1A. Continuum of Care (CoC) Identification

Instructions:

The fields on this screen are read only and reference the information entered during the CoC Registration process. Updates cannot be made at this time. If the information on this screen is not correct, contact the e-snaps help desk.

CoC Name and Number (From CoC Registration):	MD-601 - Montgomery County CoC
CoC Lead Organization Name:	Montgomery County Department of Health and Human Services

1B. Continuum of Care (CoC) Primary Decision-Making Group

Instructions:

The following questions are related to the CoC primary decision-making group. The primary responsibility of this group is to manage the overall planning effort for the entire CoC, including, but not limited to:
- Setting agendas for full Continuum of Care meetings
- Project monitoring
- Determining project priorities
- Providing final approval for the CoC application submission.

This body is also responsible for the implementation of the CoC's HMIS, either through direct oversight or through the designation of an HMIS implementing agency. This group may be the CoC Lead Agency or may authorize another entity to be the CoC Lead Agency under its direction.

Name of primary decision-making group:	Continuum of Care Governing Board
Indicate the frequency of group meetings:	Monthly or more
If less than bi-monthly, please explain (limit 500 characters):	
Indicate the legal status of the group:	Not a legally recognized organization
Specify "other" legal status:	

Indicate the percentage of group members that represent the private sector: (e.g., non-profit providers, homeless or formerly homeless persons, advocates and consumer interests)	66%

*** Indicate the selection process of group members: (select all that apply)**

Elected:	
Assigned:	X
Volunteer:	X
Appointed:	X
Other:	

Specify "other" process(es):

Briefly describe the selection process of group members. Description should include why this process was established and how it works (limit 750 characters):

Membership in the Montgomery County Continuum of Care (CoC) consists of the leadership of all government, non-profit, and faith-based organizations working with households that are homeless or at-risk of homelessness as well as advocates. The Governing Board was established by the CoC Lead Agency to replace the Homeless Policy Development Committee, which did not have leadership representation. Annually, the CoC Governing Board reviews the membership and identifies potential new members who are then invited to participate. This process was developed to ensure that a broad array of stakeholders were engaged in identifying community needs and shaping the service delivery system.

*** Indicate the selection process of group leaders: (select all that apply):**

Elected:	
Assigned:	X
Volunteer:	
Appointed:	X
Other:	

Specify "other" process(es):

If administrative funds were made available to the CoC, would the primary-decision making body, or its designee, have the capacity to be responsible for activities such as applying for HUD funding and serving as a grantee, providing project oversight, and monitoring. Explain (limit 750 characters):

With additional administrative funding, Montgomery County Government, on behalf of the CoC Governing Board, would have the capacity to apply for HUD funding, serve as a grantee, provide project oversight, and monitor. The County has a successful track record managing federal, state, and local funding to provide integrated services to homeless families and individuals.

1C. Continuum of Care (CoC) Committees, Subcommittees and Work Groups

Instructions:

Provide information on up to five of the CoCs most active CoC-wide planning committees, subcommittees, and workgroups. CoCs should only include information on those groups that are directly involved in CoC-wide planning activities such as project review and selection, discharge planning, disaster planning, completion of the Exhibit 1 application, conducting the point-in-time count, and 10-year plan coordination. For each group, briefly describe the role and how frequently the group meets. If one of more of the groups meet less than quarterly, please explain.

Committees and Frequency

Name of Group	Role of Group (limit 750 characters)	Meeting Frequency
Continuum of Care Governing Board	Provides overall policy making; coordinates Housing First implementation and the Ten Year Plan; monitors overall CoC performance using contract monitoring reports, APRs, and HMIS; coordinates disaster planning with other systems such as Public Health. Other committees such as Adult Homeless Teaming, Family Providers, and other provider groups feed information to the Governing Board and implement policies. The Governing Board is receiving technical guidance from the National Alliance to End Homelessness for Housing First implementation.	Monthly or more
Adult Homeless Teaming Group	Providers of homeless services to individuals meet bi-weekly to promote coordination among non-profit providers. The meetings, chaired by the CoC Lead Agency, MCDHHS, share information about new CoC programs and policy from Governing Board, provide program updates, coordinate with Health Care for the Homeless discharge planning, make policy and implementation recommendations to the CoC Governing Board, present speakers, provide HMIS and mainstream provider trainings, conduct the point-in-time count, and review at least bi-annually the CoC disaster plan for multiple scenarios such as contagious diseases, biological attacks, and storm power outages.	Monthly or more
Family Homeless Provider Team	Providers of homeless services to families with children meet monthly to promote coordination among non-profit providers. The meetings, chaired by the CoC Lead Agency, MCDHHS, share new CoC information and policies, discuss implementation of Housing First program for families, program updates, case reviews, policy discussion and recommendations to Governing Board; and interface with other services that assist with the special needs of homeless children such as education (a public school representative attends), health and mental health care, child care, and child welfare services. Meetings include HMIS and mainstream provider trainings, point-in-time count procedures, and at least a bi-annual review of CoC disaster plans.	Monthly or more

Continuum of Care Prioritization Panel	This unbiased decision-making panel is charged by the CoC Governing Board to select the new CoC Permanent Housing Bonus. The panel reviews competing applicant projects and selects the new project based on past McKinney project performance and/or overall program performance in the CoC. Scoring factors are APR and HMIS data for past performance, HUD scoring for leverage, and priority for new beds for the chronically homeless. The panel is updated throughout the year on the NOFA process by the CoC Lead Agency and responds to questions raised by panel members.	Annually

If any group meets less than quarterly, please explain (limit 750 characters):

The Prioritization Panel convenes during the CoC process to select the new project and meets as a group once or twice. In the past, the Prioritization Panel rank-ordered the renewals and met at least twice during the CoC process. The Prioritization Panel is kept informed of the CoC process throughout the year via email and telephone contact.

1D. Continuum of Care (CoC) Member Organizations

Identify all CoC member organizations or individuals directly involved in the CoC planning process. To add an organization or individual, click on the icon.

Organization Name	Membership Type	Organization Type	Organization Role	Subpopulations
Maryland Department of Health and Mental Hygiene	Public Sector	State g...	Committee/Sub-committee/Work Group	Seriously Me...
Maryland Department of Human Resources	Public Sector	State g...	Committee/Sub-committee/Work Group	Domestic Vio...
State's Attorney's Office	Public Sector	State g...	Committee/Sub-committee/Work Group	Domestic Vio...
Montgomery County Department of Corrections	Public Sector	Local g...	Committee/Sub-committee/Work Group	Seriously Me...
City of Gaithersburg	Public Sector	Local g...	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
City of Rockville	Public Sector	Local g...	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
Housing Opportunities Commission	Public Sector	Public ...	Primary Decision Making Group, Attend Consolidated Plan p...	NONE
Montgomery Works	Public Sector	Local w...	Committee/Sub-committee/Work Group	NONE
Affiliated Sante Group	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Seriously Me...
Bethesda Cares	Private Sector	Non-pro...	Primary Decision Making Group, Committee/Sub-committee/Wo...	Veterans, Se...
Crossways Community	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Damascus HELP	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Dwelling Place	Private Sector	Non-pro...	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
Gaithersburg HELP	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Manna Food Center	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE

Fenton House	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Seriously Me...
Mental Health Association	Private Sector	Non-pro...	Primary Decision Making Group, Committee/Sub-committee/Wo...	Seriously Me...
Mid-County United Ministries	Private Sector	Faith-b...	Committee/Sub-committee/Work Group	NONE
Ministries of United Silver Spring/Takoma Park	Private Sector	Faith-b...	Committee/Sub-committee/Work Group	NONE
National Alliance for Mentally Ill	Private Sector	Non-pro...	Primary Decision Making Group, Attend Consolidated Plan p...	Seriously Me...
On Our Own	Private Sector	Non-pro...	None	Seriously Me...
Shepherd's Table Soup Kitchen	Private Sector	Non-pro...	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
Stepping Stones Shelter	Private Sector	Non-pro...	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
St. Luke's, Inc.	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Seriously Me...
Threshold Services, Inc.	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Seriously Me...
Upper Montgomery Emergency Assistance Network	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Veterans Administration Supportive Housing Program	Public Sector	Other	Committee/Sub-committee/Work Group	Veterans
Veterans Outreach Services	Public Sector	Other	Committee/Sub-committee/Work Group	Veterans, Se...
Catholic Charities	Private Sector	Faith-b...	Primary Decision Making Group, Committee/Sub-committee/Wo...	Seriously Me...
Damascus Ecumenical Laymen's Association	Private Sector	Faith-b...	Committee/Sub-committee/Work Group	NONE
Lord's Table Soup Kitchen	Private Sector	Faith-b...	Committee/Sub-committee/Work Group	NONE
Mt. Calvary Baptist Church, Helping Hands Shelter	Private Sector	Faith-b...	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
National Center for Children and Families	Private Sector	Faith-b...	Primary Decision Making Group, Committee/Sub-committee/Wo...	Youth, Domes...
Rockville Presbyterian Church, Rainbow Place	Private Sector	Faith-b...	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
Salvation Army	Private Sector	Faith-b...	Committee/Sub-committee/Work Group	NONE

Silver Spring Interfaith Housing	Private Sector	Non-pro...	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
Volunteers of America	Private Sector	Faith-b...	Primary Decision Making Group, Committee/Sub-committee/Wo...	Seriously Me...
Upper Montgomery County YMCA	Private Sector	Faith-b...	None	NONE
Montgomery County Coalition for the Homeless	Private Sector	Non-pro...	Primary Decision Making Group, Attend Consolidated Plan p...	Seriously Me...
United Way	Private Sector	Funder ...	Committee/Sub-committee/Work Group	NONE
Adventist Health Care	Private Sector	Hospita...	Committee/Sub-committee/Work Group	NONE
Holy Cross Hospital	Private Sector	Hospita...	Committee/Sub-committee/Work Group	NONE
Mobile Medical Care, Inc.	Private Sector	Hospita...	Committee/Sub-committee/Work Group	NONE
Montgomery General Hospital	Private Sector	Hospita...	Committee/Sub-committee/Work Group	NONE
Adventist Behavioral Health	Private Sector	Hospita...	Committee/Sub-committee/Work Group	Seriously Me...
Primary Care Coalition	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Springfield Hospital Center	Private Sector	Hospita...	Committee/Sub-committee/Work Group	Seriously Me...
Suburban Hospital	Private Sector	Hospita...	Committee/Sub-committee/Work Group	NONE
Consumer #1	Individual	Homeles...	Committee/Sub-committee/Work Group	NONE
Adventist Community Services	Private Sector	Faith-b...	Committee/Sub-committee/Work Group	NONE
Arbor Education and Training	Private Sector	Businesses	None	NONE
Avery Combined Care	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Seriously Me...
Bethesda HELP	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE

Community Clinic, Inc.	Private Sector	Hospita...	Committee/Sub-committee/Work Group	NONE
Community Ministries of Rockville	Private Sector	Faith-b...	Primary Decision Making Group, Committee/Sub-committee/Wo...	Seriously Me...
Consumer #2	Individual	Homeles...	Committee/Sub-committee/Work Group	NONE
Eastern Montgomery County Assistance Network	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Germantown HELP	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Interfaith Works	Private Sector	Faith-b...	Primary Decision Making Group, Committee/Sub-committee/Wo...	Seriously Me...
Legal Aid of Montgomery County	Private Sector	Non-pro...	None	NONE
Montgomery County Department of Health and Huma...	Public Sector	Local g...	Primary Decision Making Group	Seriously Me...
Montgomery County Department of Health and Huma...	Public Sector	Local g...	Committee/Sub-committee/Work Group	Domestic Vio...
Montgomery County Department of Health and Huma...	Public Sector	Local g...	Committee/Sub-committee/Work Group	Youth
Montgomery County Department of Health and Huma...	Public Sector	Local g...	Committee/Sub-committee/Work Group	Seriously Me...
Montgomery County Department of Health and Huma...	Public Sector	Local g...	Primary Decision Making Group	HIV/AIDS
Montgomery County Department of Health and Huma...	Public Sector	Local g...	Primary Decision Making Group, Attend Consolidated Plan p...	Seriously Me...
Mercy Health Clinic	Private Sector	Faith-b...	None	NONE
Montgomery Avenue Women's Center	Private Sector	Faith-b...	Primary Decision Making Group	Seriously Me...
Montgomery College	Public Sector	Local g...	None	NONE
Montgomery County Department of Health and Huma...	Public Sector	Local g...	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
Montgomery County Department of Health and Huma...	Public Sector	Local g...	Committee/Sub-committee/Work Group	Seriously Me...
Montgomery County Department of Housing and Com...	Public Sector	Local g...	Primary Decision Making Group, Attend 10-year planning me...	NONE
Montgomery County Office of the Public Defender	Public Sector	Local g...	None	NONE
Montgomery County Police Department	Public Sector	Law enf...	Committee/Sub-committee/Work Group	NONE
Montgomery County Public Schools	Public Sector	School ...	Committee/Sub-committee/Work Group	Youth

