Before Starting the CoC Application

You must submit all three of the following parts in order for us to consider your Consolidated Application complete:

1. the CoC Application,
2. the CoC Priority Listing, and
3. all the CoC's project applications that were either approved and ranked, or rejected.

As the Collaborative Applicant, you are responsible for reviewing the following:

1. The FY 2021 CoC Program Competition Notice of Funding Opportunity (NOFO) for specific application and program requirements.
2. The FY 2021 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.

Your CoC Must Approve the Consolidated Application before You Submit It

- 24 CFR 578.9 requires you to compile and submit the CoC Consolidated Application for the FY 2021 CoC Program Competition on behalf of your CoC.
- 24 CFR 578.9(b) requires you to obtain approval from your CoC before you submit the Consolidated Application into e-snaps.

Answering Multi-Part Narrative Questions

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

Attachments

Questions requiring attachments to receive points state, "You Must Upload an Attachment to the 4B. Attachments Screen." Only upload documents responsive to the questions posed–including other material slows down the review process, which ultimately slows down the funding process. Include a cover page with the attachment name.

- Attachments must match the questions they are associated with–if we do not award points for evidence you upload and associate with the wrong question, this is not a valid reason for you to appeal HUD's funding determination.
- We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).

1A. Continuum of Care (CoC) Identification

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1A-1. CoC Name and Number: NV-500 - Las Vegas/Clark County CoC

1A-2. Collaborative Applicant Name: Clark County Social Service

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Clark County Social Service

1B. Coordination and Engagement–Inclusive Structure and Participation

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
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1B-1.	**Inclusive Structure and Participation–Participation in Coordinated Entry.**	
	NOFO Sections VII.B.1.a.(1), VII.B.1.e., VII.B.1.n., and VII.B.1.p.	

	In the chart below for the period from May 1, 2020 to April 30, 2021:
1.	**select yes or no in the chart below if the entity listed participates in CoC meetings, voted–including selecting CoC Board members, and participated in your CoC's coordinated entry system; or**
2.	**select Nonexistent if the organization does not exist in your CoC's geographic area:**

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

19.	**Mental Illness Advocates**	Yes	Yes	No
20.	**Non-CoC Funded Youth Homeless Organizations**	Yes	No	No
21.	**Non-CoC-Funded Victim Service Providers**	No	No	No
22.	**Organizations led by and serving Black, Brown, Indigenous and other People of Color**	Yes	Yes	No
23.	**Organizations led by and serving LGBT persons**	Yes	No	Yes
24.	**Organizations led by and serving people with disabilities**	No	No	No
25.	**Other homeless subpopulation advocates**	Yes	Yes	No
26.	**Public Housing Authorities**	Yes	Yes	No
27.	**School Administrators/Homeless Liaisons**	Yes	Yes	No
28.	**Street Outreach Team(s)**	Yes	Yes	Yes
29.	**Substance Abuse Advocates**	No	No	No
30.	**Substance Abuse Service Organizations**	No	No	Yes
31.	**Youth Advocates**	Yes	Yes	No
32.	**Youth Service Providers**	Yes	Yes	Yes
	Other:(limit 50 characters)			
33.	Veteran Serving Organization (U.S. VETS)	Yes	Yes	Yes
34.	Youth Action Board Member- YOUNG ADULTS IN CHARGE	Yes	Yes	No

1B-2.	**Open Invitation for New Members.**	
	NOFO Section VII.B.1.a.(2)	

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

(limit 2,000 characters)

1) SNH CoC has open enrollment for any agency/person interested in membership. CoC and Board applications are accepted throughout the year. The CoC solicits new members on an ongoing basis, especially when there are vacancies on the Board. The Community Engagement Working Group (EngageWG) provides quarterly orientation sessions for new/potential members to learn about the CoC and working groups. Board orientation is offered semi-annually. 2) The invitation to become a CoC and/or Board member is communicated during open meetings, emails, online at HelpHopeHome.org, on social media and via word of mouth. This variety of communication modes allows for all persons, including those with disabilities, to access the information. All documents are available on our website in electronic formats and agendas for working group and board meetings are sent out 2-7 days prior to the meeting to give participants a chance to review and understand the items scheduled for discussion. Sign language interpretation and TT/TDD is available upon request. 3) CoC members conduct outreach, especially to those with lived experience, and invite them to learn more about the CoC and how they can engage as a member. Members with lived experience share their story with

other potential members with lived experience and offer their support. The Board is also identifying sustainable funding for stipends for people with lived experience. 4) During the past quarter, 16 local Chambers of Commerce have been contacted for the business seats, Board vacancies, and general membership. This includes the Women, Hispanic, Colombian Armed Forces, America Indian, Latin, India, and International Chambers.

1B-3.	CoC's Strategy to Solicit/Consider Opinions on Preventing and Ending Homelessness.	
	NOFO Section VII.B.1.a.(3)	

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

(limit 2,000 characters)

1) The CoC solicits feedback from a wide array of stakeholders and persons with lived experience through various public meetings and activities to address system improvements to prevent and end homelessness. Stakeholders attend and present at monthly CoC Board Meetings that include facilitated discussions to consider feedback on how to address community homelessness and street outreach efforts. Twenty-one working groups, including sub-working and ad-hoc working groups, hold open monthly meetings to work collaboratively on actionable tasks identified during focus groups, community surveys, and planning meetings. Working Groups report back to the Steering Committee and CoC Board monthly to ensure that progress is being made on the action items and that initiatives are being fully implemented. Community partners, such as the Nevada Homeless Alliance (NHA), also solicit opinions from persons that have an interest in homelessness issues and bring these opinions and concerns to the SNH CoC Board. 2) All meetings are posted publicly in compliance with the Nevada Open Meeting Law. Meeting minutes from each working group and from the board meetings are maintained on HelpHopeHome.org, our CoC's website. There is a link on the website for the community to provide feedback and contact information for CoC dedicated staff is listed publicly. 3) At each board meeting, there are two segments dedicated to public comment. These comments are considered and speakers are encouraged to connect with applicable working groups for further development of ideas and programs.

1B-4.	Public Notification for Proposals from Organizations Not Previously Funded.	
	NOFO Section VII.B.1.a.(4)	

	Describe in the field below how your CoC notified the public:
1.	that your CoC's local competition was open and accepting project applications;
2.	that your CoC will consider project applications from organizations that have not previously received CoC Program funding;
3.	about how project applicants must submit their project applications;

4.	**about how your CoC would determine which project applications it would submit to HUD for funding; and**
5.	**how your CoC effectively communicated with individuals with disabilities, including making information accessible in electronic formats.**

(limit 2,000 characters)

1) The local application opportunity was advertised at provider meetings throughout September, through websites (9/3/21), on social media (9/3/21) and by word of mouth. On 9/3/21, public notice was sent to 1959 subscribers regarding the local application which was open to proposals. On 9/7/21 a mandatory TA session offered information on the tools for new application preparation and submission. Two agencies attended who had not previously received funding from the CoC. 2) Formal policies and procedures for scoring (based on sound management, performance and meeting local and federal priorities) and ranking of projects to determine which are included in the FY21 Competition have been established by the Evaluation, Monitoring, and Data and Systems Improvement Working Groups. All instructional guides and scoring guides are designed to prepare applicants, regardless of whether they are new or experienced, for the local application competition. New applicants that have not previously received CoC Program funding have specific questions that demonstrate their readiness to implement CoC programs. 3) All notifications for how to submit applications may be found at our CoC website under the funding opportunities tab. 4) The scoring and ranking process is publicly posted on the CoC website ensuring that all applicants understand how the CoC determines Tier 1, Tier 2, and Bonus funding recommendations. 5) All webinars have been conducted virtually this year. Closed captioning is available on this format. All written material and the recording of the webinar has been posted publicly so that all participants, including those with disabilities, are able to review the material as needed.

1C. Coordination and Engagement–Coordination with Federal, State, Local, Private, and Other Organiza

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
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1C-1.	**Coordination with Federal, State, Local, Private, and Other Organizations.**	
	NOFO Section VII.B.1.b.	

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

	Entities or Organizations Your CoC Coordinates with for Planning or Operations of Projects	Coordinates with Planning or Operations of Projects
1.	**Funding Collaboratives**	No
2.	**Head Start Program**	No
3.	**Housing and services programs funded through Local Government**	Yes
4.	**Housing and services programs funded through other Federal Resources (non-CoC)**	Yes
5.	**Housing and services programs funded through private entities, including Foundations**	Yes
6.	**Housing and services programs funded through State Government**	Yes
7.	**Housing and services programs funded through U.S. Department of Health and Human Services (HHS)**	Yes
8.	**Housing and services programs funded through U.S. Department of Justice (DOJ)**	Yes
9.	**Housing Opportunities for Persons with AIDS (HOPWA)**	Yes
10.	**Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)**	No
11.	**Organizations led by and serving Black, Brown, Indigenous and other People of Color**	Yes
12.	**Organizations led by and serving LGBT persons**	Yes
13.	**Organizations led by and serving people with disabilities**	No
14.	**Private Foundations**	No
15.	**Public Housing Authorities**	Yes
16.	**Runaway and Homeless Youth (RHY)**	Yes
17.	**Temporary Assistance for Needy Families (TANF)**	Yes
	Other:(limit 50 characters)	

18.		

1C-2.	**CoC Consultation with ESG Program Recipients.**	
	NOFO Section VII.B.1.b.	

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

(limit 2,000 characters)

1) ESG program staff from all four local ESG jurisdictions (Clark County, Las Vegas, North Las Vegas, Henderson) worked together to determine the most effective and efficient way to utilize ESG and CDBG funds. The jurisdictions combined their dollars together to ensure consistency throughout the community and submitted joint applications to the state. 2) ESG programs are monitored via the same process as CoC programs. Strategic Solutions, a third-party organization, was contracted to monitor all of the CoC and ESG programs in Southern Nevada. The monitoring reports are shared with all members of the Monitoring (MWG) and Evaluation Work Groups (EWG), including ESG staff from the four jurisdictions. These reports and any recommended courses of action are discussed prior to contact with the providers. The Monitoring Working Group works with the local jurisdictions to identify any agencies of concern to ensure that all funds being used to combat homelessness are being used effectively. 3) The Community Resources Management Unit is responsible for completing the Consolidated Plan for Clark County, North Las Vegas, Boulder City and Mesquite. The cities of Henderson and Las Vegas are responsible for those jurisdictions' Consolidated Plans. All plans are shared with partnering jurisdictions and PIT and HIC data are shared publicly so they can be included in the Consolidated Plans as appropriate. 4) The MWG and EWG include representatives from both public and private agencies, ensuring compliance with the regional 10-year strategic plan. The CoC also provides the information required to complete the Consolidated Plan, ensuring that all Plans reflect the agreed upon regional approach to ending homelessness.

1C-3.	**Ensuring Families are not Separated.**	
	NOFO Section VII.B.1.c.	

Select yes or no in the chart below to indicate how your CoC ensures emergency shelter, transitional housing, and permanent housing (PSH and RRH) do not deny admission or separate family members regardless of each family member's self-reported gender:

1.	**Conducted mandatory training for all CoC- and ESG-funded service providers to ensure families are not separated.**	Yes
2.	**Conducted optional training for all CoC- and ESG-funded service providers to ensure families are not separated.**	Yes

3.	**Worked with ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients.**	Yes
4.	**Worked with ESG recipient(s) to identify both CoC- and ESG-funded facilities within your CoC's geographic area that might be out of compliance and took steps to work directly with those facilities to bring them into compliance.**	No
5.	**Sought assistance from HUD by submitting AAQs or requesting technical assistance to resolve noncompliance of service providers.**	No
6.	**Other. (limit 150 characters)**	

1C-4.	**CoC Collaboration Related to Children and Youth–SEAs, LEAs, Local Liaisons & State Coordinators.**	
	NOFO Section VII.B.1.d.	

	Describe in the field below:
1.	**how your CoC collaborates with youth education providers;**
2.	**your CoC's formal partnerships with youth education providers;**
3.	**how your CoC collaborates with State Education Agency (SEA) and Local Education Agency (LEA);**
4.	**your CoC's formal partnerships with SEAs and LEAs;**
5.	**how your CoC collaborates with school districts; and**
6.	**your CoC's formal partnerships with school districts.**

(limit 2,000 characters)

1) Clark County School District (CCSD) McKinney-Vento (MV) Liaisons represent public education on the board of the SNH CoC. The school district MV program, CCSD Title I HOPE, collaborates with community early childhood programs and statewide higher education institutions to promote awareness of children and youth experiencing homelessness. Title I HOPE facilitates enrollment of students residing in shelters and other housing programs. 2) Through their partnership with the CCSD Title I HOPE program the CoC establishes points of contact and regular meetings between community shelter contacts and trains shelter, early childhood agency, and Nevada System of Higher Education (NSHE) staff to share procedures that promote identification and enrollment of homeless students. They also promote CoC Coordinated Entry sites and processes within CCSD to assess families and youth in need of housing. 3) The CoC collaborates with the MV Liaisons who collaborate with the MV SEA. The CoC collaborates directly with CCSD through Title I HOPE via two MV Liaisons. 4) The CCSD Title I HOPE program is formally connected with LEAs and SEAs and facilitates contact on behalf of the CoC. 5) CoC programs that serve youth and families are required to ensure that youth are enrolled in school programs. CCSD MV Liaisons support all programs and work to ensure that all youth are enrolled in appropriate educational programs. CCSD and the CoC work in tandem to ensure that students that meet both the HUD and McKinney-Vento definition of homelessness are aware of their rights under Federal law and receive the necessary support to exercise those rights. CCSD MV Liaisons sit on the CoC Board and are engaged in many working groups including the Youth Working Group (YWG). They led the 2019 100 Day Challenge to house youth and educate CoC partners on relevant opportunities. 6) Formal partnership with CoC and CCSD through the Title I HOPE Department have been memorialized in a memorandum of understanding.

1C-4a.	**CoC Collaboration Related to Children and Youth–Educational Services–Informing Individuals and Families Experiencing Homelessness about Eligibility.**	

NOFO Section VII.B.1.d.

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

(limit 2,000 characters)

As part of the local application competition, projects are monitored regarding their policies and procedures that inform individuals and families who become homeless of their eligibility for education services. All programs are encouraged to connect with Clark County School District's (CCSD) Title I Homeless Outreach Program for Education (HOPE) office, which consists of staff who are responsible for providing training and support to all of CCSD's 366 schools. Title I HOPE staff work with community-wide youth programs and ensure school staff and CCSD department staff have access to information regarding procedures to safeguard compliance with the McKinney-Vento Act requiring that all students and staff are aware of current community resources. In addition, the Title I HOPE Department supplies informational pamphlets regarding their program to all CoC funded shelters and youth providers. These pamphlets contain detailed information outlining the services provided by Title I HOPE, qualifications under the McKinney-Vento Act, and contact information for the department should anyone require help accessing their services. In response to COVID-19 and previous school shutdowns, Title I HOPE has made all of their resources and information available electronically by enhancing their public facing website as well as creating an information hub on a Google Site for CCSD employees. The development of relationships through attending CoC Board and subgroup meetings has improved coordination and collaboration among HOPE staff with multiple jurisdictional and community partners. The benefits of these fortified relationships enable Southern Nevada to further develop and strengthen a healthy system of care ensuring that the educational and personal needs of children and families experiencing homelessness are met. HOPE staff sit on the CoC Board, CoC Steering Committee, Youth Working Group and Planning Working Group.

1C-4b.	**CoC Collaboration Related to Children and Youth–Educational Services–Written/Formal Agreements or Partnerships with Early Childhood Services Providers.**	
	NOFO Section VII.B.1.d.	

Select yes or no in the chart below to indicate whether your CoC has written formal agreements or partnerships with the listed providers of early childhood services:

		MOU/MOA	Other Formal Agreement
1.	**Birth to 3 years**	No	Yes
2.	**Child Care and Development Fund**	No	No
3.	**Early Childhood Providers**	No	Yes
4.	**Early Head Start**	No	Yes
5.	**Federal Home Visiting Program–(including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)**	No	No
6.	**Head Start**	No	Yes
7.	**Healthy Start**	No	Yes

8.	**Public Pre-K**	No	Yes
9.	**Tribal Home Visiting Program**	No	No
	Other (limit 150 characters)		
10.			

1C-5.	**Addressing Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors–Annual Training–Best Practices.**	
	NOFO Section VII.B.1.e.	

	Describe in the field below how your CoC coordinates to provide training for:
1.	**Project staff that addresses safety and best practices (e.g., trauma-informed, victim-centered) on safety and planning protocols in serving survivors of domestic violence and indicate the frequency of the training in your response (e.g., monthly, semi-annually); and**
2.	**Coordinated Entry staff that addresses safety and best practices (e.g., trauma informed care) on safety and planning protocols in serving survivors of domestic violence and indicate the frequency of the training in your response (e.g., monthly, semi-annually).**

(limit 2,000 characters)

1) CoC project staff are provided with annual training through the Mainstream Programs Basic Training curriculum to address safety and best practices in serving survivors of domestic violence, dating violence, sexual assault, stalking and human trafficking. This training is open to all community providers, CoC area projects, and Coordinated Entry staff. 2) Safe Nest: Temporary Assistance for Domestic Crisis, a Continuum of Care partner, has been providing 24-hour crisis hotline and emergency shelter services for domestic violence victims in Southern Nevada since 1977. As the primary DV-focused provider in this community, they provide training and technical assistance to our community providers and Coordinated Entry staff on topics such as: human trafficking, sexual violence, the cycle of domestic violence, laws that pertain to survivors, how to recognize and assist survivors through trauma-informed care, and how to access resources. This training is offered on an annual basis and as part of the training for Coordinated Entry Short Assessment Triage Tool which all CE Assessors must complete before beginning assessments with clients. Safe Nest ensures that all CE staff have the information necessary to address safety needs of survivors of domestic violence.

