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.

CoC Name and Number (From CoC Registration): CT-507 - Norwich/New London City & County CoC

CoC Lead Organization Name: Thames River Community Service Inc.

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

Instructions:

The following questions pertain to the primary decision-making group. The primary responsibility of this group is to manage the overall planning effort for the CoC, including, but not limited to, the following types of activities: setting agendas for full Continuum of Care meetings, project monitoring, determining project priorities, and 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: Steering Committee

Indicate the frequency of group meetings: Monthly or more

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) 83%

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

Elected:	
Assigned:	
Volunteer:	X
Appointed:	
Other:	

Specify "other" process(es):

Briefly describe the selection process including why this process was established and how it works.

As a result of a strong history of collaborative efforts throughout our region, a core group of CoC members evolved. This core group ensures that there is representation from a wide cross section of private and public sectors as well as individuals invested in ending homelessness in our region. This procedure was established to ensure an all inclusive process.

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

Elected:	X
Assigned:	
Volunteer:	
Appointed:	
Other:	

Specify "other" process(es):

If HUD could provide administrative funds 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 the grantee, providing project oversight, and monitoring? Explain.

Yes. However, present non-profit HUD grantees and State of CT Department Mental Health and Addiction Services could not do this because of conflicts of interest. An independent administrator would have to be hired to carry out these duties. Additional funds of approximately $210,000.00 would be needed for such items as, but not limited to, hire a full-time administrator, clerical staff, equipment, rent, supplies and utilities.

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

List the name and role of each CoC planning committee. To add committees to this list, click on the icon and enter requested information.

Name	Meeting Frequency
The Ten Year Plan...	Monthly or more
Employment and In...	Quarterly
Community Care Te...	Monthly or more
Ten Year Plan Hou...	Quarterly
HMIS Committee	Quarterly
HUD Grant Work Group	Monthly or more
Homeless Outreach...	Quarterly
Project Homeless ...	Bi-monthly
Point in Time Cou...	Bi-monthly
Family Strengthen...	Monthly or more
Scoring and Ranki...	Quarterly

Continuum of Care (CoC) Committees, Subcommittees and Work Groups Detail

Provide information on each established committee that is part of the CoC organizational structure and involved in the planning process.

Name of Committee/Sub-Committee/Work Group: The Ten Year Plan To End Homelessness Implementation Committee

Indicate the frequency of group meetings: Monthly or more

Describe the role of this group:

Monitors and oversees implementation of goals set forth in regional ten year plan to end homelessness. Assists with identifying champions, who can eliminate and/or minimize barriers to achieve goals.

Continuum of Care (CoC) Committees, Subcommittees and Work Groups Detail

Provide information on each established committee that is part of the CoC organizational structure and involved in the planning process.

Name of Committee/Sub-Committee/Work Group: Employment and Income Ten Year Plan Committee

Indicate the frequency of group meetings: Quarterly

Describe the role of this group:

Works collaboratively to improve access to employment and/or benefits for homeless individuals and families by streamlining regional employment services, increasing success of application for social security benefits, and mitigating barriers to gaining and maintaining employment.

Continuum of Care (CoC) Committees, Subcommittees and Work Groups Detail

Provide information on each established committee that is part of the CoC organizational structure and involved in the planning process.

Name of Committee/Sub-Committee/Work Group: Community Care Teams (Norwich and New London)

Indicate the frequency of group meetings: Monthly or more

Describe the role of this group:

Meets weekly to review referrals and create care plans to assist homeless individuals and families.
Meets monthly to ensure services offered to homeless persons are streamlined and seamless. Both community care teams act as a safety net and enforce a no wrong door policy so that homeless persons have easy access to services.

Continuum of Care (CoC) Committees, Subcommittees and Work Groups Detail

Provide information on each established committee that is part of the CoC organizational structure and involved in the planning process.

Name of Committee/Sub-Committee/Work Group: Ten Year Plan Housing Committee

Indicate the frequency of group meetings: Quarterly

Describe the role of this group:

Works collaboratively to explore ways to expand supportive housing units throughout the region for both the homeless and chronically homeless populations.

Continuum of Care (CoC) Committees, Subcommittees and Work Groups Detail

Provide information on each established committee that is part of the CoC organizational structure and involved in the planning process.

Name of Committee/Sub-Committee/Work Group: HMIS Committee

Indicate the frequency of group meetings: Quarterly

Describe the role of this group:

Ensures participation in HMIS by mandated and voluntary programs. Works with statewide committee to monitor quality of data entry; reports all HMIS related issues and matters to CoC Steering Committee.

Continuum of Care (CoC) Committees, Subcommittees and Work Groups Detail

Provide information on each established committee that is part of the CoC organizational structure and involved in the planning process.

Name of Committee/Sub-Committee/Work Group: HUD Grant Work Group

Indicate the frequency of group meetings: Monthly or more

Describe the role of this group:

Works collaboratively to complete and submit local CoC Exhibit One and Exhibit Two applications.

Continuum of Care (CoC) Committees, Subcommittees and Work Groups Detail

Provide information on each established committee that is part of the CoC organizational structure and involved in the planning process.

Name of Committee/Sub-Committee/Work Group: Homeless Outreach Work Group

Indicate the frequency of group meetings: Quarterly

Describe the role of this group:

Works to provide opportunities for homeless outreach providers to network, share resources, and maximize outreach engagement efforts on a regional basis to people who are homeless.

Continuum of Care (CoC) Committees, Subcommittees and Work Groups Detail

Provide information on each established committee that is part of the CoC organizational structure and involved in the planning process.

Name of Committee/Sub-Committee/Work Group: Project Homeless Connect

Indicate the frequency of group meetings: Bi-monthly

Describe the role of this group:

This group coordinates and conducts an annual event that is held in the City of Norwich and City of New London. The event provides extensive resources and services to people who are homeless throughout our region. For example, resources and services offered include:

Housing Services
Employment and Income Services
Behavioral Health and Human Services
Medical Services
Legal Services
Transportation Resources
Mainstream Resources
Free Hair Cuts, Bicycle Repairs, Food and Clothing Vouchers

This event receives wide media coverage and includes the support and participation of politicians, small businesses, faith based organizations and general public. The event raises awareness and encourages communities to become invested in ending homelessness.

Continuum of Care (CoC) Committees, Subcommittees and Work Groups Detail

Provide information on each established committee that is part of the CoC organizational structure and involved in the planning process.

Name of Committee/Sub-Committee/Work Group: Point in Time Count Work Group

Indicate the frequency of group meetings: Bi-monthly

Describe the role of this group:

Works to organize and conduct Point in Time Count for our region, in cooperation with the University of Pennsylvania, Statewide Point in Time organizers, local law enforcement, homeless outreach, emergency shelters, transitional and permanent housing providers.

This event is successful in recruiting community stakeholders such as local politicians, small business owners, and private citizens throughout our community. These individuals volunteer in this effort to capture the volume of people who are homeless in our region.

Continuum of Care (CoC) Committees, Subcommittees and Work Groups Detail

Provide information on each established committee that is part of the CoC organizational structure and involved in the planning process.

Name of Committee/Sub-Committee/Work Group: Family Strengthening Work Group

Indicate the frequency of group meetings: Monthly or more

Describe the role of this group:

A collaboration of programs primarily focused on the prevention of family homelessness.

Continuum of Care (CoC) Committees, Subcommittees and Work Groups Detail

Provide information on each established committee that is part of the CoC organizational structure and involved in the planning process.

Name of Committee/Sub-Committee/Work Group: Scoring and Ranking Work Group

Indicate the frequency of group meetings: Quarterly

Describe the role of this group:

The Scoring and Ranking work group evaluates, reviews, and prioritizes all HUD McKinney-Vento funded programs within the continuum.

1D. Continuum of Care (CoC) Member Organizations

Identify all organizations involved in the CoC planning process. To add an organization to this list, click on the icon.

Organization Name	Membership Type	Organization Type	Organization Role	Subpopulations
Connecticut State Police	Public Sector	Law enf...	Committee/Sub-committee/Work Group	NONE
Department of Corrections	Public Sector	Law enf...	Committee/Sub-committee/Work Group	NONE
Groton Police Department	Public Sector	Law enf...	Committee/Sub-committee/Work Group	NONE
New London Police Department	Public Sector	Law enf...	Committee/Sub-committee/Work Group	NONE
Norwich Police Department	Public Sector	Law enf...	Committee/Sub-committee/Work Group	NONE
Eastern Connecticut Workforce Investment Board	Public Sector	Local w...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE
Southeast Area Transit	Public Sector	Other	Committee/Sub-committee/Work Group	NONE
Southeast Council of Governments	Public Sector	Local g...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE
Eastern Connecticut Transportation Consortium	Public Sector	Other	Committee/Sub-committee/Work Group	NONE
Veterans Administration	Public Sector	Other	Committee/Sub-committee/Work Group, Attend 10-year planni...	Veterans
Alliance for Living	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	HIV/AIDS
Backus Hospital	Private Sector	Hospita...	Committee/Sub-committee/Work Group	NONE
Lawrence and Memorial Hospital	Private Sector	Hospita...	Committee/Sub-committee/Work Group	NONE
Child and Family Agency	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Youth
Connecticut Citizens for Addiction & Recovery	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Substance Abuse
Covenant Shelter	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE
Disabilities Network of Eastern Connecticut	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Seriously Me...

Eastern Regional Service Center	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Seriously Me...
Eastern Regional Mental Health Board	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Seriously Me...
Madonna Place	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Domestic Vio...
Mystic Area Shelter and Hospitality	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE
Malta	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Martin House	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Seriously Me...
New London Homeless Coalition	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Seriously Me...
New London Community Meal Center	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Bethsaida Community Inc.	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE
New London Homeless Hospitality Center	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	Seriously Me...
Reliance House	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	Seriously Me...
SCADD	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Substance Abuse
Sound Community Services, Inc.	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	Seriously Me...
Thames River Community Service Inc.	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE
Thames Valley Council for Community Action	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE
The Connection, Inc.	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	Substance Abuse
Veteran's Center	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	Veterans
Women's Center of Southeastern Connecticut, Inc.	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	Domestic Vio...

211	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Niantic Community Church	Private Sector	Faith -b...	Committee/Sub-committee/Work Group	NONE
Catholic Charities	Private Sector	Faith -b...	Committee/Sub-committee/Work Group	NONE
All Souls Unitarian Congregation	Private Sector	Faith -b...	Committee/Sub-committee/Work Group	NONE
Diocese of Norwich	Private Sector	Faith -b...	Committee/Sub-committee/Work Group	NONE
Salvation Army	Private Sector	Faith -b...	Committee/Sub-committee/Work Group	NONE
Shiloh Baptist Development Corporation	Private Sector	Faith -b...	Committee/Sub-committee/Work Group	NONE
St. Frances House	Private Sector	Faith -b...	Committee/Sub-committee/Work Group	NONE
St. James Episcopal Church	Private Sector	Faith -b...	Committee/Sub-committee/Work Group	NONE
St. Luke Lutheran Church	Private Sector	Faith -b...	Committee/Sub-committee/Work Group	NONE
St. Patrick Cathedral	Private Sector	Faith -b...	Committee/Sub-committee/Work Group	NONE
St. Vincent DePaul Soup Kitchen	Private Sector	Faith -b...	Committee/Sub-committee/Work Group	NONE
Electric Boat Service Association	Private Sector	Fun der ...	None	NONE
Center for Urban Community Services	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Connecticut Coalition to End Homelessness	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE
Connecticut Coalition Against Domestic Violence	Private Sector	Non-pro...	None	Domestic Vio...
Connecticut Housing Coalition	Private Sector	Non-pro...	None	NONE
Corporation for Supportive Housing	Private Sector	Non-pro...	None, Attend 10-year planning meetings during past 12 months	NONE
National Alliance on Mental Illness	Private Sector	Non-pro...	None	NONE
Partnership for Strong Communities	Private Sector	Non-pro...	None	NONE
United Way of Southeastern Connecticut	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE

Bank of America	Private Sector	Fun der ...	None	NONE
Citizens Bank Foundation	Private Sector	Fun der ...	None	NONE
Community Foundation of Southeastern Connecticut	Private Sector	Non- pro.. .	None	NONE
Dime Bank Foundation	Private Sector	Fun der ...	None	NONE
Eastern Federal Bank Foundation	Private Sector	Fun der ...	None	NONE
Liberty Bank Foundation	Private Sector	Fun der ...	None	NONE
People's United Bank	Private Sector	Fun der ...	None	NONE
Community Foundation of the Tri-County Area	Private Sector	Fun der ...	None	NONE
Pfizer Foundation	Private Sector	Fun der ...	None	NONE
Big Y World Class Market	Private Sector	Busi ness es	None	NONE
Bob's Furniture	Private Sector	Busi ness es	None	NONE
Gorin's Furniture	Private Sector	Busi ness es	None	NONE
Leader Store	Private Sector	Busi ness es	None	NONE
Mashantucket Pequot Tribal Nation	Private Sector	Fun der ...	None	NONE
Mohegan Tribal Nation	Private Sector	Fun der ...	None	NONE
Shop Rite Super Market	Private Sector	Busi ness es	None	NONE
Stop & Shop Super Market	Private Sector	Busi ness es	None	NONE
Community Health Center	Private Sector	Non- pro.. .	Committee/Sub-committee/Work Group	NONE

Generations	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Hospice of Southeastern Connecticut	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
United Community and Family Services	Private Sector	Non-pro...	Committee/Sub-committee/Work Group	NONE
Visiting Nurses Association of Southeastern Con...	Private Sector	Non-pro...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE
Homeless Person # 1	Individual	Homeles...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE
Homeless Person # 2	Individual	Homeles...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE

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

The CoC should solicit and select projects in a fair and impartial manner. For each of the following sections, select the appropriate items that indicate all of the methods and processes the CoC used in the past year to assess all new and renewal projects performance, effectiveness, and quality.

Open Solicitation Methods: (select all that apply)	a. Newspapers, b. Letters/Emails to CoC Membership, c. Responsive to Public Inquiries, d. Outreach to Faith-Based Groups, e. Announcements at CoC Meetings, f. Announcements at Other Meetings
Rating and Performance Assessment Measure(s): (select all that apply)	a. CoC Rating & Review Commitee Exists, b. Review CoC Monitoring Findings, c. Review HUD Monitoring Findings, d. Review Independent Audit, e. Review HUD APR for Performance Results, f. Review Unexecuted Grants, g. Site Visit(s), h. Survey Clients, i. Evaluate Project Readiness, j. Assess Spending (fast or slow), k. Assess Cost Effectiveness, l. Assess Provider Organization Experience, m. Assess Provider Organization Capacity, n. Evaluate Project Presentation, o. Review CoC Membership Involvement, p. Review Match, q. Review All Leveraging Letters (to ensure that they meet HUD requirements), r. Review HMIS participation status
Voting/Decision Method(s): (select all that apply)	a. Unbiased Panel/Review Commitee, b. Consumer Representative Has a Vote, c. All CoC Members Present Can Vote, f. Voting Members Abstain if Conflict of Interest

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

For each housing type, indicate if there was an increase or reduction in the total number of beds in the 2008 electronic Housing Inventory Chart (e-HIC) as compared to the 2007 Housing Inventory Chart. If there was a change, please describe the reasons in the space provided for each housing type.

Emergency Shelter: Yes

Briefly describe the reasons for the change:

The WARM Shelter was in our HIC for 2007, however in 2008 we have removed it from our HIC due to the fact that it is in Rhode Island. Being sensitive to the duplication of numbers, Rhode Island will include the WARM shelter in their HIC.

Safe Haven Bed: No

Briefly describe the reasons for the change:

Transitional Housing: No

Briefly describe the reasons for the change:

Permanent Housing: Yes

Briefly describe the reasons for the change, including changes in beds designated for chronically homeless persons:

The following new supportive housing was created in 2008:
The Connection Inc. 20 beds
Reliance House Next Steps Initiative 14 beds
TVCCA Next Steps Initiative 9 beds
Alliance For Living 4 beds
Thames River Community Service 30 beds

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

Document Type	Required?	Document Description	Date Attached
Housing Inventory Chart	Yes	Housing Inventory...	10/14/2008

Attachment Details

Document Description: Housing Inventory Chart

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

Instructions:

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

Complete the following information based on data collection methods and reporting for the electronic Housing Inventory Chart (e-HIC), including Unmet need determination. The date on which the bed inventory was completed should be one day during the last ten days of January 2008.

Indicate the date on which the housing inventory count was completed: (mm/dd/yyyy)	01/30/2008
Indicate the type of data or methods used to complete the housing inventory count: (select all that apply)	Housing inventory survey
Indicate the steps taken to ensure data accuracy for the Housing Inventory Chart: (select all that apply)	Instructions, Training, Updated prior housing inventory information, Follow-up, Confirmation

Must specify other:

Indicate the type of data or method(s) used to determine unmet need: (select all that apply)	Stakeholder discussion, Local studies or non-HMIS data sources, Applied statistics, HUD unmet need formula, Unsheltered count, Housing inventory, National studies or data sources, Provider opinion through discussion or survey forms

Specify "other" data types:

If more than one method was selected, describe how these methods were used.