Montgomery County Sheriff's Office	Public Sector	Law enf...	None	NONE
Montgomery Station	Private Sector	Non-pro...	None	Seriously Me...
Olney HELP	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Projecto Salud	Private Sector	Non-pro...	None	NONE
Rockville Housing Enterprises	Public Sector	Public ...	None	NONE
Silver Spring HELP	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Spanish Catholic Center	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
The Lord's Table	Private Sector	Faith-b...	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
Veterans Administration	Public Sector	Other	Committee/Sub-committee/Work Group	Veterans
Women's Commission	Public Sector	Local g...	None	NONE
Avery Road Treatment Center	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Seriously Me...
Montgomery County Public Schools	Public Sector	School ...	Primary Decision Making Group, Committee/Sub-committee/Wo...	Youth
Emergency Assistance Coalition	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE

1E. Continuum of Care (CoC) Project Review and Selection Process

Instructions:

The CoC solicitation of projects and project selection should be conducted in a fair and impartial manner. For each of the following items, indicate all of the methods and processes the CoC used in the past year to assess all new and renewal project(s) performance, effectiveness, and quality. In addition, indicate if any written complaints have been received by the CoC regarding any CoC matter in the last 12 months, and how those matters were addressed and/or resolved.

Open Solicitation Methods: (select all that apply)	f. Announcements at Other Meetings, e. Announcements at CoC Meetings, c. Responsive to Public Inquiries, b. Letters/Emails to CoC Membership, d. Outreach to Faith-Based Groups
Rating and Performance Assessment Measure(s): (select all that apply)	g. Site Visit(s), b. Review CoC Monitoring Findings, k. Assess Cost Effectiveness, q. Review All Leveraging Letters (to ensure that they meet HUD requirements), r. Review HMIS participation status, d. Review Independent Audit, j. Assess Spending (fast or slow), p. Review Match, i. Evaluate Project Readiness, e. Review HUD APR for Performance Results, n. Evaluate Project Presentation, h. Survey Clients, o. Review CoC Membership Involvement, f. Review Unexecuted Grants, a. CoC Rating & Review Commitee Exists, m. Assess Provider Organization Capacity, l. Assess Provider Organization Experience
Voting/Decision-Making Method(s): (select all that apply)	a. Unbiased Panel/Review Commitee, e. Consensus (general agreement), d. One Vote per Organization, b. Consumer Representative Has a Vote, f. Voting Members Abstain if Conflict of Interest
Were there any written complaints received by the CoC regarding any matter in the last 12 months?	No

If yes, briefly describe complaint and how it was resolved (limit 750 characters):

No written complaints were received in the past twelve months.

1F. Continuum of Care (CoC) Housing Inventory--Change in Beds Available

For each housing type, indicate if there was any change (increase or reduction) in the total number of beds in the 2009 electronic Housing Inventory Chart (e-HIC) as compared to the 2008 e-HIC. If there was a change, please describe the reasons in the space provided for each housing type.

Emergency Shelter: No

Briefly describe the reason(s) for the change in Emergency Shelter beds, if applicable (limit 750 characters):

There was no change in year-round and seasonal Emergency Shelter beds between 2008 and 2009. There was an increase of 58 overflow beds for individuals and 77 beds for households with children in 2009 due to increased demand in emergency shelter.

Safe Haven: No

Briefly describe the reason(s) for the change in Safe Haven beds, if applicable (limit 750 characters):

There was no change in Safe Haven beds between 2008 and 2009.

Transitional Housing: Yes

Briefly describe the reason(s) for the change in Transitional Housing beds, if applicable (limit 750 characters):

For individuals, there was a decrease of 4 Transitional Housing beds between 2008 (160) and 2009 (156) due to the Mental Health Association of Montgomery County Places for People 2 program ceasing operations in 2008; project participants were placed in permanent housing.

For households with dependent children, there was a decrease of 77 Transitional Housing beds between 2008 (272) and 2009 (195) due to the conversion of the Interfaith Housing Coalition's 80 transitional housing beds to permanent supportive housing and the addition of 3 new beds from the Village of Friendship Heights.

Permanent Housing: Yes

Briefly describe the reason(s) for the change in Permanent Housing beds, if applicable (limit 750 characters):

For individuals there was an increase of 94 Permanent Housing beds between 2008 (275) and 2009 (369). Six programs began or expanded operations in 2008 that accounted for the increase: Shelter Plus Care, Partnership for Permanent Housing, Places for People, Home First, Ashmore, and Housing Initiative Program.

For households with dependent children there was a net increase of 217 Permanent Housing beds between 2008 (537) and 2009 (754) due to the start of the Housing Initiative Program, the conversion of Interfaith Housing Coalition to permanent supportive housing, the termination of the Jesup Blair House, and two programs decreasing the number of beds for households with dependent children (Shelter Plus Care and New Neighbors).

CoC certifies that all beds for homeless persons are listed in the e-HIC regardless of HMIS participation and HUD funding:	Yes

1G. Continuum of Care (CoC) Housing Inventory Chart Attachment

Instructions:

Each CoC must complete and attach the electronic Housing Inventory Chart, or e-HIC. Using the version of the document that was sent electronically to the CoC, verify that all information is accurate and make any necessary additions or changes. Click on "Housing Inventory Chart" below to upload the document . Each CoC is responsible for reading the instructions in the e-HIC carefully.

Document Type	Required?	Document Description	Date Attached
Housing Inventory Chart	Yes	MD-601 2009 e-HIC	11/17/2009

Attachment Details

Document Description: MD-601 2009 e-HIC

1H. Continuum of Care (CoC) Housing Inventory Chart (HIC) - Data Sources and Methods

Instructions:

Complete the following items based on data collection methods and reporting for the electronic Housing Inventory Chart (e-HIC), including Unmet need determination. The information should be based on a survey conducted in a 24-hour period during the last ten days of January 2009.

Indicate the date on which the housing inventory count was completed: (mm/dd/yyyy)	01/28/2009
Indicate the type of data or methods used to complete the housing inventory count: (select all that apply)	HMIS plus housing inventory survey
Indicate the steps taken to ensure data accuracy for the Housing Inventory Chart: (select all that apply)	Follow-up, Instructions, Updated prior housing inventory information, Confirmation, Training, HMIS
Must specify other:	
Indicate the type of data or method(s) used to determine unmet need: (select all that apply)	Unsheltered count, HMIS data, Other, Housing inventory, Stakeholder discussion

Specify "other" data types:

The CoC used the formula for projecting unmet need for permanent supportive housing described in the following publication by the Corporation for Supportive Housing (CSH):
Burt, M. R., & Wilkins, C. (March 2005). Estimating the need: projecting from point-in-time to annual estimates of the number of homeless people in a community and using this information to plan for permanent supportive housing. CSH Evidence Series. New York: CSH.

If more than one method was selected, describe how these methods were used together (limit 750 characters):

Stakeholders determined that there is no unmet need for emergency shelter or transitional housing in Montgomery County. It is the policy of the CoC to expand permanent supportive housing rather than year-round emergency and transitional shelter. (During the winter season, the number of emergency shelter beds is increased to meet the demand to keep people safe.) The Corporation for Supportive Housing methodology was used to determine the need for permanent supportive housing. The stakeholders reviewed the amount of unmet need identified by the CSH calculation and revised this calculation based on data from HMIS, the unsheltered count, and the housing inventory to represent accurately the unmet need for permanent housing in the CoC.

2A. Homeless Management Information System (HMIS) Implementation

Intructions:

CoCs should complete the following information in conjunction with the HMIS Lead Agency. All information is to be current as of the date in which this application is submitted. For additional instructions, refer to the detailed instructions available on the left menu bar.

Select the HMIS implementation type:	Single CoC
Select the CoC(s) covered by the HMIS: (select all that apply)	MD-601 - Montgomery County CoC
Does the CoC Lead Organization have a written agreement with HMIS Lead Organization?	No

If yes, the agreement (e.g., contract, Memorandum of Understanding, etc.) must be submitted with the application.

Is the HMIS Lead Organization the same as CoC Lead Organization?	Yes
Has the CoC selected an HMIS software product?	Yes
If "No" select reason:	
If "Yes" list the name of the product:	ServicePoint
What is the name of the HMIS software company?	Bowman Systems
Does the CoC plan to change HMIS software within the next 18 months?	No
Indicate the date on which HMIS data entry started (or will start): (format mm/dd/yyyy)	10/16/2006
Is this an actual or anticipated HMIS data entry start date?	Actual Data Entry Start Date
Indicate the challenges and barriers impacting the HMIS implementation: (select all the apply):	Inadequate ongoing user training and/or users groups

If CoC indicated that there are no challenges or barriers impacting HMIS implementation, briefly describe either why CoC has no challenges or how all barriers have been overcome (limit 1000 characters).

The CoC is experiencing the barrier of inadequate ongoing user training and/or user groups.

If CoC identified one or more challenges or barriers impacting HMIS implementation, briefly describe how the CoC plans to overcome them (limit 1000 characters).

Inadequate ongoing user training has been a challenge to implementing fully the HMIS. Although all users receive initial training, better ongoing support is critical to ensuring good data quality. To address this issue, Montgomery County Department of Health and Human Services (MCDHHS), the CoC Lead Agency, has contracted with Bowman Systems, Inc., the CoC's HMIS vendor, to provide a 0.8 Full-Time Equivalent position to provide ongoing training and support. This position provides on-site training and support to CoC provider agencies, conducts group trainings, responds to user problems as they occur, and creates monitoring reports. To monitor and improve data quality, this position trains agency HMIS administrators to generate and interpret reports, and reviews monthly provider reports to identify areas for improvement. This has led to significant improvements, which will enable the CoC to use the HMIS to conduct or validate 2010 point-in-time data.

2B. Homeless Management Information System (HMIS) Lead Organization

Enter the name and contact information for the HMIS Lead Agency. This is the organization responsible for implementing the HMIS within a CoC. There may only be one HMIS Lead Agency per CoC.

Organization Name	Montgomery County Department of Health and Human Services
Street Address 1	401 Hungerford Drive
Street Address 2	5th Floor
City	Rockville
State	Maryland
Zip Code **Format: xxxxx or xxxxx-xxxx**	20850
Organization Type	State or Local Government
If "Other" please specify	
Is this organization the HMIS Lead Agency in more than one CoC?	No

2C. Homeless Management Information System (HMIS) Contact Person

Enter the name and contact information for the primary contact person at the HMIS Lead Agency.

Prefix:	Ms.
First Name	Cherisse
Middle Name/Initial	M.
Last Name	Robles
Suffix	
Telephone Number: (Format: 123-456-7890)	240-777-4818
Extension	
Fax Number: (Format: 123-456-7890)	240-777-1575
E-mail Address:	cherisse.robles@montgomerycountymd.gov
Confirm E-mail Address:	cherisse.robles@montgomerycountymd.gov

2D. Homeless Management Information System (HMIS) Bed Coverage

Instructions:

HMIS bed coverage measures the level of participation in a CoC¿s HMIS. It is calculated by dividing the total number of year-round non-DV HMIS-participating beds available in the CoC by the total number of year-round non-DV beds available in the CoC. Participation in HMIS is defined as collection and reporting of client level data either through direct data entry into the HMIS or into an analytical database that includes HMIS data at least annually.