1C-5a.	**Addressing Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors–Using De-identified Aggregate Data.**	
	NOFO Section VII.B.1.e.	

Describe in the field below how your CoC uses de-identified aggregate data from a comparable database to assess the special needs related to domestic violence, dating violence, sexual assault, and stalking survivors.

(limit 2,000 characters)

DV dedicated providers in Southern Nevada are currently utilizing a private implementation of Clarity Human Services that serves as a Comparable Database, provided by Bitfocus, Inc., the Nevada HMIS vendor and system administrator. The comparable database, used to assess the scope of community needs related to domestic violence, dating violence, sexual assault and stalking, is configured in alignment with the most recent HUD Data

Standards providing the collection of Metadata, Project Descriptor, Universal (non-identifying), and Program Specific data elements. Due to the anonymity of client records, it is recognized that when combining system wide aggregate data, duplication will occur.

As in HMIS, grantees have access within the database to produce funder specific reports such as the APR, CAPER, HIC/PIT, and System Performance Measures. In addition, custom assessments have been added to the database, unique to survivors. The first of these is the Domestic Violence Safety and Assessment Tool (DVSAT) conducted via the Safe Nest hotline is administered to survivors fleeing dangerous situations to identify risk factors and the degree of imminent danger to the client. All collected information is entered into a comparable database to ensure client confidentiality. The level of robust data within the comparable database allows for aggregate reporting of victim/survivor specific elements as well as community focused priorities, such as chronicity and system performance measures, while ensuring the safety and anonymity of the client.

1C-5b.	**Addressing Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors–Coordinated Assessment–Safety, Planning, and Confidentiality Protocols.**	
	NOFO Section VII.B.1.e.	

	Describe in the field below how your CoC's coordinated entry system protocols incorporate trauma-informed, victim-centered approaches while maximizing client choice for housing and services that:
1.	**prioritize safety;**
2.	**use emergency transfer plan; and**
3.	**ensure confidentiality.**

(limit 2,000 characters)

1) Clients accessing coordinated entry (CE) are given a SATT (Safety Assessment Triage Tool) to assess safety and determine need for DV intervention/shelter. All CE assessors are trained so when an individual indicates they have experienced recent violence, questions determine if the individual is open to receiving services from a DV-focused provider. For those indicating willingness, a safe, private space at each location is available for the client to contact Safe Nest. Once this process begins, no new information is entered into HMIS to protect the identity of the client. Safe Nest maintains a 24-hour domestic crisis hotline that prioritizes safety while incorporating a trauma-informed, victim-centered approach. Trained staff can effectively determine if a homeless individual is fleeing domestic violence and clients may choose to engage with Safe Nest staff and create a safety plan that maximizes client choice for housing and services; clients also have access to Emergency Temporary Protection Orders that Safe Nest advocates can complete with the client via the Safe Nest hotline. 2) If appropriate for shelter, an advocate picks up the client or facilitates transportation to Safe Nest's confidential shelter. Safe Nest staff providing direct client services receive training in trauma-informed care and have an understanding that certain legal processes involved with obtaining housing can put victims at risk. Staff are trained on the legal aspects of housing and statutes through VAWA that are in place to protect DV survivors from unlawful evictions or nuisance charges that stem from abuse, preventing further barriers to survivors maintaining stable, independent housing. 3) CE protocols protect the identity of survivors of DV to prioritize their safety. Victim-

centered services, during events like Project Homeless Connect, utilize private registration/entry as safety protocols.

1C-6.	Addressing the Needs of Lesbian, Gay, Bisexual, Transgender–Anti-Discrimination Policy and Training.	
	NOFO Section VII.B.1.f.	

1.	Did your CoC implement a written CoC-wide anti-discrimination policy ensuring that LGBT individuals and families receive supportive services, shelter, and housing free from discrimination?	Yes
2.	Did your CoC conduct annual CoC-wide training with providers on how to effectively implement the Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity (Equal Access Final Rule)?	Yes
3.	Did your CoC conduct annual CoC-wide training with providers on how to effectively implement Equal Access to Housing in HUD Programs in Accordance with an Individual's Gender Identity (Gender Identity Final Rule)?	No

1C-7.	Public Housing Agencies within Your CoC's Geographic Area–New Admissions–General/Limited Preference–Moving On Strategy. You Must Upload an Attachment(s) to the 4B. Attachments Screen.	
	NOFO Section VII.B.1.g.	

Enter information in the chart below for the two largest PHAs highlighted in gray on the CoC-PHA Crosswalk Report at https://files.hudexchange.info/resources/documents/FY-2020-CoC-PHA-Crosswalk-Report.pdf or the two PHAs your CoC has a working relationship with–if there is only one PHA in your CoC's geographic area, provide information on the one:

Public Housing Agency Name	Enter the Percent of New Admissions into Public Housing and Housing Choice Voucher Program During FY 2020 who were experiencing homelessness at entry	Does the PHA have a General or Limited Homeless Preference?	Does the PHA have a Preference for current PSH program participants no longer needing intensive supportive services, e.g., Moving On?
Southern Nevada Regional Housing Authority	47%	Yes-Both	No

1C-7a.	Written Policies on Homeless Admission Preferences with PHAs.	
	NOFO Section VII.B.1.g.	

	Describe in the field below:
1.	steps your CoC has taken, with the two largest PHAs within your CoC's geographic area or the two PHAs your CoC has working relationships with, to adopt a homeless admission preference–if your CoC only has one PHA within its geographic area, you may respond for the one; or
2.	state that your CoC has not worked with the PHAs in its geographic area to adopt a homeless admission preference.

(limit 2,000 characters)

1) The Southern Nevada Regional Housing Authority (SNRHA) is the primary PHA for NV-500. Representatives from SNRHA sit on the Board of the CoC and participate in working groups and sub-working groups. They have been an active participant in the Moving On Working Group since 2017 when it was initiated. This working group, along with the Joint Housing Working Group

dedicates their efforts to improving system-wide housing for individuals and families experiencing homelessness. This includes discussions on implementing the community wide Moving On strategy and strengthening the adopted homeless admission preference. The collaborative applicant has met with the director of SNRHA to ensure their full understanding of the great need to maintain the current homeless admission preference and find other opportunities for the CoC and PHA to partner. SNRHA and the CoC have worked closely over the past 6 months to diligently implement the Emergency Housing Voucher (EHV) program. The CoC has learned much about the housing voucher process and SNRHA has learned much about the unique needs of our homeless population. The CoC is appreciative of the efforts and flexibility SNRHA has demonstrated during this process. The SNRHA has recently applied for the Mainstream Housing Voucher program in partnership with the CoC to address gaps of affordable housing for clients appropriate for the Moving On Initiative. They have also partnered with Clark County Social Service Step Up program to provide housing vouchers for former foster youth and to HELP of Southern Nevada for clients experiencing homelessness. 2) N/A

1C-7b.	**Moving On Strategy with Affordable Housing Providers.**	
	Not Scored–For Information Only	

Select yes or no in the chart below to indicate affordable housing providers in your CoC's jurisdiction that your recipients use to move program participants to other subsidized housing:

1.	**Multifamily assisted housing owners**	Yes
2.	**PHA**	Yes
3.	**Low Income Tax Credit (LIHTC) developments**	No
4.	**Local low-income housing programs**	Yes
	Other (limit 150 characters)	
5.		

1C-7c.	**Including PHA-Funded Units in Your CoC's Coordinated Entry System.**	
	NOFO Section VII.B.1.g.	

Does your CoC include PHA-funded units in the CoC's coordinated entry process?	Yes

1C-7c.1.	**Method for Including PHA-Funded Units in Your CoC's Coordinated Entry System.**	
	NOFO Section VII.B.1.g.	

	If you selected yes in question 1C-7c., describe in the field below:
1.	**how your CoC includes the units in its Coordinated Entry process; and**
2.	**whether your CoC's practices are formalized in written agreements with the PHA, e.g., MOUs.**

(limit 2,000 characters)

1) The CoC has developed a prioritization memo for EHV units that includes the populations that are prioritized for PHA units and the process in which clients will be referred for these units. The CE process matches clients on the community queue with program vacancies identified on a daily basis. The Moving On Working Group has developed the self sufficiency assessment tool to identify clients who are ready to exit housing programs. This tool has been built out in HMIS and will lead to the development of a Coordinated Exit queue. Once fully implemented, clients will be prioritized for affordable housing units based on their self-sufficiency assessment score and placed on the Coordinated Exit queue.
2) These practices have been formalized in fully executed MOUs between the CoC and the PHA. The PHA has been actively engaged in the CoC Moving On working group and the Emergency Housing Voucher team that includes the PHA, the Collaborative Applicant, and the Coordinated Entry Matchers who meet bi-weekly to address any concerns and analyze the data being collected. The PHA and CoC also created a Mainstream Housing Voucher working group that began meeting in Nov 2020 when utilization of Mainstream Vouchers was less than 40%. By discussing best practice and effective strategies for housing clients, the utilization of these vouchers hit 100% within 5 months and has maintained that level since achieving it.

1C-7d.	**Submitting CoC and PHA Joint Applications for Funding for People Experiencing Homelessness.**	
	NOFO Section VII.B.1.g.	

Did your CoC coordinate with a PHA(s) to submit a joint application(s) for funding of projects serving families experiencing homelessness (e.g., applications for mainstream vouchers, Family Unification Program (FUP), other non-federal programs)?	Yes

1C-7d.1.	**CoC and PHA Joint Application–Experience–Benefits.**	
	NOFO Section VII.B.1.g.	

	If you selected yes to question 1C-7d, describe in the field below:
1.	**the type of joint project applied for;**
2.	**whether the application was approved; and**
3.	**how your CoC and families experiencing homelessness benefited from the coordination.**

(limit 2,000 characters)

1) HCV, Mainstream Housing Vouchers, Welfare to Work, FUP, FYI
2) HCV, Mainstream Housing Vouchers, Welfare to Work, FUP approved since 2009; FUP renewal approved in 2019; Competitive FYI application was not approved
3) Based on the homeless admissions preference from SNRHA, 47% of the HCV program participants were experiencing homelessness at entry. These individuals and families are often the same clients that are on our community queue. By serving them through housing vouchers we are able to minimize the duplication of efforts in regard to clients on our CoC queue. FUP vouchers are offered to families involved with child welfare whose lack of adequate housing is a primary cause of the separation or imminent separation of a child(ren) from their families. HCV/FUP assistance is provided so that children will not be

separated from their parents because of a lack of permanent, safe, decent, and sanitary housing. The partnership has aided families in securing eligible units and providing on-going case management to assist in the stabilization of families to ensure they successfully lease-up in affordable, safe, decent and sanitary units. This results in families staying intact and children being diverted from out-of-home foster care and extended child welfare involvement. During the last two years, 93 families, with a total of 279 children, have been approved for voucher assistance.
In the past 10 months, 16 referrals for parenting, aged-out foster youth have been submitted of which 11 have been approved for and received vouchers. This expansion to the target population supported cross-sector partnering efforts and increased utilization rates of the FUP HCV to improve the qualification to apply for new and alternative HCV opportunities including FYI vouchers.

1C-7e.	**Coordinating with PHA(s) to Apply for or Implement HCV Dedicated to Homelessness Including American Rescue Plan Vouchers.**	
	NOFO Section VII.B.1.g.	

Did your CoC coordinate with any PHA to apply for or implement funding provided for Housing Choice Vouchers dedicated to homelessness, including vouchers provided through the American Rescue Plan?	Yes

1C-7e.1.	**Coordinating with PHA(s) to Administer Emergency Housing Voucher (EHV) Program–List of PHAs with MOUs.**	
	Not Scored–For Information Only	

Did your CoC enter into a Memorandum of Understanding (MOU) with any PHA to administer the EHV Program?	Yes

If you select yes, you must use the list feature below to enter the name of every PHA your CoC has entered into a MOU with to administer the Emergency Housing Voucher Program.
PHA
Southern Nevada R...

1C-7e.1. List of PHAs with MOUs

Name of PHA: Southern Nevada Regional Housing Authority

1C. Coordination and Engagement–Coordination with Federal, State, Local, Private, and Other Organiza

1C-8.	Discharge Planning Coordination.	
	NOFO Section VII.B.1.h.	

Select yes or no in the chart below to indicate whether your CoC actively coordinates with the systems of care listed to ensure persons who have resided in them longer than 90 days are not discharged directly to the streets, emergency shelters, or other homeless assistance programs.

1. Foster Care	Yes
2. Health Care	Yes
3. Mental Health Care	Yes
4. Correctional Facilities	Yes

1C-9.	Housing First–Lowering Barriers to Entry.	
	NOFO Section VII.B.1.i.	

1.	**Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects your CoC is applying for in FY 2021 CoC Program Competition.**	22
2.	**Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects your CoC is applying for in FY 2021 CoC Program Competition that have adopted the Housing First approach.**	21
3.	**This number is a calculation of the percentage of new and renewal PSH, RRH, Safe-Haven, SSO non-Coordinated Entry projects the CoC has ranked in its CoC Priority Listing in the FY 2021 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.**	95%

1C-9a.	Housing First–Project Evaluation.	
	NOFO Section VII.B.1.i.	

Describe in the field below how your CoC regularly evaluates projects to ensure those that commit to using a Housing First approach are prioritizing rapid placement and stabilization in permanent housing and are not requiring service participation or preconditions of program participants.

(limit 2,000 characters)

The SNH CoC Monitoring Working Group (MWG) contracts with a third-party vendor to assist with the completion of monitoring for all CoC and ESG funded programs in Southern Nevada. The external monitoring team has worked to customize tools for monitoring the compliance of each program on HUD

regulations. In 2019, the external monitoring team worked on and discussed various ways to monitor programs' commitment to Housing First. Ultimately, the MWG decided to adopt the "Housing First Assessment Tool" that HUD published as a resource. Projects are monitored on an annual basis and for the last two years of monitoring the external monitoring team has utilized this tool to understand how closely CoC funded programs within the SNH CoC align with the Housing First model and those best practice standards of Housing First. Once all monitoring has been completed, CoC funded agencies participate in an exit interview to discuss scores on the various tools including the Housing First Assessment Tool. During this exit interview, providers are offered the opportunity to receive technical assistance and guidance from either the MWG or the external monitoring team, or the CoC Grants Coordinator, on various aspects of monitoring where providers wish to improve their performance and scores; including alignment with Housing First principles. Additionally, providers receive scores with final tools attached outlining the expectation for where improvements can be made. Results of the Housing First Assessment Tool for each renewal project are utilized during the local CoC Competition scoring and ranking of projects. This metric is worth 10 points out of the 30 points available in the Community Coordination and Compliance section of the local application.

1C-9b.	**Housing First–Veterans.**	
	Not Scored–For Information Only	

Does your CoC have sufficient resources to ensure each Veteran experiencing homelessness is assisted to quickly move into permanent housing using a Housing First approach?	Yes

1C-10.	**Street Outreach–Scope.**	
	NOFO Section VII.B.1.j.	

	Describe in the field below:
1.	**your CoC's street outreach efforts, including the methods it uses to ensure all persons experiencing unsheltered homelessness are identified and engaged;**
2.	**whether your CoC's Street Outreach covers 100 percent of the CoC's geographic area;**
3.	**how often your CoC conducts street outreach; and**
4.	**how your CoC tailored its street outreach to persons experiencing homelessness who are least likely to request assistance.**

(limit 2,000 characters)

1) Street outreach (SO) teams' activities targeting those least likely to request assistance include: 24-hour hotlines; partner collaboration to locate clients; SO based on encampment movements, proactive and call out teams that target preidentified areas brought to the attention of the Regional Coordinator, and non-English speaking individuals. Coordinated entry assessments done in the field allow those with transportation or communication issues to receive immediate assistance and attention. SO teams employ persons with lived experience, including young people, as outreach workers and leaders. SO teams put tremendous effort into building trusting relationships with those living on the streets. 2) SO covers 100% of the geographic area including hard-to-reach tunnels and frequently identified encampments; mountainous areas; the LV Strip; washes; and desert areas through tailored outreach activities. SO

teams work with the Bureau of Land Management for safety when providing outreach in caves originally used for mining. Local jurisdictions have joined the County in providing funding for SO teams for their regions to ensure a targeted approach that does not result in duplicated efforts. To ensure a regional collaborative effort all SO teams enter data in HMIS. 3) SO is conducted 24/7/365 including nights & holidays. 4) To target those least likely to request assistance, SO teams are equipped with food, drink, clothing, hygiene supplies and information cards about shelters and other community resources and services to build trusting relationships. To ensure individuals are safe, SO teams notify those living in tunnels and washes of anticipated deadly storms and floods. The HMIS Clarity App allows tracking of individuals and their locations via unique identifiers such as “dragon tattoo” to create a history of where individuals are and when they move to ensure ongoing communication and encouragement for them to engage in services. Surveys are conducted regularly to understand the needs of clients receiving outreach.

1C-11.	**Criminalization of Homelessness.**	
	NOFO Section VII.B.1.k.	

Select yes or no in the chart below to indicate strategies your CoC implemented to prevent the criminalization of homelessness in your CoC’s geographic area:

1.	**Engaged/educated local policymakers**	Yes
2.	**Engaged/educated law enforcement**	Yes
3.	**Engaged/educated local business leaders**	Yes
4.	**Implemented communitywide plans**	Yes
5.	**Other:(limit 500 characters)**	
	Metro has implemented several collaborative teams that conduct street outreach and connect homeless individuals to services	Yes

1C-12.	**Rapid Rehousing–RRH Beds as Reported in the Housing Inventory Count (HIC).**	
	NOFO Section VII.B.1.l.	