Key community stakeholders reviewed data and determined where adjustments were necessary (based on local information) in determining unmet needs. University of Pennsylvania extrapolated local data from state-wide PIT count and applied acceptable formula in providing/projecting a final unsheltered count locally. HUD formula was used in conjunction with methods to determine the unmet need.

2A. Homeless Management Information System (HMIS) Implementation

Intructions:

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

CoCs should complete the following information in conjunction with the HMIS Lead Agency. All information is to be as of the date this application is submitted.

Select the HMIS implementation type: Statewide

Select the CoC(s) covered by the HMIS: (select all that apply) CT-500 - Danbury CoC, CT-502 - Hartford CoC, CT-503 - Bridgeport/Stratford/Fairfield CoC, CT-504 - Middletown/Middlesex County CoC, CT-505 - Connecticut Balance of State CoC, CT-506 - Norwalk/Fairfield County CoC, CT-507 - Norwich/New London City & County CoC, CT-508 - Stamford/Greenwich CoC, CT-509 - New Britain CoC, CT-510 - Bristol CoC, CT-512 - City of Waterbury CoC

Does the CoC Lead Organization have a written agreement with HMIS Lead Organization? Yes

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? No

Has the CoC selected an HMIS software product? Yes

If "No" select reason:

If "Yes" list the name of the product: Service Point

What is the name of the HMIS software company? Bowman

Does the CoC plan to change HMIS software within the next 18 months? No

Is this an actual or anticipated HMIS data entry start date? Actual Data Entry Start Date

Indicate the date on which HMIS data entry started (or will start): (format mm/dd/yyyy) 05/01/2004

Indicate the challenges and barriers impacting the HMIS implementation: (select all the apply): Inadequate staffing, Inadequate resources, No or low participation by non-HUD funded providers

If "None" was selected, briefly describe why CoC had no challenges or how all barriers were overcome:

Briefly describe the CoC's plans to overcome challenges and barriers:

Recognizing that all agencies are facing challenges due to fiscal reductions beyond our control, the CoC is committed to working with participating agencies and staff to look for creative solutions to ensure the full implementation of HMIS.

HMIS Attachment

Document Type	Required?	Document Description	Date Attached
HMIS Agreement	Yes	HMIS Agreement	10/14/2008

Attachment Details

Document Description: HMIS Agreement

CONNECTICUT COALITION TO END HOMELESSNESS

www.cceh.org

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WETHERSFIELD, CONNECTICUT 06109
(860) 721-7876 FAX (860) 257-1148

Memorandum of Understanding Signature Page
CCEH- HMIS Project and Participating Agencies

Effective January 2006

By signing below I agree to the stipulations of this Memorandum of Understanding, and agree that my agency will abide by the <u>CT HMIS Policies and Procedures Manual</u>.

Executive Director of CT Coalition to End Homelessness

Signature Mary McAtee Date 1/11/06

Print Name and Title Mary McAtee Exec. Dir.

Executive Director of Participating Agency

Executive Director's Signature [signature] Date 1-5-06

Print Name and Title Thomas J. Hyland Executive Director

Name of Agency Thames River Community Service Inc.

Mailing Address One Thames River Place, Norwich CT 06360

Agency Programs Covered by MOU

Thames River Family Program

Name of Site Technical Coordinator Kathy Allen

<u>Please provide the following for CCEH-HMIS records</u>

Two originals of this form mailed to CCEH for Executive Director's signature, one of which will be returned to agency for its records

One copy of this form to the local Systems Administrator, if applicable

One copy of this form to local Continuum of Care CCEH-HMIS Steering Committee member

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Memorandum of Understanding
CCEH- HMIS Project and Participating Agencies
Effective October 2004

The CT Coalition to End Homelessness will:

- Oversee and coordinate all aspects of the HMIS Project's Implementation;
- Oversee systems administration especially as it relates to external security protocols;
- Serve as the sole contact with Bowman Internet Systems;
- Oversee and coordinate the activities of the local systems administrators;
- Provide support to and function as a resource to the local systems administrators.

Agencies Participating in the CCEH-HMIS Project will appoint one person to serve as the site technical coordinator for the agency. This person will:

- Oversee all agency staff who have access to or generate client level data;
- Permit only those staff who are certified by CCEH or the local systems administrator to use ServicePoint and authorize as ServicePoint Users only those staff who need access to the system for data entry, editing of client records, viewing of client records, report writing, administration or other essential activities related to the use of ServicePoint;
- Ensure that each user has his/her own ServicePoint license;
- Inform all users at their agency of the following:

"Users are any persons who use the Service Point software for data processing services. They must be aware of the data's sensitivity and take appropriate measures to prevent unauthorized disclosure. Users are responsible for protecting institutional information to which they have access and for reporting security violations. Users must comply with the policies and standards of the agency as they relate to security and confidentiality of the data. Users are legally accountable for their actions and for any actions undertaken with their usernames and passwords." CCEH – HMIS Policy

- Assume responsibility for the integrity and protection of client-level data entered at their site;
- Ensure to the extent possible that all data is entered accurately and on time;
- Notify CCEH of changes in license assignments;
- Maintain agency computer equipment and access to the internet.

The Local Systems Administrator* will:

- Serve as a liaison/primary contact between end-users and CCEH on all issues related to technology;
- Provide training and technical assistance to end-users;
- Certify ServicePoint users upon satisfactory completion of an introductory training for end-users;

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- Oversee use of ServicePoint and be available for troubleshooting and phone support on an agreed upon schedule;
- Assign licenses to each CCEH certified user;
- Set up and manage user accounts, access levels and passwords for each participating agency;
- Assist participating agencies to understand security requirements as they relate to unattended workstations, physical access to work stations, policy on user account sharing.

*Each Continuum is strongly encouraged to identify at least one person (either paid or volunteer) to serve as the local Systems Administrator. The person identified for this role should be experienced in working with database software. The CCEH Systems Administrator will assist local Systems Administrators to complete their responsibilities.

I agree to the items stated in this memo of understanding.

For the CT Coalition to End Homelessness

Signature Mary McAtee Date 11/02/04

Print Name and Title MARY MCATEE Exec. Dir.

For the Agency Participating in the CCEH-HMIS Project

Executive Director's Signature [signature] Date 10/26/04

Print Name and Title Thomas J. Hyland

Name of Agency Thames River Community Service, Inc.

Mailing Address: One Thames River Place, Norwich, CT 06360

Name of Site Technical Coordinator: Kathy W. Allen

For the Local Systems Administrator

Signature __________ Date ______

Print Name __________

Please provide the following for CCEH-HMIS records
One original of this form to CCEH
One original of this form kept by agency
One copy of this form to the local Systems Administrator
One copy of this form to local continuum of care CCEH-HMIS Steering Committee member

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- Assign licenses to each CCEH certified user;
- Set up and manage user accounts, access levels and passwords for each participating agency;
- Assist participating agencies to understand security requirements as they relate to unattended workstations, physical access to work stations, policy on user account sharing.

*Each Continuum is strongly encouraged to identify at least one person (either paid or volunteer) to serve as the local Systems Administrator. The person identified for this role should be experienced in working with database software. The CCEH Systems Administrator will assist local Systems Administrators to complete their responsibilities.

I agree to the items stated in this memo of understanding.

For the CT Coalition to End Homelessness

Signature [signature] Date 11/02/04

Print Name and Title MARY McATEE Exec. Dir.

For the Agency Participating in the CCEH-HMIS Project

Executive Director's Signature [signature] Date 10/26/04

Print Name and Title Thomas J. Hyland, Executive Director

Name of Agency Thames River Community Service, Inc.

Mailing Address: One Thames River Place, Norwich, CT 06360

Name of Site Technical Coordinator: Kathy W. Allen.

For the Local Systems Administrator

Signature ______________________ Date __________

Print Name __________

ase provide the following for CCEH-HMIS records

One original of this form to CCEH
One original of this form kept by agency
One copy of this form to the local Systems Administrator
One copy of this form to local continuum of care CCEH-HMIS Steering Committee member

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

Enter the name and contact information for the HMIS Lead Organization.

Organization Name	Connecticut Coalition to End Homelessness
Street Address 1	Ste 4
Street Address 2	77 Buckingham Street
City	Hartford
State	Connecticut
Zip Code **Format: xxxxx or xxxxx-xxxx**	06106-1710
Organization Type	Non-Profit
If "Other" please specify	

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

Prefix:	Ms
First Name	Natalie
Middle Name/Initial	
Last Name	Matthews
Suffix	
Telephone Number: (Format: 123-456-7890)	860-721-7876
Extension	102
Fax Number: (Format: 123-456-7890)	860-257-1148
E-mail Address:	nmatthews@cceh.org
Confirm E-mail Address:	nmatthews@cceh.org

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

Instructions:

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.

For each housing type, indicate the percentage of the CoC's total beds (bed coverage) in the HMIS.

* Emergency Shelter (ES) Beds	76-85%
* Safe Haven (SH) Beds	No beds in CoC
* Transitional Housing (TH) Beds	76-85%
* Permanent Housing (PH) Beds	76-85%

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:

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 2008.

Universal Data Element	Records with no values (%)	Records where value is refused or unknown (%)
* Social Security Number	5%	22%
* Date of Birth	6%	0%
* Ethnicity	15%	0%
* Race	13%	0%
* Gender	3%	0%
* Veteran Status	30%	1%
* Disabling Condition	39%	4%
* Residence Prior to Program Entry	37%	1%
* Zip Code of Last Permanent Address	40%	23%
* Name	0%	0%

Did the CoC or subset of the CoC participate in AHAR 3? No

Did the CoC or subset of the CoC participate in AHAR 4? No

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 participating agencies.

Training is available for new HMIS users, as well as on and off-sight technical support and assistance for existing users.

Describe the existing policies and procedures used to ensure that valid program entry and exit dates are recorded in the HMIS.

Quality assurance policies require that HMIS data be reviewed quarterly during a CoC meeting. Additionally individual programs are asked to review and confirm their data numbers. Information is affirmed if correct. If any numbers need to be corrected, the local HMIS liaison will contact the state HMIS coordinator. All users are provided with the Connecticut HMIS Policies and Procedures handbook.

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

Instructions:

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

Indicate the frequency in which the CoC uses each of the following items:

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

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

Instructions:

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

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

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

How often does the CoC assess compliance with HMIS Data and Technical Standards?	Quarterly
How often does the CoC aggregate data to a central location (HMIS database or analytical database)?	Never
Does the CoC have an HMIS Policy and Procedures manual?	Yes
If 'Yes' indicate date of last review or update by CoC:	04/07/2008
If 'No' indicate when development of manual will be completed:	

2H. Homeless Management Information System (HMIS) Training

Instructions:

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

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

Privacy/Ethics training	Monthly
Data Security training	Monthly
Data Quality training	Monthly
Using HMIS data locally	Annually
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. HUD requires CoCs to conduct a point-in-time count at least every two years during the last 10 days of January - January 22nd to 31st - and requests that CoCs conduct a count annually if resources allow. The last required count was in January 2007. Data entered in this chart must reflect a point-in-time count that took place during the last 10 days of January in 2007 or 2008, unless a waiver was received by HUD.

There are six (6) categories of homeless populations on this form. They are:

Households with Dependent Children - Sheltered Emergency
Households with Dependent Children - Sheltered Transitional
Households with Dependent Children - Unsheltered

Households without Dependent Children - Sheltered Emergency
Households without Dependent Children - Sheltered Transitional
Households without Dependent Children - Unsheltered

For each category, the number of households must be less than or equal to the number of persons. For example, in Households with Dependent Children - Sheltered Emergency, the number entered for ?Number of Households? must be less than or equal to the number entered for ?Number of Persons (adults with children).?

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

Indicate the date of the last PIT count: 01/30/2008

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	25	29	0	54
Number of Persons (adults and children)	73	84	0	157

	Households without	Dependent Children		
	Sheltered		Unsheltered	Total
	Emergency	Transitional		
Number of Households	108	23	16	147
Number of Persons (adults and unaccompanied youth)	108	23	16	147

	All Households/	All Persons		
	Sheltered		Unsheltered	Total
	Emergency	Transitional		
Total Households	133	52	16	201

Total Persons	181	107	16	304

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 data from a point-in-time count conducted during the last ten days of January 2007 or January 2008. 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.

Complete the following information for the most recent point-in-time (PIT) count conducted using statistically reliable, unduplicated counts or estimates of homeless persons. Completion of the "Unsheltered" column is optional for all subpopulations, except for Chronically Homeless.

	Sheltered	Unsheltered	Total
* Chronically Homeless (Federal definition)	37	7	44
* Severely Mentally Ill	68	0	68
* Chronic Substance Abuse	71	0	71
* Veterans	15	0	15
* Persons with HIV/AIDS	2	0	2
* Victims of Domestic Violence	25	0	25
* Unaccompanied Youth (under 18)	0	0	0

Housing Inventory Chart: Unmet Need Totals

All Year-Round Beds/Units				Seasonal Beds	Overflow Beds
Family Beds	Family Units	Individual Beds	Total Year-Round Beds	Total Seasonal Beds	Overflow Beds
Emergency Shelters					
0	0	0		0	0
Transitional Housing					
0	0	0			
Permanent Supportive Housing					
90	45	132	222		
Safe Havens					
0	0	0			0

Program Type	Average Bed Utilization Rates
Emergency Shelters	82%
Transitional Housing	96%
Permanent Supportive Housing	0%
Safe Havens	

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

Instructions:

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%.

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

Annually (every year); Biennially (every other year); Semi-annually (every six months)

How often will the CoC conduct a PIT count? Annually

Enter the date in which the CoC plans to conduct its next annual point-in-time count: (mm/dd/yyyy) 01/28/2009

Indicate the percentage of providers supplying population and subpopulation data 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:

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 most emergency shelters and transitional housing programs.

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

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:	
Extrapolation: (Extrapolation attachment is required)	
Other:	

If Other, specify:

Describe how the sheltered population data was collected and the count produced. Additionally, comparing your most recent point-in-time count to the last biennial/annual count, describe any factors that may have resulted in an increase, decline or no change in the sheltered count.

Using standardized paper or web-based survey forms, providers reported the number of people and households residing at ES & TH programs. Those data were collected by the research team, entered into a database and aggregated to derive population counts. For family programs that failed to report the number of children, an average family size based on available data was applied to estimate the number of children. The multiplier used was 1.81 children per family. There were no methodological factors that would have resulted in an increase or decline in the sheltered population count.
This years PIT count reflects an 17% increase in homeless sheltered families and 15% increase in homeless sheltered individuals. Related factors for these increases include: (1) high cost of housing within region, (2) low wages in a service economy and (3) decrease in rental units due to increased foreclosures.

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

Instructions:

HMIS:
Only HMIS used for subpopulation data on sheltered persons (no extrapolation for missing data).

HMIS plus extrapolation:
Extrapolation to account for missing HMIS data and HUD's extrapolation tool completed.

Sample of PIT interviews plus extrapolation:
Interviews conducted with a random or stratified sample of sheltered adults and unaccompanied youth and appropriate HUD extrapolation tool completed.

Interviews:
Interviews conducted with every person staying in an emergency shelter or transitional housing program on the night of the point-in-time count.

Non-HMIS client level information:
Providers used individual client records to provide subpopulation data for each sheltered adult and unaccompanied youth for the night of the point-in-time count.

Other:
CoC used a combination of methods.

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

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

HMIS	
HMIS plus extrapolation:	
Sample of PIT interviews plus extrapolation: (PIT attachment is required)	X
Sample Strategy:	
Provider Expertise:	
Non-HMIS client level information:	
None:	
Other:	

If Other, specify:

Describe how the sheltered subpopulation data was collected and the count produced. Additionally, comparing your most recent point-in-time count to the last biennial/annual count, describe any factors that may have resulted in an increase, decline or no change in the sheltered subpopulation counts, particularly the chronically homeless count.

ES and TH providers administered surveys to a sample of residents. Based on an analysis of 2007 PIT data, the research team determined the following sampling frame: programs with 40 or fewer adults on the night of the count surveyed every adult, & programs with 41 or more adults surveyed every second adult (50%). Programs that interviewed only 50% selected participants by creating a random numbered list of all adults staying at the program on the night of the count then interviewed every second person.

2008 Findings for sheltered subpopulation counts are as follows:
16% increase in chronically homeless
1% increase in severely mentally ill
13% decrease in chronic substance abuse
32% decrease in veterans
50% decrease in persons with HIV/AIDS
47% increase in victims of domestic violence
0% no change/no unaccompanied youth identified
The 16% increase in sheltered chronically homeless, in part, is due to the fact that our New London shelter has been allowed to remain open year round rather than just seasonal. Homeless Outreach workers and shelter staff have been extremely successful with convincing chronically homeless persons to utilize the shelter rather than live in the streets, woods or encampments.

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

Instructions:

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

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

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

If Other, specify:

The Connecticut Coalition to End Homelessness (CCEH) convened a series of meetings across the state to engage key stakeholders in the count and to ensure broad participation and implementation of a standardized methodology. CCEH also staffed a toll-free hotline to answer questions and resolve logistical issues. To improve data accuracy, a web-based survey was available for submission of sheltered count data.

Describe the non-HMIS de-duplication techniques (if Non-HMIS de-duplication was selected):

To minimize the possibility of double counting, programs conducted the count on the same day from 7-11PM. Interviewers also asked each person who completed a survey if he/she had already been interviewed. All date were centrally collected and analyzed. Count organizers used several strategies to de-duplicate data including, discarding data from surveys in which the respondent indicated being previously interviewed, discarding duplicate data submitted on-line and in paper format by the same provider, discarding photocopied submissions that were identical to original surveys also received.

