**Lake County Coalition for the Homeless**

**Project Application for FY2017 Continuum of Care Funds**

**Transitional Housing Renewal**

Agency and Program Information:

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| --- | --- | --- | --- | --- | --- |
| 1. **Agency Name** |  | | | | |
| 1. **Program Name** |  | | | | |
| 1. **Subpopulation Focus (must choose one)** | 🞏 Domestic Violence  🞏 Substance Abuse  🞏 Youth (up to 24 years old) | | | No Score. Must choose one. Do not complete application, if you do not have a subpopulation focus. | |
| 1. **CoC Grant Amount FY2016** | $ | | | No Score | |
| 1. **Amount of Funding Unspent from last submitted APR** | $ | | | No Score – use to determine possible grant reduction depending on answer below | |
| **If applicable, please explain reason for unspent funds.** |  | | | | |
| 1. **Dates of draws in each quarter.**   **If not at least quarterly, please explain** | 1.  2.  3.  4. | | | Score = 1 point if at least quarterly | |
| **If applicable, please explain reason for lack of draws.** |  | | | | |
| 1. **Staff to Client Ratio** |  | | | No Score | |
| 1. **Is your agency a member of the Lake County Homeless Coalition in good standing?** |  | | Score 1 point if yes. | | |
| 1. **Which of the following committee(s) does your agency attend and what percentage of meetings did your agency attend in the last year?**  * **Community Outreach and Engagement** * **Project Performance and Monitoring** * **System Coordination and Entry** * **Homeless Management Information System**  1. **Strategic Planning and System Performance** |  | | Informational only. Could be scored in future applications. | | |
| 1. **What percentage of HMIS Agency Administrator meetings did your agency attend?** |  | | Score 1 point if greater than 60% | | |
| ***Possible Points for this Section =*** | | **3** | | |  |

Program Data from the Last Submitted Annual Performance Report (APR):

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| 1. **Total Number of Year-Round Beds/Units (APR question 5a)**  |  |  |  | | --- | --- | --- | |  | **Beds** | **Units** | | **Households Without Children** |  |  | | **Households With Children** |  |  | | **Total** |  |  | | No Score |
| 1. **HMIS Data Quality (APR question 7)**  | **Data Element** | **Don’t Know or Refused** | **Missing Data** | | --- | --- | --- | | First Name |  |  | | Last Name |  |  | | SSN |  |  | | Date of Birth |  |  | | Race |  |  | | Ethnicity |  |  | | Gender |  |  | | Veteran Status |  |  | | Disabling Condition |  |  | | Residence Prior to Entry |  |  | | Zip of Last Permanent Address |  |  | | Housing Status (at entry) |  |  | | Income (at entry) |  |  | | Income (at exit) |  |  | | Non-Cash Benefits (at entry) |  |  | | Non-Cash Benefits (at exit) |  |  | | Physical Disability (at entry) |  |  | | Developmental Disability (at entry) |  |  | | Chronic Health Condition (at entry) |  |  | | HIV/AIDS (at entry) |  |  | | Mental Health (at entry) |  |  | | Substance Abuse (at entry) |  |  | | Domestic Violence (at entry) |  |  | | Destination |  |  | | Score 1 point if ALL data elements have less than 10% Don’t Know or Refused.  Score 2 points if all data elements are 0% missing data. Score 1 point for 1% to 5% missing data. |
| 1. **Number of Persons in Households Served (APR Question 8)**  |  |  |  |  | | --- | --- | --- | --- | |  | **Total** | **Without Children** | **With Children and Adults** | | **Adults** |  |  |  | | **Children** |  |  |  | | **Total** |  |  |  | | No Score – Use for Comparison if needed for tied scores |
| 1. **Average Number of Persons Served Each Night (APR question 8)**  |  |  |  |  | | --- | --- | --- | --- | |  | **Total** | **Without Children** | **With Children and Adults** | | Average Number of Persons |  |  |  | | No Score – Use for Comparison |

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| 1. **Point in Time Bed or Unit Utilization Rate - Choose whichever best reflects true capacity for your program. (APR question 10 or 11)**  |  |  | | --- | --- | | **January** |  | | **April** |  | | **July** |  | | **October** |  | | Score = Overall Percentage |
| 1. **What is the percentage of the total number of people from the chosen subpopulation? (APR question 19a for domestic violence, question 16 for youth and question 18a for substance use disorders.)** | No score |
| 1. **Please list types of disabilities of participants served (APR question 18a)**  |  |  | | --- | --- | |  | **Total Persons** | | **Mental Illness** |  | | **Alcohol Abuse** |  | | **Drug Abuse** |  | | **Chronic Health Condition** |  | | **HIV/AIDS** |  | | **Developmental Disability** |  | | **Physical Disability** |  | | No score |
| 1. **Number of known conditions (APR question 18b)**  |  |  | | --- | --- | |  | **Total Persons** | | **None** |  | | **1 Condition** |  | | **2 Conditions** |  | | **3+ Conditions** |  | | **Total** |  | | No Score |