	2020	**2021**
Enter the total number of RRH beds available to serve all populations as reported in the HIC–only enter bed data for projects that have an inventory type of “Current.”	1,006	953

1C-13.	**Mainstream Benefits and Other Assistance–Healthcare–Enrollment/Effective Utilization.**	
	NOFO Section VII.B.1.m.	

Indicate in the chart below whether your CoC assists persons experiencing homelessness with enrolling in health insurance and effectively using Medicaid and other benefits.

	Type of Health Care	Assist with Enrollment?	Assist with Utilization of Benefits?
1.	**Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services)**	Yes	Yes
2.	**Private Insurers**	No	No
3.	**Nonprofit, Philanthropic**	Yes	Yes
4.	**Other (limit 150 characters)**		
	Managed Care Organizations	Yes	Yes

1C-13a.	**Mainstream Benefits and Other Assistance–Information and Training.**	
	NOFO Section VII.B.1.m	

	Describe in the field below how your CoC provides information and training to CoC Program-funded projects by:
1.	**systemically providing up to date information on mainstream resources available for program participants (e.g., Food Stamps, SSI, TANF, substance abuse programs) within your CoC's geographic area;**
2.	**communicating information about available mainstream resources and other assistance and how often your CoC communicates this information;**
3.	**working with projects to collaborate with healthcare organizations to assist program participants with enrolling in health insurance; and**
4.	**providing assistance with the effective use of Medicaid and other benefits.**

(limit 2,000 characters)

1) To ensure program staff are kept up to date regarding mainstream resources available for persons experiencing homelessness, local SOAR Coordinators hold regular meetings to address barriers and improve efficiency for clients. For more than 15 years, Mainstream Programs Basic Training (MPBT) has offered free, monthly, training geared toward agencies who work directly with homeless or low-income individuals to increase access to resources and income and includes information on community resources; mainstream benefits and eligibility; TANF, SNAP, Medicaid/Medicare, and substance use resources; Screening, Brief Intervention and Referral to Treatment (SBIRT); education and employment support; and childcare subsidies. While MPBT has been put on hold due to COVID, the Nevada Homeless Alliance (NHA) has incorporated these topics into their trainings to ensure the community remains informed. 2) MPBT and CoC-wide email blasts are sent when opportunities for resources and assistance become available. These are also posted in HHH & NHA newsletters to increase visibility on a monthly basis. 3) Programs such as Healthy Living partner with managed care organizations (MCOs) who provide medical case management for clients enrolled in housing programs. Case managers assist clients with enrolling in health insurance and SOAR trained case managers help them apply for SSI/SSDI and mainstream benefits. The State and MCOs conduct outreach at health fairs and community centers to provide information on available mainstream resources. 4) The CoC helps programs establish prioritization for payees, ensuring the effective utilization of all funding types including Medicaid and other benefits. CoC programs bill Medicaid when appropriate as a standard practice. The CoC is working innovatively with the State to develop a program to use benefits for pre-tenancy support for clients and benefit specialists can help clients apply for benefits that help them secure housing options.

1C-14.	**Centralized or Coordinated Entry System–Assessment Tool. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.1.n.	

	Describe in the field below how your CoC's coordinated entry system:
1.	**covers 100 percent of your CoC's geographic area;**
2.	**reaches people who are least likely to apply for homeless assistance in the absence of special outreach;**
3.	**prioritizes people most in need of assistance; and**
4.	**ensures people most in need of assistance receive assistance in a timely manner.**

(limit 2,000 characters)

1) The SNH CoC Coordinated Entry System (CES) covers 100% of the CoC's geographic area including the urban, suburban, and rural areas. 2) To reach people who are least likely to apply for homeless assistance, outreach teams cover the geographic areas and conduct assessments in the field. The Coordinated Outreach Working Group is a subgroup of the CES to support continuum-wide efforts. 3) Prior to the pandemic the CES prioritized those most in need of assistance by assigning priority points to clients based on their needs, length of time homeless, age, and other vulnerability factors. During the pandemic, CES adopted a temporary COVID pandemic prioritization exception (PPE) that including considerations of vulnerability based on the CDC and the local public health authority. The PPE has been flexible and has been adapted to address the changing recommendations of the CDC and health authority. 4) The CES has remained reflective of the needs of the community and the changing understanding of COVID. To ensure access for all individuals during the pandemic, most of the CES converted to virtual and/or telephonic assessments to complete housing assessments. These practices have proven to be very effective for most sub-populations of homelessness, including those in rural areas who now have greater access to CES. Virtual and telephonic assessments are anticipated to be continued indefinitely.

1C-15.	**Promoting Racial Equity in Homelessness–Assessing Racial Disparities.**	
	NOFO Section VII.B.1.o.	

Did your CoC conduct an assessment of whether disparities in the provision or outcome of homeless assistance exists within the last 3 years?	Yes

1C-15a.	**Racial Disparities Assessment Results.**	
	NOFO Section VII.B.1.o.	

Select yes or no in the chart below to indicate the findings from your CoC's most recent racial disparities assessment.

1.	**People of different races or ethnicities are more likely to receive homeless assistance.**	Yes
2.	**People of different races or ethnicities are less likely to receive homeless assistance.**	Yes

3.	**People of different races or ethnicities are more likely to receive a positive outcome from homeless assistance.**	No
4.	**People of different races or ethnicities are less likely to receive a positive outcome from homeless assistance.**	Yes
5.	**There are no racial or ethnic disparities in the provision or outcome of homeless assistance.**	No
6.	**The results are inconclusive for racial or ethnic disparities in the provision or outcome of homeless assistance.**	No

1C-15b.	**Strategies to Address Racial Disparities.**	
	NOFO Section VII.B.1.o.	

Select yes or no in the chart below to indicate the strategies your CoC is using to address any racial disparities.

1.	**The CoC's board and decisionmaking bodies are representative of the population served in the CoC.**	Yes
2.	**The CoC has identified steps it will take to help the CoC board and decisionmaking bodies better reflect the population served in the CoC.**	Yes
3.	**The CoC is expanding outreach in geographic areas with higher concentrations of underrepresented groups.**	Yes
4.	**The CoC has communication, such as flyers, websites, or other materials, inclusive of underrepresented groups.**	Yes
5.	**The CoC is training staff working in the homeless services sector to better understand racism and the intersection of racism and homelessness.**	Yes
6.	**The CoC is establishing professional development opportunities to identify and invest in emerging leaders of different races and ethnicities in the homelessness sector.**	Yes
7.	**The CoC has staff, committees, or other resources charged with analyzing and addressing racial disparities related to homelessness.**	Yes
8.	**The CoC is educating organizations, stakeholders, boards of directors for local and national nonprofit organizations working on homelessness on the topic of creating greater racial and ethnic diversity.**	Yes
9.	**The CoC reviewed coordinated entry processes to understand their impact on people of different races and ethnicities experiencing homelessness.**	Yes
10.	**The CoC is collecting data to better understand the pattern of program use for people of different races and ethnicities in its homeless services system.**	Yes
11.	**The CoC is conducting additional research to understand the scope and needs of different races or ethnicities experiencing homelessness.**	Yes
	Other:(limit 500 characters)	
12.	The CoC is working with federal technical assistance providers to improve our strategies to ensure equitable services to all races and ethnicities	Yes

1C-15c.	**Promoting Racial Equity in Homelessness Beyond Areas Identified in Racial Disparity Assessment.**	
	NOFO Section VII.B.1.o.	

Describe in the field below the steps your CoC and homeless providers have taken to improve racial equity in the provision and outcomes of assistance beyond just those areas identified in the racial disparity assessment.

(limit 2,000 characters)

SNH CoC is currently in the midst of evaluating the entire system from entry to exit for equity. This work, conducted in collaboration with technical assistance

providers is being done at all levels, within every working group, for every CoC process, and every data pull. Each group is open to making process adjustments as needed to ensure that our system is fair and equitable for all populations.

SNH CoC conducted an initial Racial Disparity Report in 2019. The conclusions were that there may be a disproportion in Clark County's racial representation in poverty to homelessness, however there were no clear indicators that racial disparity existed in the overall view of the SNH CoC. This initial analysis was preliminary and limited in scope. Further analysis was recommended to determine equity among access to individual project types in order to conclude any concrete findings.

In May of 2021 the SNH CoC asked ICF International Inc., a HUD Technical Assistance provider, to assist in analysis of the different data sets of the homeless response system for racial equity. Results have been presented at multiple working groups and at Board meetings to ensure the community has a clear understanding of the findings and next steps.

The CoC Youth Working Group conducted a survey of youth with lived experience who were assessed with he VI-SPDAT tool to understand the impact it has had on program access for subpopulations of youth. Results will lead the team to next steps which may include adoption of a locally-specific housing assessment similar to the one used for single adult and family subpopulations.

The SNH CoC is in the process of memorializing its commitment to racial equity by including this language into the Governance Charter of the Board and each of its respective work groups responsibilities. The SNH CoC has developed a Data Dashboard that will be public facing on its website and will include data points that measure disparity/equity and allow for full transparency.

1C-16.	**Persons with Lived Experience–Active CoC Participation.**	
	NOFO Section VII.B.1.p.	

Enter in the chart below the number of people with lived experience who currently participate in your CoC under the five categories listed:

	Level of Active Participation	Number of People with Lived Experience Within the Last 7 Years or Current Program Participant	Number of People with Lived Experience Coming from Unsheltered Situations
1.	**Included and provide input that is incorporated in the local planning process.**	2	2
2.	**Review and recommend revisions to local policies addressing homelessness related to coordinated entry, services, and housing.**	2	2
3.	**Participate on CoC committees, subcommittees, or workgroups.**	2	2
4.	**Included in the decisionmaking processes related to addressing homelessness.**	2	2
5.	**Included in the development or revision of your CoC's local competition rating factors.**	0	0

1C-17.	**Promoting Volunteerism and Community Service.**	
	NOFO Section VII.B.1.r.	

Select yes or no in the chart below to indicate steps your CoC has taken to promote and support community engagement among people experiencing homelessness in the CoC's geographic area:

1.	**The CoC trains provider organization staff on connecting program participants and people experiencing homelessness with education and job training opportunities.**	Yes
2.	**The CoC trains provider organization staff on facilitating informal employment opportunities for program participants and people experiencing homelessness (e.g., babysitting, housekeeping, food delivery, data entry).**	No
3.	**The CoC works with organizations to create volunteer opportunities for program participants.**	Yes
4.	**The CoC works with community organizations to create opportunities for civic participation for people experiencing homelessness (e.g., townhall forums, meeting with public officials).**	Yes
5.	**Provider organizations within the CoC have incentives for employment and/or volunteerism.**	Yes
6.	**Other:(limit 500 characters)**	

1D. Addressing COVID-19 in the CoC's Geographic Area

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1D-1.	**Safety Protocols Implemented to Address Immediate Needs of People Experiencing Unsheltered, Congregate Emergency Shelter, Transitional Housing Homelessness.**	
	NOFO Section VII.B.1.q.	

	Describe in the field below protocols your CoC implemented during the COVID-19 pandemic to address immediate safety needs for individuals and families living in:
1.	**unsheltered situations;**
2.	**congregate emergency shelters; and**
3.	**transitional housing.**

(limit 2,000 characters)

In response to the COVID-19 pandemic, the Multi-Agency Coordination Center (MACC) activated a Level 2 to bring together public and private partners throughout the Southern NV region to plan for the continuation and expansion of services for more than 2.3 million citizens, including those experiencing unsheltered homelessness. Southern Nevada Health District (SNHD) conducted training sessions with all agency staff to ensure they understood how to check for signs and symptoms and schedule medical screenings as needed. Training was also provided on how to properly use personal protective equipment. 1) To address the immediate safety needs for unsheltered individuals, washing stations, mobile showers, and food services were quickly activated. Inclement weather shelter contracts were extended beyond the program expiration date to provide continuous sheltering services to those persons experiencing homelessness. 2) Early on in the pandemic, our largest overnight shelter (514 beds) shut down due to a client claim of being positive with no way to confirm. This led to the increased use of vacant hotels/motels for non-congregate sheltering for highly vulnerable clients as well as the development of Camp Cashman, an Isolation and Quarantine Facility (ISO-Q) (500 beds) where clients could be tested, triaged, and housed safely based on their presumptive COVID exposure and medical needs. Additional non-congregate shelter options included the use of vacant hotels and motels (approx. 600 beds) where clients were provided three daily meals, two daily snacks, hygiene and living essentials, as well as strategic non-essential items, on a case-by-case basis, that supported harm- reduction best practices. 3) Clark County contracted with local providers to support clients placed as various hotels/motels through the community to ensure case management and housing stability services were

provided, to support the clients exiting homelessness.

1D-2.	Improving Readiness for Future Public Health Emergencies.	
	NOFO Section VII.B.1.q.	

Describe in the field below how your CoC improved readiness for future public health emergencies.

(limit 2,000 characters)

An increase in community leadership and collaboration across sectors was prevalent throughout the pandemic. Organizations unfamiliar with one another were now reliant on partnership to successfully secure PPE and services for clients. The Multi-Agency Coordination Center (MACC) led daily meetings and organized Emergency Support Function (ESF) Groups, including ESF6 which took on the task of evaluating all available options for alternative housing types to meet the needs of homeless and patients being discharged from hospitals or needing isolation. ESF6 also stood up isolation and quarantine facilities for emergency service personnel; ensured PPE needs were met for all facilities and personnel; and there was an adequate plan for childcare within Parks and Rec facilities for emergency service, hospital, and county personnel. ESF groups transitioned to Recovery Support Function Groups (RSF) when immediate safety needs were addressed and COVID-related cases declined. RSF4 addressed post-disaster housing issues and coordination and facilitation of the delivery of resources to assist local and tribal governments in the development of interim housing options. Regular meetings of the MACC, ESF, and RSF allowed for updates from leads to share progress being made, brainstorm ideas for next steps, and ensure that everyone moved forward with the same information. Notes were made on the project management plan to capture important details regarding the development of specific tasks. The notes were memorialized in written standards, playbooks, and protocol that can be duplicated in case of similar situations. These protocols are continually being revisited and reevaluated to ensure lessons learned and emerging information are incorporated in action plans for future public health emergencies. Especially important are lessons learned related to vulnerable populations, which were not included in original plans. Representatives of the CoC Collaborative Applicant were in lead roles for the ESF and RSF working groups.

1D-3.	CoC Coordination to Distribute ESG Cares Act (ESG-CV) Funds.	
	NOFO Section VII.B.1.q	

	Describe in the field below how your CoC coordinated with ESG-CV recipients to distribute funds to address:
1.	safety measures;
2.	housing assistance;
3.	eviction prevention;
4.	healthcare supplies; and
5.	sanitary supplies.

(limit 2,000 characters)

The CoC has coordinated efforts with all 4 local and state jurisdictions receiving ESG-CV and CDBG-CV funds to ensure that community needs related to the pandemic were met. This included protective safety measures as well as recovery-oriented activities. 1) Funds were used to ensure that all individuals experiencing homelessness have immediate safety needs met. Outreach teams provided personal protective equipment and information about COVID and social distancing. Mobile showers were deployed, and hand washing stations were put up near major encampments. Since the initial deployment of showers three more units have been obtained for community use. 2) Non-congregate shelter and connection to housing programs was prioritized for those most at risk for complications due to the COVID virus. Funding was identified to support Operation HOME! Southern Nevada's housing surge. To date, funding for over 1,000 RRH units have been contracted out to community partners for housing support and landlord incentives. 3) Since July 2020, the CARES Housing Assistance Program has provided more than 35,000 households with rent, mortgage, and utility assistance using $177 million in CARES and ERAP funds. CHAP also works directly with the eviction courts and has prevented the eviction of 3,588 households. 4) The Basic Needs Assistance (BNA) Program supported clients who lacked sufficient income and resources for the most basic needs, including healthcare supplies. During the first 6 months of the program, over $24 million was distributed via 34 non-profit agency partners to ensure clients had access to healthcare supplies, food and nutrition, legal and other services to ensure they were safe and stably housed. 5) BNA funds were used to make workspaces safer and enabled clients to resume in office services by implementing touchless door entry, hand sanitizing stations, thermal scanners, plexiglass, and other measure to keep clients safe.

1D-4.	**CoC Coordination with Mainstream Health.**	
	NOFO Section VII.B.1.q.	

	Describe in the field below how your CoC coordinated with mainstream health (e.g., local and state health agencies, hospitals) during the COVID-19 pandemic to:
1.	**decrease the spread of COVID-19; and**
2.	**ensure safety measures were implemented (e.g., social distancing, hand washing/sanitizing, masks).**

(limit 2,000 characters)

1) As with the engagement of the hospital surge planning, CCSS also participated in broader community protocol development to ensure that the health and safety needs of unsheltered homeless, first responders, and visitors were met and decrease the spread of COVID-19. One example of these efforts is the revision of the CoC community matching system to support non-congregate shelter and visitor emergency lodging protocol as referenced in the Clark County Recovery Framework Multi-Jurisdictional COVID-19 Visitor Isolation and Quarantine Operational Annex. This revision also included expanded service hours to include a 24/7 matching hotline. The Clark County Recovery Framework Multi-Jurisdictional COVID-19 Resident Isolation/Quarantine Operational Annex B also includes sections dedicated to addressing the needs of Southern Nevada's homeless population. The med surge meetings have been continued to ensure that if COVID cases rise we are able to continue providing collaboration and community response to ensure that needs of all people are met. 2) In addition to hosting training sessions with shelters to ensure they staff understood how to check for COVID signs and

symptoms, the Southern Nevada Health District (SNHD) offered walk-through visits in early 2020 to help shelter staff redesign their space to meet social distancing requirements. When the Isolation-Quarantine site was scheduled to be closed, the SNHD created a complex on their site for similar services that could be sustained. This location was also identified to serve tourists who are unable to return home due to positive test results and signs and symptoms of illness. Services remain in place for tourists unable to return home due to positive tests. SNHD accompanied street outreach teams to conduct hundreds of in-the-field COVID screenings, providing PPE and creating hand-washing stations at known encampments.