HMIS bed coverage is calculated by dividing the total number of year-round non-DV HMIS-participating beds in each housing type by the total number of non-DV beds available in each program type. For example, the bed coverage rate for Emergency Shelters (ES) is equal to the total number of year-round, non-DV HMIS-participating ES beds divided by the total number of non-DV ES beds available in the CoC. CoCs can review or assess HMIS bed coverage by calculating their rate monthly, quarterly, semiannually, annually, or never. CoCs are considered to have low bed coverage rates if they only have a rate of 0-64% among any one of the housing types. CoCs that have a housing type with a low bed coverage rate should describe the CoCs plan to increase bed coverage in the next 12-months in the space provided.

The 2005 Violence Against Women Act (VAWA) Reauthorization bill restricts domestic violence provider participation in HMIS unless and until HUD completes a public notice and comment process. Until the notice and comment process is completed, HUD does not require nor expect domestic violence providers to participate in HMIS. HMIS bed coverage rates are calculated excluding domestic violence provider beds from the universe of potential beds.

Indicate the HMIS bed coverage rate (%) for each housing type within the CoC. If a particular housing type does not exist anywhere within the CoC, select "Housing type does not exist in CoC" from the drop-down menu.

*** Emergency Shelter (ES) Beds**	86%+
*** Safe Haven (SH) Beds**	86%+
*** Transitional Housing (TH) Beds**	86%+
*** Permanent Housing (PH) Beds**	86%+

How often does the CoC review or assess its HMIS bed coverage? Quarterly

If bed coverage is 0-64%, describe the CoC's plan to increase this percentage during the next 12 months:

2E. Homeless Management Information System (HMIS) Data Quality

Instructions:

Enter the percentage of missing or unknown records AND the percentage of records where the value is "refused" or unknown ("don't know") for each Universal Data Element listed below. Universal Data Elements are information fields that HUD requires all homeless service providers participating in a local HMIS to collect on all homeless clients seeking housing and/or services. They include personal identifying information as well as information on a client's demographic characteristics and recent residential history. The elements target data that are essential to the administration of local homeless assistance programs as well as obtaining an accurate picture of the extent, characteristics and the patterns of service use of the local homeless population.

Where the collection of Social Security Numbers is not authorized by law, failure to collect this data element will not competitively disadvantage an application. Additionally, in lieu of the actual SSN, the response categories of "Don't Know" and "Refused" are considered valid response categories, per the HMIS Data and Technical Standards.

For additional instructions, refer to the detailed instructions available on the left menu bar.

Indicate the percentage of unduplicated client records with null or missing values on a day during the last ten days of January 2009.

Universal Data Element	Records with no values (%)	Records where value is refused or unknown (%)
* Social Security Number	7%	11%
* Date of Birth	2%	0%
* Ethnicity	2%	0%
* Race	2%	0%
* Gender	3%	0%
* Veteran Status	4%	4%
* Disabling Condition	4%	7%
* Residence Prior to Program Entry	4%	0%
* Zip Code of Last Permanent Address	4%	20%
* Name	0%	0%

Instructions:

The Annual Homeless Assessment Report (AHAR) is a national report to Congress on the extent and nature of homelessness in America. The AHAR uses data from Homeless Management Information Systems (HMIS) to estimate the number and characteristics of people who use homeless residential services and their patterns of service use. The data collection period for AHAR 4 began on October 1, 2007 and ended on September 30, 2008. Communities must have had a minimum bed coverage rate of 65 percent throughout the entire reporting period in two or more reporting categories¿i.e., emergency shelters for individuals (ES-IND), emergency shelters for families (ES-FAM), transitional housing for individuals (TH-IND), and transitional housing for families (TH-FAM)¿to be eligible to participate in AHAR 4.

Did the CoC or subset of CoC participate in AHAR 4?	Yes
Did the CoC or subset of CoC participate in AHAR 5?	Yes
How frequently does the CoC review the quality of client level data?	Monthly
How frequently does the CoC review the quality of program level data?	Monthly

Describe the process, extent of assistance, and tools used to improve data quality for agencies participating in the HMIS (limit 750 characters):

From a process perspective, on a daily basis the CoC's HMIS Administrator reviews the data; this includes, but is not limited to, merging duplicate client data and reviewing and correcting data incongruities. In addition, on a monthly basis all program sites must send a year-to-date HUD APR and Client Served reports generated from the HMIS application to the CoC. The reports are reviewed by contract monitors and anomalies with the reports are identified and the data corrected.

Describe the existing policies and procedures used to ensure that valid program entry and exit dates are recorded in the HMIS (limit 750 characters):

On a monthly basis all participating program sites must send a year to date HUD APR generated from the HMIS application to the CoC. The report is reviewed by contract monitors and anomalies with the reports are identified and the data corrected. This report is compared to the Client Served report for data consistency.

2F. Homeless Management Information System (HMIS) Data Usage

Instructions:

HMIS can be used for a variety of activities. These include, but are not limited to:
- Data integration/data warehousing to generate unduplicated counts¿Involves assembling HMIS data from multiple data collection systems into a single system in order to de-duplicate client records.
- Use of HMIS for point-in-time count of sheltered persons
- Use of HMIS for point-in-time count of unsheltered persons
- Use of HMIS for performance measurement¿Using HMIS to evaluate program or system-level performance, focusing on client-level outcomes, or measurable changes in the well-being of homeless clients.
- Use of HMIS for program management¿Using HMIS data for grant administration, reporting, staff supervision, or to manage other program activities.
- Integration of HMIS data with mainstream system¿Merging HMIS data with data from other mainstream systems, such as welfare, foster care, educational, or correctional systems.

Indicate the frequency in which each of the following activities is completed:

Data integration/data warehousing to generate unduplicated counts:	Never
Use of HMIS for point-in-time count of sheltered persons:	Monthly
Use of HMIS for point-in-time count of unsheltered persons:	Quarterly
Use of HMIS for performance assessment:	Monthly
Use of HMIS for program management:	Monthly
Integration of HMIS data with mainstream system:	Never

2G. Homeless Management Information System (HMIS) Data and Technical Standards

Instructions:

For each item, indicate whether the activity is completed monthly, quarterly (once each quarter), semiannually (two times per year), annually (every year), or never.
- Unique user name and password: CoC assesses that system user name and password protocols are followed and meet HMIS technical standards.
- Secure location for equipment: CoC manages physical access to systems with access to HMIS data in compliance with HMIS technical standards.
- Locking screen savers: CoC makes HMIS workstations and HMIS software automatically turn on password-protected screen savers when a workstation is temporarily not in use.
- Virus protection with auto update: CoC protects HMIS systems from viruses by using virus protection software that regularly updates virus definitions from the software vendor.
- Individual or network firewalls: CoC protects systems from malicious intrusion behind a secure firewall.
- Restrictions on access to HMIS via public forums: CoC allows secure connections to HMIS data only through PKI certificate or IP filtering as defined in the HMIS technical standards.
- Compliance with HMIS Policy and Procedures manual: CoC ensures HMIS users are in compliance with community-defined policies and protocols for HMIS use.
- Validation of off-site storage of HMIS data: CoC validates that off-site storage of HMIS data is secure.

Indicate the frequency in which the CoC or HMIS Lead completes a compliance assessment for each of the following HMIS privacy and security standards:

*** Unique user name and password**	**Monthly**
*** Secure location for equipment**	Quarterly
*** Locking screen savers**	Quarterly
*** Virus protection with auto update**	Quarterly
*** Individual or network firewalls**	Quarterly
*** Restrictions on access to HMIS via public forums**	Never
*** Compliance with HMIS Policy and Procedures manual**	Monthly
*** Validation of off-site storage of HMIS data**	Monthly

How often does the CoC assess compliance with HMIS Data and Technical Standards?	Monthly
How often does the CoC aggregate data to a central location (HMIS database or analytical database)?	Monthly
Does the CoC have an HMIS Policy and Procedures manual?	Yes
If 'Yes' indicate date of last review or update by CoC:	03/06/2008
If 'No' indicate when development of manual will be completed (mm/dd/yyyy):	

2H. Homeless Management Information System (HMIS) Training

Instructions:

An important component of a functioning HMIS is providing comprehensive training to homeless assistance providers that are participating in the HMIS. In the section below, indicate the frequency in which the CoC and/or HMIS Lead Agency offers each of the following training activities:
- Privacy/Ethics training: Training to homeless assistance program staff on established community protocols for ethical collection of client data and privacy protections required to manage clients¿ PPI (protected personal information).
- Data Security training: Training to homeless assistance program staff on established community protocols for user authentication, virus protection, firewall security, disaster protection, and controlled access to HMIS.
- Using HMIS data locally: Training on use of HMIS data to understand the local extent and scope of homelessness.
- Using HMIS data for assessing program performance: Training on use of HMIS to systematically evaluate the efforts programs are making to address homelessness.
- Basic computer skills training: Training on computer foundation skills such as mouse and keyboard functions, web searching, document saving, and printing.
- HMIS software training: Training on use and functionality of HMIS software including adding new clients, updating client data, running reports, and managing client cases.

Indicate the frequency in which the CoC or HMIS Lead Agency offers each of the following training activities:

Privacy/Ethics training	Monthly
Data Security training	Monthly
Data Quality training	Monthly
Using HMIS data locally	Monthly
Using HMIS data for assessing program performance	Monthly
Basic computer skills training	Never
HMIS software training	Monthly

2I. Continuum of Care (CoC) Point-in-Time Homeless Population

Instructions:

This section must be completed using statistically reliable, unduplicated counts or estimates of homeless persons in sheltered and unsheltered locations on a single night. Because 2009 was a required point-in-time count year, CoCs were required to conduct a one day, point-in-time count during the last 10 days of January--January 22nd to 31st. Although point-in-time counts are only required every other year, HUD requests that CoCs conduct a count annually if resources allow. Data entered in this chart must reflect a point-in-time count that took place during the last 10 days of January 2009, unless a waiver was received by HUD.

Additional instructions on conducting the point-in-time count can be found in the detailed instructions, located on the left hand menu.

Indicate the date of the most recent point-in-time count (mm/dd/yyyy): 01/28/2009

For each homeless population category, the number of households must be less than or equal to the number of persons.

Households with	Dependent Children		
Sheltered		Unsheltered	Total
Emergency	Transitional		
Number of Households: 90	78	0	168
Number of Persons (adults and children): 275	251	0	526

Households without	Dependent Children		
Sheltered		Unsheltered	Total
Emergency	Transitional		
Number of Households: 402	192	127	721
Number of Persons (adults and unaccompanied youth): 402	192	127	721

All Households/	All Persons		
Sheltered		Unsheltered	Total
Emergency	Transitional		
Total Households: 492	270	127	889
Total Persons: 677	443	127	1,247

2J. Continuum of Care (CoC) Point-in-Time Homeless Subpopulations

Instructions:

Enter the number of sheltered and unsheltered adults who belong in each subpopulation category. As in the Homeless Populations chart, this chart must be completed using statistically reliable and unduplicated counts or estimates of homeless persons based on the point-in-time count conducted during the last ten days of January 2009. Only adults should be included in the counts for this chart, except for the Unaccompanied Youth (those under age 18) category. Subpopulation data is required for sheltered persons and optional for unsheltered persons, with the exception of Chronically Homeless.

	Sheltered	Unsheltered	Total
*** Chronically Homeless (Federal definition)**	136	37	173
*** Severely Mentally Ill**	328	37	365
*** Chronic Substance Abuse**	302	38	340
*** Veterans**	35	12	47
*** Persons with HIV/AIDS**	13	2	15
*** Victims of Domestic Violence**	115	1	116
*** Unaccompanied Youth (under 18)**	0	0	0

2K. Continuum of Care (CoC) Sheltered Homeless Population & Subpopulation: Point-In-Time (PIT) Count

Instructions:

CoCs are only required to conduct a one-day point-in-time count every two years (biennially) however, HUD strongly encourages CoCs to conduct an annual point-in-time count, if resources allow. Below, select the time period that corresponds with how frequently the CoC plans to conduct a point-in-time count:
- biennially (every other year);
- annually (every year);
- semi-annually (twice a year); or
- quarterly (once each quarter).

