, in addition to traditional Street Outreach providers like the Mount Carmel Street Medicine, Southeast PATH, Veterans Affairs, and Volunteers of America. The COT coordinates the community work, collaboration and improvements.

- Homes for Families targets unsheltered pregnant women including pregnant women who have been victims and survivors of domestic violence and/or of human trafficking.
- Out of Darkness serves the population traumatized by human trafficking and are working on referral opportunities for clients to be linked with street outreach and re-housing support.
- Sanctuary Night hires staff who have histories of homelessness to serve as outreach peer-supporters to help unsheltered individuals access substance abuse treatment facilities. In addition, they reach the community of female sex workers, providing them with resources and referrals.
- For transition age youth, Huckleberry House CARR Team and the Star House drop-in center for youth are working together to engage with unsheltered youth that otherwise are not participating in the system.
- Equitas Safe Point program, an agency serving the HIV/AIDS and LGBTQ+ population, engage individuals currently using substances and not currently linked with either street outreach or re-housing support. The Southeast PATH team has collaborated with this program to provide motivational interviewing with these individuals through a harm reduction lens to build rapport.
- Southeast and Primary One, Healthcare for the Homeless funded agencies, provide health care in the jail systems, maintaining contact with people released from jail along their pathway to stable housing.
- There are 18 drop-in centers or meal locations that provide support to people experiencing homelessness in the community that are key to engaging those that are reluctant to participate: The Open Shelter, Stowe Mission, Church for all People, Reeb Avenue Center, The Dream Center, Saint Sophia's, Star House, Clintonville Community Resource Center, Jordan's Crossing, PEER Center West, PEER Center East, Columbus Coalition for the Homeless Drop-in Centers, Community Kitchen, Sanctuary Night, Como Recovery, Out of Darkness, 1DivineLine2Health, and The Hope House. Mount Carmel focuses on empowering partners to help clients engage with the system and start the sheltering or housing path.
- We recognize that although unsheltered individuals may not engage with the homeless system, they might interact with other systems (e.g., mental health) which can be used as a collaboration to leverage all resources that may benefit the client. The RREACT (Rapid Response Emergency Addiction Crisis Team) is a partnership with the Columbus Police Division, Columbus Fire, ADAMH, Southeast Healthcare, Central Ohio Area Agency on Aging, and the Central Ohio Hospital Association. The team consists of paramedics and social workers who respond to overdoses in attempts to engage and link clients to treatment. This team consistently serves unsheltered homeless individuals who are difficult to engage due to addiction.