1D-5.	**Communicating Information to Homeless Service Providers.**	
	NOFO Section VII.B.1.q.	

	Describe in the field below how your CoC communicated information to homeless service providers during the COVID-19 pandemic on:
1.	**safety measures;**
2.	**changing local restrictions; and**
3.	**vaccine implementation.**

(limit 2,000 characters)

1) The SNH CoC staff was involved in planning and community response from day one. This included posting community wide information on the website: HelpHopeHome.org. They also coordinated technical assistance from HUD. CoC staff were involved in the development of safety protocol for community partners, the implementation of the Isolation and Quarantine center, non-congregate shelter, and weekly collaboration with subject matter experts from the Southern Nevada Health District. CoC staff was instrumental in updating social media and press about safety measures that were recommended for all homeless service providers and community partners. 2) Within the HMIS system, a separate HMIS agency (*SNV COVID-19) was created in order to house any program that catered to helping or serving homeless clients in relation to exposure to COVID-19. This enabled CCSS management to compile and download COVID-19 related reports and determine how it affected human services specifically for the homeless. Some programs, like the Cashman ISO-Q, created their own database to store client information. These databases were imported and replicated in HMIS to ensure that HMIS contained up-to-date client activities and served as the one-stop shop for information. These tools were important as local restrictions and guidance was updated in order to understand the community need and communicate the information to partners. 3) CoC staff and the vaccine working group assisted with the coordination and dissemination of vaccines targeted for the homeless population. These were conducted at outreach events such as “Pop-Up Project Homeless Connect” and at local shelters where clients visit regularly for services. CoC staff attended a variety of virtual provider meetings and working groups to answer questions about vaccine clinics and ensure that providers felt confident in the implementation process.

1D-6.	**Identifying Eligible Persons Experiencing Homelessness for COVID-19 Vaccination.**	

NOFO Section VII.B.1.q.

Describe in the field below how your CoC identified eligible individuals and families experiencing homelessness for COVID-19 vaccination based on local protocol.

(limit 2,000 characters)

The Southern Nevada Health District led efforts related to COVID vaccination distribution. The vaccine working group held weekly meetings with homeless service providers and the CoC identified individuals and families at highest risk for complications related to COVID infections. Street outreach teams were deployed to search for those individuals and bring them to vaccination sites. Each of the local providers offered some type of vaccination option including hosting on-site vaccination clinics or providing transportation to vaccination sites. Vaccine clinics were offered in conjunction with pop-up homeless connect events and incentives were offered for individuals over the age of 65 to be vaccinated. Sheltering services were offered to street-based clients for the period of time after receiving the vaccination when they may experience side effects such as weakness and pain.

1D-7.	Addressing Possible Increases in Domestic Violence.	
	NOFO Section VII.B.1.e.	

Describe in the field below how your CoC addressed possible increases in domestic violence calls for assistance due to requirements to stay at home, increased unemployment, etc. during the COVID-19 pandemic.

(limit 2,000 characters)

The need for DV services grew as families experienced stress from unemployment and isolation in their homes due to the pandemic. Safe Nest, Clark County's primary victim service provider, increased sheltering options; transitioned counseling, advocacy, & education services to remote provision; and made organizational adjustments to continue serving clients at usual program capacity. Shelter, hotline, and Project Safe 417 (on-scene crisis response) increased program capacity. Safe Nest's shelter remains at capacity, and hotline calls continue at increased levels. To expand shelter options, 6 apartment units and 30+ hotel rooms were acquired to meet the increased demand for shelter for those fleeing domestic violence with medical quarantine needs. Safe Nest opened a distance learning center w/ hired staff to oversee remote learning & provide supervision for children navigating distance learning. Safe Nest worked closely with Legal Aid Center of S NV to transition Protection Order (PO) applications online. Safe Nest advocates aided clients needing assistance or services via phone and in-person at Family Court. Due to the reduction of in-person court hearings, Safe Nest implemented a service for advocates to reach out virtually to clients who have applied for Emergency Temporary PO to provide court preparation, safety planning, & resources. Safe Nest began providing protection order services and live streaming of PO hearings to prevent survivors from having to encounter their abusers at court, which can be unsafe and traumatizing, and allows survivors to have increased access to POs.
In 2020, Safe Nest provided more than 25,000 bednights of transitional housing and saved 48 families from eviction and/or utility shut-offs. Safe Nest and the

Las Vegas Metro Police Department (LVMPD) expanded the Project Safe 417 crisis response program so that these services are now available 24 hours per day across all Las Vegas police area commands in the Valley.

1D-8.	Adjusting Centralized or Coordinated Entry System.	
	NOFO Section VII.B.1.n.	

Describe in the field below how your CoC adjusted its coordinated entry system to account for rapid changes related to the onset and continuation of the COVID-19 pandemic.

(limit 2,000 characters)

May 19, 2020 - the Coordinated Entry system began prioritizing the people most vulnerable to complications resulting from COVID-19 for non-congregate shelter. The Coordinated Entry System Working Group voted to enact a Pandemic Priority Exception (PPE) to be used in conjunction with housing assessments for prioritization on and referral from the Coordinated Entry Community Queue. The PPE was applied to the client's prioritization for services based upon ages 65 or older or any of the CDC identified high-risk factors and was amended as CDC guidance changed as new information emerged.

The first step in creating a system and provider response to COVID-19 was to visualize the flow of clients. The Social Service management team, the CoC Data Analyst, and the service provider agency leads met and discussed the ideal process. This yielded the "System-wide Pandemic Response Chart" and the "Provider COVID-19 Response" chart. After a couple of weeks of trial and revision, as well as technical assistance, a revised flow chart was provided in the form of "Southern Nevada CoC Client COVID-19 Workflow."

The point of origin, or referral, for clients was varied to provide a safety net for several populations. Community providers and health care workers identified clients and referred them for testing and coordination of housing assessments in order to triage and prioritize individuals based on need and vulnerability. This process was designed to efficiently move clients into a safe, temporary living situation, with an ultimate goal of connecting clients to permanent housing.

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

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1E-1.	**Announcement of 30-Day Local Competition Deadline–Advance Public Notice of How Your CoC Would Review, Rank, and Select Projects. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.2.a. and 2.g.	

1.	**Enter the date your CoC published the 30-day submission deadline for project applications for your CoC's local competition.**	09/03/2021
2.	**Enter the date your CoC publicly posted its local scoring and rating criteria, including point values, in advance of the local review and ranking process.**	09/03/2021

1E-2.	**Project Review and Ranking Process Your CoC Used in Its Local Competition. You Must Upload an Attachment to the 4B. Attachments Screen. We use the response to this question as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criteria listed below.**	
	NOFO Section VII.B.2.a., 2.b., 2.c., and 2.d.	

Select yes or no in the chart below to indicate how your CoC ranked and selected project applications during your local competition:

1.	**Established total points available for each project application type.**	Yes
2.	**At least 33 percent of the total points were based on objective criteria for the project application (e.g., cost effectiveness, timely draws, utilization rate, match, leverage), performance data, type of population served (e.g., DV, youth, Veterans, chronic homelessness), or type of housing proposed (e.g., PSH, RRH).**	Yes
3.	**At least 20 percent of the total points were based on system performance criteria for the project application (e.g., exits to permanent housing destinations, retention of permanent housing, length of time homeless, returns to homelessness).**	Yes
4.	**Used data from a comparable database to score projects submitted by victim service providers.**	Yes
5.	**Used objective criteria to evaluate how projects submitted by victim service providers improved safety for the population they serve.**	Yes
6.	**Used a specific method for evaluating projects based on the CoC's analysis of rapid returns to permanent housing.**	Yes

1E-2a.	**Project Review and Ranking Process–Addressing Severity of Needs and Vulnerabilities.**	

	NOFO Section VII.B.2.d.

	Describe in the field below how your CoC reviewed, scored, and selected projects based on:
1.	**the specific severity of needs and vulnerabilities your CoC considered when ranking and selecting projects; and**
2.	**considerations your CoC gave to projects that provide housing and services to the hardest to serve populations that could result in lower performance levels but are projects your CoC needs in its geographic area.**

(limit 2,000 characters)

1)The CoC's publicly advertised Scoring & Ranking Team (SRT) process accounts for the severity of needs and vulnerabilities, including chronic homelessness, mental illness, substance use disorders, and domestic violence history (SRT P&Ps p.8). Four CoC Working Groups (Evaluation, Monitoring, Data & Systems Improvement, SRT) collaborate on the development of the SNHCoC Scoring and Ranking Policies & Procedures (P&Ps) to ensure a well-rounded systematic approach to the development and refinement of the local application process. Project Reports evaluate the degree to which a project meets local needs and helps to identify projects that may be defunded due to substandard performance. Project scores are based on information and data from: Annual Performance Report (APR) data and matching of local priorities including objective performance criteria unavailable in the APR and instead measured through local monitoring processes, including Performance, Compliance and HMIS data from systematized annual reviews of each renewal project based on desk and on-site monitoring. Lastly, applicant responses to supplemental narratives related to various local factors including organizational capacity and experience.

2)Per P&Ps, SRT considered how outcomes are lower for projects w/more difficult to serve pops, including chronic homelessness, current/past substance abuse, & behavioral health or disability requiring heavy support to maintain PH. SRT reviewed final listing in context of preserving projects that served most vulnerable (e.g., chronically homeless & youth), & preserved or supported projects that best met community needs.

1E-3.	**Promoting Racial Equity in the Local Review and Ranking Process.**	
	NOFO Section VII.B.2.e.	

	Describe in the field below how your CoC:
1.	**obtained input and included persons of different races, particularly those over-represented in the local homelessness population, when determining the rating factors used to review project applications;**
2.	**included persons of different races, particularly those over-represented in the local homelessness population, in the review, selection, and ranking process;**
3.	**rated and ranked projects based on the degree to which their program participants mirror the homeless population demographics (e.g., considers how a project promotes racial equity where individuals and families of different races are over-represented).**

(limit 2,000 characters)

1) The Evaluation Working Group included a racially diverse group of individuals that is reflective of the demographic breakdown of our community's homeless population based on the Census conducted in 2020.
2) The Scoring and Ranking Team included a racially diverse group of individuals included a racially diverse group of individuals that is reflective of the

demographic breakdown of our community's homeless population based on the Census conducted in 2020.
3) Projects were assessed upon their ability to describe how client feedback processes solicit input across language barriers, and further identify barriers to participation faced by persons of different races and ethnicities, and better involve clients in the elimination of those barriers in the design and operation of their projects.

1E-4.	**Reallocation–Reviewing Performance of Existing Projects. We use the response to this question as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criterion below.**	
	NOFO Section VII.B.2.f.	

	Describe in the field below:
1.	**your CoC's reallocation process, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed;**
2.	**whether your CoC identified any projects through this process during your local competition this year;**
3.	**whether your CoC reallocated any low performing or less needed projects during its local competition this year;**
4.	**why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable; and**
5.	**how your CoC communicated the reallocation process to project applicants.**

(limit 2,000 characters)

1) The CoC's Scoring and Ranking Policies and Procedures dictate that the Scoring & Ranking Team may exercise discretion to reallocate funds from underperforming renewals if deemed necessary. Projects may also voluntarily reallocate. Reasons for reallocation based on underperformance include, but are not limited to, a significant history of unspent funds. 2) The CoC identified three projects for reallocation through its 2021 local competition. 3) The CoC identified for voluntary reallocation in-full, St. Jude's Moving Forward based on chronic low project performance. The CoC identified for voluntary reallocation in-part, Clark County Social Service's STAR TH-RRH. The project voluntarily reallocated its funding and reapplied as a new project for its RRH funding alone, forgoing its TH component. The CoC identified for involuntary reallocation in-full, Lutheran Social Services of Nevada's Welcome HOME due to chronic underperformance including underspending. When it was considered for partial reallocation, its remaining competitive funding available (approx. $48k) was unsustainable for the project's continuation therefore it was reallocated in-full. 4) N/A. Per the response in item 2, the CoC identified projects for reallocation this year. 5) The Collaborative Applicant emailed separately Moving Forward and Welcome HOME both on October 19 to confirm and notify, respectively, of their reallocations. The Collaborative Applicant emailed STAR TH-RRH on November 1 to confirm its reallocated funding amount.

1E-4a.	**Reallocation Between FY 2016 and FY 2021. We use the response to this question as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criterion below.**	
	NOFO Section VII.B.2.f.	

Did your CoC cumulatively reallocate at least 20 percent of its ARD between FY 2016 and FY 2021?	Yes

1E-5.	**Projects Rejected/Reduced–Public Posting. You Must Upload an Attachment to the 4B. Attachments Screen if You Select Yes.**	
	NOFO Section VII.B.2.g.	

1.	**Did your CoC reject or reduce any project application(s)?**	Yes
2.	**If you selected yes, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps.**	10/19/2021

1E-5a.	**Projects Accepted–Public Posting. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.2.g.	

Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps.	10/19/2021

1E-6.	**Web Posting of CoC-Approved Consolidated Application. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.2.g.	

Enter the date your CoC's Consolidated Application was posted on the CoC's website or affiliate's website–which included: 1. the CoC Application; 2. Priority Listings; and 3. all projects accepted, ranked where required, or rejected.	11/10/2021

2A. Homeless Management Information System (HMIS) Implementation

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

2A-1.	**HMIS Vendor.**	
	Not Scored–For Information Only	

Enter the name of the HMIS Vendor your CoC is currently using.	Bitfocus, Inc.

2A-2.	**HMIS Implementation Coverage Area.**	
	Not Scored–For Information Only	

Select from dropdown menu your CoC's HMIS coverage area.	Statewide

2A-3.	**HIC Data Submission in HDX.**	
	NOFO Section VII.B.3.a.	

Enter the date your CoC submitted its 2021 HIC data into HDX.	05/17/2021

2A-4.	**HMIS Implementation–Comparable Database for DV.**	
	NOFO Section VII.B.3.b.	

	Describe in the field below actions your CoC and HMIS Lead have taken to ensure DV housing and service providers in your CoC:
1.	**have a comparable database that collects the same data elements required in the HUD-published 2020 HMIS Data Standards; and**
2.	**submit de-identified aggregated system performance measures data for each project in the comparable database to your CoC and HMIS lead.**

(limit 2,000 characters)

1) DV dedicated providers in Southern Nevada are currently utilizing a private implementation of Clarity Human Services that serves as a Comparable Database, provided by Bitfocus, Inc., the Nevada HMIS vendor and system administrator. The comparable database, used to assess the scope of community needs related to domestic violence, dating violence, sexual assault and stalking, is configured in alignment with the most recent HUD Data Standards, providing the collection of Metadata, Project Descriptor, Universal (non-identifying), and Program Specific data elements. Due to the anonymity of client records, it is recognized that, when combining system wide aggregate data, duplication will occur.

2) As in HMIS, grantees have access within the database to produce funder specific reports such as the APR, CAPER, HIC/PIT, and System Performance Measures. In addition, custom assessments have been added to the database, unique to survivors. The first of these is a Danger/Lethality Assessment, which is administered to survivors fleeing dangerous situations to identify risk factors and the degree of imminent danger to the client. The level of robust data within the Comparable Database allows for de-identified aggregate reporting of victim/survivor specific elements as well as community focused priorities, such as chronicity and system performance measures, while ensuring the safety and anonymity of the client. It also allows the community to more accurately examine fluctuations in severity for survivors seeking assistance, over time. This de-identified aggregate data is available to CoC, HMIS leads, and to the CoC working groups that analyze performance measures to support project outcomes.

2A-5.	**Bed Coverage Rate–Using HIC, HMIS Data–CoC Merger Bonus Points.**	
	NOFO Section VII.B.3.c. and VII.B.7.	

Enter 2021 HIC and HMIS data in the chart below by project type:

Project Type	Total Beds 2021 HIC	Total Beds in HIC Dedicated for DV	Total Beds in HMIS	HMIS Bed Coverage Rate
1. Emergency Shelter (ES) beds	1,853	102	1,751	100.00%
2. Safe Haven (SH) beds	0	0	0	
3. Transitional Housing (TH) beds	724	0	724	100.00%
4. Rapid Re-Housing (RRH) beds	953	9	944	100.00%
5. Permanent Supportive Housing	2,257	0	758	33.58%
6. Other Permanent Housing (OPH)	26	0	26	100.00%

2A-5a.	**Partial Credit for Bed Coverage Rates at or Below 84.99 for Any Project Type in Question 2A-5.**	
	NOFO Section VII.B.3.c.	

	For each project type with a bed coverage rate that is at or below 84.99 percent in question 2A-5, describe:
1.	**steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type; and**
2.	**how your CoC will implement the steps described to increase bed coverage to at least 85 percent.**

(limit 2,000 characters)

1) The low bed coverage rate in PSH is due to 1,551 VASH Housing Choice Vouchers not being entered into HMIS. Both the HMIS Lead and System Administrator are connecting regularly with the local VA and the Southern Nevada Regional Housing Authority (SNRHA) to remove barriers and move towards the collection of HUD-VASH client data within the HMIS. The addition of these beds in HMIS would result in a 99.88% bed coverage rate. The SNH CoC Board, along with the Data & System Improvement and HMIS Working Groups will continue to meet with the local VA leadership to stress the critical nature of inputting the HUD-VASH data into HMIS. Bitfocus staff have volunteered to provide technical assistance and other homeless service providers have volunteered to help with the initial mass data entry to get all existing recipients of HUD-VASH entered into HMIS within the next 12 months. 2)The CoC Steering Committee will continue meeting with VA, SNRHA, Bitfocus and Collaborative Applicant to develop the detailed plan for implementation and will report this to the CoC Board as to when all data will be current in HMIS. The HMIS Working Group and Data and System Improvement Working Group will provide oversight and follow-up to ensure consistent entries are being made going forward after the initial data entry process which will result in a bed coverage rate that can be maintained at 99% or above.