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

Instructions:

Public places count:
Count conducted based on observation of unsheltered persons without interviews

Public places count with interviews:
Interviewed either all unsheltered persons encountered during public places count or a sample

Service-based count:
Counted homeless persons using non-shelter services based on interviews.

HMIS:
HMIS used to collect, analyze or report data on unsheltered persons.

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

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:	
HMIS:	
Other:	

If Other, specify:

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

Instructions:

Complete coverage:
Every part of a specified geography (e.g. entire city, downtown area, etc.) is covered by enumerators.

Known locations:
Counting in areas where unsheltered homeless people are known to congregate or live.

Combination:
Conducting counts for every block in a portion of the jurisdiction (e.g. central city) AND conducting counts in other portions of the jurisdiction where unsheltered persons are known to live.

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

Indicate the level of coverage of the PIT count of unsheltered homeless people: Probability Sampling

If Other, specify:

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

Instructions:

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

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

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

If Other, specify:

The Connecticut Coalition to End Homelessness (CCEH) convened a series of meetings across the state to engage key stakeholders in the count and to ensure broad participation and participation and implementation of a standardized methodology. CCEH also staffed a toll-free hotline to answer questions and resolve logistical issues. Density ratings were assigned to each census tract or block group based on the number of homeless people expected to be found in each area. To determine density ratings, the CoC consulted with key informants, such as outreach teams, service providers, and government agencies. Teams canvassed 100% of areas designated as certain and high and a statistically valid sample of areas designated as low or extremely low. The research team used a web-based randomization calculator to assign the areas to be included in the sample.

Describe the techniques used to reduce duplication.

To minimize the possibility of double counting, staff and volunteers conducted the count on the same day from 7-11PM. Interviewers also asked each person who completed a survey if he/she had already been interviewed. All data were centrally collected and analyzed. Count organizers used several strategies to de-duplicate data including, discarding data from surveys in which the respondent indicated being previously interviewed, discarding duplicate data submitted via surveys and tally sheets, and discarding photocopied submissions that were identical to original surveys also received.

Describe the CoCs efforts, including outreach plan, to reduce the number of unsheltered homeless households with dependent children.

The CoC routinely consults with homeless outreach providers, local police and various human service providers to identify, engage and assist unsheltered homeless families. No unsheltered families with dependent children were identified on the night of the PIT count. However, emergency family shelters were prepared to provide overflow beds for homeless families if necessary. Additionally, motel vouchers for families with dependent children were set aside on the night of the PIT count.

Describe the CoCs efforts to identify and engage persons routinely sleeping on the streets and other places not meant for human habitation. Additionally, comparing your most recent point-in-time count to the last biennial/annual count, describe any factors that may have resulted in an increase, decline or no change in the unsheltered population (especially the chronically homeless and families with children).

Homeless outreach and engagement throughout our region is performed through a collaborative effort consisting of several agencies and programs. Street outreach is conducted in the woods, train and bus stations, libraries, parking lots, under bridges; as well as at shelters, soup kitchens, drop in centers and at all other locations where homeless individuals and families are known to frequent and/or establish encampments. It is through this collaboration that our region has been successful in achieving a solid understanding of whom and where our homeless populations are located.
Our most recent Point in Time Count reflected a marked decrease in unsheltered individuals (47% decline) as well as a marked decrease in unsheltered families with children (100% decline/no families with children were found).
Factors for these decreases include;
The collaborative efforts of the homeless outreach providers to locate and engage individuals and families living in the streets; and the fact that priority is given to chronically homeless persons and to families with children.
Another factor is that the survey instrument was revised in 2008 to include an additional question about the specific location where the respondent slept on the night of the count. Respondents who cited sheltered locations were excluded from the unsheltered count. The 2008 survey was also revised to collect additional information about unsheltered families with children. That data was used to exclude families whose children did not meet the HUD definition of homelessness, e.g., if a respondent reported that his/her children were residing with a relative on the night of the count, the respondent was counted as a single adult and the children were excluded. These changes likely resulted in a decrease in the overall unsheltered count and in the count of unsheltered families.

Attachment Details

Document Description:

PIT Attachment

Document Type	Required?	Document Description	Date Attached
PIT Sample Attachment Worksheet	Yes	PIT Attachment	10/14/2008

Attachment Details

Document Description: PIT Attachment

Tab 2: PIT C ts and Sampled Subpopulation Survey Data by Projec

Project Information					Subpopulation Results from Sample						
					Number of Clients Sampled at the Project who are in the Subpopulation						
Provider	Facility Name	Program Type	***PIT Client Population*** at the Project (Adults and Unaccompanied Youth)	Number of ***Surveys Completed*** at the Project	Chronically Homeless (*ES only*)	Severely Mentally Ill	Chronic Substance Abusers	Veterans	Persons with HIV/AIDS	Victims of Domestic Violence	Unaccompanied Youth (under 18)
Provider A	*HUD Example 1*	*ES*	*34*	*16*	*2*	*0*	*10*	*4*	*1*	*1*	*2*
Provider B	*HUD Example 2*	*TH*	*14*	*10*	*0*	*4*	*4*	*1*	*1*	*0*	*0*
Provider C	*HUD Example 3*	*TH*	*6*	*6*	*0*	*0*	*3*	*0*	*0*	*1*	*0*
Covenant Shelter	Covenant Shelter	ES	18	18	6	7	10	3	0	2	0
Mystic Area Shelter & Hospitality	Mystic Area Shelter & Hospitality	ES	7	7	1	3	2	0	0	1	0
New London Homeless Hospitality Center	New London Hospitality Center	ES	65	65	17	20	22	4	1	1	0
Norwich Human Services	Norwich Hospitality Center	ES	16	15	5	4	8	3	0	0	0
Reliance House Incorporated	Outreach to Homeless Emergency Shelter	ES	6	6	5	3	2	1	0	0	0
Thames Valley Council for Community Action	TVCCA Emergency Shelter for Families*	ES	15	15	1	3	1	0	1	2	0
Warm Shelter	Warm	ES	5	5	2	2	2	2	0	0	0
Women's Center of Southeastern Connecticut	Genesis House	ES	5	5	0	2	1	0	0	5	0
Bethsaida Community, Incorporated	Katie Blair Transitional Living Program	TH	8	8		5	6	0	0	1	0
Reliance House Incorporated	Transitional Living Community (Mens)	TH	7	7		7	6	1	0	0	0
Reliance House Incorporated	Transitional Living Community (Women's)	TH	7	7		5	6	0	0	0	0
Thames River Community Service	Thames River Family Program	TH	21	21		6	3	1	0	4	0
Women's Center of Southeastern Connecticut	Phoenix House	TH	9	9		1	1	0	0	9	0

Tab 3: Extra ated Subpopulation Counts by Project

Project Information					Extrapolated Subpopulation Estimates: Extrapolated Number of Clients at the Project by Subpopulation						
Provider	Facility Name	Program Type	Total ***PIT Client Population*** at the Project (Adults and Unaccompanied Youth)	Number of ***Surveys Completed*** at the Project	Chronically Homeless	Severely Mentally Ill	Chronic Substance Abusers	Veterans	Persons with HIV/AIDS	Victims of Domestic Violence	Unaccompanied Youth (under 18)
Covenant Shelter	Covenant Shelter	ES	18	18	6	7	10	3	0	2	0
Mystic Area Shelter & Hospitality	Mystic Area Shelter & Hospitality	ES	7	7	1	3	2	0	0	1	0
New London Homeless Hospitality Center	New London Hospitality Center	ES	65	65	17	20	22	4	1	1	0
Norwich Human Services	Norwich Hospitality Center	ES	16	15	5	4	9	3	0	0	0
Reliance House Incorporated	Outreach to Homeless Emergency Shelter	ES	6	6	5	3	2	1	0	0	0
Thames Valley Council for Community Action	TVCCA Emergency Shelter for Families*	ES	15	15	1	3	1	0	1	2	0
Warm Shelter	Warm	ES	5	5	2	2	2	2	0	0	0
Women's Center of Southeastern Connecticut	Genesis House	ES	5	5	0	2	1	0	0	5	0
Bethsaida Community, Incorporated	Katie Blair Transitional Living Program	TH	8	8		5	6	0	0	1	0
Reliance House Incorporated	Transitional Living Community (Mens)	TH	7	7		7	6	1	0	0	0
Reliance House Incorporated	Transitional Living Community (Women's)	TH	7	7		5	6	0	0	0	0
Thames River Community Service	Thames River Family Program	TH	21	21		6	3	1	0	4	0
Women's Center of Southeastern Connecticut	Phoenix House	TH	9	9		1	1	0	0	9	0

Tab 4: 2007 SuperNOFA Exhibit 1 Application Chart K

Part 2: Homeless Subpopulations (Adults only, except **g.** below)	Sheltered
a. Chronically Homeless *(ES only)*	**37**
b. Severely Mentally Ill	**68**
c. Chronic Substance Abuse	**71**
d. Veterans	**15**
e. Persons with HIV/AIDS	**2**
f. Victims of Domestic Violence	**25**
g. Unaccompanied Youth (under 18)	**0**

Extrapolated Subpopulation Counts by Program Ty

	Extrapolated Number of Clients in you CoC by Subpopulation by Program Type						
Program Type	Chronically Homeless	Severely Mentally Ill	Chronic Substance Abusers	Veterans	Persons with HIV/AIDS	Victims of Domestic Violence	Unaccompanied Youth (under 18)
ALL EMERGENCY SHELTERS	*37*	*44*	*49*	*13*	*2*	*11*	*0*
ALL TRANSITIONAL HOUSING		*24*	*22*	*2*	*0*	*14*	*0*
TOTAL IN CoC	***37***	***68***	***71***	***15***	***2***	***25***	***0***

3A. Continuum of Care (CoC) 10-Year Plan, Objectives and Action Steps

Click on the icon and add requested information for each of the national objectives.

Objective
Create new PH beds for chronically homeless persons
Increase percentage of homeless persons staying in PH over 6 months to at least 71.5%
Increase percentage of homeless persons moving from TH to PH to at least 63.5%
Increase percentage of homeless persons employed at exit to at least 19%
Decrease the number of homeless households with children

CoC 10-Year Plan, Objectives and Action Steps Detail

Instructions:

Provide local action steps and measurable achievements for attaining each of the five national HUD objectives listed, as part of the goal to end chronic homelessness and help to move families and individuals into permanent housing.

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

Select Objective: Create new PH beds for chronically homeless persons

Objectives to End Chronic Homelessness and Move Families and Individuals to Permanent Housing

2008 Local Action Steps
List local action steps for attaining this objective within the next 12 months. Also, in the "Lead Person" column, identify the title of one person responsible for accomplishing each action step and the organization which they represent.

		Lead Person
Action Step 1	Develop 23 units of supportive housing for chronically homeless individuals from 2007 Next Steps Initiative Scattered Site Round.	Housing Coordinator, Southeastern Mental Health Authority
Action Step 2	Apply for and develop 28 units of supportive housing for chronically homeless individuals through the Next Steps Initiative 2008 Development Round.	Housing Coordinator, Southeastern Mental Health Authority
Action Step 3		

Proposed Numeric Achievements

	%/Beds/Households
Baseline (Current Level)	89
Numeric Achievement in 12 months	140
Numeric Achievement in 5 years	180
Numeric Achievement in 10 years	235

CoC 10-Year Plan, Objectives and Action Steps Detail

Instructions:

Provide local action steps and measurable achievements for attaining each of the five national HUD objectives listed, as part of the goal to end chronic homelessness and help to move families and individuals into permanent housing.

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

Select Objective: Increase percentage of homeless persons staying in PH over 6 months to at least 71.5%

Objectives to End Chronic Homelessness and Move Families and Individuals to Permanent Housing

2008 Local Action Steps
List local action steps for attaining this objective within the next 12 months. Also, in the "Lead Person" column, identify the title of one person responsible for accomplishing each action step and the organization which they represent.

		Lead Person
Action Step 1	Continue to enhance knowledge base of service providers by providing mandatory and voluntary education and training offered by the Corporation for Supportive Housing. Training will be specific to providing services to individuals and families in PH, and will focus on approaches to assisting program participants with maintaining housing.	Housing Coordinator, Southeastern Mental Health Authority
Action Step 2	Permanent supportive housing programs will continue to work collaboratively to ensure services are provided in ways that will maximize the ability for homeless individuals and families to stay in PH for 6 months at a level greater than 71.5%.	Executive Director, Thames River Community Service Inc.
Action Step 3		

Proposed Numeric Achievements

	%/Beds/Households
Baseline (Current Level)	94
Numeric Achievement in 12 months	95
Numeric Achievement in 5 years	96
Numeric Achievement in 10 years	97

CoC 10-Year Plan, Objectives and Action Steps Detail

Instructions:

Provide local action steps and measurable achievements for attaining each of the five national HUD objectives listed, as part of the goal to end chronic homelessness and help to move families and individuals into permanent housing.

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

Select Objective: Increase percentage of homeless persons moving from TH to PH to at least 63.5%

Objectives to End Chronic Homelessness and Move Families and Individuals to Permanent Housing

2008 Local Action Steps
List local action steps for attaining this objective within the next 12 months. Also, in the "Lead Person" column, identify the title of one person responsible for accomplishing each action step and the organization which they represent.

		Lead Person
Action Step 1	Maintain current funding level for all transitional housing programs.	Executive Director, Thames River Community Service Inc.
Action Step 2	CoC to continue to monitor progress of moving homeless persons from transitional housing programs to permanent housing programs annually via APR Reviews and program Site Visits.	Executive Director, Thames River Community Services Inc.
Action Step 3	Increase percentage of homeless individuals moving from TH to PH by creating 51 additional permanent supportive housing units before the end of 2008.	Executive Director, Thames River Community Service Inc.

Proposed Numeric Achievements

	%/Beds/Households
Baseline (Current Level)	68
Numeric Achievement in 12 months	70
Numeric Achievement in 5 years	72
Numeric Achievement in 10 years	75

CoC 10-Year Plan, Objectives and Action Steps Detail

Instructions:

Provide local action steps and measurable achievements for attaining each of the five national HUD objectives listed, as part of the goal to end chronic homelessness and help to move families and individuals into permanent housing.

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

Select Objective: Increase percentage of homeless persons employed at exit to at least 19%

Objectives to End Chronic Homelessness and Move Families and Individuals to Permanent Housing

2008 Local Action Steps
List local action steps for attaining this objective within the next 12 months. Also, in the "Lead Person" column, identify the title of one person responsible for accomplishing each action step and the organization which they represent.

		Lead Person
Action Step 1	Service providers to continue ongoing engagement of homeless persons, which includes identifying employment goals, job readiness, and progress made toward gaining employment.	Director, Norwich Human Services
Action Step 2	Employment and Income Committee for the SECT 10 Year Plan to End Homelessness will build an active network of consistent contacts drawn from One Stop partners and Community Care Team Leaders to increase the percentages of homeless persons employed.	Regioanl Job Center Director, Connecticut Department of Labor
Action Step 3		

Proposed Numeric Achievements

	%/Beds/Households
Baseline (Current Level)	35
Numeric Achievement in 12 months	36
Numeric Achievement in 5 years	37
Numeric Achievement in 10 years	38

CoC 10-Year Plan, Objectives and Action Steps Detail

Instructions:

Provide local action steps and measurable achievements for attaining each of the five national HUD objectives listed, as part of the goal to end chronic homelessness and help to move families and individuals into permanent housing.

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

Select Objective: Decrease the number of homeless households with children

Objectives to End Chronic Homelessness and Move Families and Individuals to Permanent Housing

2008 Local Action Steps
List local action steps for attaining this objective within the next 12 months. Also, in the "Lead Person" column, identify the title of one person responsible for accomplishing each action step and the organization which they represent.

Lead Person

Action Step 1	The Connection Inc. will create (6) 3BR units for families who are homeless.	Program Director, The Connection Inc.
Action Step 2	Thames River Community Service Inc will create (9) Family units of Permanent Supportive Housing through the Next Steps Intiative Scattered Site Round.	Director of Services and Operations, Thames River Community Service Inc.
Action Step 3		

Proposed Numeric Achievements

	%/Beds/Households
Baseline (Current Level)	48
Numeric Achievement in 12 months	63
Numeric Achievement in 5 years	81
Numeric Achievement in 10 years	100

3B. Continuum of Care (CoC) Discharge Planning Protocols: Level of Development

Instructions:

Pursuant to the McKinney-Vento Act, to the maximum extent practicable, persons dicharged from publicly funded institutions or systems of care should not be discharged into homelessness. For each system of care, the CoC should indicate the level of development for its discharge planning policy.

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

Foster Care Discharge Protocol:	Formal Protocol Implemented
Health Care Discharge Protocol:	Formal Protocol Implemented
Mental Health Discharge Protocol:	Formal Protocol Implemented
Corrections Discharge Protocol:	Formal Protocol Implemented

3C. Continuum of Care (CoC) Discharge Planning Protocols: Narratives

For each system of care describe the discharge planning protocol. For addtional instructions, refer to the detailed instructions available on the left menu bar.