CoCs will separately calculate and enter the percentage of emergency shelter and transitional housing providers that provided data for the Homeless Population and Subpopulation charts. For example, if 9 out of 12 transitional housing programs provided point-in-time data, enter 75%. If all providers for a program type contributed data, enter 100%.

How frequently does the CoC conduct a point-in-time count?	Annually
Enter the date in which the CoC plans to conduct its next point-in-time count: (mm/dd/yyyy)	01/27/2010

Indicate the percentage of homeless service providers supplying population and subpopulation data that was collected via survey, interview, and/or HMIS.

Emergency shelter providers:	100%
Transitional housing providers:	100%

2L. Continuum of Care (CoC) Sheltered Homeless Population and Subpopulation: Methods

Instructions:

CoCs may use one or more methods to count sheltered homeless persons. Indicate the method(s) used to gather and calculate population data on sheltered homeless persons. Check all applicable methods:
- Survey Providers¿Providers counted the total number of clients residing in each program on the night designated as the point-in-time count.
- HMIS¿The CoC used HMIS to complete the point-in-time sheltered count.
- Extrapolation¿The CoC used extrapolation techniques to estimate the number and characteristics of sheltered homeless persons from data gathered at emergency shelters and transitional housing programs. CoCs that use extrapolation techniques are strongly encourage to use the HUD General Extrapolation worksheet.

Indicate the method(s) used to count sheltered homeless persons during the last point-in-time count:
(Select all that apply):

Survey Providers:	X
HMIS:	X
Extrapolation:	
Other:	

If Other, specify:

Describe how the data on the sheltered homeless population, as reported on 2I, was collected and the sheltered count produced (limit 1500 characters):

The sheltered population count was collected in two ways. First, for emergency shelters, clients were interviewed and information was entered into an Excel form and HMIS. The Excel form was forwarded to the CoC (MCDHHS) for tabulation. Second, transitional shelter and housing providers entered information into the Excel form using HMIS and case record information. The Excel form was forwarded to the CoC for tabulation and validated by HMIS. Discrepancies were resolved at the agency level to match Excel and HMIS counts.

Comparing the 2009 point-in-time count to the previous point-in-time count (2008 or 2007), describe any factors that may have resulted in an increase, decline, or no change in the sheltered population count (limit 1500 characters):

Between 2008 and 2009 there was an increase in the sheltered homeless population for both individuals and households with dependent children. The number of sheltered homeless individuals increased by 94 persons (18.8%) between 2008 (500) and 2009 (594). This is the result of making overflow shelter beds available to any county resident in need during the winter months and conducting outreach to the unsheltered to encourage them to enter shelters to prevent hypothermia. The increase parallels a decrease in the number of unsheltered homeless counted during the point-in-time.

The number of sheltered households with dependent children increased by 38 (29.2%) between 2008 (130) and 2009 (168). The economic recession has caused an increase in homelessness among households with children that follows a national trend. On the day of the point-in-time, there were more families in overflow/voucher beds than in 2008; the CoC has a policy of not turning away households with children.

2M. Continuum of Care (CoC) Sheltered Homeless Population and Subpopulation Data

Instructions:

Check all methods used by the CoC to produce the sheltered subpopulations data reported in the subpopulation table.
- HMIS: The CoC used HMIS to gather subpopulation information on sheltered homeless persons without extrapolating for any missing data.
- HMIS data plus extrapolation: The CoC used HMIS data and extrapolation techniques to estimate the number and subpopulation characteristics of sheltered homeless persons in the CoC. Extrapolation techniques accounted for missing HMIS data and the CoC completed HUD¿s Extrapolation Tool.
- Sample of PIT interviews plus extrapolation: The CoC conducted interviews with a random or stratified sample of sheltered homeless adults and unaccompanied youth to gather subpopulation information. The results from the interviews were extrapolated to the entire sheltered homeless population to provide statistically reliable subpopulation estimates for all sheltered persons. CoCs that made this selection are encourage to used the applicable HUD Sample Strategy tool.
- Interviews: The CoC conducted interviews with every homeless person staying in an emergency shelter or transitional housing program on the night designated for the point-in-time count.
- Non-HMIS client level information: Providers used individual client records (e.g., case management files) to provide the CoC with subpopulation data for each adult and unaccompanied youth living in a sheltered program on the night designated for the point-in-time count.

Additional instructions on this section can be found in the detailed instructions, located on the left hand menu. Also, for more information about any of the techniques listed above, see: ¿A Guide for Counting Sheltered Homeless People¿ at http://www.hudhre.info/documents/counting_sheltered.pdf.

Indicate the method(s) used to gather and calculate subpopulation data on sheltered homeless persons (select all that apply):

HMIS	X
HMIS plus extrapolation:	
Sample of PIT interviews plus extrapolation:	
Sample strategy:	
Provider expertise:	X
Non-HMIS client level information:	X
None:	
Other:	X

If Other, specify:

Interviews with residents of emergency and transitional shelters.

Describe how data on sheltered subpopulations, as reported on 2J, was collected and the subpopulation data produced (limit 1500 characters):

The sheltered subpopulation count was collected in two ways. First, for emergency shelters, clients were interviewed and information was entered into an Excel form and HMIS. Subpopulation data was derived from client interviews, case record, HMIS information, and input from case managers. The Excel form was forwarded to the CoC (MCDHHS) for tabulation. Second, transitional shelter and housing providers entered subpopulation data into the Excel form using HMIS, case record information, and case manager input. Using these data sources, the CoC gathered information about client characteristics and special needs including chronic homelessness, serious mental illness, substance abuse, veteran status, HIV/AIDS, domestic violence, and others.

Comparing the 2009 point-in-time count to the previous point-in-time count (2008 or 2007), describe any factors that may have resulted in an increase, decline, or no change in the sheltered subpopulations data. Response should address changes in all sheltered subpopulation data (limit 1500 characters):

Between 2008 and 2009 there was an increase in the number of sheltered subpopulations in all cases with the exception of youth. Small percent increases were reported among the following subpopulations: chronically homeless persons increased from 119 to 136 (14.3%); persons with serious mental illness increased from 279 to 328 (17.6%); and veterans increased from 29 to 35 (20.7%). Larger percent increases were noted among the following: persons with chronic substance abuse increased from 201 to 302 (50.2%); survivors of domestic violence increased from 61 to 115 (88.5%); and persons living with HIV/AIDS increased from 5 to 13 (160.0%).

Factors that contributed to these increases were a decrease in the number of state psychiatric hospital beds, an increase in veterans returning to the community from Iraq and Afghanistan, a decrease in the availability of substance abuse treatment caused by funding cuts, and improved reporting for domestic violence.

2N. Continuum of Care (CoC) Sheltered Homeless Population and Subpopulation: Data Quality

Instructions:

CoCs often undertake a variety of steps to improve the quality of the sheltered population and subpopulation data. These include, but are not limited to:
- Instructions: The CoC provided written instructions to providers to explain protocol for completing the sheltered PIT count.
- Training: The CoC trained providers on the protocol and data collection forms used to complete the sheltered PIT count.
- Remind/Follow-up: The CoC reminded providers about the count and followed up with providers to ensure the maximum possible response rate from all programs.
- HMIS: The CoC used HMIS to verify data collected from providers for the sheltered count.
- Non-HMIS De-duplication techniques: The CoC used strategies to ensure that each sheltered and unsheltered homeless person was not counted more than once during the point in time count. The non-HMIS de-duplication techniques must be explained in the box below.

CoCs that select "Non-HMIS de-duplication techniques" must describe the techniques used. De-duplication is the process by which information on the same homeless clients within a program or across several programs is combined into unique records.

Indicate the steps used by the CoC to ensure the data quality of the sheltered persons count: (select all that apply)

Instructions:	X
Training:	X
Remind/Follow-up	X
HMIS:	X
Non-HMIS de-duplication techniques:	X
None:	
Other:	

If Other, specify:

Describe the non-HMIS de-duplication techniques, if selected (limit 1000 characters):

During the point-in-time count, four items of identifying information were collected from clients: first three letters of the last name, date of birth, gender, and social security number. The data collected at all provider agencies were merged using these identifying variables. These variables allowed the CoC to de-duplicate the data using statistical software as well as to identify those individuals who were sheltered rather than street homeless (i.e., individuals who were counted in both a shelter and on the street would be considered sheltered rather than unsheltered).

2O. Continuum of Care (CoC) Unsheltered Homeless Population and Subpopulation: Methods

Instructions:

CoCs can use a number of methodologies to count unsheltered homeless persons. These include, but are not limited to:
- Public places count: The CoC conducted a point-in-time count based on observation of unsheltered homeless persons, but without interviews.
- Public places count with interviews: The CoC conducted a point-in-time count and either interviewed all unsheltered homeless persons encountered during the public places count or a sample of these individuals.
- Service-based count: The CoC interviewed people using non-shelter services, such as soup kitchens and drop-in centers, screened for homelessness, and counted those that self-identified as unsheltered homeless persons. In order to obtain an unduplicated count, every person interviewed in a service-based count must be asked where they were sleeping on the night of the last point-in-time count.
- HMIS: The CoC used HMIS in some way to collect, analyze, or report data on unsheltered homeless persons. For example, the CoC entered respondent information into HMIS in an effort to check personal identifying information to de-duplicate and ensure persons were not counted twice.

For more information on any of these methods, see ¿A Guide to Counting Unsheltered Homeless People¿ at: http://www.hudhre.info/documents/counting_unsheltered.pdf.

Indicate the method(s) used to count unsheltered homeless persons: (select all that apply)

Public places count:	
Public places count with interviews:	X
Service-based count:	X
HMIS:	
Other:	

If Other, specify:

2P. Continuum of Care (CoC) Unsheltered Homeless Population and Subpopulation - Level of Coverage

Instructions:

Depending on a number of factors, the level of coverage for a count of unsheltered persons may vary from place to place. Below, indicate which level of coverage best applies to the count of unsheltered homeless persons in the CoC.

¿ Complete coverage means that every part of a specified geography, such as an entire city or a downtown area, every street is canvassed by enumerators looking for homeless people and counting anyone who is found.
¿ Known locations means counting in areas where unsheltered homeless people are known to congregate or live.
¿ A combined approach merges complete coverage with known locations by counting every block in a portion of the jurisdiction (e.g. central city) AND conducting counts in other areas of the jurisdiction where unsheltered persons are known to live or congregate.

Indicate the level of coverage of unsheltered homeless persons in the point-in-time count: Other

If Other, specify:

Known locations such as soup kitchens, day centers, and locations where homeless people congregate were identified and homeless persons counted. In addition, outreach teams canvassed areas of high probability of finding homeless persons using information from police and businesses.

2Q. Continuum of Care (CoC) Unsheltered Homeless Population and Subpopulation - Data Quality

Instructions:

CoCs may undertake one or more methods to improve data quality of the unsheltered population and subpopulation data, as reported on 2I and 2J, respectively. Check all steps that the CoC has taken to ensure data quality:
- Training: The CoC conducted trainings(s) for point-in-time enumerators or CoC staff.
- HMIS: The CoC used HMIS to check for duplicate entries or for some other purpose.
- De-duplication techniques: The CoC used strategies to ensure that each unsheltered homeless person was not counted more than once during the point-in-time count.

All CoCs should have a strategy for reducing the occurrence of counting persons more than once during a point-in-time count, also known as de-duplication. De-duplication techniques should always be implemented when the point-in-time count extends beyond one night or takes place during the day at service locations used by homeless people that may or may not use shelters.

For more information on de-duplication and other techniques used to improve data quality, see ¿A Guide for Counting Unsheltered Homeless People¿ at: www.hudhre.info/documents/counting_unsheltered.pdf.