2A-5b.	**Bed Coverage Rate in Comparable Databases.**	
	NOFO Section VII.B.3.c.	

Enter the percentage of beds covered in comparable databases in your CoC's geographic area.	100.00%

2A-5b.1.	**Partial Credit for Bed Coverage Rates at or Below 84.99 for Question 2A-5b.**	
	NOFO Section VII.B.3.c.	

	If the bed coverage rate entered in question 2A-5b. is 84.99 percent or less, describe in the field below:
1.	**steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent; and**
2.	**how your CoC will implement the steps described to increase bed coverage to at least 85 percent.**

(limit 2,000 characters)

n/a

2A-6.	**Longitudinal System Analysis (LSA) Submission in HDX 2.0.**	
	NOFO Section VII.B.3.d.	

Did your CoC submit LSA data to HUD in HDX 2.0 by January 15, 2021, 8 p.m. EST?	Yes

2B. Continuum of Care (CoC) Point-in-Time (PIT) Count

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
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- 24 CFR part 578

2B-1.	**Sheltered and Unsheltered PIT Count–Commitment for Calendar Year 2022**	
	NOFO Section VII.B.4.b.	

Does your CoC commit to conducting a sheltered and unsheltered PIT count in Calendar Year 2022?	Yes

2B-2.	**Unsheltered Youth PIT Count–Commitment for Calendar Year 2022.**	
	NOFO Section VII.B.4.b.	

Does your CoC commit to implementing an unsheltered youth PIT count in Calendar Year 2022 that includes consultation and participation from youth serving organizations and youth with lived experience?	Yes

2C. System Performance

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
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- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

2C-1.	**Reduction in the Number of First Time Homeless–Risk Factors.**	
	NOFO Section VII.B.5.b.	

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

(limit 2,000 characters)

1) SNHCoC examined community-wide racial /ethnic disparities & conditions that lead to 1st time homelessness, ie poverty levels, loss of employment, drug/alcohol misuse, gambling, child welfare & criminal justice engagement, and recent changes in livelihood. 2) The CoC has utilized models of prevention services and crisis stabilization; provided rent vouchers & rental assistance for emergency housing options; & assisted households in becoming self-sufficient through workforce support, mainstream benefits applications, and referrals for mental/physical/financial health, addiction & legal counseling. In response to COVID, housing assistance and eviction mitigation programs have been implemented to address the risk of becoming homeless. The funder of EFSP sits on the CoC Board and many CoC members sit on the EFSP Board to support community-wide efforts. CCSS administers the Welfare Set-Aside Program (WSAP) to provide funding for prevention strategies for elderly, families, and persons with disabilities; a RRH program has been established using county marijuana business licensing fees, where 60 beds have been prioritized for families involved w/child welfare services; and the CARES Housing Assistance Program helps COVID impacted households meet their housing payments and avoid entering the homeless system. Housing Problem Solving strategies including prevention, diversion, and rapid exit, are being implemented systemwide and problem-solving conversation trainings are provided to influence the mindset and interactions discharge planners have with those exiting systems so that resources can be accessed, and plans solidified for clients to enter housing thus preventing them from entering the homeless system. 3) The CoC Board is responsible for overseeing the strategy to reduce the number of individuals and families experiencing homelessness for the first time.

2C-2.	**Length of Time Homeless–Strategy to Reduce.**	
	NOFO Section VII.B.5.c.	

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

(limit 2,000 characters)

1) The CoC utilizes local funds to support programs that fill gaps in the homeless service system. One strategy to reduce the length of time homeless (LOTH) is the utilization of a bridge housing (BH) program. There is a significant time delay between when a person is placed on the CE queue and when they are referred for program eligibility determination. Dedicated county general fund dollars are used to administer BH to provide temporary/emergency shelter for persons and/or families when traditional shelters may not be appropriate. This was especially true during the pandemic due to medical needs. BH significantly increases the likelihood of completion of the coordinated referral and placement process into PH reducing LOTH however with the current housing market, it's been extremely difficult to identify suitable housing for clients resulting in longer than average LOTH. A pilot program for families to divert households to permanent placement rather than entering the homeless service system and the use of county marijuana business licensing fees to house 180 families in RRH and eliminate the wait list on the CE community queue has been successful at reducing LOTH. 2) The CoC CE process utilizes dynamic prioritization to identify and house individuals and families with the longest LOTH, the most vulnerable individuals and families, and those who have recently re-entered homelessness to offer the most appropriate level of intervention to end homelessness as quickly as possible. The most intensive programs (ie PSH) are reserved for the most vulnerable clients. The CoC has increased efforts to identify funding sources to increase the number of RRH and PSH community beds. Additionally, the ES Learning Collaborative targeted long stayers of shelters for exit to housing; reduced barriers to exits, and helped ES become housing focused to reduce LOTH. 3) Oversight is provided by CCSS RAD staff, CE Working Group.

2C-3.	**Exits to Permanent Housing Destinations/Retention of Permanent Housing.**	
	NOFO Section VII.B.5.d.	

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

(limit 2,000 characters)

1) Modeled on Veteran Functional Zero efforts, CE Working Group (CE WG) assessed barriers and problem solving to increase the rate households exit to

PH destinations. Comprehensive supportive services increase self-sufficiency among participants. Recent ES & RRH learning collaboratives, increased performance measures and improved shelter & RRH outcomes by improving service delivery and ensuring case managers and housing navigators remain housing focused. Conversation around improving data collection and lowering barriers for facilities grew to an action plan with shelters for monthly data submissions and workshops. Efforts targeted ES to decrease long stays, increase exits to PH, decrease returns to shelters, and increase shelter utilization. The 2019 Landlord Engagement Campaign included focus groups w/ landlords informing CoC about what would entice them (ie mitigation funds) to work with this population and increase the number of PH destinations available. The community has employed Mainstream Voucher Program and Emergency Voucher Programs to create churn in the system and support PH exits to affordable housing and self-sufficiency. 2) To increase the rate at which households retain their housing status, CE WG and SNRHA teams collaborate to increase the number of affordable and Section 8 units for Moving On efforts. The Landlord Engagement and Property Services (LEAPS) team and the Landlord Engagement Specialist work to develop relationships with property managers, landlords and affordable housing providers and increase the number of community housing options. They are currently implementing a landlord incentive program to support efforts to engage and retain landlords. Regularly scheduled Lunch & Learns and Landlord Appreciation events allow programs to honor and recognize existing landlords, orient potential landlords to the program, and provide a place for landlord peer-to-peer sharing.

2C-4.	**Returns to Homelessness–CoC's Strategy to Reduce Rate.**	
	NOFO Section VII.B.5.e.	

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

(limit 2,000 characters)

1) The CoC uses HMIS reports on recidivism to analyze demographics, trends, & rates of individuals and persons in families who return to homelessness (RTH). In addition to evaluating system-wide recidivism results displayed in HUD system performance measures, individual agencies can monitor and analyze their own programs' rates of RTH. By running a Program Recidivism Report from HMIS, programs can determine the number of clients who exited during a specific date range, the number of clients that exited to permanent destinations, and the number of clients returning to homelessness. Programs can also review the average number of days from program exit to re-entry. These agency-level reports encourage agencies to evaluate their systems and improve their policies, procedures and processes. The Data and Systems Improvement Working Group (DSIWG) looks at recidivism rates for the whole system as well as subpopulations. DSIWG looks at this data monthly and has conversations with providers as warranted. 2) CoC providers focus on providing services that empower clients to live independently so they don't feel compelled to return to the streets due to a lack of resources. Tenancy Training based on Keys to Good Tenancy (Family Promise) delivers 8 modules over 3 sessions to

support client stability. When there has been a RTH, mobile crisis teams (MCIT, MORE) meet clients in the field to restabilize them and offer encouragement to ensure continuous housing. To reduce additional returns to homelessness, clients receive assistance in accessing public benefits and a community resource manual they can rely on after program exit. Program graduates are encouraged to continue participating in alumni activities, community activities and support groups. CoC partners continue to provide supportive services 6 months post-discharge. 3) Oversight of the CoC's strategy to reduce the rate of returns to homelessness is provided by DSIWG & Coordinated Outreach Working Groups.

2C-5.	**Increasing Employment Cash Income-Strategy.**	
	NOFO Section VII.B.5.f.	

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

(limit 2,000 characters)

1) The CoC is constantly working with stakeholders to provide workforce development and training to homeless clients. Most recently, Clark County Social Service and the Culinary Academy of Las Vegas launched the Workforce Development project to aid in quality-of-life improvements for clients. The CoC also continues working with Workforce Connections (WFC) to strengthen partnerships and implement strategies to provide broader access to employment/training services to individuals experiencing homelessness including new access points for training and employment. Formal relationships between WFC, their sub-recipients, CoC providers, and County Departments increase employment income via job skills training, resume building, and connections to potential employers. 2) The City of Las Vegas partners with a staffing agency to employ individuals accessing shelters at the Courtyard Homeless Resource Center in positions such as operations worker or peer navigator. Providers ResCare and HELP of SNV receive WIOA funds for workforce training and skills development. Vegas PBS also provides vocational assistance and adult education to increase access to employment. To help individuals and families increase their cash income, agency advocates work with clients to address barriers to employment such as lack of job training and criminal history. Intensive Case Managers (ICM) address employment at the start of, during and after exiting the program. Clients are referred to NV Partners, WFC, and others for job skills training and employment assistance. 3) Oversight of the CoC's strategy to increase job and income growth from employment is provided by the CoC Monitoring Working Group which is comprised of CoC members, state and regional representatives, and WFC representatives.

2C-5a.	**Increasing Employment Cash Income–Workforce Development–Education–Training.**	
	NOFO Section VII.B.5.f.	

	Describe in the field below how your CoC:
1.	promoted partnerships and access to employment opportunities with private employers and private employment organizations, such as holding job fairs, outreach to employers, and partnering with staffing agencies; and
2.	is working with public and private organizations to provide meaningful education and training, on-the-job training, internships, and employment opportunities for program participants.

(limit 2,000 characters)

1) The One-Stop Delivery System (OSDS) in Southern Nevada operated by Workforce Connections, hosts hiring events, employers who might be hiring for multiple positions, and often partners with other agencies to support large job fairs. For example, they supported Clark County, City of North Las Vegas, City of Las Vegas and City of Henderson in the planning of the Small Business Job Fair held on November 6th 2021. Clark County commissioners also hosted regional job fairs in many of the jurisdictions to encourage job applicants to find employment within their immediate community.
2) The OSDS provides education, training, and supportive services to eligible individuals throughout Clark County and other Nevada jurisdictions.

2C-5b.	Increasing Non-employment Cash Income.	
	NOFO Section VII.B.5.f.	

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

(limit 2,000 characters)

) To increase non-employment cash income, SSI/SSDI Outreach, Access and Recovery (SOAR) trained case managers encourage all who qualify for mainstream benefits to apply and assist clients with applications for program enrollment. During the time period 07/1/19-6/30/20, there were 68 approvals received on 112 initial applications submitted (61% approval rate) and 20 approvals received on 38 appeal application submitted (53%). 2) To help project participants increase access to non-employment cash sources, support is offered through Mainstream Programs Basic Training (MPBT) on a monthly basis. MPBT covers topics such as community programs, referrals, mainstream benefits, workforce programs and educational/employment services. It is offered free of charge. Sessions are also recorded for public viewing. Case managers are encouraged to become SOAR certified. All SOAR training and technical assistance is provided free of charge to all community-based service providers throughout the state of Nevada. During the time period of 11/1/19-8/30/20, 65 case managers participated in SOAR Training and Technical Assistance. An annual Summit provides a full curriculum of training opportunities as well as face-to-face connections for case managers, Welfare Office representatives, and others involved in these programs. 3) The Nevada Department of Health and Human Services oversees strategies to increase non-employment cash income.

3A. Coordination with Housing and Healthcare Bonus Points

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

3A-1.	**New PH-PSH/PH-RRH Project–Leveraging Housing Resources.**	
	NOFO Section VII.B.6.a.	

Is your CoC applying for a new PSH or RRH project(s) that uses housing subsidies or subsidized housing units which are not funded through the CoC or ESG Programs to help individuals and families experiencing homelessness?	Yes

3A-1a.	**New PH-PSH/PH-RRH Project–Leveraging Housing Commitment. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.6.a.	

Select yes or no in the chart below to indicate the organization(s) that provided the subsidies or subsidized housing units for the proposed new PH-PSH or PH-RRH project(s).

1.	**Private organizations**	No
2.	**State or local government**	Yes
3.	**Public Housing Agencies, including use of a set aside or limited preference**	No
4.	**Faith-based organizations**	No
5.	**Federal programs other than the CoC or ESG Programs**	No

3A-2.	**New PSH/RRH Project–Leveraging Healthcare Resources.**	
	NOFO Section VII.B.6.b.	

Is your CoC applying for a new PSH or RRH project that uses healthcare resources to help individuals and families experiencing homelessness?	Yes

3A-2a.	**Formal Written Agreements–Value of Commitment–Project Restrictions. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.6.b.	

1.	**Did your CoC obtain a formal written agreement that includes: (a) the project name; (b) value of the commitment; and (c) specific dates that healthcare resources will be provided (e.g., 1-year, term of grant, etc.)?**	Yes
2.	**Is project eligibility for program participants in the new PH-PSH or PH-RRH project based on CoC Program fair housing requirements and not restricted by the health care service provider?**	Yes

3A-3.	**Leveraging Housing Resources–Leveraging Healthcare Resources–List of Projects.**	
	NOFO Sections VII.B.6.a. and VII.B.6.b.	

If you selected yes to question 3A-1. or 3A-2., use the list feature icon to enter information on each project you intend for HUD to evaluate to determine if they meet the bonus points criteria.

Project Name	Project Type	Rank Number	Leverage Type
HomeLink Thrive	RRH	24	Housing
STAR RRH	RRH	19	Healthcare
Healthy Living RRH	RRH	20	Healthcare

3A-3. List of Projects.

1. What is the name of the new project? HomeLink Thrive

2. Select the new project type: RRH

3. Enter the rank number of the project on your CoC's Priority Listing: 24

4. Select the type of leverage: Housing

3A-3. List of Projects.

1. What is the name of the new project? STAR RRH

2. Select the new project type: RRH

3. Enter the rank number of the project on your CoC's Priority Listing: 19

4. Select the type of leverage: Healthcare

3A-3. List of Projects.

1. What is the name of the new project? Healthy Living RRH

2. Select the new project type: RRH

3. Enter the rank number of the project on your CoC's Priority Listing: 20

4. Select the type of leverage: Healthcare

3B. New Projects With Rehabilitation/New Construction Costs

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

3B-1.	**Rehabilitation/New Construction Costs–New Projects.**	
	NOFO Section VII.B.1.r.	

Is your CoC requesting funding for any new project application requesting $200,000 or more in funding for housing rehabilitation or new construction?	No

3B-2.	**Rehabilitation/New Construction Costs–New Projects.**	
	NOFO Section VII.B.1.s.	

	If you answered yes to question 3B-1, describe in the field below actions CoC Program-funded project applicants will take to comply with:
1.	**Section 3 of the Housing and Urban Development Act of 1968 (12 U.S.C. 1701u); and**
2.	**HUD's implementing rules at 24 CFR part 75 to provide employment and training opportunities for low- and very-low-income persons, as well as contracting and other economic opportunities for businesses that provide economic opportunities to low- and very-low-income persons.**

(limit 2,000 characters)

n/a

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

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

3C-1.	**Designating SSO/TH/Joint TH and PH-RRH Component Projects to Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes.**	
	NOFO Section VII.C.	

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

3C-2.	**Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.C.	

	If you answered yes to question 3C-1, describe in the field below:
1.	**how serving this population is of equal or greater priority, which means that it is equally or more cost effective in meeting the overall goals and objectives of the plan submitted under Section 427(b)(1)(B) of the Act, especially with respect to children and unaccompanied youth than serving the homeless as defined in paragraphs (1), (2), and (4) of the definition of homeless in 24 CFR 578.3; and**
2.	**how your CoC will meet requirements described in Section 427(b)(1)(F) of the Act.**

(limit 2,000 characters)

n/a

4A. DV Bonus Application

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

4A-1.	**New DV Bonus Project Applications.**	
	NOFO Section II.B.11.e.	

Did your CoC submit one or more new project applications for DV Bonus Funding?	Yes

4A-1a.	**DV Bonus Project Types.**	
	NOFO Section II.B.11.	

Select yes or no in the chart below to indicate the type(s) of new DV Bonus project(s) your CoC included in its FY 2021 Priority Listing.

	Project Type	
1.	**SSO Coordinated Entry**	Yes
2.	**PH-RRH or Joint TH/RRH Component**	Yes

4A-2.	**Number of Domestic Violence Survivors in Your CoC's Geographic Area.**	
	NOFO Section II.B.11.	

1.	**Enter the number of survivors that need housing or services:**	2,317
2.	**Enter the number of survivors your CoC is currently serving:**	967
3.	**Unmet Need:**	1,350

4A-2a.	**Calculating Local Need for New DV Projects.**	
	NOFO Section II.B.11.	