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| 1. **Income changes of participants who exited (Chart 24b2 from APR)**  |  |  |  |  | | --- | --- | --- | --- | |  | **Total Adults** | **Adults who Increased Income** | **Percentage Adults who Increased Income** | | **Number of Adults with Earned Income** |  |  |  | | **Number of Adults with Other Income** |  |  |  | | **Number of Adults with Any Income** |  |  |  | | Score = Percentage in last column |
| 1. **Number of Non-Cash Benefits by Exit Status – Leavers (APR Question 26a2)**  |  |  | | --- | --- | | **No Sources** |  | | **1+ Sources** |  | | **TOTAL** |  | | **% of Total with 1+ Sources** |  | | Score = Percentage in bottom row |
| 1. **Length of Participation for LEAVERS (APR Question 27)**  |  |  | | --- | --- | | **30 days or less** |  | | **31 to 60 days** |  | | **61 to 180 days** |  | | **181 to 365 days** |  | | **366 to 730 days (1-2 years)** |  | | **More than 2 years** |  | | **Information Missing** |  | | **TOTAL** |  | | No score. |

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| 1. **Percentage exited to Permanent Destinations (APR Question 36b)**  |  |  | | --- | --- | | **Actual # of persons served** |  | | **Actual # of person who accomplished this measures** |  | | **Actual % of persons who accomplished the measure** |  | | Score = Percentage multiplied by 3 | |
| 1. **Percentage of Households Returned to Homelessness (ServicePoint 701 Report for 6/1/15 – 5/31/17)**  |  |  | | --- | --- | | **Total Persons Exited to Permanent Housing** |  | | **% Returns within 6 months after Exit** |  | | Score = One minus the percentage | |
| **Comments, if needed. Please reference question number:** |
|  | | |
| ***Possible Points for this Section =*** | 10 |  | |

Program Design Questions and Policies: *Please answer the following questions in the space provided.*

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| --- | --- |
| 1. Does your program have Sobriety Requirements? If so, please explain. (Score 1 if no) | |
|  | |
| 1. Does your program have income requirements? If so, please explain. (Score 1 if no.) | |
| 1. Agency licensed or certified for subpopulation specific services, e.g., DASA, DMH, Joint Commission, CARF, etc. (Score 1 if yes) 🞏 Yes 🞏No | |
| 1. At least one staff member at agency is licensed or holds certification (Score 1 if yes)   🞏 Yes 🞏No | |
| 1. At least 50% of program staff hold degrees or certification in the subpopulation area or related field. (Score = 1 if yes) 🞏 Yes 🞏No | |
| 1. Current trainings specific to subpopulation are provided by agency or attended by program staff at least annually. (Score = 1 if yes) 🞏 Yes 🞏No | |
| 1. At least one member of subpopulation serves in a policy influencing position, e.g., agency board, advisory group, or staff member. \*Please provide membership list or indicate staff member. (Score = 1 if yes) 🞏 Yes 🞏No | |
| 1. Describe how your program connects clients to mainstream resources such as Medicaid, ACA, SNAP, Housing Authorities, Energy Assistance, etc. (Score 1 point for clearly defined plan, 1 point for a Policy and 1 point for an assessment form.) | |
|  | |
| 1. Please indicate what specific supportive services and/or training your agency or a partner agency provides to prepare participants to successfully live independently: (Score 3 points if 10 or more, 2 if 3 -9, 1 if less than 3.)   **Service Agency Provides Partner Provides Not Provided**  Assessment of Service Needs  Assistance with Moving Costs  Case Management  Child Care  Education Services  Employment Assistance and Job Training  Financial Management or Skills Training  Food  HIV/AIDS Services  Housing Search and Counseling Services  Legal Services  Life Skills Training  Mental Health Services  Outpatient Health Services  Outreach Services  Parenting Skills  Substance Abuse Treatment Services  Transportation  Utility Deposits | |
| ***Maximum Points for this Section =*** | **13** |
| Funding Impact | |
| 1. What percentage of this program is funded through the CoC grant? Please state additional resources or funding sources (public or private) that are utilized to maintain and sustain this program. Attach another sheet if needed. (Score 2 points if 25% or less HUD-funded. 1 point of 26-75% HUD funded and .5 point if greater than 75% HUD funded.) | |
|  | |
| 1. Please describe any changes you have implemented during the past year regarding population served, capacity served, or similar programmatic changes? (No score.) | |
|  | |
| 1. Please provide any other information that is important and useful for the funding allocation workgroup to know when making decisions about your program and/or funding. (No score.) | |
|  | |
| ***Possible Points for this Section =*** | **2** |
| 1. Please provide a copy of the following or a clear explanation of why you don’t have one.   Please label each item in the top right corner with the corresponding letter. (Score 3 points for all submitted on time. 0 points for a missing or late submission.) | |
| 1. Tenant Selection or Program Eligibility Criteria 2. Client Grievance Procedures and Appeal Process 3. Involuntary Termination of Services Policy or Procedure 4. Equal Housing / Non-Discrimination Policy or Procedure related to gender and family composition 5. Any Policy or Procedure that shows your program’s adoption of Harm Reduction Service Philosophies. 6. Your Program Budget 7. Program Organizational Chart 8. Any other policies, procedures or forms that describe your program or your program’s outcomes | |
| ***Possible Points for this Section =*** | **3** |

By signing below I attest the information above is accurate. I understand that the information on this form will be utilized to make funding decisions and that completing and submitting this form is no guarantee that funding for this program will remain at its current level for the coming fiscal year.

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| Signature of Authorizing Agent |  | Date |
|  |  |  |
| Name |  | Title |

Contact Person for Questions Regarding this Application:

|  |  |
| --- | --- |
| Name and Title: |  |
| Phone Number: |  |
| Email: |  |

*Completed applications with attachments should be submitted electronically to* [*boconnell@lakecountyil.gov*](mailto:boconnell@lakecountyil.gov) *no later than 5PM on Friday, June 30.*