Indicate the steps used by the CoC to ensure the data quality of the unsheltered persons count.
(select all that apply)

Training:	X
HMIS:	X
De-duplication techniques:	X
Other:	

If Other, specify:

Describe the techniques used by the CoC to reduce duplication, otherwise known as de-duplication (limit 1500 characters):

During the point-in-time count, four items of identifying information were collected from clients: first three letters of the last name, date of birth, gender, and social security number. The data collected at all provider agencies were merged using these identifying variables. These variables allowed the CoC to de-duplicate the data using statistical software as well as to identify those individuals who were sheltered rather than street homeless (i.e., individuals who were counted in both a shelter and on the street would be considered sheltered rather than unsheltered).

Describe the CoCs efforts to reduce the number of unsheltered homeless household with dependent children. Discussion should include the CoCs outreach plan (limit 1500 characters):

Unsheltered households with dependent children are always offered emergency shelter. The unofficial policy of the CoC is that households with children will never be unsheltered. When unsheltered households with children are identified by the police or the outreach team, they are directed to the CoC central point of intake at the Montgomery County Department of Health and Human Services that is staffed seven days a week, 24 hours a day to access emergency shelter.

Prevention of homelessness is also an important strategy to reduce the number of unsheltered households with dependent children. The CoC has implemented a variety of initiatives designed to prevent eviction and help families preserve their housing including emergency grants, rental and home energy subsidies, as well as case management services to help households improve budgeting, increase vocational skills, and access needed services. The programs are supported with state, local, and federal HPRP funding.

Describe the CoCs efforts to identify and engage persons that routinely sleep on the streets or other places not meant for human habitation (limit 1500 characters):

1. Volunteers of America provides county-wide street outreach and engagement, access to shelters, linkages to entitlements, housing, and other mainstream services;
2. Bethesda Cares is a daytime outreach center that provides meals, outreach, and linkages to shelter and other resources;
3. The Montgomery Avenue Women's Center operates a day shelter for homeless women that offers meals, counseling, case management, access to a computer lab, help with resume writing, and linkages to shelter and other services;
4. Community Vision at Progress Place operates a homeless resource day center that provides meals, substance abuse and mental health counseling, street outreach in Silver Spring, and linkages to shelter, housing, and mainstream providers;
5. Shepherd's Table, Inc. at Progress Place provides an evening soup kitchen, mail service, transportation tokens, and access to emergency shelter in the evenings;
6. MCDHHS Public Inebriate Team engages public inebriates in Silver Spring, many of whom are homeless, to access services and detoxification;
7. Lord's Table in Gaithersburg provides a soup kitchen and outreach services in partnership with the Mental Health Association of Montgomery County; and
8. Montgomery County Police has a formal protocol to report street homeless persons to Volunteers of America and other officials for follow-up. During severe weather, the police will bring homeless persons to shelters.

Comparing the 2009 point-in-time count to the previous point-in-time count (2008 or 2007), describe any factors that may have resulted in an increase, decline, or no change in the unsheltered population data (limit 1500 characters):

There was no change in the unsheltered population of households with dependent children as none were unsheltered in either 2008 or 2009. There was a 47.1% decrease in unsheltered individuals between 2008 (240) and 2009 (127) due to the CoC's efforts to identify and engage persons who routinely sleep on the streets or other places not meant for human habitation. Of 94 new permanent supportive housing (PSH) beds, 23 are targeted or available to street homeless individuals. Many PSH providers and all transitonal shelters for individuals admit persons from the streets.

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 1: Create new permanent housing beds for chronically homeless individuals.

Instructions:

Ending chronic homelessness is a HUD priority. CoCs can work towards accomplishing this by creating new beds for the chronically homeless. Describe the CoCs short-term and long-term plan for creating new permanent housing beds for the chronically homeless. For additional instructions, refer to the detailed instructions available on the left menu bar.

In the next 12-months, what steps will the CoC take to create new permanent housing beds for the chronically homeless (limit 1000 characters)?

The CoC will take the following steps to create 41 new chronically homeless beds, will evaluate progress quarterly to ensure meeting this goal, and will assign additional beds in the CoC if new beds cannot be developed:
1. The Montgomery County Coalition for the Homeless (MCCH) will implement Home First 3 to create 8 chronically homeless beds;
2. MCCH will apply for the Permanent Housing Bonus to create 8 chronically homeless beds in the Cordell project;
3. MCDHHS Housing Initiative Program (HIP) has designated 25 beds under development as of the 2009 point-in-time count for the chronically homeless. All chronically homeless applicants to HIP receive extra preference points to this Housing First program;
4. Permanent supportive housing providers will identify new openings for designation for chronically homeless beds; and
5. The CoC will evaluate progress quarterly, and will designate additional beds within the CoC for the chronically homeless if new beds cannot be developed.

Describe the CoC plan for creating new permanent housing beds for the chronically homeless over the next ten years (limit 1000 characters)?

The CoC will continue to create permanent housing beds for the chronically homeless over the next 10 years in the following manner:
1. The CoC will continue to apply for the HUD CoC Permanent Housing Bonus;
2. Permanent housing providers will apply for federal, state, local, and private foundation funding to create additional chronically homeless beds; and
3. Existing permanent supportive housing projects will designate existing beds occupied by chronically homeless persons as beds dedicated for chronically homeless individuals in future CoC competitions.

How many permanent housing beds do you currently have in place for chronically homeless persons?	90
How many permanent housing beds do you plan to create in the next 12-months?	131
How many permanent housing beds do you plan to create in the next 5-years?	211

How many permanent housing beds do you plan to create in the next 10-years?	371

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 2: Increase percentage of homeless persons staying in permanent housing over 6 months to at least 77 percent.

Instructions:

Increasing the self-sufficiency and stability of homeless participants is an important outcome measurement of HUD's homeless assistance programs. Describe the CoCs short-term and long-term plan for increasing the percentage of homeless persons staying in permanent housing over 6 months to at least 77 percent. For additional instructions, refer to the detailed instructions available on the left menu bar.

In the next 12-months, what steps will the CoC take to increase the percentage of homeless persons remaining in permanent housing for at least six months to at least 77 percent? If the CoC has already reached this threshold, describe how it will be exceeded or maintained (limit 1000 characters)?

The CoC exceeds the threshold for homeless persons remaining in permanent housing for at least 6 months and will continue to:
1. Link participants to mental health, substance abuse, health care, financial counseling, emergency rent and utility assistance, life skills, and parenting assistance;
2. Conduct outreach to landlords to ensure that tenant-based subsidy participants are closely monitored;
3. Disseminate best practices on integrating property management and supportive services to all housing providers;
4. Sponsor a conference for providers emphasizing in-home case management and supportive housing services;
5. Ensure providers partner with outpatient mental health providers for offsite psychiatric rehabilitation and Assertive Community Treatment;
6. Implement best practices demonstrated to retain project participants; and
7. Review progress quarterly and assist project(s) that have problems retaining project participants.

Describe the CoC's long-term plan to increase the percentage of homeless persons remaining in permanent housing for at least six months to at least 77 percent? CoCs response should include how it will continue to work towards meeting and exceeding this objective (limit 1000 characters).

The CoC exceeds the threshold for homeless persons remaining in permanent housing and will continue to meet this by:
1. Adding a case manager to serve the most vulnerable participants;
2. Linking participants to mental health, substance abuse, health care, financial counseling, emergency rent and utility assistance, life skills, and parenting services;
3. Conducting outreach to landlords to ensure that tenant-based subsidy participants are closely monitored;
4. Disseminating best practices on integrating property management and supportive services to housing providers;
5. Providing accredited trainings on behavioral and somatic health issues;
6. Sponsoring a provider conference to emphasize in-home case management and supportive housing services;
7. Partnering providers with outpatient mental health providers for offsite psychiatric rehabilitation and Assertive Community Treatment; and
8. Implementing best practices demonstrated to retain project participants.

What percentage of homeless persons in permanent housing have remained for at least six months?	90
In 12-months, what percentage of homeless persons in permanent housing will have remained for at least six months?	90
In 5-years, what percentage of homeless persons in permanent housing will have remained for at least six months?	91
In 10-years, what percentage of homeless persons in permanent housing will have remained for at least six months?	92

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 3: Increase percentage of homeless persons moving from transitional housing to permanent housing to at least 65 percent.

Instructions:

The ultimate objective of homeless assistance is to achieve the outcome of helping homeless families and individuals obtain permanent housing and self-sufficiency. Describe the CoC's short-term and long-term plan to increase the percentage of homeless persons moving from transitional housing to permanent housing to at least 65 percent. For additional instructions, refer to the detailed instructions available on the left menu bar.

In the next 12-months, what steps will the CoC take to increase the percentage of homeless persons moving from transitional housing to permanent housing to at least 65 percent? If the CoC has already reached this threshold, describe how it will be exceeded or maintained (limit 1000 characters)?

To increase the percentage of homeless persons moving from transitional to permanent housing, the CoC, over the next 12 months, will:
1. Establish a Performance Review Committee to review all CoC programs' performance to identify problems and provide technical assistance for improvements;
2. Explore conversion of Carroll House to permanent supportive housing (PSH);
3. Implement a new PSH program (Cordell) to serve 24 participants, with the majority referred from transitional shelters and Safe Havens programs--these do not include the 8 beds being requested from HUD for chronically homeless;
4. Acquire two buildings to serve 10 households referred from transitional programs (MCCH);
5. Provide new funding to the NCCF Supportive Housing Project to enhance case management and further improve program outcomes to permanent housing (MCDHHS); and
6. Provide security deposits, utility deposits, first month's rent to transitional participants moving into permanent housing (MCDHHS).

Describe the CoC's long-term plan to increase the percentage of homeless persons moving from transitional housing to permanent housing to at least 65 percent? CoCs response should include how it will continue to work towards meeting and exceeding this objective (limit 1000 characters).

To increase the percentage of homeless persons moving from transitional to permanent housing over the long term, the CoC will take the following steps:
1. Encourage existing transitional shelter/housing programs to convert to permanent supportive housing (PSH) units where appropriate and possible;
2. Continue to monitor project performance through the CoC Governing Board's Performance Review Committee and provide technical assistance to any transitional program that does not meet this performance goal;
3. Provide move in costs such as security deposits, utility deposits, and first month of rent to transitional participants moving into permanent housing (MCDHHS); and
4. Continue to emphasize PSH and permanent housing and pursue additional funding for deep subsidies.

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 4: Increase percentage of persons employed at program exit to at least 20 percent.

Instructions:

Employment is a critical step for homeless persons to achieve greater self-sufficiency, which represents an important outcome that is reflected both in participants' lives and the health of the community. Describe the CoCs short-term and long-term plans for increasing the percentage of persons employed at program exit to at least 20 percent. For additional instructions, refer to the detailed instructions available on the left menu bar.

In the next 12-months, what steps will the CoC take to increase the percentage of persons employed at program exit to at least 20 percent? If the CoC has already reached this threshold, describe how it will be exceeded or maintained (limit 1000 characters)?

The CoC exceeds the threshold for persons employed upon program exit and over the next 12 months will continue to:
1. Maintain close partnerships with the local Workforce Development Program, TANF employment support and training program, Maryland State Department of Rehabilitation Services, the Developmental Disability Administration, and mental health Supported Employment programs;
2. Continue vocational training and job placement programs within the CoC operated by MCCH, Montgomery Avenue Women's Center, Community Vision, and Chase Partnership Shelter;
3. Provide financial literacy and vocational training through Community Development Block Grant funding for individuals within the CoC; and
4. Include homeless service providers on advisory boards of organizations that address workforce issues.

Describe the CoC's long-term plan to increase the percentage of persons employed at program exit to at least 20 percent. CoCs response should include how it will continue to work towards meeting and exceeding this objective (limit 1000 characters).

The CoC exceeds the threshold for persons employed upon program exit and will continue to meet this goal over the long term by:
1. Continuing close partnerships with the local Workforce Development Program, TANF employment support and training program, Maryland State Department of Rehabilitation Services, the Developmental Disability Administration, and mental health Supported Employment programs;
2. Continuing vocational training and job placement programs within the CoC operated by MCCH, Montgomery Avenue Women's Center, Community Vision, and Chase Partnership Shelter;
3. Providing CDBG-funded financial literacy and vocational training for individuals within the CoC; and
4. Including homeless service providers on advisory boards of organizations that address workforce issues.

What percentage of persons are employed at program exit? 42

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 5: Decrease the number of homeless households with children.