	Describe in the field below:
1.	**how your CoC calculated the number of DV survivors needing housing or services in question 4A-2 element 1 and element 2; and**

2.	**the data source (e.g. comparable database, other administrative data, external data source, HMIS for non-DV projects); or**
3.	**if your CoC is unable to meet the needs of all survivors please explain in your response all barriers to meeting those needs.**

(limit 2,000 characters)

1) In the past year, 2,317 individual clients answered 'yes' on the enrollment question tied to HUD data element 4.11.2. Of those clients, 967 are currently enrolled in at least one programs and 1,350 are not currently enrolled in any. Of the 1,350 clients not enrolled in programs, 302 had a 'housed' exit destination and 1,048 had a 'not housed' exit destination. This calculation determined our unmet need.
2) This data was compiled from HMIS and the comparable database and includes clients currently served with any type of housing, emergency and day shelters and outreach.
3) Based on the number of clients that can be served annually via the proposed projects, we will not be able to meet the needs of all survivors through these programs alone. Our community will continue to identify other funding sources and other programs that can be implemented to meet the needs of all survivors in our community.

4A-3.	**New Support Services Only Coordinated Entry (SSO-CE) DV Bonus Project–Applicant Information.**	
	NOFO Section II.B.11.(c)	

Enter in the chart below information about the project applicant applying for the new SSO-CE DV Bonus project:

1. Applicant Name	HELP of Southern Nevada
2. Project Name	DV Community Outreach and Matching

4A-3a.	**New SSO-CE Project–Addressing Coordinated Entry Inadequacy.**	
	NOFO Section II.B.11.(c)	

	Describe in the field below:
1.	**how the current Coordinated Entry is inadequate to address the needs of survivors of domestic violence, dating violence, sexual assault, or stalking; and**
2.	**how the proposed project addresses inadequacies identified in element 1. above.**

(limit 2,000 characters)

1) The SNH CoC has developed and implemented CE for individuals, families, and youth. The CE process for DV survivors has been developed in partnership with Victim Service Providers (VSP) and is in the process of being refined. While the current CE process does not have access to the Comparable Database, the matchers maintain a manual listing of DV assessments and place these individuals and families on the community queue in relation to the percentage score received on their assessment. Our community recognizes there is a gap in matching of survivors to available beds as DV assessments are limited to those being served and/or assessed by VSP. The proposed application for SSO-CE will support the safety needs of survivors and provide a

collaborative effort to best serve this vulnerable population.
2) The proposed CE project will include a comprehensive training for all assessors to ensure they are adhering to the safety precautions needed for this vulnerable population. As the current VSP who conducts DV-specific assessments is not able to provide service to the entire continuum, the DV CE program will allow for an assessor to be specifically trained for DV and trafficking needs and will provide an option for them to meet clients where they are at, rather than having clients going to one location for assessments. Although abbreviated, DV training is currently part of the training for mandatory assessors and matchers. This project will allow for a DV-focused training to expand on the abbreviated version. Sensitivity and awareness training along with trauma-informed engagement will expand the work that is already being done. The proposed program will also allow for on-going quarterly technical assistance once training has been completed.

4A-4.	**New PH-RRH and Joint TH and PH-RRH Component DV Bonus Projects–Project Applicant Information.**	
	NOFO Section II.B.11.	

Use the list feature icon to enter information on each unique project applicant applying for New PH-RRH and Joint TH and PH-RRH Component DV Bonus projects–only enter project applicant information once, regardless of how many DV Bonus projects that applicant is applying for.

Applicant Name
HopeLink
St Jude's Ranch f...

Project Applicants Applying for New PH-RRH and Joint TH and PH-RRH DV Bonus Projects

4A-4.	New PH-RRH and Joint TH and PH-RRH Component DV Bonus Projects–Project Applicant Information–Rate of Housing Placement and Rate of Housing Retention–Project Applicant Experience.	
	NOFO Section II.B.11.	

Enter information in the chart below on the project applicant applying for one or more New PH-RRH and Joint TH and PH-RRH Component DV Bonus Projects included on your CoC's FY 2021 Priority Listing:

1.	Applicant Name	HopeLink
2.	Rate of Housing Placement of DV Survivors–Percentage	100.00%
3.	Rate of Housing Retention of DV Survivors–Percentage	90.00%

4A-4a.	Calculating the Rate of Housing Placement and the Rate of Housing Retention–Project Applicant Experience.	
	NOFO Section II.B.11.	

	Describe in the field below:
1.	how the project applicant calculated the rate of housing placement and rate of housing retention reported in question 4A-4; and
2.	the data source (e.g. comparable database, other administrative data, external data source, HMIS for non-DV projects).

(limit 1,000 characters)

1) During the past 2 years, HopeLink has served 120 households fleeing or surviving domestic violence. Of the 52 clients that have exited the program 47 (90%) have remained stably housed. The remaining clients remain enrolled in the program. For SJRC clients, 90% also remain stably housed. The average number of days from program exit to return to homelessness is 314 days. 2) Data was sourced from the HMIS database, the comparable database, and other administrative data.

4A-4b.	Providing Housing to DV Survivor–Project Applicant Experience.	
	NOFO Section II.B.11.	

	Describe in the field below how the project applicant:
1.	ensured DV survivors experiencing homelessness were assisted to quickly move into safe affordable housing;
2.	prioritized survivors–you must address the process the project applicant used, e.g., Coordinated Entry, prioritization list, CoC's emergency transfer plan, etc.;
3.	connected survivors to supportive services; and
4.	moved clients from assisted housing to housing they could sustain–address housing stability after the housing subsidy ends.

(limit 2,000 characters)

1) SNV DV providers ensure that DV survivors experiencing homelessness are assisted to quickly move into safe affordable housing by providing DV assessments to victim-survivors wherever they are found. HELP of S NV provides 7-day coverage to help relocate victims immediately through safety and housing, versus having them admitted into an emergency shelter. They are then quickly connected to housing services and programs to identify and move into permanent housing. 2) Case Managers utilize coordinated entry and a prioritization list with DV survivors with the highest vulnerability being housed first. HELP of S NV works on a Housing First model and does not screen people out of programming. 3) DV survivors are connected with mainstream resources every day. HELP of S NV has worked with community partners such as addiction services, family housing services, employment, financial assistance, housing, managed care organizations, and mental health services since it opened its doors 51 years ago. DV-specific partners, such as SafeNest and Safe House provide targeted services for this population ensuring that all services are trauma-informed and respect the privacy of the client. 4) SafeNest & St. Jude's ensure clients do not exit to homelessness by selecting units that meet FMR and are financially sustainable for clients when they exit housing programs. Furthermore, clients are encouraged to begin paying a portion of their rent as soon as they gain income. This helps form buy-in and keeps the survivor engaged in the program. As the clients exit the program, they are able to confidently pay the full amount of their monthly costs. The program also provides 6-months of after-care services for clients to continue the connection with case management support and be helped to obtain on-going community-based services. This consistent connection after program exit allows for the participant to seek out the services when they need and to stay in contact with program staff.

4A-4c.	**Ensuring DV Survivor Safety–Project Applicant Experience.**	
	NOFO Section II.B.11.	

	Describe in the field below examples of how the project applicant ensured the safety of DV survivors experiencing homelessness by:
1.	**training staff on safety planning;**
2.	**adjusting intake space to better ensure a private conversation;**
3.	**conducting separate interviews/intake with each member of a couple;**
4.	**working with survivors to have them identify what is safe for them as it relates to scattered site units and/or rental assistance;**
5.	**maintaining bars on windows, fixing lights in the hallways, etc. for congregate living spaces operated by the applicant; and**
6.	**keeping the location confidential for dedicated units and/or congregate living spaces set-aside solely for use by survivors.**

(limit 5,000 characters)

1) SNV providers conduct regular staff training to ensure the safety of DV survivors experiencing homelessness. HopeLink provides case management training with the Nevada Homeless Alliance and specialized training quarterly in supporting domestic violence survivors, recognizing child abuse and neglect, cultural competency, victim centered case planning and communication, de-escalation, and physical safety. St. Jude's in conjunction with SafeNest works to have staff fully trained in an evidence-based framework that combines the specific needs of DV survivors and those of homeless individuals. The ongoing

training helps the case managers effectively work with the DV survivor as they choose the direction of their personal safety planning and goal setting. 2) All CE assessors provide a safe, private space at each location for clients to ensure all conversations are kept private and confidential. 3) Individual interviews are held with DV survivors to ensure their safety and confidentiality, especially when they enroll as a couple. 4) The providers provide DV survivors with options that will best suit their needs. In addition to safety planning, options include a variety of locations where the clients feel most safe and relocation assistance if the client no longer feel safe in their chosen unit. TH units allow clients to remain anonymous as the lease is in the agency's name and RRH is provided when the client is ready and chooses to move into permanent housing. 5) All congregate living spaces are maintained so DV survivors are safe in their new living arrangements. 6) All DV information is maintained manually and stored in a locked filing cabinet. SafeNest provides confidential, emergency shelter to victims of DV including children and pets. They provide rides to the shelter, ensure cell phones and vehicles do not have GPS capabilities and don't allow visitors in the shelter. Off-site apartments are leased in the organization's name to ensure safety for clients.

4A-4c.1.	**Evaluating Ability to Ensure DV Survivor Safety–Project Applicant Experience.**	
	NOFO Section II.B.11.	

Describe in the field below how the project evaluated its ability to ensure the safety of DV survivors the project served.

(limit 2,000 characters)

Upon the survivor having participated in a lethality and/or housing assessment, the case manager works with the individual to ensure their confidentiality, safety of all members of the household, and determine the severity of abuse by their abuser. The DV survivor has a choice in the direction of their personal safety planning and goal setting. Throughout the course of the survivor's experience in the program, feedback is continually requested. Emphasis is placed on ways how a survivor can access services faster, ensure the safety of the children, and identify anything that may have been overlooked in relation to safety, health, and confidentiality. Policies and procedures are evaluated according to the feedback and other internal assessments completed on the procedures. The collaboration of SJRC and SafeNest allows best practices to be re-evaluated and for staff to be cross trained in the best practices to ensure the survivor and/or family's safety, child well-being, justice, and judicial assistance for survivors and providing for the needed confidentiality and stability while the survivor recovers from past traumatization. Additionally, policies and procedures were revised in both agencies for survivor's safety, confidentiality, and well-being to help maintain a consistent and clear delivery of service for staff to implement. Lastly, should a survivor find themselves in an unsafe situation where their abuser is threatening them and their children, the program will work to relocate this individual immediately, re-evaluate and update the safety plan, and reassess and address the survivor's needs to ensure a stable environment will be maintained.

4A-4d.	**Trauma-Informed, Victim-Centered Approaches–Project Applicant Experience.**	

	NOFO Section II.B.11.

	Describe in the field below examples of the project applicant's experience in using trauma-informed, victim-centered approaches to meet needs of DV survivors in each of the following areas:
1.	prioritizing program participant choice and rapid placement and stabilization in permanent housing consistent with participants' preferences;
2.	establishing and maintaining an environment of agency and mutual respect, e.g., the project does not use punitive interventions, ensures program participant staff interactions are based on equality and minimize power differentials;
3.	providing program participants access to information on trauma, e.g., training staff on providing program participants with information on trauma;
4.	emphasizing program participants' strengths, e.g., strength-based coaching, questionnaires and assessment tools include strength-based measures, case plans include assessments of program participants strengths and works towards goals and aspirations;
5.	centering on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination;
6.	providing opportunities for connection for program participants, e.g., groups, mentorships, peer-to-peer, spiritual needs; and
7.	offering support for parenting, e.g., parenting classes, childcare.

(limit 5,000 characters)

1) HopeLink, SJRC, and SafeNest (the Partners) prioritize participant choice and rapidly housing DV survivors. Partner clients choose their own residences and sign their own leases in RRH programs. The average length of time from program enrollment to housing placement for Partner clients is 15 days. When clients are searching for housing, Partners provide temporary housing in shelters or hotels and offer housing navigation services to assist clients in finding viable units in their preferred locations. Safety is always a priority with survivors of abuse, and they are consulted in every phase of the process including using a confidential address, protocols to keep their children safe, and the safe use of social media. 2) CoC agencies participate in annual training around trauma informed care, equal access, cultural competency, DV, and multi-cultural sensitivity. The Partners treat survivors with dignity and respect and encourage all clients to implement their own family goals and be part of the creation of the housing stability plan. Clients are never mandated to accomplish their stated case goals. Instead, client interactions are done in an environment where the client feels comfortable, and they are encouraged and empowered to accomplish their goals. These programs do not use any punitive interventions. 3) SafeNest, our community's DV expert, has multiple staff members who are DV certified and have successfully completed training courses to provide confidential support services. Guiding principles and best practices include educating the survivors on trauma and the effects of past traumatization on an individual's mental health, the importance of survivor confidentiality, and safety planning. Current programs have connections with community partners and resources to help survivors navigate through the trauma, build their coping skills, and secure a stable living environment. Partners and services include clinical therapy both in-house and through trusted community partners. 4) The Partners use the case plan assessment and interview to identify client strengths and weaknesses, what they need coaching with, and what careers can capitalize on their strengths. Barriers are identified and a team-based approach is used to assist clients in overcoming barriers. When clients display leadership, organizational, empowerment, and peer-to-peer strengths, they are paired with other clients to help build-up the client's leadership strengths and to support the other client with peer-to-peer mentoring and support. Partner staff are fully trained in an evidence-based framework that combines the specific needs of DV

survivors and those of homeless individuals. Case managers are trained to assess strengths from the survivor's lived experiences and how they have navigated in the past to overcome challenges. This offers support to help survivors refocus and begin moving forward. Policies and procedures are developed that ensure the survivor's voice is paramount in the case management direction and that services are client driven and appropriate to meet the individual's goals and aspirations. 5) Partner staff are ethnically and culturally diverse and are trained on cultural competence and equal access as they provide services and housing for all subpopulations of clients. This competence is revealed in thoughtful case planning, case management communications and all referrals that are given. Case managers trained in motivational interviewing use active listening and empathy to ensure all interactions are respectful and encouraging to the clients. Ongoing training options are offered locally to ensure staff remain culturally competent and aware of sensitivities in the day-to-day cultural climate of our community. 6) Partners collaborate with a variety of local providers including mental and physical health professionals, children's health and welfare groups, victim advocacy centers, legal assistance centers, food assistance, and justice organizations. All 3 organizations have relationships with faith-based religious groups who also play a huge part in helping refer and identify survivors that are eligible for services. Partnerships have also been formed with culturally specific groups including but not limited to the Hispanic, Native American, and Asian Pacific groups. The Partners offer connections to recreational activities such as scouting and after-school programs, sports, yoga, meditation, and spiritual connections. 7) Support services provided to the participant include mental health and substance abuse therapy, life skills training, employment and education opportunities, childcare, and all items necessary for them to immediately begin living on their own and providing for the safety of their children. Parenting programs sponsored by the local health authority and local providers connect young parents to necessary skills and strategies for parenting young children through teens.

4A-4e.	**Meeting Service Needs of DV Survivors–Project Applicant Experience.**	
	NOFO Section II.B.11.	

	Describe in the field below:
1.	**supportive services the project applicant provided to domestic violence survivors experiencing homelessness while quickly moving them into permanent housing and addressing their safety needs; and**
2.	**provide examples of how the project applicant provided the supportive services to domestic violence survivors.**

(limit 5,000 characters)

1) The Partners' case managers provide an initial assessment for survivor needs, and then provide ongoing assessments for survivors as a part of their standard case management. Case management staff are qualified to assist with mainstream benefits including SNAP, TANF, and Medicaid applications as necessary. Program participants have the benefit of an employment specialist to assist them in becoming interview and job ready, and their employment relationships provide jobs and job training opportunities. Staff attend networking events to remain up to date on all available social services in our community, and work closely with other agencies, Clark County, and local jurisdictions to provide best practice and survivor-centered care for their program participants.

The Partners offer counseling/rehabilitation services to all clients via in-house and community partners that are specifically trained to support survivors dealing with the trauma of domestic violence and/or sexual trafficking. When necessary and requested by clients licensed substance use counseling is also provided. The Partners provide a full range of supportive services to ensure that clients are quickly moved into permanent housing and their safety needs are fully addressed. 2) The Partners provide case management services on a continual basis, working with survivors on personal goals such as securing childcare or job placement and utilizing partnerships with local employment agencies. Mental health or substance abuse issues are addressed as needed and referrals to community partners provide individualized support that may continue after clients exit housing programs. Staff are trained in and provide a trauma-informed approach and utilizes federal Housing First guidelines in the delivery of services. This is also in combination with best practices learned by the CoC and the partner agencies in working with DV survivors and trafficked youth. Upon initial assessment, the case managers work with the survivor to identify the severity of their traumatization. Oftentimes the survivor will be in immediate danger and have the need to quickly gain access to housing. Other times, a survivor may be living with past traumatization that is compounding her barriers to living independently. The case manager helps identify barriers and is responsible for securing housing. SafeNest operates the only confidential women's emergency shelter in Las Vegas. The facility serves up to 94 individuals and does not turn away any victims. Open 24 hours 7 days a week the shelter provides immediate access to trained personnel who work with the victim to ensure their immediate safety and confidentiality. Women are encouraged to stay at the shelter as long as necessary and begin their recovery process and ensure their family's safety. SafeNest then provides a warm handoff of clients to HopeLink and SJRC to ensure a smooth transition of services for clients exiting homelessness and fleeing DV situations.

4A-4f.	**Trauma-Informed, Victim-Centered Approaches–New Project Implementation.**	
	NOFO Section II.B.11.	