Foster Care Discharge
For Protocol Implemented, provide a summary of the formal and specific protocol, plan, process or policy that has been agreed upon.

Must attach protocol copy. Go to 3D.Discharge Planning Attachments page

The discharge planning protocol for foster care is in the policy manual of the CT State Department of Children & Families (DCF). Sect 42-10-3 says that a discharge conference is required for all youth 18 years of age or older at least 180 days prior to the anticipated discharge. The Plan includes the living arrangement for the youth & connection to aftercare services. Discharge planning is a collaborative effort and mandates participation from: Client, clients attorney, Adolescent Specialist, Adolescent Services Social Work Supervisor, specialized staff, community service providers, & family members. Housing is a key component of DCF Treatment Planning, is included in all administrative case reviews and is the responsibility of the Adolescent Specialist. DCFs Independent living Program offers life skills education & training, supervised transitional & practice living in their own community housing. Youth routinely are discharged into: group homes; the Community Housing Assistance Program; (includes a rent subsidy), & independent housing with community supports. DCF receives 1.3 million from the Chafee Foster Care Independence Program to provide housing and other appropriate support and services to former foster care recipients between 18-21 years of age.
CoC has received a copy of this policy, aggress with and understands that this policy is critical to preventing discharging into homelessness. DCF works as a member of our CoC to prevent discharging into homelessness.

Health Care Discharge
For Protocol Implemented, provide a summary of the formal and specific protocol, plan, process or policy that has been agreed upon.

Must attach protocol copy. Go to 3D.Discharge Planning Attachments page

The Department of Public Health (DPH) licenses & regulates hospitals in the State of CT. Section 19a-504c-1 of the Public Health Code outlines the requirements for hospitals regarding discharge planning. It says, Every hospitalized patient shall have a written discharge plan, which shall be given to the patient or family or representative prior to discharge. The plan must be signed off by the treating physician and is meant to identify the continued needs of the patient as well as the resources required to meet those needs including housing. The discharge plan is to be completed in collaboration with the patient, or appropriate family or representative & other care givers. If a determination is made that the patient cannot return home or cannot care for oneself, the patient is referred to the Social Work Department of the hospital. This department assists patients and families in completing and processing applications for extended care, rehabilitation, group homes, substance abuse treatment facilities, & other residential placements. Social work staff of hospitals evaluates financial & psychological needs, assists in the completion of housing applications & addresses barriers to appropriate discharges.
Our CoC has received a copy of this discharge policy, aggress with this policy, and understands that this policy is critical to preventing discharging into homelessness. DPH works collaboratively as a member of our CoC to prevent discharging into homelessness.

Mental Health Discharge
For Protocol Implemented, provide a summary of the formal and specific protocol, plan, process or policy that has been agreed upon.

Must attach protocol copy. Go to 3D.Discharge Planning Attachments page

The State of Connecticut Mental Health and Addiction Services (DMHAS) discharge protocol specifies that every patient treated in a DMHAS facility must have a specialized treatment plan which includes a discharge plan which necessarily entails attention to the persons living situation. The person treating the patient & community based providers collaborate to ensure that aftercare services needed by the patient are provided. The policy states, Under no circumstances shall an emergency shelter be considered appropriate housing disposition, & patients shall not be directly discharged from a DMHAS facility without documented evidence that discharge and aftercare plans have been an integral part of the treatment plan. Persons discharged from DMHAS facilities are routinely discharged into permanent supportive housing; housing with short or long-term subsidies; & independent living depending on the intensity of ongoing service needs.
Our CoC has received a copy of this discharge policy, aggress with this policy, and understands that this policy is critical to preventing discharging into homelessness. DMAHS works collaboratively as a member of our CoC to prevent discharging into homelessness.

Corrections Discharge
For Formal Protocol Implemented, provide a summary of the formal and specific protocol, plan, process or policy that has been agreed upon.

Must attach protocol copy. Go to 3D.Discharge Planning Attachments page

The State of Connecticut Department of Corrections (DOC) re-entry model provides service to facilitate the transition from incarceration to community placement. Administrative Directive 9.3 Discharge Planning mandates that Housing and aftercare program referrals are topics to be addressed in the discharge planning process. Discharge planning protocols are described in the Offender Accountability Plan created for each inmate and stipulating that offenders begin participation in discharge planning no less than 6 months before discharge. Discharge planning is a collaborative effort between the inmate and multiple staff assigned to assist in the discharge & community service staff. To prevent the release of inmates into homelessness, DOC has significantly increased staffing and the number of housing options for inmates released; there are greater number of halfway house beds for parole and community services; & DOC contracts for a variety of residential & non-residential services in the community. Between agency protocol and programs, contracted services & assistance from multiple other state agencies, the DOC is working to increase successful community reintegration for offenders, thereby reducing homelessness among this population.
CoC has received a copy of this policy, aggress with this and understands that this policy is critical to preventing discharging into homelessness. DOC works as a member of our CoC to prevent discharging into homelessness.

3D. Continuum of Care (CoC) Discharge Planning Protocol: Attachments

Document Type	Required?	Document Description	Date Attached
Foster Care Discharge Protocol	No	Foster Care Disch...	10/13/2008
Mental Health Discharge Protocol	No	Mental Health Dis...	10/13/2008
Corrections Discharge Protocol	No	Corrections Disch...	10/13/2008
Health Care Discharge Protocol	No	Health Care Disch...	10/13/2008

Attachment Details

Document Description: Foster Care Discharge Protocol

Please Note: Any CoC that seleced "Formal Protocol Finalized" or "Formal Protocol Implemented" must attach a copy of the protocol for the applicable system of care in order to receive full credit.

Attachment Details

Document Description: Mental Health Discharge Protocol

Please Note: Any CoC that seleced "Formal Protocol Finalized" or "Formal Protocol Implemented" must attach a copy of the protocol for the applicable system of care in order to receive full credit.

Attachment Details

Document Description: Corrections Discharge Protocol

Please Note: Any CoC that seleced "Formal Protocol Finalized" or "Formal Protocol Implemented" must attach a copy of the protocol for the applicable system of care in order to receive full credit.

Attachment Details

Document Description: Health Care Discharge Protocol

Please Note: Any CoC that seleced "Formal Protocol Finalized" or "Formal Protocol Implemented" must attach a copy of the protocol for the applicable system of care in order to receive full credit.

Policy Manual

Treatment Planning

Adolescent Discharge Plan

42-10-3

Policy

A conference shall be held to finalize an Adolescent Discharge Plan for all youth eighteen (18) years of age or older in out-of-home placement at least one hundred and eighty (180) days (six months) prior to the anticipated discharge from Department care.

Any youth who is younger than eighteen (18) years of age shall only be discharged from Department care via a legal mechanism such as a revocation of commitment or emancipation.

Any youth who is married or on active duty in any of the armed forces of the United States shall be the subject of emancipation procedures initiated by the Department, per Connecticut General Statutes §46b-150b.

Cross-reference: See policy 42-10-4, Decision to Decline Services.

Adolescent Discharge Plan Conference

The Adolescent Specialist shall schedule a conference prior to the finalization of the Adolescent Discharge Plan (DCF-2092). If the youth is under the age of eighteen (18), the Administrative Case Review (ACR) can take the place of the conference.

Note: The conference shall be held at a place and time that meet the youth's needs.

Adolescent Discharge Plan Conference Invitees

The conference invitees shall be:

- the Adolescent Specialist
- his/her supervisor
- the youth
- any significant individuals, as requested by the youth, especially family members and supportive adults
- youth's attorney
- youth's GAL
- foster parent or caregiver and
- community service providers

The Adolescent Specialist shall document the invitation in LINK

Adolescent Discharge Plan Conference Topics

Topics which shall be discussed at this conference include, but are not limited to:

Safety:

- any difficulties with the move toward more independence which the foster parents, biological parents, relatives, or any professional who has been providing services to the youth foresee

Permanency:

- identification of at least three adults committed to lifelong family relationships and a definition of their commitment to the youth
- expectations about the youth's continuation with any service program, including responsibilities of the youth, Adolescent Specialist, foster parents, biological parents or relatives, and any community connections

Well-Being:

- any concerns the youth has about being discharged from the care of the Department
- any benefits which the youth shall be entitled to such as housing allowance, terms for payment of educational expenses, and continuation of financial support if the youth is in school
- any benefits, such as Medicaid, which may become available or which shall be discontinued, shall be identified and the effects on the youth's plan discussed,
- medical coverage and
- aftercare services

Youth Eighteen Years of Age or Older Not Available to Meet / Sign Document

If the youth's whereabouts are unknown, or if the youth is not available to meet, then the Adolescent Specialist shall send a Notice of Proposed Denial, Suspension, Reduction, or Discontinuance of Department of Children and Families Benefits, DCF-800 to:

- the youth, at his or her last known address
- the youth's last provider on record.

If the youth chooses to challenge the Department's discontinuance of benefits, he or she may request that a Fair Hearing be held pursuant to the DCF-800.

Cross-reference: Passing From Care, policy 42-20-30.

Discharge Plan

The Adolescent Discharge Plan shall be finalized at this conference and shall include, but not be limited to:

- the anticipated date the youth will leave Department care
- names and contact information for at least three (3) significant family members or other adults in the youth's network

- the youth's anticipated living arrangements
- an estimated budget
- sources and amount of income/assets.

Note: The Adolescent Specialist shall document any trust account funds and shall assist the youth in proper financial management of account funds.

- assistance to be provided by the Department, including specification of aftercare services, to help the youth fulfill any aspect of the plan as well as assistance in obtaining essential documents and records
- a schedule for meeting with the Adolescent Specialist if the youth chooses to meet
- any other plans necessary to facilitate the youth's discharge from care.

Important: In the event that discharge from the Department occurs prior to the anticipated date, the written plan must be completed prior to closing the case.

Cross Reference: Policy 42-20-30, Passing From Care.

Youth shall receive a discharge plan from the Department even if he/she is terminated for non-compliance with services. In the event that the youth is not available to meet, the discharge plan shall be mailed to the youth.

Policy Manual

Treatment Planning

Adolescent Planning Conference

42-10-2

Purpose

The Area Office shall identify all DCF youth fourteen (14) years of age or older who are placed in out of home care, including those receiving Voluntary Services, with the purpose of holding a case conference for each youth. This conference will be held yearly until the youth's eighteenth (18th) birthday.

The conference shall be held separately from, and prior to, the Administrative Case Review (ACR) scheduled before the youth's fourteenth (14th) birthday.

The conference shall be held prior to any assignment of a goal of another permanent planned living arrangement, other (APPLA) as it relates to youth 16 or older who are participating in an independent living program and who refuse a family setting living arrangement. (See APPLA definitions)

For youth placed in out of home care after their fourteenth (14th) birthday, the conference shall be held separately from, and prior to, the first occurring ACR after placement.

The purpose of the conference is to determine the permanency goal for the youth, and to discuss services to be provided by the Department and others to meet that goal.

Case Conference Participants

The following individuals shall participate in the case conference:

- youth
- Significant adults and/or family members identified by the youth
- the current Social Worker
- Adolescent Services Unit Social Work Supervisor
- ARG staff (educational specialist, clinical specialist, substance abuse specialist, and/or nurse, as appropriate)
- a permanency planning team representative

Other Participants to Be Invited:

- youth's surrogate parent (if applicable)
- youth's Juvenile Court Appointed Attorney, (if applicable)

Case Conference Topics

Topics to be discussed at the conference may include, but not be limited to the following:

- the youth's need to develop Life Skills and/or knowledge to enable him/her to live self-sufficiently
- the need to achieve timely permanency and the identification, development and support of family members and significant adults willing and able to make a lifelong commitment
- the need for an assessment to determine the youth's educational and/or vocational interests and level of ability, and/or post high school educational interests
- whether the youth has taken a career interest assessment
- whether the youth has taken a learning-style inventory
- the need to achieve timely permanency
- whether the youth has been referred to a Life-Long Family Ties Program
- issues of sexual orientation
- issues of cultural awareness
- the need for future referral to Adult Services
- the Treatment Plan goal
- the quality and appropriateness of the current placement
- the current legal status
- whether the case should be transferred to a specialty unit
- medical coverage
- mental and medical health status (including identifying future needs)
- housing
- finances (including any ongoing sources of income and any survivor benefits)
- substance abuse
- legal issues
- parenting issues
- Independent Living Passport and essential documents.

Note: The Independent Living Passport holds documents belonging to the youth, which shall be kept until the youth leaves DCF care. The Social Worker/Adolescent Specialists shall compile copies of all essential documents as described in the Adolescent Planning Conference Form, DCF-2250.

Process

Upon identifying all cases that meet these criteria, the Social Work Supervisor shall meet with the Social Worker assigned to each case to determine the conference topics and participants. The Social Work Supervisor shall then notify the Adolescent Services Social Work Supervisor in the Area Office of the cases requiring that a conference be held.

A manager will chair the meetings. Chairmanship can rotate every 6 months. The Social Worker assigned to each case identified for a conference shall be responsible for inviting the conference participants. The chairperson or their designee will record the meeting. The Social Worker shall document the conference in LINK using DCF-2250.

ACR Review

The conference is viewed as a component of the youth's treatment plan. The topics shall be discussed and updated as appropriate at the Administrative Case Reviews (ACRs) and shall include, but not be limited to, the following:

- Permanency Planning
- Education/Vocation
- Employment

- Life Skills
- Housing
- Financial
- Health/Mental Health
- Substance Abuse
- Parenting
- Legal Issues
- Independent Living Passport and essential documents
- Other

Subsequent meetings to discuss these or any other topics may be held on an annual basis. It is mandatory that at least one other case conference be held at the time the youth turns seventeen (17).

Documentation

The currently assigned Social Worker shall document the following in the DCF-2250:

- when the conference occurred,
- the discussions held, and
- recommendations made.

The DCF-2250 shall be pasted onto the LINK narrative within five (5) working days.

Use of Another Planned Permanency Living Arrangement (APPLA) -

- APPLA should not be an option for any child and not recommended for any child under the age of 16. The reasons for use of APPLA must be compelling and made only after the Agency has made and documented reasonable efforts to reunify the child with parents, place the child with kin for adoption or guardianship or pursued adoption with non-related resources regardless of the age or special needs of the child. In rare cases APPLA could be considered as a short-term interim option while the more permanent concurrent plans of reunification, adoption or guardianship are being pursued. Careful consideration must be given in each case to make the determination of why APPLA is in the child's best interest. The goal of APPLA must be reassessed every six months thereafter through supervision and the treatment planning and ACR review process where careful consideration and documentation must be provided addressing why such a goal remains in the child's best interest. The other more permanent plans of reunification, adoption, or guardianship must be re-considered each time based on the child's circumstances.

- The central point to the use of APPLA as a permanency goal is the compelling reason, and it must be clearly enumerated in the treatment plan and in documents presented to the Court pertaining to permanency.

Preferred Permanency Goals-

- Reunification
- Adoption
- Guardianship
- Permanent and Legal Placement with a Relative

Non-Preferred Permanency Goals -

All children need permanent families or family relationships. The federal government eliminated long term foster care as an acceptable permanency goal and Another Planned Permanent Living Arrangement is not a replacement for that goal, instead it is designed as permanent and to ensure lifelong connections for children and youth. Careful consideration must be given in each case to make the determination of why APPLA is in the child's best interest. APPLA is not to be chosen lightly and is to be regularly reconsidered to determine if a more legally permanent goal can be achieved. Allowing adolescents to "age out" of the child welfare system without an attachment to a caring, committed adult is not permanency planning.

APPLA: Children/Youth 14 and Older -

- As noted in the definition of use, APPLA as a goal should not be recommended for children under 16 years of age except in rare circumstances.
- In those situations where APPLA is determined for a child 14 or older such determinations must be reviewed by the full adolescent planning conference team in the area office serving the case.
- The Team's decision will be documented in LINK narrative under the heading of case consultation adolescent planning team.
- The plan for a youth must be developed with the youth's active participation and include implementation of services and supports necessary to maintain the child in the least restrictive, most permanent placement.
- Each plan must outline steps to ensure the youth has enduring relationships with positive, supportive adults who are committed to maintaining such a relationship beyond the child's involvement in the child welfare system.
- The decision of the team may be appealed to the area director or his/her supervisors in the organization.
- This decision will be formally reviewed every six months as part of the treatment planning and ACR process. The decision to continue with this goal must be clearly documented in the treatment plan.
- For Native American children and youth, where the tribe placed the child with a non-relative tribal member for the purposes of permanent foster care.

State of Connecticut Department of Mental Health and Addiction Services

Commissioner's Policy Statement No. 33

Individualized Recovery Planning

In accordance with Section 17a-542 of the Connecticut General Statutes, as well as Federal and Joint Commission standards, regarding each person's right to individualized care and the provision of informed consent, it is the policy of the Department of Mental Health and Addiction Services that all services to be provided shall be based on an individualized, multidisciplinary recovery plan. Pursuant to Connecticut law, this process shall recognize that all individuals served by DMHAS, including those receiving inpatient services, are presumed to be competent and retain all of their civil rights to make informed choices about their own care unless they have been declared incapable by a court of law or unless such rights are specifically limited by law. Service providers shall not take coercive or retaliatory action against a person because the person has exercised his or her civil rights. The individualized recovery plan is thus to be developed in collaboration with the person receiving these services, advocates of the person's choice and others that he or she identifies as supportive of this process, with provisions to ensure that they have the opportunity to play active, meaningful roles in the decision-making process and to provide informed consent to all aspects of the plan. The person is encouraged to provide his or her goals and treatment preferences before the plan is developed. All changes in the recovery plan and the rationale for the changes shall be documented in the person's record. Service providers shall offer outreach and engagement services and client contact to the fullest extent possible for persons who refuse treatment.