Instructions:

Ending homelessness among households with children is a HUD priority. CoCs can work towards accomplishing this by creating beds and/or increasing supportive services for this population. Describe the CoCs short-term and long-term plans for decreasing the number of homeless households with children. For additional instructions, refer to the detailed instructions available on the left menu bar.

In the next 12-months, what steps will the CoC take to decrease the number of homeless households with children (limit 1000 characters)?

To decrease the number of homeless households with children, over the next 12 months the CoC will:
1. Provide HPRP-funded rapid re-housing services, rent subsidies, and case management for up to 18 months to eligible families in emergency and transitional programs;
2. Provide HPRP-funded emergency assistance to eligible households to prevent loss of permanent affordable housing;
3. Implement a rapid re-housing approach in emergency shelters funded by MCDHHS to house families within 30 days;
4. Conduct outreach to neighborhoods with a high risk of eviction (MCDHHS);
5. Provide approximately $3.15 million in local and $1 million in state eviction prevention assistance, and $8 million in state and federal utility assistance to prevent utility cutoffs or restore service;
6. Provide 8 family permanent housing units through the Neighborhood Stabilization Program; and
7. Implement HUD-funded Rapid Re-housing program through NCCF to permanently house families from emergency shelter.

Describe the CoC's long-term plan to decrease the number of homeless households with children (limit 1000 characters)?

To decrease the number of homeless households with children over the long term, the CoC will:
1. Continuously refine the rapid re-housing approach to produce better permanent housing outcomes;
2. Continue to conduct outreach to neighborhoods shown to experience a high risk of eviction (MCDHHS);
3. Continue to provide approximately $3.15 million in locally-funded eviction prevention assistance, $1 million in state-funded eviction prevention assistance, and $8 million from federal and state utility assistance programs to prevent utility cutoffs or restore service; and
4. Continue to explore the conversion of transitional housing programs to permanent housing.

What is the current number of homeless households with children, as indicated on the Homeless Populations section (2l)? 168

In 12-months, what will be the total number of homeless households with children?	135
In 5-years, what will be the total number of homeless households with children?	110
In 10-years, what will be the total number of homeless households with children?	80

3B. Continuum of Care (CoC) Discharge Planning

Instructions:

The McKinney-Vento Act requires that State and local governments have policies and protocols developed to ensure that persons being discharged from a publicly- funded institution or system of care are not discharged immediately into homelessness. To the maximum extent practicable, Continuums of Care should similarly have in place or be developing policies and protocols to ensure that discharged persons are not released directly onto the streets or into CoC funded homeless assistance programs. In the space provided, provide information on the policies and/or protocols that the CoC either has in place or is developing for each system of care, to ensure that persons are not routinely discharged into homelessness (this includes homeless shelters, the streets, or other homeless assistance housing programs). Response should address the following:

¿ What? Describe the policies that have been developed or are in the process of being developed.
¿ Where? Indicate where persons routinely go upon discharge from a publicly funded institution or system of care.
¿ Who? Identify the stakeholders or collaborating agencies.

Failure to respond to each of these questions will be considered unresponsive.

For each of the systems of care identified below, describe any policies and/or protocols that the CoC either has in place or is developing for each system of care, to ensure that persons are not routinely discharged into homelessness (this includes homeless shelters, the streets, or other homeless assistance housing programs) (limit 1500 characters).

Foster Care:

The Montgomery County Department of Health and Human Services (MCDHHS) Child Welfare Services only reunifies a child with a parent who has stable housing. Children are not reunified with parents who are homeless; however, Child Welfare Services makes every effort to secure permanent housing using all available housing resources within MCDHHS and with other public and non-profit housing providers. HOC, the public housing authority, has applied for Family Reunification Program vouchers to provide subsidies to homeless families with children in foster care so that the family can reunify in affordable housing. Foster children transitioning to adulthood are provided mainstream housing in the community by their case workers and are never discharged into the homeless system unless the foster child is noncompliant with planning efforts.

Health Care:

The Montgomery County Department of Health and Human Services, through its Public Health Services, has implemented a Health Care for the Homeless Initiative (HCH) funded by Montgomery County Government. This initiative developed discharge protocols with local private hospitals within the CoC (there are no state hospitals located within the CoC). Three HCH nurses work collaboratively with local hospital discharge planners to ensure that patients are not discharged to homeless shelters unless the patient is without resources from family or friends; that nursing home and assisted living facilities are not available or appropriate; and that the homeless patient can be maintained safely in a shelter. Even in these cases, HCH nurses work with homeless services staff to locate more suitable housing in the community. This program was implemented in May 2009.

Mental Health:

For publicly-funded psychiatric facilities, the Mental Hygiene Administration (MHA) uses Maryland Health General Article of Annotated Code 10-809, which prohibits discharges from state facilities to homelessness. The inpatient hospital social worker or treatment team must complete a needs assessment and develop a treatment plan to address needs such as mental health, housing, substance abuse, and job and life skills. An aftercare plan is required before release and must include medical and psychiatric care, housing, vocational and social rehabilitation, case management, and other supportive services. The MHA provides funding to provide mental health services in local detention centers, including discharge planning. Persons discharged from publicly-funded mental health institutions are never discharged to McKinney-Vento programs and are referred to the Core Service Agency for follow-up.

When a patient is scheduled for release, the hospital social worker contacts the Mental Health Core Services Agency at MCDHHS for referral to psychiatric residential rehabilitation program housing, the MCDHHS Behavioral Health Access Team for referral and linkage to community mental health treatment, and the MCDHHS Crisis Center if the patient is being discharged against medical advice and the hospital social worker was unable to make a complete discharge plan.

Corrections:

The Montgomery County Department of Corrections, through its Community Re-Entry Program, provides services to inmates prior to release to secure housing in the community. This program links inmates with mainstream treatment and housing programs to prevent substance abuse relapse, psychiatric stability, and stable housing with the goal of preventing recidivism. The Pre-Release Center works with inmates for several months prior to release by providing employment and vocational counseling in a minimum security setting. These inmates exit the correctional system with employment and housing.

3C. Continuum of Care (CoC) Coordination

Instructions:

A CoC should regularly assess the local homeless system and identify shortcomings and unmet needs. One of the keys to improving a CoC is to use long-term strategic planning to establish specific goals and then implement short-term/medium-term action steps. Because of the complexity of existing homeless systems and the need to coordinate multiple funding sources, there are often multiple long-term strategic planning groups. It is imperative for CoCs to coordinate, as appropriate, with each of these existing strategic planning groups to meet the local CoC shortcomings and unmet needs.

New in 2009, CoCs are expected to describe the CoC's level of involvement and coordination with HUD's American Recovery and Reinvestment Act of 2009 programs, such as the Homelessness Prevention and Rapid Re-housing Program (HPRP), the Community Development Block Grant-Recovery (CDBG-R), the Tax Credit Assistance Program and the Neighborhood Stabilization Program (NSP1 or NSP2). Finally, CoCs with jurisdictions that are receiving funds through the HUD-VASH initiative should describe coordination with this program as well. CoCs that include no jurisdictions receiving funds from any one of these programs, should indicate such in the text box provided.

Does the Consolidated Plan for the jurisdiction(s) that make up the CoC include the CoC strategic plan goals for addressing homelessness?	Yes
If yes, list the goals in the CoC strategic plan that are included in the Consolidated Plan:	1. Prevent homelessness through early intervention, coordinated case management, and financial assistance. 2. Provide long-term transitional and permanent housing to homeless persons. 3. Provide supportive services to homeless persons.

Describe how the CoC is participating in or coordinating with the local Homeless Prevention and Rapid re-housing Program (HPRP) initiative, as indicated in the substantial amendment to the Consolidated Plan 2008 Action Plan (1500 character limit):

The Montgomery County Department of Health and Human Services (CoC Lead Agency) is the Prime Recipient to administer the $2,104,743 HPRP grant over a 2-3 year grant period. Rapid re-housing services will be provided to households residing in emergency shelters with shallow and deep rental subsidies provided up to 18 months with case management. Prevention services will be provided to households threatened with loss of permanent housing so they do not enter the homeless system. Financial assistance up to $6,000 per household can be provided for three months of rental and utility arrears and up to three months of rent subsidy to enable the household to overcome temporary financial barriers to become independent.

Describe how the CoC is participating in or coordinating with the local Neighborhood Stabilization Program (NSP) initiative, HUD VASH, and/or any HUD managed American Reinvestment and Recovery Act programs (2500 character limit)?

Under the Neighborhood Stabilization Program, the Housing Opportunities Commission (HOC), which is the local public housing authority, will receive funding to purchase seven housing units that will be available to rent by any household with a rent subsidy. This will provide opportunities for participants in the Housing Initiative Program (HIP) and other permanent supportive housing programs who have rental barriers in the private market to rent from HOC.

Under the HUD-VASH program, there were approximately 250 VASH units available in the Washington, D.C. metropolitan area in 2009. The VA homeless outreach coordinator from the D.C. VA hospital attends the Adult Teaming Meetings and disseminated information and referral procedures resulting in referrals of veterans. Priority is given to veterans of the Gulf War, Iraq, and Afghanistan.

Under the HUD CSBG/ARRA program, the Employment Program operated by Arbor Inc., under contract to MCDHHS, will provide employment-related services to recipients of MCDHHS Housing Stabilization Services. This employment program targets homeless families residing in emergency shelters and households at risk of eviction/losing permanent housing. Participants will receive intensive services to assist them in gaining and retaining employment. Services include behavior and skill assessment, employment plan, work preparation workshops, skills training, job placement, and 90-day job retention.

4A. Continuum of Care (CoC) 2008 Achievements

Instructions:

For the five HUD national objectives in the 2009 CoC application, enter the 12-month numeric achievements that you provided in Exhibit 1, Part 3A of the 2008 electronic CoC application. Enter this number in the first column, "Proposed 12-Month Achievement". Under "Actual 12-Month Achievement" enter the actual numeric achievement that your CoC attained within the past 12 months that is directly related to the national objective. CoCs that did not submit an Exhibit 1 application in 2008 should answer no to the question, "Did CoC submit an Exhibit 1 application in 2008?"

Objective	Proposed 12-Month Achievement (number of beds or percentage)		Actual 12-Month Achievement (number of beds or percentage)	
Create new permanent housing beds for the chronically homeless.	71	**Beds**	90	**Beds**
Increase the percentage of homeless persons staying in permanent housing over 6 months to at least 71.5%.	87	**%**	90	**%**
Increase the percentage of homeless persons moving from transitional housing to permanent housing to at least 63.5%.	64	**%**	56	**%**
Increase percentage of homeless persons employed at exit to at least 19%	40	**%**	42	**%**
Decrease the number of homeless households with children.	50	**Households**	168	**Households**

Did CoC submit an Exhibit 1 application in 2008? Yes

For any of the HUD national objectives where the CoC did not meet the proposed 12-month achievement as indicated in 2008 Exhibit 1, provide explanation for obstacles or other challenges that prevented the CoC from meeting its goal:

The CoC did not meet the proposed achievement for increasing the percentage of homeless persons moving from transitional to permanent housing. Carroll House, a transitional program for individuals, struggled with high participant turnover and an increase in behaviorally disabled men. The Housing Initiative Program (HIP), a permanent supportive housing program that targets individuals in emergency shelters and the streets, cannot serve persons from transitional programs unless they are within 4 months of the programs' maximum length of stay. With an unmet need of 837 individual permanent supportive housing beds, it is a challenge to find suitable permanent housing for disabled individuals.

The CoC did not meet the proposed achievement for the number of homeless households with dependent children. One key reason is that this goal was based on incorrect 2008 baseline data that counted 55 households but did not include those living in transitional shelter; therefore, the goal was set too low. A corrected baseline count revealed 130 homeless households with dependent children. Even with this recalculation, the number of these households increased in 2009 due to the continued shortage of affordable housing in this high-cost area; foreclosures that displaced renters, in some cases leading to homelessness; continued unemployment leading to homelessness; and a shortage of HUD housing subsidies relative to the waiting list for federal housing subsidy programs.