	Provide examples in the field below of how the new project will:
1.	**prioritize program participant choice and rapid placement and stabilization in permanent housing consistent with participants' preferences;**
2.	**establish and maintain an environment of agency and mutual respect, e.g., the project does not use punitive interventions, ensures program participant staff interactions are based on equality and minimize power differentials;**
3.	**provide program participants access to information on trauma, e.g., training staff on providing program participants with information on trauma;**
4.	**place emphasis on program participants' strengths, e.g., strength-based coaching, questionnaires and assessment tools include strength-based measures, case plans include assessments of program participants strengths and works towards goals and aspirations;**
5.	**center on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination;**
6.	**provide opportunities for connection for program participants, e.g., groups, mentorships, peer-to-peer, spiritual needs; and**
7.	**offer support for parenting, e.g., parenting classes, childcare.**

(limit 5,000 characters)

1) The Partners will work with each survivor to establish a safety plan and begin the process of placing them in safe housing. Case managers are trained in

trauma informed care and will assess the severity of barriers to housing and self-sustainability while considering the survivor's expressed wants and needs when developing an effective client-centered case plan. Safety is always a priority with DV survivors, and they are consulted in every phase of the process; including using a confidential address, protocols to keep their children safe, and the safe use of social media. As a Housing First provider, survivors can choose from units in several communities where they feel safe. Survivor demographics or subpopulations do not influence program or housing entry. If survivors have difficulty qualifying for a lease, the Partners can assist with their property partnerships. The Partners each have relationships with property partners which enables them to remove barriers to initial placement. Properties are strategically close to schools, transportation, and additional services. In the event a DV survivor is found by their abuser, all Partners will immediately relocate them to an alternate property. Once the survivor has been stabilized or re-stabilized, an employment specialist will work with survivor to establish and increase income throughout their time in the program leading to sustained self-sufficiency post program exit. 2) All applicants have equal access to support services provided. Staff are trained on cultural competency to ensure staff interactions are based on equality. The policies and procedures work in hand with the trainings to minimize power differentials and punitive interventions. Participants are surveyed to address any gaps in the services provided, and to improve the quality of our service delivery. 3) All case managers have been extensively trained with the Nevada Homeless Alliance including trauma informed care, housing first principles, harm reduction techniques, and evidence based best practices. Intensive training from SafeNest in supporting DV survivors, recognizing child abuse and neglect, cultural competence, victim centered case planning, de-escalation, and physical safety support all Partner staff. New project staff will be trained to work with clients to establish a safety plan and begin the process of finding housing in a location they deem safe. 4) Case Managers provide an initial assessment for DV survivor needs, and then provide ongoing assessments for survivors as a part of the standard case management. Assessment tools used at intake are capturing survivors' strengths as well as their needs. While interacting through case management, the case manager continuously observes the survivors' strengths and continues to help devise a success plan incorporating the survivors' strengths while helping them to aspire to their desired goals. 5) The Partners practice equal access to all participants of the program and ensure that all partners understand the importance of this concept. Staff are trained in cultural competence and continue to assess the program to ensure their practices are nondiscriminatory and exercise inclusivity to all. 6) The Partners collaborate with local providers that include mental and physical health professionals, children's health and welfare groups, victim advocacy centers, legal assistance centers, food assistance, justice organizations, and faith-based religious groups. 7) The Partners will provide support for parenting including access to Women, Infant, Children (WIC) services, diaper services, parenting classes for newborns through teens, childcare services, after-school activities, sports, and tutoring as needed.

Project Applicants Applying for New PH-RRH and Joint TH and PH-RRH DV Bonus Projects

4A-4.	**New PH-RRH and Joint TH and PH-RRH Component DV Bonus Projects–Project Applicant Information–Rate of Housing Placement and Rate of Housing Retention–Project Applicant Experience.**	
	NOFO Section II.B.11.	

Enter information in the chart below on the project applicant applying for one or more New PH-RRH and Joint TH and PH-RRH Component DV Bonus Projects included on your CoC's FY 2021 Priority Listing:

1.	**Applicant Name**	St Jude's Ranch for Children / SafeNest
2.	**Rate of Housing Placement of DV Survivors–Percentage**	100.00%
3.	**Rate of Housing Retention of DV Survivors–Percentage**	90.00%

4A-4a.	**Calculating the Rate of Housing Placement and the Rate of Housing Retention–Project Applicant Experience.**	
	NOFO Section II.B.11.	

	Describe in the field below:
1.	**how the project applicant calculated the rate of housing placement and rate of housing retention reported in question 4A-4; and**
2.	**the data source (e.g. comparable database, other administrative data, external data source, HMIS for non-DV projects).**

(limit 1,000 characters)

1) During the past 2 years, HopeLink has served 120 households fleeing or surviving domestic violence. Of the 52 clients that have exited the program 47 (90%) have remained stably housed. The remaining clients remain enrolled in the program. For SJRC clients, 90% also remain stably housed. The average number of days from program exit to return to homelessness is 314 days. 2) Data was sourced from the HMIS database, the comparable database, and other administrative data.

4A-4b.	**Providing Housing to DV Survivor–Project Applicant Experience.**	
	NOFO Section II.B.11.	

	Describe in the field below how the project applicant:
1.	**ensured DV survivors experiencing homelessness were assisted to quickly move into safe affordable housing;**
2.	**prioritized survivors–you must address the process the project applicant used, e.g., Coordinated Entry, prioritization list, CoC's emergency transfer plan, etc.;**
3.	**connected survivors to supportive services; and**
4.	**moved clients from assisted housing to housing they could sustain–address housing stability after the housing subsidy ends.**

(limit 2,000 characters)

1) SNV DV providers ensure that DV survivors experiencing homelessness are assisted to quickly move into safe affordable housing by providing DV

assessments to victim-survivors wherever they are found. HELP of S NV provides 7-day coverage to help relocate victims immediately through safety and housing, versus having them admitted into an emergency shelter. They are then quickly connected to housing services and programs to identify and move into permanent housing. 2) Case Managers utilize coordinated entry and a prioritization list with DV survivors with the highest vulnerability being housed first. HELP of S NV works on a Housing First model and does not screen people out of programming. 3) DV survivors are connected with mainstream resources every day. HELP of S NV has worked with community partners such as addiction services, family housing services, employment, financial assistance, housing, managed care organizations, and mental health services since it opened its doors 51 years ago. DV-specific partners, such as SafeNest and Safe House provide targeted services for this population ensuring that all services are trauma-informed and respect the privacy of the client. 4) SafeNest & St. Jude's ensure clients do not exit to homelessness by selecting units that meet FMR and are financially sustainable for clients when they exit housing programs. Furthermore, clients are encouraged to begin paying a portion of their rent as soon as they gain income. This helps form buy-in and keeps the survivor engaged in the program. As the clients exit the program, they are able to confidently pay the full amount of their monthly costs. The program also provides 6-months of after-care services for clients to continue the connection with case management support and be helped to obtain on-going community-based services. This consistent connection after program exit allows for the participant to seek out the services when they need and to stay in contact with program staff.

4A-4c.	**Ensuring DV Survivor Safety–Project Applicant Experience.**	
	NOFO Section II.B.11.	

	Describe in the field below examples of how the project applicant ensured the safety of DV survivors experiencing homelessness by:
1.	**training staff on safety planning;**
2.	**adjusting intake space to better ensure a private conversation;**
3.	**conducting separate interviews/intake with each member of a couple;**
4.	**working with survivors to have them identify what is safe for them as it relates to scattered site units and/or rental assistance;**
5.	**maintaining bars on windows, fixing lights in the hallways, etc. for congregate living spaces operated by the applicant; and**
6.	**keeping the location confidential for dedicated units and/or congregate living spaces set-aside solely for use by survivors.**

(limit 5,000 characters)

1) SNV providers conduct regular staff training to ensure the safety of DV survivors experiencing homelessness. HopeLink provides case management training with the Nevada Homeless Alliance and specialized training quarterly in supporting domestic violence survivors, recognizing child abuse and neglect, cultural competency, victim centered case planning and communication, de-escalation, and physical safety. St. Jude's in conjunction with SafeNest works to have staff fully trained in an evidence-based framework that combines the specific needs of DV survivors and those of homeless individuals. The ongoing training helps the case managers effectively work with the DV survivor as they choose the direction of their personal safety planning and goal setting. 2) All CE

assessors provide a safe, private space at each location for clients to ensure all conversations are kept private and confidential. 3) Individual interviews are held with DV survivors to ensure their safety and confidentiality, especially when they enroll as a couple. 4) The providers provide DV survivors with options that will best suit their needs. In addition to safety planning, options include a variety of locations where the clients feel most safe and relocation assistance if the client no longer feel safe in their chosen unit. TH units allow clients to remain anonymous as the lease is in the agency's name and RRH is provided when the client is ready and chooses to move into permanent housing. 5) All congregate living spaces are maintained so DV survivors are safe in their new living arrangements. 6) All DV information is maintained manually and stored in a locked filing cabinet. SafeNest provides confidential, emergency shelter to victims of DV including children and pets. They provide rides to the shelter, ensure cell phones and vehicles do not have GPS capabilities and don't allow visitors in the shelter. Off-site apartments are leased in the organization's name to ensure safety for clients.

4A-4c.1.	**Evaluating Ability to Ensure DV Survivor Safety–Project Applicant Experience.**	
	NOFO Section II.B.11.	

Describe in the field below how the project evaluated its ability to ensure the safety of DV survivors the project served.

(limit 2,000 characters)

Upon the survivor having participated in a lethality and/or housing assessment, the case manager works with the individual to ensure their confidentiality, safety of all members of the household, and determine the severity of abuse by their abuser. The DV survivor has a choice in the direction of their personal safety planning and goal setting. Throughout the course of the survivor's experience in the program, feedback is continually requested. Emphasis is placed on ways how a survivor can access services faster, ensure the safety of the children, and identify anything that may have been overlooked in relation to safety, health, and confidentiality. Policies and procedures are evaluated according to the feedback and other internal assessments completed on the procedures. The collaboration of SJRC and SafeNest allows best practices to be re-evaluated and for staff to be cross trained in the best practices to ensure the survivor and/or family's safety, child well-being, justice, and judicial assistance for survivors and providing for the needed confidentiality and stability while the survivor recovers from past traumatization. Additionally, policies and procedures were revised in both agencies for survivor's safety, confidentiality, and well-being to help maintain a consistent and clear delivery of service for staff to implement. Lastly, should a survivor find themselves in an unsafe situation where their abuser is threatening them and their children, the program will work to relocate this individual immediately, re-evaluate and update the safety plan, and reassess and address the survivor's needs to ensure a stable environment will be maintained.

4A-4d.	**Trauma-Informed, Victim-Centered Approaches–Project Applicant Experience.**	
	NOFO Section II.B.11.	

	Describe in the field below examples of the project applicant's experience in using trauma-informed, victim-centered approaches to meet needs of DV survivors in each of the following areas:
1.	prioritizing program participant choice and rapid placement and stabilization in permanent housing consistent with participants' preferences;
2.	establishing and maintaining an environment of agency and mutual respect, e.g., the project does not use punitive interventions, ensures program participant staff interactions are based on equality and minimize power differentials;
3.	providing program participants access to information on trauma, e.g., training staff on providing program participants with information on trauma;
4.	emphasizing program participants' strengths, e.g., strength-based coaching, questionnaires and assessment tools include strength-based measures, case plans include assessments of program participants strengths and works towards goals and aspirations;
5.	centering on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination;
6.	providing opportunities for connection for program participants, e.g., groups, mentorships, peer-to-peer, spiritual needs; and
7.	offering support for parenting, e.g., parenting classes, childcare.

(limit 5,000 characters)

1) HopeLink, SJRC, and SafeNest (the Partners) prioritize participant choice and rapidly housing DV survivors. Partner clients choose their own residences and sign their own leases in RRH programs. The average length of time from program enrollment to housing placement for Partner clients is 15 days. When clients are searching for housing, Partners provide temporary housing in shelters or hotels and offer housing navigation services to assist clients in finding viable units in their preferred locations. Safety is always a priority with survivors of abuse, and they are consulted in every phase of the process including using a confidential address, protocols to keep their children safe, and the safe use of social media. 2) CoC agencies participate in annual training around trauma informed care, equal access, cultural competency, DV, and multi-cultural sensitivity. The Partners treat survivors with dignity and respect and encourage all clients to implement their own family goals and be part of the creation of the housing stability plan. Clients are never mandated to accomplish their stated case goals. Instead, client interactions are done in an environment where the client feels comfortable, and they are encouraged and empowered to accomplish their goals. These programs do not use any punitive interventions. 3) SafeNest, our community's DV expert, has multiple staff members who are DV certified and have successfully completed training courses to provide confidential support services. Guiding principles and best practices include educating the survivors on trauma and the effects of past traumatization on an individual's mental health, the importance of survivor confidentiality, and safety planning. Current programs have connections with community partners and resources to help survivors navigate through the trauma, build their coping skills, and secure a stable living environment. Partners and services include clinical therapy both in-house and through trusted community partners. 4) The Partners use the case plan assessment and interview to identify client strengths and weaknesses, what they need coaching with, and what careers can capitalize on their strengths. Barriers are identified and a team-based approach is used to assist clients in overcoming barriers. When clients display leadership, organizational, empowerment, and peer-to-peer strengths, they are paired with other clients to help build-up the client's leadership strengths and to support the other client with peer-to-peer mentoring and support. Partner staff are fully trained in an evidence-based framework that combines the specific needs of DV survivors and those of homeless individuals. Case managers are trained to assess strengths from the survivor's lived experiences and how they have

navigated in the past to overcome challenges. This offers support to help survivors refocus and begin moving forward. Policies and procedures are developed that ensure the survivor's voice is paramount in the case management direction and that services are client driven and appropriate to meet the individual's goals and aspirations. 5) Partner staff are ethnically and culturally diverse and are trained on cultural competence and equal access as they provide services and housing for all subpopulations of clients. This competence is revealed in thoughtful case planning, case management communications and all referrals that are given. Case managers trained in motivational interviewing use active listening and empathy to ensure all interactions are respectful and encouraging to the clients. Ongoing training options are offered locally to ensure staff remain culturally competent and aware of sensitivities in the day-to-day cultural climate of our community. 6) Partners collaborate with a variety of local providers including mental and physical health professionals, children's health and welfare groups, victim advocacy centers, legal assistance centers, food assistance, and justice organizations. All 3 organizations have relationships with faith-based religious groups who also play a huge part in helping refer and identify survivors that are eligible for services. Partnerships have also been formed with culturally specific groups including but not limited to the Hispanic, Native American, and Asian Pacific groups. The Partners offer connections to recreational activities such as scouting and after-school programs, sports, yoga, meditation, and spiritual connections. 7) Support services provided to the participant include mental health and substance abuse therapy, life skills training, employment and education opportunities, childcare, and all items necessary for them to immediately begin living on their own and providing for the safety of their children. Parenting programs sponsored by the local health authority and local providers connect young parents to necessary skills and strategies for parenting young children through teens.

4A-4e.	**Meeting Service Needs of DV Survivors–Project Applicant Experience.**	
	NOFO Section II.B.11.	

	Describe in the field below:
1.	**supportive services the project applicant provided to domestic violence survivors experiencing homelessness while quickly moving them into permanent housing and addressing their safety needs; and**
2.	**provide examples of how the project applicant provided the supportive services to domestic violence survivors.**

(limit 5,000 characters)

1) The Partners' case managers provide an initial assessment for survivor needs, and then provide ongoing assessments for survivors as a part of their standard case management. Case management staff are qualified to assist with mainstream benefits including SNAP, TANF, and Medicaid applications as necessary. Program participants have the benefit of an employment specialist to assist them in becoming interview and job ready, and their employment relationships provide jobs and job training opportunities. Staff attend networking events to remain up to date on all available social services in our community, and work closely with other agencies, Clark County, and local jurisdictions to provide best practice and survivor-centered care for their program participants. The Partners offer counseling/rehabilitation services to all clients via in-house and community partners that are specifically trained to support survivors dealing

with the trauma of domestic violence and/or sexual trafficking. When necessary and requested by clients licensed substance use counseling is also provided. The Partners provide a full range of supportive services to ensure that clients are quickly moved into permanent housing and their safety needs are fully addressed. 2) The Partners provide case management services on a continual basis, working with survivors on personal goals such as securing childcare or job placement and utilizing partnerships with local employment agencies. Mental health or substance abuse issues are addressed as needed and referrals to community partners provide individualized support that may continue after clients exit housing programs. Staff are trained in and provide a trauma-informed approach and utilizes federal Housing First guidelines in the delivery of services. This is also in combination with best practices learned by the CoC and the partner agencies in working with DV survivors and trafficked youth. Upon initial assessment, the case managers work with the survivor to identify the severity of their traumatization. Oftentimes the survivor will be in immediate danger and have the need to quickly gain access to housing. Other times, a survivor may be living with past traumatization that is compounding her barriers to living independently. The case manager helps identify barriers and is responsible for securing housing. SafeNest operates the only confidential women's emergency shelter in Las Vegas. The facility serves up to 94 individuals and does not turn away any victims. Open 24 hours 7 days a week the shelter provides immediate access to trained personnel who work with the victim to ensure their immediate safety and confidentiality. Women are encouraged to stay at the shelter as long as necessary and begin their recovery process and ensure their family's safety. SafeNest then provides a warm handoff of clients to HopeLink and SJRC to ensure a smooth transition of services for clients exiting homelessness and fleeing DV situations.

4A-4f.	**Trauma-Informed, Victim-Centered Approaches–New Project Implementation.**	
	NOFO Section II.B.11.	