The multi-disciplinary, individualized recovery plan will incorporate treatment, service, or care plans required by other bodies (e.g., CMS), and will include a comprehensive and culturally sensitive assessment of the person's hopes, assets, interests, goals, and preferences in addition to a holistic understanding of his or her behavioral health conditions and other medical concerns within the context of his or her ongoing life. Whether a person has a psychiatric disability or an addiction, focusing solely on deficits in the absence of a thoughtful analysis of strengths leads to disregarding the most critical resources an individual has on which to build in his or her efforts to adapt to stressful situations, confront environmental challenges, improve his or her quality of life, and advance in his or her unique recovery journey. The individualized recovery plan will thus be based on a strengths-based assessment that allows providers to balance critical needs that must be met with the resources and strengths each individual possesses, at that time, to assist in this process. Typical examples of the life context issues that may be addressed in the plan include education, employment, housing, spirituality, social and sexual relationships, legal issues, and involvement in meaningful and pleasurable activities. In order to ensure competence in these respective areas, the multidisciplinary team will not be limited to physician/psychiatrists, nurses, psychologists, and social workers, but may also include rehabilitative staff, peer providers, and relevant community representatives and/or others identified by the person.

When carried out in the context of acute inpatient psychiatric care or detoxification, the recovery planning process will view these treatment facilities as providing an essential, if time-limited, foundation for the person's future efforts toward recovery. As such, services to be provided within these facilities will identify and address, in addition to those elements described above, the precipitants to the person's admission and those elements of community-based care, supports, and activities that will be required to foster or sustain the person's recovery following discharge. To this end, discharge planning, including the identification of housing options, is to be initiated on admission and is to take into account, and address, any pending legal issues, potential needs for specialized assessments, or other potential barriers to discharge that the person will encounter as the acute episode resolves. Admission to inpatient facilities, regardless of projected length of stay, also must involve an assessment of the person's preferences for preventing and/or dealing with potential episodes of behavioral dyscontrol, as described in Commissioner's Policy No. 22F: Patient Personal Safety Preferences for Preventing and Managing Behavioral Dyscontrol.

To facilitate continuity of care across levels of care and over time, discharge planning is to include the active participation of those community-based providers who were working with the person prior to admission and those who most likely will be working with the person following discharge. As elaborated in detail in the person-centered planning principles attached, the inclusion of any parties in this process in addition to the person and his or her facility-based treatment team is contingent on the person's agreement, including his or her permission to release and/or obtain information from these parties unless a legal exception or requirement provides otherwise. In the case of individuals who have guardians or conservators of person, the agreement and consent is to be obtained from this person as well. Permission of the conservator or guardian is not required, however, for the person to authorize his or her advocate or attorney to be involved in the recovery planning process or to be provided with any relevant information under a release signed by the individual.

While inpatient or detox care can provide an essential foundation for recovery for individuals in acute distress, recovery planning is based on the recognition that for most people, most of the time, recovery involves the process of establishing or reestablishing a meaningful and gratifying life in the community. The primary focus of recovery planning, therefore, is on what services, structures, and/or supports the person desires and needs in order to establish and maintain a safe and healthy life in the community. Even in the case of prolonged hospitalization or residential addiction treatment, the primary focus of the person's recovery plan needs to continue to focus on the services, structures, and supports the person needs and desires in order to live successfully in the least restrictive environment possible. To the degree possible, the primary function of any institutional milieu should be to offer an opportunity to assess the person's capacities and needs for living successfully in the least restrictive environment possible and to equip the person with the skills, compensatory strategies, and other resources he or she will need in order to do so.

Given this community focus, one tool required for effective recovery planning is an adequate knowledge of the person's local community, including its opportunities, resources, and potential barriers. This knowledge is to be obtained and updated regularly at a community-wide level for the areas in which a program's service recipients live, but also is to be generated on an individual basis in relation to each person's interests, talents, and needs. Historically falling under the

purview of social work and rehabilitation staff, the function of identifying, cataloguing, and being familiar with community resources both within and beyond the formal behavioral health system can be carried out by staff from any discipline with adequate training and supervision. In most cases, however, this expertise will reside with local community-based providers rather than with inpatient staff located at a distance from the person's community of origin. In such cases, close coordination between inpatient and outpatient staff will be required to obtain and integrate this information into individualized recovery plans. Regardless of how it is obtained, a

comprehensive understanding of the community resources and supports that are available to address the range of a person's needs as he or she identifies them is essential to the recovery planning process across the continuum of care.

No person is to be discharged from a program, unit, or facility without ensuring that the person has been provided with a reasonable opportunity to develop adequate plans to obtain services and supports he or she will need following discharge. This shall include, but not be limited to, assuring that timely applications are submitted to establish an individual's eligibility for public benefits, medical assistance, and subsidized housing. For continuity of care and recovery planning to be maximized, it is preferable for the person to make connections with such services and supports prior to leaving the program or unit. This can be accomplished in a number of ways, including making scheduled visits, transitional meetings, phone contact, etc.

In addition to services and supports, discharge planning necessarily entails attention to the person's living situation and to the possibility of a continued need for a safe recovery environment. Given the importance of stable housing to sustaining recovery, it will be a goal of every provider to assure that the individuals they serve, including those being discharged from inpatient or residential settings, reside in the least restrictive, safest, and most dignified recovery environment with appropriate supports. The staff's primary role in this respect will be to explore and provide information to the person about available options for housing, services, supports, and resources following discharge, assuring that the individual's preferences are given full consideration. As it is with most other healthcare decisions, it will then be up to the individual—in consultation with staff and his or her natural supports—to make choices about which of these will be useful in his or her continued recovery. For such choices to be meaningful, staff are responsible for informing and educating the person about what realistic options are available and within what timeframes, and also for anticipating barriers, delays, and other difficulties so that alternative backup plans can be developed. Discussions about exploring and weighing different options, and the person's responses to them, are to be recorded in the person's medical record so that there is adequate documentation of this process.

Finally, an emergency shelter will not be considered by providers to be an acceptable permanent housing disposition following inpatient psychiatric care. Rather, individuals who have yet to acquire stable housing and who continue to require a safe recovery environment will be offered opportunities to move to transitional housing or other supportive environments in which they will be offered assistance in continuing to pursue stable housing and recovery supports. In the rare circumstance that an individual receiving inpatient or residential care refuses all reasonable options and is determined to no longer require that level of care, the options offered and the basis for the person's refusals will be documented, the person will be advised of his or her right to

access advocacy services, and the DMHAS Medical Director will be consulted in development of an appropriate disposition. This includes those circumstances in which a person expresses the desire to remain in a hospital setting despite staff assessments that the person no longer requires such an intensive and restrictive level of care. If it is documented that an individual has made an informed and voluntary decision to be discharged to a shelter, a motel, or another temporary setting, the person retains the right to pursue that option and to continue to receive services, supports, and assistance in obtaining more stable housing.

Thomas A. Kirk, Jr., Ph.D.
Commissioner

PUBLIC HEALTH CODE

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The Public Health Code contains the Regulations of Connecticut State Agencies that specifically concern the Department of Public Health.

Public Health Code prepared by:

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The Public Health Code is not the official version of the regulations.

In the event of an inconsistency the official regulations are published by the State of Connecticut, Judicial Branch, Commission on Official Legal Publications, their publication shall serve as the official version.

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Discharge Planning

Section 19a-504c-1. Discharge planning

(a) Every hospitalized patient shall have a written discharge plan, which shall be given to the patient or family or representative prior to discharge.

(b) The discharge plan shall include but not necessarily be limited to identification of the patient's needs for continued skill care or support services, and the specific resources to be utilized to meet these needs.

(c) The discharge plan must be completed on a timely basis so that appropriate arrangements for post hospital care management are made before discharge.

(d) The discharge plan is to be developed in collaboration with the patient, or appropriate family or representative and other care givers.

(e) The discharge plan shall be approved by the physician of record.

(f) The written discharge plan must be signed by the patient and/or family member or representative indicating their understanding of the discharge plan of care.

(g) The documentation of the written discharge plan shall be retained as a permanent part of the patient's medical record.

(h) Information necessary to ensure the continuity of care will be sent to participating providers, as appropriate, a copy of which will be retained as a permanent part of the patient's medical record.

(Effective September 25, 1989.)

Department of Correction
ADMINISTRATIVE DIRECTIVE

Supersedes Inmate Admissions, Transfers and Discharges, dated 3/5/2003
Title: Inmate Admissions, Transfers and Discharges

1. Policy. Admissions, transfers and discharges shall occur in an accurate and consistent manner.
2. Authority and Reference.
A. Public Law 108-79, Prison Rape Elimination Act of 2003.
B. Connecticut General Statutes, Sections 7-135, 9-46a, 18-81, 18-93, 53-21, 53a-13, 53a-70, 53a-70a, 53a-70b, 53a-71, 53a-72a, 53a-72b, 54-97, 54-102g, 54-102h and 54-102r.
C. American Correctional Association, Standards for the Administration of Correctional Agencies, Second Edition, April 1993, Standards 2-CO-1E-02, 2-CO-4A-01 and 2-CO-4E-01.
D. American Correctional Association, Standards for Adult Correctional Facilities, Fourth Edition, January 2003, Standards 4-4096, 4-4103, 4-4189, 4-4285, 4-4292, 4-4335, 4-4446.
E. American Correctional Association, Performance-Based Standards for Adult and Local Detention Facilities, Fourth Edition, June 2004, Standards 4-ALDF-1B-06, 4-ALDF-2A-16, 4-ALDF-4C-22, 4-ALDF-5B-18, 4-ALDF-7D-19 and 4-ALDF-7D-20.
F. Administrative Directives 3.11, Gate Money; 4.2, Sentence Computation and Time Keeping; 6.4, Transportation and Community Supervision of Inmates; 6.6, Reporting of Incidents; 6.7, Searches Conducted in Correctional Facilities; 6.10, Inmate Property; 8.1, Scope of Health Services Care; 8.5, Mental Health Services; 9.1, Population Management; 9.2, Offender Classification; 9.10, Inmate Identification and Movement; and 10.7, Inmate Communications.
3. Definitions. For the purposes stated herein, the following definitions apply:
A. Admission. The intake processing of an inmate into the legal custody of the Commissioner of Correction.
B. Closed Account. A discharged inmate's account with no balance.
C. Commitment. The court order remanding an inmate to the legal custody of the Commissioner of Correction.
D. Direct Admission Facility. A correctional facility designated to receive inmates committed by the courts. The following facilities are designated as direct admission facilities: Bridgeport Correctional Center; Corrigan-Radgowski Correctional Center; Hartford Correctional Center; Manson Youth Institution; New Haven Correctional Center; and, York Correctional Institution.
E. Discharge. The release of an inmate from the legal custody of the Department of Correction.
F. Facility. An institution of the Connecticut Department of Correction, including all correctional institutions, correctional centers and residential community service programs.
G. Gate Money. A predetermined amount of money given to an eligible inmate upon discharge.
H. Inmate. Any person, male or female, adult or minor, residing in a Connecticut Department of Correction facility or contracted community residential facility. This term shall include any person serving a state or federal sentence, any person admitted

to await trial in any jurisdiction, and any person admitted pursuant to any other provision of law.
I. New Admission. The initial intake of an inmate, committed by the courts, to the Department of Correction.
J. Personal Identification. Forms of personal identification shall include, but are not limited to, a birth certificate, social security card, driver's license, non-driver identification card, State identification card, social services identification card, military identification card, passport, Green card. Credit cards and non-official identification papers shall not be considered valid forms of identification.
K. Transfer. Movement of an inmate from one correctional unit to another.
4. Admission Area. Each correctional facility shall have an area specifically designated for admitting, receipt processing and discharging inmates.
Each direct admission facility shall provide for the following accommodations: bathing and toilet areas; potable water; secure maintenance of inmate property; access to monitored and privileged telephone services; private screening and intake areas; and on-line booking computer terminals.
5. Admissions. Each unit shall ensure the following:
A. Authorized Commitment. One (1) or more of the following legal commitments or official documents shall be required prior to the new admission of an inmate to a Department facility:
1. Continuance Mittimus;
2. Judgment Mittimus;
3. Remand to Custody;
4. Bench Warrant;
5. Family Matters Mittimus;
6. Capias;
7. Governor's Warrant;
8. Interstate Agreement on Detainers; and,
9. Temporary Surrender.
B. Authorized Transfer. A copy of the Department RT-15 transfer form, RT-50 printout and a photograph of the inmate shall be presented to the receiving facility prior to an inmate being admitted to the facility on a transfer.
C. Identification. Identification of the committing agent or transporting staff member shall be established prior to admittance to the secured admitting area. Identification of each inmate shall be established prior to the admission of the inmate to the custody of the receiving correctional facility.
1. The identification of a new admission inmate shall be verified as the inmate stated on the commitment papers.
2. The identification of a transferred inmate shall be established as that of the inmate on the transfer form in accordance with Administrative Directive 9.10, Inmate Identification and Movement
D. Arresting/Transporting Officer Documentation. The arresting/transporting officer(s) shall complete Attachment A,Form JD-MS-5, Detainee Behavior Questionnaire to document the inmate's behavior, physical condition and verbal statements while in the custody of the arresting/transporting officer(s).
E. Search and Shower. Upon admission to a correctional facility each

newly admitted or transferred inmate shall be searched in accordance with Administrative Directive 6.7, Searches Conducted in Correctional Facilities, and at a minimum, each new admission inmate, shall shower with the appropriate pediculosis control shampoo with the exception of pregnant inmates who shall be provided an alternative process of quelling by a Physician or Physician Extender.

F. Property Inventory. Upon admission to a facility an inmate's property shall be inventoried and processed in accordance with Administrative Directive 6.10, Inmate Property.

G. Inmate Data. Each Unit Administrator shall ensure that the CN 9301, Inmate Admission Form or RT-05A/RT-05R and CN 9307, Inmate Intake Form, are completed and/or updated within three (3) business days for each inmate admitted to the facility. The completed form and/or a hard copy of the RT-50 computer screen shall be placed in the inmate's master file. A trained staff member shall verify and update relevant computer information for each admitted inmate in accordance with Administrative Directive 4.2, Sentence Computation and Time Keeping.

H. Health Evaluation. Prior to admission, each inmate shall be visually screened and interviewed by admitting staff to check the inmate for any obvious health problems in accordance with Administrative Directives 8.1, Scope of Health Services Care and 8.5, Mental Health Services. Custody staff shall complete the "Custody Information" section of Attachment B, HR 001, Intake Health Screening. Health services staff and/or the Shift Commander shall be contacted upon discovery of any health-related problems to determine if an inmate may be refused admittance to the facility due to the problem. No new admission inmate shall be admitted if a serious health problem exists. It shall be the responsibility of the committing agent to provide treatment prior to admission.

Inmates identified with statistically high risk factors for self harm shall be referred to the Mental Health Unit. Inmates determined to be detoxifying from drugs or alcohol, medically unstable or mentally ill shall be identified and referred to unit and treatment staff for appropriate follow-up, and shall be considered for specialized housing (i.e., inpatient hospitalization).

Admitting staff shall be aware of any suicide risk factors or behavior and shall report the observation of any suicide factors to the health services staff and/or the Shift Commander in accordance with Administrative Directive 8.14, Suicide Prevention. Suicide factors shall include, but are not limited to, the following:

1. First DOC incarceration;
2. Recent loss (e.g., death, divorce, etc.);
3. Auditory/visual hallucinations 4. Recent transfer or status change;
5. Recent court disappointment;
6. Changes in personal relationships;
7. Detoxifying from drugs and/or alcohol;
8. Changes in physical condition;
9. Deteriorating health condition;
10. Statements made by the inmate;
11. Statements from family, friends or community providers;

12. Threats or perceived threats from other inmates; and,
13. Encouragement from other inmates to commit suicide.

I. Refusal of Inmate. An inmate may be refused admission to a facility if the conditions of Section 5 of this Directive are not met. Such refusal shall be documented through the completion of CN 6601, Incident Report, with photographs, whenever possible, in accordance with Administrative Directive 6.6, Reporting of Incidents.

J. Health Intake Screening. Attachment B, HR 001, Intake Health Screening shall be completed by a health services staff member and a custody staff member for each new admission to the Department.

K. Mail and Phone Regulations. A new admission inmate shall be requested to sign CN 100701, Notification and Acknowledgment for Inmates in accordance with Administrative Directive 10.7, Inmate Communications, prior to making a phone call.

L. Zero Tolerance Policy. Each inmate shall receive a copy of the Prison Rape Elimination Act Zero Tolerance Policy.

6. Transfers. Each inmate shall be transferred in accordance with Administrative Directives 6.4, Transportation and Community Supervision of Inmates; 6.7, Searches Conducted in Correctional Facilities; 6.10, Inmate Property; 9.1, Population Management; 9.2, Offender Classification; and 9.10, Inmate Identification and Movement.