4B. Continuum of Care (CoC) Chronic Homeless Progress

Instructions:

HUD must track each CoCs progress toward ending chronic homelessness. A chronically homeless person is defined as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four episodes of homelessness in the past three years. To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency shelter during that time. An episode is a separate, distinct, and sustained stay on the streets and/or in an emergency homeless shelter.

This section asks each CoC to track changes in the number of chronically homeless persons as well the number of beds available for this population. For each year, indicate the total unduplicated point-in-time count of the chronically homeless. For 2006 and 2007, this number should come from Chart K in that that year¿s Exhibit 1. The 2008 and 2009 data has automatically been pulled forward from the respective years 2I. Next, enter the total number of existing and new permanent housing beds, from all funding sources, that were/are readily available and targeted to house the chronically homeless for each year listed.

CoCs must also identify the cost of new permanent housing beds for the chronically homeless. The information in this section can come from point-in-time data and the CoCs housing inventory.

Indicate the total number of chronically homeless persons and total number of permanent housing beds designated for the chronically homeless persons in the CoC for 2007, 2008, and 2009.

Year	Number of CH Persons	Number of PH beds for the CH
2007	231	55
2008	208	53
2009	173	90

Indicate the number of new permanent housing beds in place and made available for occupancy for the chronically homeless between February 1, 2008 and January 31, 2009. 23

Identify the amount of funds from each funding source for the development and operations costs of the new permanent housing beds designated for the chronically homeless, that were created between February 1, 2008 and January 31, 2009.

Cost Type	HUD McKinney-Vento	Other Federal	State	Local	Private
Development	$0	$0	$0	$0	$0
Operations	$137,143	$0	$0	$146,465	$54,356
Total	$137,143	$0	$0	$146,465	$54,356

If the number of chronically homeless persons increased or if the number of permanent beds designated for the chronically homeless decreased, please explain (limit 750 characters):

Between 2008 and 2009 the number of chronically homeless persons in the CoC decreased and the number of beds for chronically homeless persons increased by 37 beds; 23 chronically homeless beds are new inventory and 14 existing beds in other permanent supportive housing programs are newly designated for the chronically homeless and are currently occupied by formerly chronically homeless individuals.

4C. Continuum of Care (CoC) Housing Performance

Instructions:

In this section, CoCs will provide information from the recently submitted APR for all projects within the CoC, not just those being renewed in 2009.

HUD will be assessing the percentage of all participants who remain in S+C or SHP permanent housing (PH) for more than six months. SHP permanent housing projects include only those projects designated as SH-PH. Safe Havens are not considered permanent housing. Complete the following table using data based on the most recently submitted APR for Question 12(a) and 12(b) for all permanent housing projects within the CoC.

Does CoC have permanent housing projects for which an APR should have been submitted? Yes

Participants in Permanent Housing (PH)	
a. Number of participants who exited permanent housing project(s)	55
b. Number of participants who did not leave the project(s)	310
c. Number of participants who exited after staying 6 months or longer	50
d. Number of participants who did not exit after staying 6 months or longer	277
e. Number of participants who did not exit and were enrolled for less than 6 months	34
TOTAL PH (%)	90

Instructions:

HUD will be assessing the percentage of all transitonal housing (TH) participants who moved to a PH situation. TH projects only include those projects identified as SH-TH. Safe Havens are not considered transitional housing. Complete the following table using data based on the most recently submitted APR for Question 14 for all transitional housing projects within the CoC.

Does CoC have any transitional housing programs for which an APR should have been submitted? Yes

Participants in Transitional Housing (TH)	
a. Number of participants who exited TH project(s), including unknown destination	84
b. Number of participants who moved to PH	46
TOTAL TH (%)	564

4D. Continuum of Care (CoC) Enrollment in Mainstream Programs and Employment Information

Instructions:

HUD will be assessing the percentage of clients in all of your existing projects who gained access to mainstream services, especially those who gained employment. This includes all S+C renewals and all SHP renewals, excluding HMIS projects. Complete the following charts based on responses to APR Question 11 for all projects within the CoC.

Total Number of Exiting Adults: 139

Mainstream Program	Number of Exiting Adults	Exit Percentage (Auto-calculated)	
SSI	32	23	%
SSDI	26	19	%
Social Security	1	1	%
General Public Assistance	2	1	%
TANF	17	12	%
SCHIP	6	4	%
Veterans Benefits	1	1	%
Employment Income	58	42	%
Unemployment Benefits	1	1	%
Veterans Health Care	0	0	%
Medicaid	23	17	%
Food Stamps	27	19	%
Other (Please specify below)	14	10	%
Medicare, Child Support			
No Financial Resources	23	17	%

The percentage values will be calculated by the system when you click the "save" button.

Does CoC have projects for which an APR should have been submitted? Yes

4E. Continuum of Care (CoC) Participation in Energy Star and Section 3 Employment Policy

Instructions:

HUD promotes energy-efficient housing. All McKinney-Vento funded projects are encouraged to purchase and use Energy Star labeled products. For information on Energy Star initiative go to: http://www.energystar.gov

A "Section 3 business concern" is one in which: 51% or more of the owners are section 3 residents of the area of service; or at least 30% of its permanent full-time employees are currently section 3 residents of the area of service, or within three years of their date of hire with the business concern were section 3 residents; or evidence of a commitment to subcontract greater than 25% of the dollar award of all subcontracts to businesses that meet the qualifications in the above categories is provided. The "Section 3 clause" can be found at 24 CFR Part 135.

Has the CoC notified its members of the Energy Star Initiative?	Yes
Are any projects within the CoC requesting funds for housing rehabilitation or new construction?	No

4F. Continuum of Care (CoC) Enrollment and Participation in Mainstream Programs

It is fundamental that each CoC systematically help homeless persons to identify, apply for, and follow-up to receive benefits under SSI, SSDI, TANF, Medicaid, Food Stamps, SCHIP, WIA, and Veterans Health Care as well as any other State or Local program that may be applicable.

Does the CoC systematically analyze its projects APRs in order to improve access to mainstream programs?	Yes

If 'Yes', describe the process and the frequency that it occurs.

APRs are sent to the CoC on a monthly basis. The CoC will begin using the CoC Governing Board, Performance Review Committee to review projects' performance.

Does the CoC have an active planning committee that meets at least 3 times per year to improve CoC-wide participation in mainstream programs?	Yes

If "Yes", indicate all meeting dates in the past 12 months.

October 15, 2008
November 10, 2008
November 19, 2008
December 3, 2008
December 17, 2008
January 8 2009
February 26, 2009
March 24, 2009
April 23, 2009
May 28, 2009
August 12, 2009
October 28, 2009

Does the CoC coordinate with the State Interagency Council on Homelessness to reduce or remove barriers to accessing mainstream services?	Yes
Does the CoC and/or its providers have specialized staff whose primary responsibility is to identify, enroll, and follow-up with homeless persons on participation in mainstream programs?	Yes
If yes, identify these staff members	Both
Does the CoC systematically provide training on how to identify eligibility and program changes for mainstream programs to provider staff.	Yes

If "Yes", specify the frequency of the training. Bi-monthly

Does the CoC use HMIS as a way to screen for mainstream benefit eligibility? Yes

If "Yes", indicate for which mainstream programs HMIS completes screening.

Homeless provider staff routinely assess clients using HMIS assessment screens that prompt for information on income, current benefits, assets, health status, disabilities, family, and other resources. Staff are trained in basic entitlement eligibility criteria and will refer clients to the appropriate mainstream resource such as Food Stamps, TANF, SSI, Medical Assistance, emergency assistance, SSA, and other benefits, if eligible. HMIS is not used directly by Income Support staff to determine benefits but to verify homeless status and address of record.

Has the CoC participated in SOAR training? Yes

If "Yes", indicate training date(s).

October 1, 2009.

4G: Homeless Assistance Providers Enrollment and Participation in Mainstream Programs

Indicate the percentage of homeless assistance providers that are implementing the following activities:

Activity	Percentage
1. Case managers systematically assist clients in completing applications for mainstream benefits. **1a. Describe how service is generally provided:**	100%
All programs have case managers who are responsible for referring clients to mainstream programs.	

2. Homeless assistance providers supply transportation assistance to clients to attend mainstream benefit appointments, employment training, or jobs.	100%

3. Homeless assistance providers use a single application form for four or more mainstream programs: **3.a Indicate for which mainstream programs the form applies:**	100%
Food Stamps, Medicaid, TANF, TDAP (state-funded cash assistance for single adults)	

4. Homeless assistance providers have staff systematically follow-up to ensure mainstream benefits are received.	100%
4a. Describe the follow-up process:	
Case managers work with their clients and mainstream providers to complete and follow-up with applications for assistance.	

Questionnaire for HUD's Initiative on Removal of Regulatory Barriers (HUD 27300)

Complete Part A if the CoC Lead Agency is a local jurisdiction (a county exercising land use and building regulatory authority and another applicant type applying for projects located in such jurisdiction or county (collectively or jurisdiction).

Complete Part B if the CoC Lead Agency is a State agency, department, or other applicant for projects located in unincorporated areas or areas otherwise not covered in Part A.

Indicate the section applicable to the CoC Lead Agency: Part A

Part A - Questionnaire for HUD's Initiative on Removal of Regulatory Barriers

Part A. Local Jurisdictions. Counties Exercising Land Use and Building Regulatory Authority and Other Applicants Applying for Projects Located in such Jurisdictions or Counties [Collectively, Jurisdiction]

***1. Does your jurisdiction's comprehensive plan (or in the case of a tribe or TDHE, a local Indian Housing Plan) include a "housing element"?** **A local comprehensive plan means the adopted official statement of a legislative body of a local government that sets forth (in words, maps, illustrations, and/or tables) goals, policies, and guidelines intended to direct the present and future physical, social, and economic development that occurs within its planning jurisdiction and that includes a unified physical plan for the public development of land and water. If your jurisdiction does not have a local comprehensive plan with a housing element, please select No. If you select No, skip to question # 4.**	Yes
2. If your jurisdiction has a comprehensive plan with a housing element, does the plan provide estimates of current and anticipated housing needs, taking into account the anticipated growth of the region, for existing and future residents, including low, moderate and middle income families, for at least the next five years?	Yes
3. Does your zoning ordinance and map, development and subdivision regulations or other land use controls conform to the jurisdiction's comprehensive plan regarding housing needs by providing: a)sufficient land use and density categories (multi-family housing, duplexes, small lot homes and other similar elements); and, b) sufficient land zoned or mapped "as of right" in these categories, that can permit the building of affordable housing addressing the needs identified in the plan? **(For purposes of this notice, "as-of-right" as applied to zoning, means uses and development standards that are determined in advance and specifically authorized by the zoning ordinance. The ordinance is largely self-enforcing because little or no discretion occurs in its administration). If the jurisdiction has chosen not to have either zoning, or other development controls that have varying standards based upon districts or zones, the applicant may also enter yes.**	Yes
4. Does your jurisdiction's zoning ordinance set minimum building size requirements that exceed the local housing or health code or that are otherwise not based upon explicit health standards?	No
***5. If your jurisdiction has development impact fees, are the fees specified and calculated under local or state statutory criteria?** **If no, skip to question #7. Alternatively, if your jurisdiction does not have impact fees, you may select Yes.**	Yes
6. If yes to question #5, does the statute provide criteria that sets standards for the allowable type of capital investments that have a direct relationship between the fee and the development (nexus), and a method for fee calculation?	Yes

Part A - Page 2

***7. If your jurisdiction has impact or other significant fees, does the jurisdiction provide waivers of these fees for affordable housing?**	Yes
***8. Has your jurisdiction adopted specific building code language regarding housing rehabilitation that encourages such rehabilitation through gradated regulatory requirements applicable as different levels of work are performed in existing buildings?** **Such code language increases regulatory requirements (the additional improvements required as a matter of regulatory policy) in proportion to the extent of rehabilitation that an owner/developer chooses to do on a voluntary basis. For further information see HUD publication: Smart Codes in Your Community: A Guide to Building Rehabilitation Codes (http://www.huduser.org/publications/destech/smartcodes.html.)**	Yes
***9. Does your jurisdiction use a recent version (i.e. published within the last 5 years or, if no recent version has been published, the last version published) of one of the nationally recognized model building codes (i.e. the International Code Council (ICC), the Building Officials and Code Administrators International (BOCA), the Southern Building Code Congress International (SBCI), the International Conference of Building Officials (ICBO), the National Fire Protection Association (NFPA)) without significant technical amendment or modification.** **In the case of a tribe or TDHE, has a recent version of one of the model building codes as described above been adopted or, alternatively, has the tribe or TDHE adopted a building code that is substantially equivalent to one or more of the recognized model building codes?**	Yes
Alternatively, if a significant technical amendment has been made to the above model codes, can the jurisdiction supply supporting data that the amendments do not negatively impact affordability.	
***10. Does your jurisdiction's zoning ordinance or land use regulations permit manufactured (HUD-Code) housing "as of right" in all residential districts and zoning classifications in which similar site-built housing is permitted, subject to design, density, building size, foundation requirements, and other similar requirements applicable to other housing that will be deemed realty, irrespective of the method of production?**	Yes
***11. Within the past five years, has a jurisdiction official (i.e., chief executive, mayor, county chairman, city manager, administrator, or a tribally recognized official, etc.), the local legislative body, or planning commission, directly, or in partnership with major private or public stakeholders, convened or funded comprehensive studies, commissions, or hearings, or has the jurisdiction established a formal ongoing process, to review the rules, regulations, development standards, and processes of the jurisdiction to assess their impact on the supply of affordable housing?**	Yes
***12. Within the past five years, has the jurisdiction initiated major regulatory reforms either as a result of the above study or as a result of information identified in the barrier component of the jurisdiction's "HUD Consolidated Plan?" If yes, briefly describe. (Limit 2,000 characters.)**	Yes
The Annual Growth Policy (AGP) was revised four years ago to eliminate Policy Area Review and the imposition of moratoriums on housing development in certain Policy Areas due to lack of transportation or school capacity. The same revision imposed much higher County-wide impact taxes on new development but most, if not all, new assisted, subsidized, and inclusionary housing is exempt from paying the tax.	
***13. Within the past five years has your jurisdiction modified infrastructure standards and/or authorized the use of new infrastructure technologies (e.g. water, sewer, street width) to significantly reduce the cost of housing?**	No

Part A - Page 3

***14. Does your jurisdiction give "as-of-right" density bonuses sufficient to offset the cost of building below market units as an incentive for any market rate residential development that includes a portion of affordable housing?** **(As applied to density bonuses, "as of right" means a density bonus granted for a fixed percentage or number of additional market rate dwelling units in exchange for the provision of a fixed number or percentage of affordable dwelling units and without the use of discretion in determining the number of additional market rate units.)**	Yes
***15. Has your jurisdiction established a single, consolidated permit application process for housing development that includes building, zoning, engineering, environmental, and related permits?** **Alternatively, does your jurisdiction conduct concurrent, not sequential, reviews for all required permits and approvals?**	No
***16. Does your jurisdiction provide for expedited or "fast track" permitting and approvals for all affordable housing projects in your community?**	Yes
***17. Has your jurisdiction established time limits for government review and approval or disapproval of development permits in which failure to act, after the application is deemed complete, by the government within the designated time period, results in automatic approval?**	No
***18. Does your jurisdiction allow "accessory apartments" either as: a) a special exception or conditional use in all single-family residential zones or, b) "as of right" in a majority of residential districts otherwise zoned for single-family housing?**	Yes
***19. Does your jurisdiction have an explicit policy that adjusts or waives existing parking requirements for all affordable housing developments?**	Yes
***20. Does your jurisdiction require affordable housing projects to undergo public review or special hearings when the project is otherwise in full compliance with the zoning ordinance and other development regulations?**	No

Continuum of Care (CoC) Project Listing

Instructions:

To upload all Exhibit 2 applications that have been submitted to this CoC, click on the "Update List" button. This process may take several hours depending on the size of the CoC, however the CoC can either work on other parts of Exhibit 1 or it can log out of e-snaps and come back later to view the updated list. To rank a project, click on the icon next to each project to view project details.

For additional instructions, refer to the 2008 Project Listing Instructions on the left-hand menu bar.

EX1_Project_List_Status_field List Updated Successfully

Project Name	Date Submitted	Grant Term	Applicant Name	Budget Amount	Proj Type	Prog Type	Comp Type	Rank
Hope Housing	2009-11-02 17:44:...	1 Year	Montgomery County...	511,058	Renewal Project	SHP	PH	F
Carroll House	2009-11-20 09:32:...	1 Year	Interfaith Works	235,903	Renewal Project	SHP	TH	F
Wells/Robertson H...	2009-11-13 16:18:...	1 Year	Wells/Robertson H...	128,247	Renewal Project	SHP	TH	F
New Neighbors I	2009-11-09 14:19:...	1 Year	Housing Opportuni...	232,092	Renewal Project	S+C	SRA	U
Home First I	2009-11-03 09:10:...	1 Year	Montgomery County...	134,433	Renewal Project	SHP	PH	F
Supportive Housin...	2009-11-06 15:59:...	1 Year	National Center f...	640,658	Renewal Project	SHP	TH	F
Permanent Support...	2009-10-26 14:59:...	1 Year	Housing Opportuni...	1,188,244	Renewal Project	SHP	PH	F
Cordell	2009-11-03 11:37:...	2 Years	Montgomery County...	270,868	New Project	SHP	PH	P1
Permanent Support...	2009-11-11 15:43:...	1 Year	Housing Opportuni...	217,406	Renewal Project	SHP	PH	F
Safe Havens	2009-11-02 16:43:...	1 Year	Montgomery County...	826,569	Renewal Project	SHP	SH	F
Montgomery Avenue...	2009-11-10 12:20:...	1 Year	Montgomery Avenue...	138,183	Renewal Project	SHP	SSO	F
Permanent Support...	2009-10-26 14:51:...	1 Year	Housing Opportuni...	79,533	Renewal Project	SHP	PH	F

Shelter Plus Care	2009-11-09 13:46:...	1 Year	Housing Opportuni...	1,201,872	Renewal Project	S+C	TRA	U
Personal Living Q...	2009-11-02 17:16:...	1 Year	Montgomery County...	359,232	Renewal Project	SHP	PH	F
Home First II	2009-11-02 18:26:...	1 Year	Montgomery County...	131,260	Renewal Project	SHP	PH	F
Permanent Support...	2009-10-26 14:18:...	1 Year	Housing Opportuni...	1,119,532	Renewal Project	SHP	PH	F

Budget Summary

FPRN	$5,710,258
Permanent Housing Bonus	$270,868
SPC Renewal	$1,433,964
Rejected	$0

Attachments

Document Type	Required?	Document Description	Date Attached
Certification of Consistency with the Consolidated Plan	Yes	Certification of ...	11/10/2009

Attachment Details

Document Description: Certification of Consistency with the Consolidated Plan

KEY: Target Population A
CO: couples only, no children
HC: households with children
SF: single females
SFHC: single females and households with children
SM: single males
SMHC: single males and households with children
SMF: single males and females
SMF + HC: Single male and female plus households with children
YF: youth females (under 18 years old)
YM: youth males (under 18 years old)
YMF: youth males and females (under 18 years old)

KEY: Target Population B
DV - Domestic Violence victims only
VET - Veterans only
HIV - HIV/AIDS populations only

KEY: Inventory type
C: Current Inventory
N: New Inventory
U: Under development

Housing Inventory Chart: Emergency Shelter

Total Year-Round Beds - Household without Children	
1. Current Year-Round Emergency Shelter (ES) Beds for Households without Children	111
1A. Number of DV Year-Round ES Beds for Households without Children	6
1B. Subtotal, non-DV Year-Round ES Beds for Households without Children	105
2. New Year-Round ES Beds for Households without Children	0
3. Under Development Year-Round ES Beds for Households without Children	0
4. Total Year Round ES HMIS Beds for Households without Children	105
5. HMIS Bed Coverage: ES Beds for Households without Children	100%

Total Year-Round Beds - Households with Children	
6. Current Year-Round ES Beds for Households with Children	133
6A. Number of DV Year-Round ES Beds for Households with Children	48
6B. Subtotal, non-DV Year-Round ES Beds for Households with Children	85
7. New Year-Round ES Beds for Households with Children	0
8. Under Development Year-Round ES Beds for Households with Children	0
9. Total Year-Round ES HMIS Beds for Households with Children	85
10. HMIS Bed Coverage: ES Beds for Households with Children	100%

Housing Inventory Chart: Transitional Housing

Total Year-Round Beds - Household without Children	
1. Current Year-Round Transitional Housing (TH) Beds for Households without Children	156
1A. Number of DV Year-Round TH Beds for Households without Children	0
1B. Subtotal, non-DV Year-Round TH Beds for Households without Children	156
2. New Year-Round ES Beds for Households without Children	0
3. Under Development Year-Round TH Beds for Households without Children	0
4. Total Year Round TH HMIS Beds for Households without Children	156
5. HMIS Bed Coverage: TH Beds for Households without Children	100%

Total Year-Round Beds - Households with Children	
6. Current Year-Round TH Beds for Households with Children	195
6A. Number of DV Year-Round TH Beds for Households with Children	0
6B. Subtotal, non-DV Year-Round TH Beds for Households with Children	195
7. New Year-Round TH Beds for Households with Children	3
8. Under Development Year-Round TH Beds for Households with Children	0
9. Total Year-Round TH HMIS Beds for Households with Children	195
10. HMIS Bed Coverage: TH Beds for Households with Children	100%

Housing Inventory Chart: Safe Haven

Total Year-Round Beds - Household without Children	
1. Current Year-Round Safe Haven (SH) Beds for Households without Children	40
1A. Number of DV Year-Round SH Beds for Households without Children	0
1B. Subtotal, non-DV Year-Round SH Beds for Households without Children	40
2. New Year-Round ES Beds for Households without Children	0
3. Under Development Year-Round SH Beds for Households without Children	0
4. Total Year Round SH HMIS Beds for Households without Children	40
5. HMIS Bed Coverage: SH Beds for Households without Children	100%

Total Year-Round Beds - Households with Children	
6. Current Year-Round SH Beds for Households with Children	0
6A. Number of DV Year-Round SH Beds for Households with Children	0
6B. Subtotal, non-DV Year-Round SH Beds for Households with Children	0
7. New Year-Round SH Beds for Households with Children	0
8. Under Development Year-Round SH Beds for Households with Children	0
9. Total Year-Round SH HMIS Beds for Households with Children	0
10. HMIS Bed Coverage: SH Beds for Households with Children	

Housing Inventory Chart: Permanent Supportive Housing

Total Year-Round Beds - Household without Children	
1. Current Year-Round Permanent Housing (PH) Beds for Households without Children	369
1A. Number of DV Year-Round PH Beds for Households without Children	0
1B. Subtotal, non-DV Year-Round PH Beds for Households without Children	369
2. New Year-Round ES Beds for Households without Children	94
3. Under Development Year-Round PH Beds for Households without Children	157
4. Total Year Round PH HMIS Beds for Households without Children	364
5. HMIS Bed Coverage: PH Beds for Households without Children	99%

Total Year-Round Beds - Households with Children	
6. Current Year-Round PH Beds for Households with Children	754
6A. Number of DV Year-Round PH Beds for Households with Children	0
6B. Subtotal, non-DV Year-Round PH Beds for Households with Children	754
7. New Year-Round PH Beds for Households with Children	164
8. Under Development Year-Round PH Beds for Households with Children	348
9. Total Year-Round PH HMIS Beds for Households with Children	754
10. HMIS Bed Coverage: PH Beds for Households with Children	100%

Housing Inventory Chart: Unmet Need Totals

All Year-Round Beds/Units				**Seasonal Beds**	**Overflow Beds**
Beds for Households with Children	Units for Households with Children	Beds for Households without Children	Total Year-Round Beds	Total Seasonal Beds	Overflow Beds
Emergency Shelter					
0	0	0		0	0
Transitional Housing					
0	0	0			
Safe Haven					
0	0	0			
Permanent Supportive Housing					
446	132	837	1283		