A. Facility Transfers. At a minimum, the following steps shall be followed prior to transferring an inmate to another correctional facility:

1. the inmate's identification shall be verified in accordance with Administrative Directive 9.10, Inmate Identification and Movement;
2. the master file shall be reviewed to check for warrants, detainers, pending court cases, release date confirmation, classification ratings, and any other information that may affect the transfer;
3. the RT-15 and RT-50 shall be compared for accuracy;
4. the transfer authorization shall be confirmed by a custody supervisor;
5. the CN 9302, Transfer and Discharge Checklist shall be completed; and,
6. all requirements of sexual offender registration are satisfied when transferring from a higher level facility to a Level 2 facility.

B. Community Transfer. At a minimum, the following steps shall be completed prior to transferring an inmate to the community, to include furloughs

1. the inmate's identification shall be verified in accordance with Administrative Directive 9.10, Inmate Identification and Movement;
2. the master file shall be reviewed to check for warrants, detainers, pending court cases, release date confirmation, classification ratings, and any other information that may effect the transfer;
3. the RT-15 and RT-50 completed and compared for accuracy;
4. the transfer authorization shall be confirmed by a custody supervisor;
5. the RTM1 screen shall be completed and acknowledgment of

such shall be confirmed between the sending facility's Unit Administrator or designee and the field office;
6. the CN 9302, Transfer and Discharge Checklist shall be Completed;
7. all requirements of sexual offender registration and Felony DNA are satisfied, when applicable;
8. for a transfer to a residential community program, CN 9303, Facility to Residential Program Transfer Acknowledgement, shall be initiated;
9. for a transfer to a residential community program, the Health Services Unit shall be notified; and,
10. if the inmate does not have a valid form of identification upon transfer to a community program, a special CAPI photo shall be provided to the inmate for identification purposes in order to obtain official identification from the Connecticut Department of Motor Vehicles. The special CAPI photo shall contain language identifying the purpose of the photo, a contact number for verification and a raised seal to indicate authenticity

7. Registration of Sexual Offenders/Felony DNA Collection. The Director of Offender Classification and Population Management shall issue and revise as necessary guidelines for the registration of sexual offenders and the collection of a biological samples for the purposes of Felony DNA.

8. Discharges. No inmate shall be discharged from the Department until it is established that the inmate has satisfied all legal commitment requirements. However, an inmate may not be held beyond the authority of commitment. At a minimum, the following steps shall be followed prior to discharging an inmate:

A. A check of the inmate's master file to see that the requirements of sexual offender registration have been satisfied.
B. The inmate's identity shall be verified, and a new photograph taken, in accordance with Administrative Directive 9.10, Inmate Identification and Movement. If the inmate does not have a valid form of identification upon discharge, a special CAPI photo shall be provided to the inmate for identification purposes in order to obtain official identification from the Connecticut Department of Motor Vehicles. The special CAPI photo shall contain language identifying the purpose of the photo, a contact number for verification and a raised seal to indicate authenticity.
C. A warrant and detainer check shall be conducted.
D. The discharge authorization shall be confirmed by the Unit Administrator or designee

E. Expiration of sentence shall be verified by the records office.
F. CN 9302, Transfer and Discharge Checklist shall be completed and returned to the Records Office for filing in the inmate's master file.
G. An RT-50 shall be generated and compared to the inmate being discharged.
H. A copy of CN 9304, Certification of Discharge shall be provided to the inmate.
I. For inmates discharging from parole, CN 9305, Parole Notification of Parolee Discharge and CN 9304, Certification of Discharge shall be sent to the appropriate Parole Supervisor 45 days prior

to the inmate's discharge date by the facility or Parole and Community Services office with jurisdiction over the inmate

9. Health Procedures for Discharge Planning.
A. Inmate Discharge. Record's staff shall provide a 45-day End of Sentence List to the Health Services Unit. The Correctional Hospital Nursing Supervisor (CHNS) or designee shall be responsible for completing Attachment C, W-10, Inter-Agency Patient Referral Report for inmates with a health and/or mental health score of 3 or above. Attachment C, W-10, Inter-Agency Patient Referral Report shall be completed as close to the discharge date as possible. Attachment C, W-10, Inter-Agency Patient Referral Report shall be sealed in an envelope with a confidential sticker and hand delivered to the Records Department, where Attachment C, W-10, Inter-Agency Patient Referral Report shall be attached to the CN 9302, Transfer and Discharge Checklist. The Health Services Unit, at a minimum shall provide a two-week supply of discharge medication to the inmate. In facilities with 24-hour health services coverage, discharge medications shall be dispensed to the inmate with instructions by health services staff upon release. In facilities with less than 24-hour coverage, medication instructions shall be reviewed with the inmate, the day prior to discharge, which shall be documented in the inmate's health record. The discharge medications with written instructions shall be placed in a lockbox in the Shift Commander's office to be provided to the inmate upon discharge.
B. Community Release. The procedure outlined in subsection A of this Section shall be followed for inmate's being released to a community release program. A hold may be placed on an inmate with a health or mental health 3 or 4 for up to 72 hours so that medications can be delivered prior to release.
C. Parole Release. The Records staff shall notify the Health Services Unit of an inmate being released on parole. The CHNS shall be responsible for completing Attachment C, W-10, Inter-Agency Patient Referral Report and having it hand delivered to the Records Department in an envelope sealed with a confidential sticker. Medication shall then be ordered to the facility closest to the inmate for pickup.
D. Inmates Leaving From Court. Inmates shall be provided an Information Card which shall state to call the facility for health information. Inmates currently taking prescription medications shall be provided an opportunity to receive a twoweek supply of discharge medications. The contracted health care provider shall make the medication available for pick up, by the inmate, at either the discharging facility or the contracted pharmacy.
E. Records of Inmates with HIV Infection. Prior to the release of an inmate with HIV infection from a facility to the community, health care staff shall prepare a discharge packet. The information which is provided in the discharge packet shall include all current diagnoses, current problems, treatments which have been provided, the inmate's response to treatment, complications noted, allergies description of condition on discharge, and any follow-up instructions. A copy of the discharge packet shall be placed in the inmate's health record as

well as being forwarded to the community health care provider. The inmate shall be offered a copy of the discharge packet. When an inmate with HIV infection is transferred to community release or discharged from the Department, HIV health information shall be forwarded to the contract provider's Risk Management Unit.

10. Closed Accounts. Thirty days prior to discharge, an Attachment D, Request for Account Balance Form shall be submitted by a staff member to the Inmate Trust Fund Office to release an inmate's balance of account. Upon notice of release or discharge and receipt of authorizing documentation, a check for the inmate's account balance shall be prepared. The check shall be mailed to an address provided by the inmate. The inmate may receive the check upon discharge at the facility if 30 days notification is provided. The reconciling and check cutting transactions shall close the account. Closed account records shall be retained until audited by the Auditors of Public Accounts.

11. Gate Money. Thirty days prior to discharge, an Attachment E, Gate Money Request Form shall be submitted, in accordance with Administrative Directive 3.11, Gate Money, to the Inmate Trust Fund Office for eligible discharging inmates. Upon discharge, the gate money check shall be given to the inmate. In the event the inmate does not receive it upon discharge, the gate money shall not be forwarded.

12. Discharge Planning Policy. CN 9306, Discharge Planning Checklist and Transportation Log shall be initiated by the Records Department 45 days prior to an inmate's discharge. The checklist shall then be forwarded to the inmate's unit counselor so arrangements can be made in the following areas to facilitate a smooth transition into the community:

A. DNA Sample, if applicable;
B. Sex Offender Registration, if applicable;
C. Medication;
D. Transportation;
E. Discharge clothing;
F. Personal identification;
G. Housing;
H. Inmate account and gate money;
I. Aftercare program referrals (i.e., mental health and addiction services); and,
J. Receipt of Attachment F, Department of Correction Discharge Resource Card

The completed CN 9306, Discharge Planning Checklist and Transportation Log shall be returned to the Records Department for filing in the inmate's master file.
Inmates released at court shall be provided, when possible, with Attachment F, Department of Correction Discharge Resource Card to assist with their transition into the community.
Each facility shall, in accordance with this Directive, develop and maintain a unit policy governing the procedure for community release placement and discharge to provide a continuum of care into the community.

13. Forms and Attachments. The following forms and attachments are applicable to this Administrative Directive and shall be utilized for the intended function.

A. CN 9301, Inmate Admission Form;
B. CN 9302, Transfer and Discharge Checklist;
C. CN 9303, Facility to Residential Program Transfer Acknowledgement;

D. CN 9304, Certification of Discharge;
E. CN 9305, Parole Notification of Parolee Discharge;
F. CN 9306, Discharge Planning Checklist and Transportation Log;
G. CN 9307, Inmate Intake Form;
H. Attachment A, Form JD-MS-5, Detainee Behavior Questionnaire;
I. Attachment B, HR 001, Intake Health Screening;
J. Attachment C, W-10, Inter-Agency Patient Referral Report;
K. Attachment D, Request for Account Balance Form;
L. Attachment E, Gate Money Request Form; and,
M. Attachment F, Department of Correction Discharge Resource Card.

14. Exceptions. Any exceptions to the procedures in this Administrative Directive shall require prior written approval from the Commissioner.

2007

OFFENDER ACCOUNTABILITY PLAN MANUAL

SECTION I: PURPOSE OF THE MANUAL

This manual outlines the Connecticut State Department of Correction's Offender Accountability Plan and procedures for initiation and review of the plan throughout an offender's incarceration.

The manual is a reference tool developed to assist Department of Correction staff in articulating behavioral and programmatic expectations of offenders. The Offender Accountability Plan works in conjunction with the Objective Classification System to set realistic performance objectives that are tied to reasonable expectations about discretionary release in accordance with the Department's mission statement which asserts that "The Department of Correction shall protect the public, protect staff, and provide safe, secure, and humane supervision of offenders with opportunities that support successful community reintegration."

The manual will be updated as the need arises to reflect current Department policies and procedures.

The Director of Offender Classification and Population Management and the Director of Offender Programs and Victim Services are responsible for the contents of the manual. Interpretation and clarification may be requested through the Audits and Training Unit of OCPM. Occasionally these requests may be required to be submitted in writing to: Offender Classification & Population Management, 1153 East Street South, Suffield, CT 06080, attention Director of OCPM.

SECTION II: OFFENDER ACCOUNTABLILTY PLAN GOALS AND OBJECTIVES

A. INTRODUCTION

An Offender Accountability Plan (OAP) shall be developed for each fully sentenced offender, formulating treatment goals and programming needs. The OAP is a tool designed to identify and address specific areas that need to be modified in order to assist the offender in a successful reintegration into the community. The foundation of the OAP is accountability, with each individual accepting responsibility to engage in productive endeavors.

Each offender's OAP shall be reviewed, and when necessary modified, on a regular basis throughout the term of incarceration in order to assess progress and reinforce achievement of stated goals. In addition to participation in identified treatment, educational and vocational programs, the OAP addresses safety and security issues, to include behavioral expectations (i.e. disciplinary reports, etc).

The final phase of the OAP prepares the offender for transition into the community, either by way of supervised community release or full discharge from their sentence.

SECTION II: OFFENDER ACCOUNTABLILTY PLAN GOALS AND OBJECTIVES (cont.)

B. OAP MANAGEMENT –

The OAP shall be initiated for each offender within 2 weeks of an offender becoming fully sentenced and transferred from a correctional center to a correctional institution.

An offender sentenced to 6 months or more shall have an accountability plan implemented. Newly sentenced male offenders with sentences greater than 2 years shall have their OAP initiated during the assessment process at MacDougall Walker CI. Newly sentenced offenders with sentences from 6 months to 2 years shall have their OAP initiated at their permanent facility after transfer from a correctional center. Offenders housed at Manson Youth Institution or York Correctional Institution shall have an OAP completed upon becoming fully sentenced.

For those offenders sentenced to less than 6 months the OAP shall consist of discharge planning in accordance with Administrative Directive 9.3, Inmate Admission, Transfer and Discharge.

Offenders on accused status or those housed at a correctional center and not fully sentenced shall not be subject to an OAP. These offenders should be encouraged to participate in programming commensurate with identified treatment needs. Offenders shall have their OAP reviewed during a number of classification actions to include: regular review (RR), disciplinary increase (RD), new information (RI), level reduction review (RP) and community release review (RC).

Classification staff shall meet with each offender to review the initial OAP and discuss any recommended programs. Recommendations for programs shall reflect an inmates needs pursuant to:

1. The Objective Classification System as articulated in Administrative Directive 9.2 and the Objective Classification Manual;
2. Review of an offender's master file, including but not limited to, disciplinary and police reports, Pre-Sentence Investigations, and criminal history;
3. Review of any other available documentation;
4. Counselor Supervisor and/or Program Supervisor discretion.

An offender's failure to participate in recommended programming shall be a factor in any discretionary release consideration. OAP program recommendations may be appealed directly to the Unit Administrator.

No offender shall be held accountable for non-participation in programs that were not available due to facility placement or waitlist constraints. Recommendations for programs shall not be limited by a facility's ability to provide a program. In addition, offenders may request to participate in programs not recommended as part of their OAP with approval from the Program Supervisor who shall allow participation based on space availability. Program prioritization will be based on departmental and offender needs.

SECTION II: OFFENDER ACCOUNTABLILTY PLAN GOALS AND OBJECTIVES (cont.)

An offender who initially refuses to participate in the OAP process will not be eligible for treatment program participation until the next scheduled classification review, at which time another opportunity to develop an OAP with classification staff will be offered. This time frame may be changed at the discretion of the Unit Administrator.

Each offender shall be advised of program recommendations and behavioral expectations via the Orientation and Offender Accountability Plan (CN9701) form. The offender shall also be reminded of the obligation to act in accordance with departmental policy/procedures and that failure to do so shall be a factor in any discretionary release consideration.

The Board of Pardons and Paroles (BOPP) shall initiate the Parole Orientation Program for each offender with a parole eligible sentence. Representatives from the BOPP will meet with each offender during the assessment process at MacDougall Walker CI, Manson Youth Institution and York CI to advise the offender of their eligibility status and make program recommendations based upon the offender's identified needs. Each offender will be informed that failure to comply with the recommendations, or conduct which results in discipline or an increase in overall risk level, could negatively impact consideration of release to discretionary parole. Each offender shall receive a copy of the Orientation and Offender Accountability Plan (CN9701) form, and the original shall be filed in section 6 of the master file. This information shall be formalized electronically utilizing the automated program tracking management system (RT3I).

SECTION III: OFFENDER ACCOUNTABLILTY PLAN REVIEW PROCEDURES

A. OFFENDER ACCOUNTABILITY PLAN REVIEW

Classification staff shall meet with and review the OAP with each offender at the following times:

1. During the initial OAP, which shall be implemented no later than 2 weeks after an offender becoming fully sentenced and transferred from a correctional center to a correctional institution;
2. At each regular reclassification review (RR) in accordance with the Objective Classification Manual;
3. At any assignment to or completion of an Administrative Segregation, Close Custody or Close Monitoring program;
4. At any new mental health assignment resulting in transfer to Garner CI;
5. Upon preparation of any DOC community release package, parole hearing disposition, or consideration for release to re-entry furlough;
6. At any time new information becomes available that indicates a different programming need.

Offenders with greater than 10 years to their maximum release date or parole eligibility shall have their OAP consist of recommendations for behavioral expectations and available non-core programs as outlined in the Department of Correction Compendium of Programs and Services. There may be up to 5 core programs recommended for offenders with 5 to 10 years to their end of sentence or parole eligibility date. Offenders with less than 5 years shall have up to 3 core programs recommended on their OAP.

During all reviews of the OAP, Classification staff shall review the automated Program Tracking Management System (RT3K), discuss the offenders progress and review any new programs that are being recommended to the plan. Upon completion of those programs, additional core programs can be added. In all cases, when an offender does not have their high school diploma or GED, or has a substance abuse treatment need score equal to or greater than 3, a general referral code will be made for those services. Classification staff shall also solicit input from other disciplines to determine appropriate program recommendations. Notation of the OAP review shall be documented on the Program Activity Log (CN101302) in Section 6 of the Master File.

SECTION III: OFFENDER ACCOUNTABILITY PLAN REVIEW PROCEDURES (cont.)

1. INITIAL OFFENDER ACCOUNTABILITY PLAN -

During the implementation of the initial OAP, Classification Staff and/or BOPP shall work in conjunction with other disciplines to include Mental Health, Addiction Services and Educational Services to ensure appropriate programs are being recommended for each offender based on identified treatment needs.

Initial program recommendations shall be indicated on the CN9701 form and the offender shall be expected to sign the CN9701 form. Any refusal to sign this form shall be documented in writing on the form in place of the offender's signature. A copy of the CN9701 form shall be provided to the offender with the original filed in section 6 of the master file under the Program Activity Log (CN101302). In addition, notation of the new OAP shall be documented on the Program Activity Log (CN101302) in Section 6 of the Master File.

Any program recommendations made on the CN9701 form shall be entered into RT3I by the classification staff member. Refer to Appendix A, of this manual, for core program descriptions and corresponding program codes for input into the automated system. Descriptions of available programs not listed in Appendix A can be found in the Department of Correction Compendium of Programs and Services.

2. REVISION TO OFFENDER ACCOUNTABILITY PLAN –

Any changes to the OAP shall be indicated on the Offender Accountability Plan Revision form (CN9702) and the appropriate box(es) shall be checked indicating the type of classification review, the specific reason for the revision and program recommendation(s). The offender shall be expected to sign the CN9702 form when additional programs are recommended. Any refusal shall be documented in writing on the form in place of the offender's signature. A copy of the CN9702 form shall be provided to the offender with the original filed in section 6 of the master file under the Program Activity Log (CN101302). Any additional revisions to the OAP shall be noted on the original CN9702 form.

It shall not be necessary to initiate a CN9702 form if there are no recommended changes to the offenders OAP. Notation of the OAP review shall be documented on the Program Activity Log (CN101302) in section 6 of the master file.

SECTION III: OFFENDER ACCOUNTABILITY PLAN REVIEW PROCEDURES (cont.)

a. REGULAR RECLASSIFICATION REVIEW (RR)

Classification staff shall meet with each offender when reviewing the OAP during a Regular Reclassification Review. This shall include a review of the offenders needs to determine participation in recommended programs and to make modifications as necessary. Classification staff shall review the OAP in conjunction with other disciplines to include Mental Health, Addiction Services and Educational Services.

During all reviews of the OAP, Classification staff shall review the RT3 system, discuss the offenders progress and review any new programs that are being added to the plan. In addition, notation of the review of the OAP shall be documented on the Program Activity Log (CN101302) in Section 6 of the Master File.

b. DISCIPLINARY INCREASE (RD) –

Classification staff shall meet with each offender being considered for a level increase due to disciplinary infractions or placement on Administrative Segregation, Close Custody or Close Monitoring status to review the OAP and discuss behavioral expectations. Modifications to the CN9702 form shall be made accordingly on the RT3 system. Notation of the OAP review shall be documented on the Program Activity Log (CN101302) in Section 6 of the Master File.

c. NEW INFORMATION (RI) –

Classification staff shall meet with each offender when new information received dictates a change in the offenders OAP. New information includes parole hearings, violation of community release/parole/special parole that resulted in a return to custody, etc. If that offender is returned from community supervision to the department with new charges, the OAP shall be reviewed to reevaluate and update recommendations based on the new offense, or new sentence if applicable. The RT3 system shall be updated accordingly. In addition, notation of the review of the OAP shall be documented on the Program Activity Log (CN101302) in Section 6 of the Master File.

d. LEVEL REDUCTION (RP) –

Classification staff shall meet with each offender upon review for a level reduction, to determine program participation and if any changes to the offenders OAP are warranted. If no changes are made to the offender's OAP, classification staff members are not required to complete a CN9702 form. If any changes are recommended a CN9702 form shall be completed and the RT3 system shall be updated accordingly. In addition, notation of the review of the OAP shall be documented on the Program Activity Log (CN101302) in Section 6 of the Master File.

SECTION III: OFFENDER ACCOUNTABILITY PLAN REVIEW PROCEDURES (cont.)

e. COMMUNITY RELEASE (RC)-

Classification staff shall meet each offender and review the OAP prior to the initiation of the community release package to determine if the offender has met the requirements set forth in his/her OAP. No offender shall be held accountable for non-participation in programs that were not available due to facility placement or waitlist constraints. Notation of the review of the OAP shall be documented on the Program Activity Log (CN101302) in Section 6 of the Master File.

3. DISCHARGE TO END OF SENTENCE -

Counseling Staff shall meet with each offender with less than 6 months to discharge to encourage participation in any discharge planning program(s) offered at their assigned facility, to include the facility based Re-Entry Program and/or the Transition Program offered by the Education Department. A Discharge Planning Checklist (CN9301) shall be filled out for each offender to prepare for discharge in accordance with Administrative Directive 9.3, Admissions, Transfers and Discharges.

COMMUNITY PROCEDURES –

Offenders supervised in the community shall have their OAP continued in a less formal manner which may consist of :

1. Conditions of release (to include reporting times if applicable);
2. Community based programs recommended by the supervising Parole Officer, Parole Supervisor or Program Supervisor;
3. Verified employment and/or residence;
4. Any additional stipulations ordered as part of their release to the community.

Appendix A OAP Core Program Reference Sheet

Education			
Code	**Classification Score**	**Assigned**	**Pre-Requisites / Comments**
E1	General Referral for scores E-3, 4, or 5	General Referral - individuals with an Education score of 3, 4, or 5 should receive a general referral to Education Staff to determine appropriate class assignment.	Education staff will assign individuals to program code 50, 51, 52, 55, or 86 after evaluation of the individuals need.
50	E- 5	ABE 1 – Any individual who has been assessed by the education unit with a 0-4 grade level.	
51	E – 4	ABE 2 – Any individual who has been assessed by the education unit with a 5-8 grade level.	
52	E – 3	ABE 3 – Any individual who has been assessed by the education unit with a 9 – 12 grade level.	
86	E- 2	HSD/ GED – Any individual who the education department has verified as having a high school or GED diploma.	Sub Code of "U" is utilized If GED or High School Diploma is unverified
55	E- 1	College - Any individual who the education department has verified as having participated in vocational or college programming or has a post-secondary degree.	Sub Code of "U" is utilized If participation in post- secondary program is unverified
87	Education Re-Entry Program	Individuals who are within 9 months of discharge.	This is a different program than the DOC re-entry program. This program focuses on access to services.
37	Family Education & Parenting	Any individual who would like to improve their relationships with their children or those who have children and have contact with their children.	Recommend one of the Parenting Programs: Parenting, Fatherhood Initiative, Family Education & Parenting or Embracing Fatherhood. Do not recommend all 4

Appendix A OAP Core Program Reference Sheet

Addiction Services			
Code	**Program Name**	**Assigned**	**Pre-Requisites / Comments**
A1	General Referral	General Referral - individuals with a Substance Abuse Treatment Need score of 3, 4, or 5 should receive a general referral to Addiction Services Staff to determine appropriate program assignment.	Addiction Services staff will assign individuals to appropriate addiction services programming after evaluation of the offenders needs.
13	Tier One: Beat the Streets	Any Individual within 90 days of release to the community.	
14	Tier Two	Any individual with a T-score of 3,4,5 with an "A" or "S" sub-code.	
15	Tier Three	Any individual with a T-score of 3,4,5 with an "A" or "S" sub-code.	
16	Tier Four	Any individual with a T-Score of 3,4,5 without an "A" or "S" subcode. Have a MH score of 3 or lower.	
17	Co-occurring Disorders	Any individual convicted of a substance abuse crime and who shows a diagnosed mental illness and with a T-score of 3,4,5 without the "A" or "S" sub-code.	
35	DUI	Offenders that have a DUI conviction.	

Appendix A OAP Core Program Reference Sheet

Volunteer Programs			
Code	**Program Name**	**Assigned**	**Pre-Requisites / Comments**
45	Alternatives to Violence	Any individual that have a violent charge or have been convicted of a violent charge that is reflected on the court mittimus or Any offender that has a severity of violence score/level of a 3 or higher.	An Alternatives to Violence Programs program can be recommended please be aware that we have, Anger Management & Stop the Violence also available.
38	Parenting	Any individual who would like to improve their relationships with their children or those who have children and have contact with their children.	Recommend one of the Parenting Programs: Parenting, Fatherhood Initiative, Family Education & Parenting or Embracing Fatherhood. Do not recommend all 4
25	Fatherhood Initiative	Any individual who is a non-custodial father that would like to improve and promote positive involvement with their children.	Recommend one of the Parenting Programs: Parenting, Fatherhood Initiative, Family Education & Parenting or Embracing Fatherhood. Do not recommend all 4
24	Youthful Offender Mentoring	Any individual who is a youthful offenders that is interested in working with a mentor that will assist them with re-entry and transition back into the community.	Program is available to offenders under 18 years of age
41	Stop the Violence	Any individual who has a Mittimus from court that directs it or any offender who states he had a problem controlling his anger or any offender with an Assault charge.	A Stop the Violence Program can be recommended please be aware that we have Alternatives to Violence Programs & Anger Management, also available
28	CORP-CT. Offender Re-entry Program	Individuals who have one year until discharge, have a mental Health score of 3 or higher and are returning to the Hartford area.	
48	Beyond Fear	Any individual who would like seeking information regarding HIV & AIDS education.	

Appendix A OAP Core Program Reference Sheet

Offender Programs & Victim Services			
Code	**Program Name**	**Assigned**	**Pre-Requisites / Comments**
44	DOC Re-Entry Program	Any individual who is within 6 months of release to any form of re-entry including those discharging end of sentence.	This is a different program than the education re-entry program. This program focuses on behavior change.
26	Anger Management	Any individual who has a Mittimus from court that directs it or any offender who states he had a problem controlling his anger or any offender with an Assault charge.	An Anger Management program can be recommended please be aware that we have Alternatives to Violence Programs & Stop the Violence, also available
02	Domestic Violence – Facility Based	Any individual who has a "DV" sub-code or who has a Mittimus from court that directs it or who have been charged with a domestic violence crime.	This program is a perquisite for offenders who are eligible for Parole or Community Services.
01	Thinking for a Change	Any individual who would like to learn how to change and improve their problem solving and social skills or who has a pattern of criminal thinking. Also eligible are those with a history of repeated delinquent or criminal behavior.	This program is 22 sessions long and should only be recommended to offenders with sentences more than two years.
03	VOICES	Any individual who would like to understand the impact their crime had on the victim.	Most offenders should be refereed for this program
39	Charlene Perkins Center	Any individual who is eighteen months of release, and has completed identified educational and substance abuse treatment programs.	This program should be recommended to female offenders only.
04	Embracing Fatherhood	Any individual who would like to improve their relationships with their children or those who have children and have contact with their children.	Recommend one of the Parenting Programs: Parenting, Fatherhood Initiative, Family Education & Parenting or Embracing Fatherhood. Do not recommend all 4

Appendix A OAP Core Program Reference Sheet

Close Custody Programs			
Code	**Program Name**	**Assigned**	**Pre-Requisites / Comments**
12	Close Monitoring – SRG Affiliate	Any individual who meets the criteria to be placed in a Close Monitoring Unit.	See Administrative Directive
09	Close Custody – SRG Threat	Any individual who meets the criteria to be placed in a Close Custody Unit.	See Administrative Directive
06	Administrative Segregation	Any individual who meets the criteria to be placed in an Administrative Segregation Unit.	See Administrative Directive
21	Chronic Discipline Adult	Any individual who meets the criteria to be placed in an Chronic Discipline Unit.	See Administrative Directive
40	Chronic Discipline Youth	Any individual who meets the criteria to be placed in an Chronic Discipline Unit.	See Administrative Directive
Medical & Mental Health			
36	Sex Offender	Any individual who has a court mittimus reflecting a sexual offender charge or anyone assigned a Sex Offender Treatment score of:S-2, S-3, S-4, S-5.	

3E. Continuum of Care (CoC) Coordination

CoCs should coordinate, as appropriate, with any existing strategic planning groups to assess the local homeless system and identify shortcomings and unmet needs. Answer the following questions regarding coordination in the CoC.

Does the CoC's Consolidated Plan include the CoC strategic plan goals to address homelessness and chronic homelessness?	No
If yes, briefly list a few of the goals included in the Consolidated Plan:	
Within the CoC's geographic area, is one or more jurisdictional 10-year plan(s) being developed or implemented (separate from the CoC 10-year plan)?	No
Does the 10-year plan include the CoC strategic plan goals to address homelessness and chronic homelessness?	Yes

If yes, briefly list a few of the goals included in the 10-year plan(s):

Overarching goals established in Southeastern Connecticut 10 Year Plan to End Homelessness include;
Assure access to safe, decent, affordable housing with support services available if needed (Goal includes the recommendation to develop 148 units of permanent supportive housing specifically for chronically homeless persons);
Provide for seamless coordination of services, assuring that no door is the wrong door for those that are homeless or at risk for being homeless;
Create partnerships with local institutions and facilities to support a zero tolerance for discharge into homelessness;
Increase access to income and/or employment services;
Work with local community, including the faith community, to make sure citizens of Southeastern Connecticut know of our efforts and have the opportunity to participate in our work.

3F. Hold Harmless Need (HHN) Reallocation

Instructions:

CoC's that are in Hold Harmless Need status may choose to eliminate or reduce one or more of their SHP grants eligible for renewal in the 2008 CoC competition. CoC's may reallocate the funds made available through this process to create new permanent housing projects or HMIS. Reallocation projects may be SHP (1, 2, or 3 years), SPC (5 years) or Section 8 SRO (10 years). CoC's that are in Preliminary Pro Rate Need (PPRN) status are not eligible to reallocate projects. Reallocated funds cannot be used for Samaritan Housing project(s).

Refer to the NOFA for addtional guidance on reallocating projects.

Is the CoC reallocating funds from one or more expiring renewal grant(s) to one or more new project(s)? No

CoC's that are in Preliminary Pro Rata Need (PPRN) status are not eligible to reallocate projects.

4A. Continuum of Care (CoC) 2007 Achievements

Instructions:

For the five HUD national objectives in the 2007 CoC application, enter the 12-month numeric achievements that you provided in Exhibit 1, Chart N of the 2007 CoC application in the first column, "Proposed 12-Month Achievement". Under "Actual 12-Month Achievement" enter the numeric achievement that you CoC attained within the past 12 months that is directly related to the relevent national objective.

Objective	Proposed 12-Month Achievement (number of beds or percentage)		Actual 12-Month Achievement (number of beds or percentage)	
Create new PH beds for CH	32	Beds	4	Beds
Increase percentage of homeless persons staying in PH over 6 months to at least 71%	95	%	91	%
Increase percentage of homeless persons moving from TH to PH to at least 61.5%	89	%	68	%
Increase percentage of homeless persons employed at exit to at least 18%	58	%	35	%
Ensure that the CoC has a functional HMIS system	75	%	84	%

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

Complete the following fields using data from the last point-in-time (PIT) count and housing inventory count. For additional instructions, refer to the detailed instructions available on the left menu bar.

Indicate the total number of chronically homeless persons and total number of permanent housing beds designated for the chronically homeless persons in your CoC for each year

Year	Number of CH Persons	Number of PH beds for the CH
2006	148	48
2007	53	53
2008	44	53

Indicate the number of new PH beds in place and made available for occupancy for the chronically homeless between February 1, 2007 and January 31, 2008 0

Identify the amount of funds from each funding source for the development and operations costs of the new CH beds created between February 1, 2007 and January 31, 2008.

Cost Type	HUD McKinney-Vento	Other Federal	State	Local	Private
Development	$0	$0	$0	$0	$0
Operations	$0	$0	$0	$0	$0
Total	$0	$0	$0	$0	$0

4C. Continuum of Care (CoC) Housing Performance

Using data from the most recently submitted APRs for each of the projects within the CoC, provide information about the CoCs progress in reducing homelessness by helping clients move to and stabilize in permanent housing.

Participants in Permanent Housing (PH)	
a. Number of participants who exited permanent housing project(s)	18
b. Number of participants who did not leave the project(s)	100
c. Number of participants who exited after staying 6 months or longer	16
d. Number of participants who did not exit after staying 6 months or longer	92
e. Number of participants who did not leave and were enrolled for 5 months or less	8
TOTAL PH (%)	92

Participants in Transitional Housing (TH)	
a. Number of participants who exited TH project(s), including unknown destination	44
b. Number of participants who moved to PH	30
TOTAL TH (%)	68

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

Using data from the most recently submitted APRs for each of the projects within the CoC, provide information about the CoCs progress in reducing homelessness by helping clients access mainstream services and gain employment.

Total Number of Exiting Adults: 62

Mainstream Program	Number of Exiting Adults	Exit Percentage (Auto-calculated)	
SSI	8	13	%
SSDI	6	10	%
Social Security	2	3	%
General Public Assistance	3	5	%
TANF	11	18	%
SCHIP	0	0	%
Veterans Benefits	0	0	%
Employment Income	22	35	%
Unemployment Benefits	0	0	%
Veterans Health Care	0	0	%
Medicaid	11	18	%
Food Stamps	23	37	%
Other (Please specify below)	4	6	%
Child support and Tribal support			
No Financial Resources	7	11	%

The percentage values are automatically calculated by the system when you click the "save" button.

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

Does the CoC systematically analyze the APRs for its projects to assess and improve access to mainstream programs? Yes

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

Annually, the CoC allocates this task to the Scoring and Ranking work group of the HUD Grant Committee. This work group reviews and analyzes all project APRs as part of the ranking and scoring process to assess and improve access to mainstream programs.

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.

The Community Care team meets every Tuesday afternoon at 2:00 pm.

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 Provider Staff

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. Monthly or more

Does the CoC uses HMIS to screen for benefit eligibility? No

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

Has the CoC participated in SOAR training? Yes

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

May 24-25, 2007
June 18-19, 2008

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%
Application assistance is provided during case management meetings specifically addressing client stabilization goals.	
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%
The State of Connecticut's Department of Social Services has a single application for the following programs: TANF, Food Stamps, Medicaid, and general assistance benefits.	
4. Homeless assistance providers have staff systematically follow-up to ensure mainstream benefits are received.	100%
4a. Describe the follow-up process:	
Follow-up occurs during individual case management meetings.	

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]

Question	Answer
*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.	No
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?	

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?**	No
***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.)**	No
***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.)**	No
***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

Question	Response
***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.)**	No
***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?**	No
***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?**	Yes
***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?**	No
***19. Does your jurisdiction have an explicit policy that adjusts or waives existing parking requirements for all affordable housing developments?**	No
***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.

Project Name	Date Submitted	Grant Term	Applicant Name	Budget Amount	Proj Type	Prog Type	Comp Type	Rank
Thames River Fami...	2008-10-17 17:17:...	1 Year	Thames River Comm...	195,983	Renewal Project	SHP	TH	F3
Supportive Housin...	2008-10-18 17:23:...	1 Year	Women's Center of...	50,584	Renewal Project	SHP	TH	F5
Norwich/New Londo...	2008-10-16 09:51:...	5 Years	Connecticut Depar...	48,000	New Project	S+C	TRA	S1
Alliance for Livi...	2008-10-15 06:32:...	1 Year	Alliance for Living	73,932	Renewal Project	SHP	PH	F7
Katie Blair House	2008-10-17 15:27:...	1 Year	Bethsaida Communi...	87,528	Renewal Project	SHP	TH	F4
Rapid Rehousing P...	2008-10-20 15:17:...	3 Years	Thames River Comm...	130,079	New Project	SHP	TH	R10
The Homeless Coll...	2008-10-16 10:52:...	1 Year	The Thames Valley...	655,247	Renewal Project	SHP	PH	F2
Flora O'Neil Apar...	2008-10-17 15:26:...	1 Year	Bethsaida Communi...	86,984	Renewal Project	SHP	PH	F6
New London Shelte...	2008-10-16 09:50:...	1 Year	Connecticut Depar...	177,336	Renewal Project	S+C	TRA	U8
New London Shelte...	2008-10-16 09:49:...	1 Year	Connecticut Depar...	108,624	Renewal Project	S+C	TRA	U9

Budget Summary

FPRN	$1,150,258
Rapid Re-Housing	$130,079
Samaritan Housing	$48,000
SPC Renewal	$285,960
Rejected	$0

Submission Summary

Part	Last Updated
Part 1: CoC Structure	
1A. Identification	No Input Required
1B. Primary Decision-Making Group	09/24/2008
1C. Committees	10/13/2008
1D. Member Organizations	10/13/2008
1E. Project Review and Selection	08/28/2008
1F. e-HIC Change in Beds	08/28/2008
1G. e-HIC Attachment	10/14/2008
1H. e-HIC Sources and Methods	09/03/2008
Part 2: Data Collection and Quality	
2A. HMIS Implementation	10/13/2008
HMIS Attachment	10/14/2008
2B. HMIS Lead Organization	10/13/2008
2C. HMIS Contact Person	10/13/2008
2D. HMIS Bed Coverage	10/20/2008
2E. HMIS Data Quality	10/20/2008
2F. HMIS Data Usage	09/04/2008
2G. HMIS Data and Techni	10/14/2008
2H. HMIS Training	10/14/2008
2I. Homeless Population	09/04/2008
2J. Homeless Subpopulatic	10/13/2008
2K. Sheltered Data - PIT	10/13/2008
2L. Sheltered Data - Methods	10/13/2008
2M. Sheltered Data - Subpopulations	10/20/2008
2N. Sheltered Data - Quality	No Input Required
2O. Unsheltered Data - Methods	No Input Required
2P. Unsheltered Data - Coverage	09/04/2008
2Q. Unsheltered Data - Quality	10/14/2008
PIT Attachment	10/14/2008
Part 3: CoC Strategic Planning	
3A. CoC 10 Year Plan	10/13/2008
3B. Discharge Planning Protocol Status	10/13/2008
3C. Discharge Planning Narratives	10/14/2008
3D. Discharge Planning Attachments	10/13/2008
3E. CoC Coordination	10/13/2008
3F. HHN Reallocation	10/13/2008
Part 4: CoC Performance	
4A. 2007 CoC Achievements	10/14/2008
4B. Chronic Homeless Progress	10/14/2008

Exhibit 1
2008
PDF

4C. Housing Performance	09/10/2008
4D. Mainstream Services Enrollment	09/10/2008
4E. Energy Star & Section 3	09/10/2008
4F. CoC Mainstream Programs	09/10/2008
4G. Provider Mainstream Programs	09/10/2008
Regulatory Barriers	
4I. Removing Regulatory Barriers	
Page 1	No Input Required
Page 2	No Input Required
Page 3	No Input Required
Submission Summary	No Input Required

Back Next

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Housing Inventory Chart: Emergency Shelters

Total Year-Round Beds - Individuals	
1. Current Year-Round Individual Emergency Shelter (ES) Beds	76
1A. Number of DV Year-Round Individual ES Beds	1
1B. Subtotal, non-DV Year-Round Individual ES Beds	75
2. New Year-Round Individual ES beds	0
3. Under Development Year-Round Individual Beds	0
3. Total Year Round Individual ES Beds in HMIS	75
4. HMIS Bed Coverage: Individual ES Beds	100%

Total Year-Round Beds - Families	
5. Current Year-Round Family Emergency Shelter (ES) Beds:	101
5A. Number of DV Year-Round Family ES Beds:	14
5B. Subtotal, non-DV Year-Round Family ES Beds	87
5. New Year-Round Family ES Beds	0
6. Under Development Year-Round Family ES Beds	0
7. Total Year-Round Family ES Beds in HMIS	63
8. HMIS Bed Coverage: Family ES Beds	72%

KEY: Inventory type
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N: New inventory
U: Under development

KEY: Target Population A and B

SM: single males	YF: youth females
SF: single females	YMF: youth males and females
SMF: single males and females	SMF + HC: Single male and female plus households with children
CO: couples only, no children	
SMHC: single males and households with cl	
SFHC: single females and households with	DV - Domestic Violence victims only
HC: households with children	VET - Veterans only
YM: youth males	HIV - HIV/AIDS populations only

Error Messages

ERROR MSG: PROGRAM DETAILS	None
ERROR MSG: FAMILY BEDS/UNITS	None
ERROR MSG: DV HMIS COVERAGE	None

Program Information					Target Population		HUD Funding Information	All Year-Round Beds/Units				Year-Round Beds covered in HMIS				Seasonal Beds				O/V Beds	PIT Counts	Utilization Rates
#	Provider	Facility Name	Geo Code	Inventory type	A	B	Does this facility receive HUD McKinney-Vento funding?	Family Beds	Family Units	Individual Beds	Total Year-Round Beds	Year-Round Family beds covered in HMIS	Year-Round Individual Beds covered in HMIS	Percentage family beds covered in HMIS	Percentage individual beds covered in HMIS	Total Seasonal Beds	Number Available in HMIS	Availability Start Date	Availability End Date	O/V Beds	Point-In-Time Homeless Count	Program Utilization Rate
ES1	Covenant Shelter	Covenant Shelter	090738	C	SMF+HC		No	18	5	17	35	18	17	100%	100%	0	0			0	26	74%
ES2	Mystic Area Shelter and Hospitality	Mystic Area Shelter and Hospitality	090738	C	HC		No	24	5	0	24	0	0	0%		0	0				21	88%
ES3	New London Homeless Hospitality Center	New London Homeless Hospitality Center	090738	C	SMF		No	0	0	50	50	0	50		100%	0	0			15	64	128%
ES4	Norwich Human Services	Norwich Hospitality Center	090816	C	SMF		No	0	0	0	0	0	0			20	0	November-07	March-08		16	80%
ES5	Reliance House, Inc.	Outreach to Homeless Emergency Shelter	090816	C	SMF		No	0	0	8	8	0	8		100%	0	0				6	75%
ES6	Thames Valley Council for Community Action, Inc.	TVCCA Family Shelter	090816	C	HC		No	45	14	0	45	45	0	100%		0	0				35	78%
ES7	Women's Center of Southeastern Connecticut, Inc.	Genesis House	090738	C	SFHC	DV	No	14	6	1	15	0	0	0%	0%	0	0				8	53%
	Insert provider name										0											

Housing Inventory Chart: Transitional Housing

Total Year-Round Beds - Individuals	
1. Current Year-Round Individual Transitional Housing (TH) Beds	23
1A. Number of DV Year-Round Individual TH Beds	1
1B. Subtotal, non-DV Year-Round Individual TH Beds	22
2. New Year-Round Individual TH beds	0
3. Under Development Year-Round Individual Beds	0
4. Total Year Round Individual TH Beds in HMIS	8
5. HMISBed Coverage: Individual TH Beds	36%

Total Year-Round Beds - Families	
6. Current Year-Round Family Transitional Housing (TH) Beds:	99
6A. Number of DV Year-Round Family TH Beds:	27
6B. Subtotal, non-DV Year-Round Family TH Beds	72
7. New Year-Round Family TH Beds	0
8. Under Development Year-Round Family TH Beds	0
9. Total Year-Round Family TH Beds in HMIS	72
10. HMIS Bed Coverage: Family TH Beds	100%

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N: New Inventory
U: Under development

KEY: Target Population A and B

SM: single males
SF: single females
SMF: single males and females
CO: couples only, no children
SMHC: single males and households with c
SFHC: single females and households with
HC: households with children
YM: youth males
YF: youth females
YMF: youth males and females
SMF + HC: Single male and female plus households with children
DV - Domestic Violence victims only
VET - Veterans only
HIV - HIV/AIDS populations only

Error Messages

ERROR MSG: PROGRAM DETAILS	None
ERROR MSG: FAMILY BEDS/UNITS	None
ERROR MSG: DV HMIS COVERAGE	None

Program Information					Target Population		HUD Funding Information	All Year-Round Beds/Units				Year-Round Beds covered in HMIS				PIT Counts	Utilization Rates
#	Provider	Facility Name	Geo Code	Inventory type	A	B	Does this facility receive HUD McKinney-Vento funding?	Family Beds	Family Units	Individual Beds	Total Year-Round Beds	Year-Round Family beds covered in HMIS	Year-Round Individual Beds covered in HMIS	Percentage family beds covered in HMIS	Percentage individual beds covered in HMIS	Point-in-Time Homeless Count	Program Utilization Rate
TH1	Bethsaida Community, Inc.	Katie Blair Transitional Living Program	090816	C	SF		Yes	0	0	8	8	0	8		100%	8	100%
TH2	Reliance House, Inc.	Transitional Living Communtiy (Men)	090816	C	SM		No	0	0	7	7	0	0		0%	7	100%
TH3	Reliance House, Inc.	Transitional Living Communtiy (Women)	090816	C	SF		No	0	0	7	7	0	0		0%	7	100%
TH4	Thames River Community Service, Inc.	Thames River Family Program	090816	C	SFHC		Yes	72	24	0	72	72	0	100%		61	85%
TH5	Women's Center of Southeastern Connecticut, Inc.	Phoenix House	090738	C	SFHC	DV	Yes	27	7	1	28	0	0	0%	0%	26	93%
	Insert provider name										0						

Housing Inventory Chart: Permanent Supportive Housing

Total Year-Round Beds - Individuals	
1. Current Year-Round Individual Permanent Housing (PH) Beds	94
1A. Number of DV Year-Round Individual PH Beds	0
1B. Subtotal, non-DV Year-Round Individual PH Beds	94
2. New Year-Round Individual PH beds	0
3. Under Development Year-Round Individual Beds	31
4. Total Year Round Individual PH Beds in HMIS	62
5. HMIS Bed Coverage: Individual PH Beds	66%

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

Total Year-Round Beds - Families	
6. Current Year-Round Family Permanent Housing (PH) Beds:	146
6A. Number of DV Year-Round Family PH Beds:	23
6B. Subtotal, non-DV Year-Round Family PH Beds	123
7. New Year-Round Family PH Beds	0
8. Under Development Year-Round Family PH Beds	44
9. Total Year-Round Family PH Beds in HMIS	117
10. HMIS Bed Coverage: Family PH Beds	95%

KEY: Target Population A and B	
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SMF: single males and females	SMF + HC: Single male and female plus households with children
CO: couples only, no children	
SMHC: single males and households with c	
SFHC: single females and households with	DV - Domestic Violence victims only
HC: households with children	VET - Veterans only
YM: youth males	HIV - HIV/AIDS populations only

Error Messages	
ERROR MSG: PROGRAM DETAILS	None
ERROR MSG: FAMILY BEDS/UNITS	None
ERROR MSG: DV HMIS COVERAGE	None

Program Information					Target Population		HUD Funding Information	All Year-Round Beds/Units					Year-Round Beds covered in HMIS				PIT Counts	Utilization Rates
#	Provider	Facility Name	Geo Code	Inventory type	A	B	Does this facility receive HUD McKinney-Vento funding?	Family Beds	Family Units	Individual Beds	CH Beds	Total Year-Round Beds	Year-Round Family beds covered in HMIS	Year-Round Individual Beds covered in HMIS	Percentage family beds covered in HMIS	Percentage individual beds covered in HMIS	Point-in-Time Homeless Count	Program Utilization Rate
PH1	Alliance for Living	Supportive Housing Program	090738	C	SMF+HC	HIV	Yes	4	2	5	0	9	4	5	100%	100%		0%
PH2	Bethsaida Community, Inc.	Flora O'Neil Supportive Housing Program	090816	C	SFHC		Yes	6	2	4	0	10	6	4	100%	100%		0%
PH3	Reliance House, Inc.	Next Steps Initiative	090816	C	SMF		No	0	0	5	0	5	0	0		0%		0%
PH4	Reliance House, Inc.	PILOTs Development	090816	C	SMF		No	0	0	4	0	4	0	0		0%		0%
PH5	Southeastern Mental Health Authority	New London Shelter Plus Care Combo Grant	099011	C	SMF+HC		Yes	19	7	11	11	30	19	11	100%	100%		0%
PH6	Sound Community Services, Inc.	Next Steps Initiative	090738	C	SMF		No	0	0	10	0	10	0	0		0%		0%
PH7	Sound Community Services, Inc.	PILOTs Development	090738	C	SMF		Yes	0	0	13	0	13	0	0		0%		0%
PH8	Southeastern Mental Health Authority	New London Shelter Plus Care 2003 Renewal	099011	C	SMF+HC		Yes	8	2	9	9	17	8	9	100%	100%		0%
PH9	Thames Valley Council for Community Action, Inc.	Supportive Housing Program	090816	C	SMF+HC		Yes	73	25	25	25	98	73	25	100%	100%		0%
PH10	The Connection, Inc.	Groton PILOTs Development	090738	C	HC		No	6	2	0	0	6	0	0	0%			0%
PH11	Southeastern Mental Health Authority	Norwich/New London Shelter Plus Care 2004	099011	C	SMF+HC		Yes	7	3	8	8	15	7	8	100%	100%		0%
PH12	The Women's Center of Southeastern Connecticut	PILOTs Development	099011	C	HC	DV	No	23	7	0	0	23	0	0	0%			0%
PH13	Alliance for Living	Supportive Housing Program	090738	U	SMF	HIV	Yes	0	0	8	8	8	0	8		100%		0%
PH14	Reliance House, Inc.	Next Steps Initiative	090816	U	SMF		No	0	0	14	14	14	0	0		0%		0%
PH15	Thames River Community Service, Inc.	Thames River Supportive Housing	099011	U	HC		No	30	9	0	0	30	0	0	0%			0%
PH16	Thames Valley Council for Community Action, Inc.	Next Steps Initiative	099011	U	SMF		No	0	0	9	9	9	0	0		0%		0%
PH17	The Connection, Inc.	Groton PILOTs Development	090738	U	HC		No	14	4	0	0	14	0	0	0%			0%
	Insert provider name											0						

Total Year-Round Beds - Individuals	
1. Current Year-Round Individual Safe Haven (SH) Beds	0
1A. Number of DV Year-Round Individual SH Beds	0
1B. Subtotal, non-DV Year-Round Individual SH Beds	0
2. New Year-Round Individual SH beds	0
3. Under Development Year-Round Individual Beds	0
4. Total Year Round Individual SH Beds in HMIS	0
5. HMIS Bed Coverage: Individual SH Beds	

Total Year-Round Beds - Families	
6. Current Year-Round Family Save Haven (SH) Beds:	0
6A. Number of DV Year-Round Family SH Beds:	0
6B. Subtotal, non-DV Year-Round Family SH Beds	0
7. New Year-Round Family SH Beds	0
8. Under Development Year-Round Family SH Beds	0
9. Total Year-Round Family SH Beds in HMIS	0
10. HMIS Bed Coverage: Family SH Beds	

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YMF: youth males and females
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Error Messages
ERROR MSG: PROGRAM DETAILS None
ERROR MSG: FAMILY BEDS/UNITS None
ERROR MSG: DV HMIS COVERAGE None

Program Information					Target Population		HUD Funding Information	All Year-Round Beds/Units				Year-Round Beds covered in HMIS				PIT Counts	Utilization Rates
#	Provider	Facility Name	Geo Code	Inventory type	A	B	Does this facility receive HUD McKinney-Vento funding?	Family Beds	Family Units	Individual Beds	Total Year-Round Beds	Year-Round Family beds covered in HMIS	Year-Round Individual Beds covered in HMIS	Percentage family beds covered in HMIS	Percentage individual beds covered in HMIS	Point-in-Time Homeless Count	Program Utilization Rate
	Insert provider name										0						
	Insert provider name										0						
	Insert provider name										0						
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