	Provide examples in the field below of how the new project will:
1.	**prioritize program participant choice and rapid placement and stabilization in permanent housing consistent with participants' preferences;**
2.	**establish and maintain an environment of agency and mutual respect, e.g., the project does not use punitive interventions, ensures program participant staff interactions are based on equality and minimize power differentials;**
3.	**provide program participants access to information on trauma, e.g., training staff on providing program participants with information on trauma;**
4.	**place emphasis on program participants' strengths, e.g., strength-based coaching, questionnaires and assessment tools include strength-based measures, case plans include assessments of program participants strengths and works towards goals and aspirations;**
5.	**center on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination;**
6.	**provide opportunities for connection for program participants, e.g., groups, mentorships, peer-to-peer, spiritual needs; and**
7.	**offer support for parenting, e.g., parenting classes, childcare.**

(limit 5,000 characters)

1) The Partners will work with each survivor to establish a safety plan and begin the process of placing them in safe housing. Case managers are trained in trauma informed care and will assess the severity of barriers to housing and self-sustainability while considering the survivor's expressed wants and needs

when developing an effective client-centered case plan. Safety is always a priority with DV survivors, and they are consulted in every phase of the process; including using a confidential address, protocols to keep their children safe, and the safe use of social media. As a Housing First provider, survivors can choose from units in several communities where they feel safe. Survivor demographics or subpopulations do not influence program or housing entry. If survivors have difficulty qualifying for a lease, the Partners can assist with their property partnerships. The Partners each have relationships with property partners which enables them to remove barriers to initial placement. Properties are strategically close to schools, transportation, and additional services. In the event a DV survivor is found by their abuser, all Partners will immediately relocate them to an alternate property. Once the survivor has been stabilized or re-stabilized, an employment specialist will work with survivor to establish and increase income throughout their time in the program leading to sustained self-sufficiency post program exit. 2) All applicants have equal access to support services provided. Staff are trained on cultural competency to ensure staff interactions are based on equality. The policies and procedures work in hand with the trainings to minimize power differentials and punitive interventions. Participants are surveyed to address any gaps in the services provided, and to improve the quality of our service delivery. 3) All case managers have been extensively trained with the Nevada Homeless Alliance including trauma informed care, housing first principles, harm reduction techniques, and evidence based best practices. Intensive training from SafeNest in supporting DV survivors, recognizing child abuse and neglect, cultural competence, victim centered case planning, de-escalation, and physical safety support all Partner staff. New project staff will be trained to work with clients to establish a safety plan and begin the process of finding housing in a location they deem safe. 4) Case Managers provide an initial assessment for DV survivor needs, and then provide ongoing assessments for survivors as a part of the standard case management. Assessment tools used at intake are capturing survivors' strengths as well as their needs. While interacting through case management, the case manager continuously observes the survivors' strengths and continues to help devise a success plan incorporating the survivors' strengths while helping them to aspire to their desired goals. 5) The Partners practice equal access to all participants of the program and ensure that all partners understand the importance of this concept. Staff are trained in cultural competence and continue to assess the program to ensure their practices are nondiscriminatory and exercise inclusivity to all. 6) The Partners collaborate with local providers that include mental and physical health professionals, children's health and welfare groups, victim advocacy centers, legal assistance centers, food assistance, justice organizations, and faith-based religious groups. 7) The Partners will provide support for parenting including access to Women, Infant, Children (WIC) services, diaper services, parenting classes for newborns through teens, childcare services, after-school activities, sports, and tutoring as needed.

4B. Attachments Screen For All Application Questions

We prefer that you use PDF files, though other file types are supported. Please only use zip files if necessary.

Attachments must match the questions they are associated with.

Only upload documents responsive to the questions posed–including other material slows down the review process, which ultimately slows down the funding process.

We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).

Document Type	Required?	Document Description	Date Attached
1C-14. CE Assessment Tool	Yes		
1C-7. PHA Homeless Preference	No	1C-7. PHA Homeles...	11/08/2021
1C-7. PHA Moving On Preference	No	1C-7. PHA Moving ...	11/08/2021
1E-1. Local Competition Announcement	Yes		
1E-2. Project Review and Selection Process	Yes		
1E-5. Public Posting–Projects Rejected-Reduced	Yes		
1E-5a. Public Posting–Projects Accepted	Yes		
1E-6. Web Posting–CoC-Approved Consolidated Application	Yes		
3A-1a. Housing Leveraging Commitments	No		
3A-2a. Healthcare Formal Agreements	No	3a-2a combined	11/09/2021
3C-2. Project List for Other Federal Statutes	No		

Attachment Details

Document Description:

Attachment Details

Document Description: 1C-7. PHA Homeless Preference

Attachment Details

Document Description: 1C-7. PHA Moving On Preference

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: 3a-2a combined

Attachment Details

Document Description:

Submission Summary

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

Page	Last Updated
1A. CoC Identification	11/08/2021
1B. Inclusive Structure	11/08/2021
1C. Coordination	11/08/2021
1C. Coordination continued	11/08/2021
1D. Addressing COVID-19	11/08/2021
1E. Project Review/Ranking	11/08/2021
2A. HMIS Implementation	11/09/2021
2B. Point-in-Time (PIT) Count	11/08/2021
2C. System Performance	11/08/2021
3A. Housing/Healthcare Bonus Points	11/08/2021
3B. Rehabilitation/New Construction Costs	11/08/2021

3C. Serving Homeless Under Other Federal Statutes	11/08/2021
4A. DV Bonus Application	11/08/2021
4B. Attachments Screen	Please Complete
Submission Summary	No Input Required

silversummit healthplan

2500 N. Buffalo Drive
Suite 250
Las Vegas, NV 89128

September 28, 2021

Clark County Social Services
Fiscal Unit
1600 Pinto Lane
Las Vegas, NV 89106

RE: HEALTHY LIVING CONSOLIDATED PROJECT
HUD GRANT NUMBER - NV0071

To Whom It May Concern:

SilverSummit Healthplan is a Medicaid Managed Care Organization (MCO) in the State of Nevada and seeks to provide a safety net of medical services for the growing community of Southern Nevada. This safety net provides support to low-income, at-risk, and high-risk populations attaining self-sufficiency. The Healthy Living Consolidated Project seeks to house 133 medically fragile individuals and families experiencing homelessness in permanent supportive housing and wrapping them in intensive case management, medical case management and supportive services to assist them with becoming self-sufficient.

Healthy Living Consolidated Project is an innovative project for Southern Nevada and will serve as a model for other programs supporting highly vulnerable, medically fragile individuals experiencing homelessness who are seeking permanent housing stability and medical wellness.

SilverSummit Healthplan is dedicated to supporting Healthy Living Consolidated Project with cash match funds. SilverSummit Healthplan is committing the following amount:

Type	Source	Value	Date of Commitment
Cash	SSHP	$110,000	10/1/2022-9/30/2023

For: Intensive case management and supportive services for 15 clients directly linked to the Healthy Living Consolidated Project.
If you have any questions or require further information, please contact me at Nicole.L.Figles@SilverSummitHealthPlan.com.

Sincerely,

Nicole L. Figles

Nicole L. Figles

Lisa J. Bogard
President & CEO

Anthem Blue Cross and Blue Shield Healthcare Solutions
9133 W. Russell Road
Las Vegas, Nevada 89148

September 28, 2021

Anthem.

RE: HEALTHY LIVING CONSOLIDATED PROJECT

HUD GRANT NUMBER - NV0071

To Whom It May Concern:

Anthem, Inc. is a Medicaid Managed Care Organization (MCO) in the State of Nevada and seeks to provide a safety net of medical services for the growing community of Southern Nevada. This safety net provides support to low-income, at-risk, and high-risk populations attaining self-sufficiency. The Healthy Living Consolidated Project seeks to house 133 medically fragile individuals and families experiencing homelessness in permanent supportive housing and wrapping them in intensive case management, medical case management and supportive services to assist them with becoming self-sufficient.

Healthy Living Consolidated Project is an innovative project for Southern Nevada and will serve as a model for other programs supporting highly vulnerable, medically fragile individuals experiencing homelessness who are seeking permanent housing stability and medical wellness.

Anthem, Inc. is dedicated to supporting Healthy Living Consolidated Project with cash match funds. Anthem, Inc. is committing up to the following amount:

Type	Source	Value	Date of Commitment
Cash	undisclosed	$220,000	10/1/2022–9/30/2023

For: Intensive case management and supportive services for 30 clients directly linked to the Healthy Living Consolidated Project.

If you have any questions or require further information, please contact me at (lisa.bogard@anthem.com) +1 702-545-9842 Ext. 757513-1652.

Sincerely,

Lisa J. Bogard
President & CEO

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

October 13, 2021

Clark County Social Services
1600 Pinto Lane
Las Vegas, NV 89106

RE: HEALTHY LIVING CONSOLIDATED PROJECT
HUD GRANT NUMBER - NV0071

To Whom It May Concern:

Health Plan of Nevada (HPN) is a Medicaid Managed Care Organization (MCO) in the State of Nevada and seeks to provide a safety net of medical services for the growing community of Southern Nevada. This safety net provides support to low-income, at-risk, and high-risk populations attaining self-sufficiency. The Healthy Living Consolidated Project seeks to house 90 medically fragile individuals and families experiencing homelessness in permanent supportive housing and wrapping them in intensive case management, medical case management and supportive services to assist them with becoming self-sufficient.

Healthy Living Consolidated Project is an innovative project for Southern Nevada and will serve as a model for other programs supporting highly vulnerable, medically fragile individuals experiencing homelessness who are seeking permanent housing stability and medical wellness.

HPN is dedicated to supporting Healthy Living Consolidated Project with cash match funds. HPN is committing up to the following amount:

Type	Source	Value	Date of Commitment
Cash	undisclosed	$330,000	10/1/2022–9/30/2023

For: Intensive case management and supportive services for 45 clients directly linked to the Healthy Living Expansion Program.

If you have any questions or require further information, please contact Rachel Rosensteel (Rachel.Rosensteel@uhc.com).

Sincerely,

Donald J. Giancursio
Chief Executive Officer, UnitedHealthcare
NV, UT, & ID Markets

AGREEMENT
FOR SHARED SERVICES FOR
HEALTHY LIVING EXPANSION

This AGREEMENT (hereinafter referred to as "AGREEMENT"), is made and entered into this 1st day, of October 2020, by and between the COUNTY of CLARK, DEPARTMENT OF SOCIAL SERVICE (hereinafter referred to as "COUNTY"), and ANTHEM BLUE CROSS AND BLUE SHIELD (hereinafter referred to as "ANTHEM") for shared services for Healthy Living Expansion collectively hereinafter referred to as PROJECT.

INTRODUCTION

WHEREAS, The PROJECT is a permanent supportive housing project for medically fragile, highly vulnerable households experiencing homelessness. The PROJECT serves medically fragile, highly vulnerable individuals experiencing homelessness, discharged from local hospitals or other medical facilities using a Housing First model. The PROJECT places homeless individuals, and if needed, their families in an affordable housing situation, providing intensive case management and access to addiction and mental health counseling and medical supports;

WHEREAS, there is a need for permanent supportive housing for medically fragile, highly vulnerable individuals and families experiencing homelessness based on data which reflects 100 percent of enrolled clients have special needs in the PROJECT as they all have a disability. Community Management Information System (CMIS) reporting of condition distributions indicate that approximately 88 percent have chronic health conditions, 70 percent have mental illness, 68 percent have physical disabilities, and 53 percent suffer with alcohol and/or substance abuse. The need to coordinate supportive housing post hospital discharge is substantial based on piloted data from the PROJECT;

WHEREAS, the PARTIES to this AGREEMENT believe that the coordination of supportive housing post medical discharge can most effectively be accomplished through the cooperation between the PARTIES through collaboration of case management and housing service provision for the PROJECT to serve more clients utilizing combined resources; and

WHEREAS, it is deemed that the services hereinafter set forth are both necessary and in the best interests of the COUNTY and ANTHEM;

NOW, THEREFORE, in consideration of the aforementioned premises, the following have been mutually agreed upon by all PARTIES:

PARTICIPANTS

Clark County, Department of Social Service (COUNTY)
Anthem Blue Cross and Blue Shield (ANTHEM)

TIME FRAME AND ASSOCIATION

This AGREEMENT has been entered into in good faith. This AGREEMENT will remain in effect for four (4) years expiring on September 30, 2024, or until such time as COUNTY and ANTHEM collectively revise the expiration in writing or if funding is not available. The AGREEMENT will

automatically renew for successive annual terms. Any PARTY may terminate its participation under this AGREEMENT upon not less than sixty (60) days written notice to the other PARTY as provided herein. The AGREEMENT will be reviewed by each PARTY annually.

This AGREEMENT shall not act, nor be construed, to otherwise restrict the PARTIES from participating in similar activities with other public or private agencies, organizations, and individuals.

SPECIFIC ROLES AND RESPONSIBILITIES OF PARTICIPANTS

COUNTY and ATHEM have been collaborating since March of 2019 to develop an expansion of the PROJECT which provides intensive case management (ICM) to highly vulnerable, medically fragile individuals experiencing homelessness discharged from local hospitals and other medical facilities;

The grant funds that provide rental assistance to eligible clients are provided by U.S. Department of Housing and Urban Development's (HUD), Continuum of Care Program governed by title IV of the McKinney-Vento Homeless Assistance Act, as amended by S. 896 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 and the Continuum of Care Program regulation 24 CFR 578. Funds for grant year October 1, 2020 – September 30, 2021 are contingent upon receipt of grant funds awarded by HUD to Clark County Social Service;

The Board of County Commissioners (BCC) approved acceptance of the grant award on October 15, 2019;

Direct service is provided through a subcontract with HELP of Southern Nevada which provides outreach, intensive case management, housing placement and supportive services; and

ClarityNet software operating the CMIS is the case management tool of record.

SCOPE OF SERVICES TO BE PROVIDED BY COUNTY:

1. BACKBONE SERVICES: COUNTY will serve as Project Manager for the PROJECT with primary responsibility of organizing meetings and facilitating communication among partnering and contracted agencies.
2. COUNTY will participate as the fiscal agent for the HUD Continuum of Care grant funding to facilitate subcontracts with direct service provider, HELP of Southern Nevada.
3. COUNTY will utilize additional funding resources provided by ANTHEM to enhance HELP of Southern Nevada's Healthy Living Expansion Intensive Case Management Contract with additional resources.
4. COUNTY will dedicate a caseload of one (1) case manager at a maximum of fifteen (15) highly vulnerable, medically fragile households experiencing homelessness with supportive housing through rental assistance resources provided by HUD grant Continuum of Care funding for the PROJECT while grant funds are available.

SCOPE OF SERVICES TO BE PROVIDED BY ANTHEM BLUE CROSS AND BLUE SHIELD

1. ANTHEM will utilize ANTHEM social work staff at various hospitals to identify presumptively eligible clients who meet the criteria for the PROJECT through the web-based database, ClarityNet Human Services CMIS, which acts as a referral portal, data repository, and case management tool of record for client information.
2. ANTHEM will follow the admission criteria for the PROJECT to include referring clients who:
   - ❖ Meet the PROJECT's definition of medically fragile, highly vulnerable and homeless
   - ❖ Have a chronic health condition and/or disabling factors of mental health/substance abuse.
   - ❖ Are independent in performing activities of daily living (ADLs) and medication administration.
   - ❖ Have an acute medical condition with an identifiable end point of care.
   - ❖ Are independent in mobility (individual can ambulate with assistive devices such as walkers, wheelchairs, cane, crutches).
   - ❖ Are willing to see medical and community staff and comply with medical recommendations in accordance with treatment plans (Harm reduction methods will be incorporated with treatment plans).
   - ❖ Are medically and psychiatrically stable; patient must be ready for discharge to independent living and cannot be suicidal or homicidal.
3. Provide $209,040 for year one (1) and three (3) percent increases per year thereafter for services to case manage a maximum of thirty (30) clients for the PROJECT.
4. Share client level cost benefit data with COUNTY to include, at a minimum, pre-intervention cost six (6) months prior to enrollment and six (6) months post enrollment to evaluate program intervention cost.
5. Share client level information with PROJECT case manager pertinent to providing individualized holistic services.

COLLECTIVE RESPONSIBILITY

The PARTIES shall engage in continuous communication which will allow for a consistent and honest platform where concerns will be addressed and ideas discussed between organizations. This communication method will support common language, a foundation for support, a common agenda, an agreement of common targets, and monitoring of results.

The PARTIES shall participate in regular meetings and conference calls for PROJECT and be responsible for respective data entry, reporting, and processes for using data to improve service delivery and coordination.

The PARTIES understand that nothing contained in the AGREEMENT shall require any PARTY to refer any individual or clients to any other PARTY, or to any affiliate or subsidiary of any PARTY.

CONFIDENTIALITY

The PARTIES hereto shall treat as confidential all information relating to any PARTY'S operations or the general business affairs or any of the operations or general business affairs of the

PARTY (including the PARTY'S parent, affiliate, subcontractor for the project, or subsidiary companies) which any other party may observe or which may be disclosed as a result of the PARTY'S performance under this AGREEMENT. No PARTY shall disclose any such confidential information to third parties or use any such information for any purpose other than the performance under this AGREEMENT, without the prior written consent of the other PARTY.

Additionally, the PARTIES shall abide by all State and Federal laws, rules and regulations, including, but not limited to, 42 C.F.R., Part 2 and the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC § 1320d ("HIPAA"). Specifically, and to the extent applicable to this AGREEMENT and the relationships between the PARTIES, each PARTY shall comply with HIPAA, and any current and future regulations promulgated thereunder, and all the amendments to HIPAA contained in Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), all collectively referred to as "HIPAA Requirements". The PARTIES understand it may be necessary to enter into further agreements to facilitate compliance with HIPAA. Each PARTY shall not use or further disclose any Protected Health Information (as defined in 45 C.F.R. § 132d), other than as permitted by the HIPAA Requirements, including the law enforcement exception to HIPAA.

Any medical information concerning any client or individual that is necessary to share with the COUNTY for the safety of the PROJECT, the client or in furtherance of this AGREEMENT is confidential and will be protected and not disclosed other than to those who have a need and right to know the information and who is subject to like terms of confidentiality.

NOTICES

Any notices required or permitted to be given pursuant to this AGREEMENT shall be in writing and sent by certified mail, postage prepaid, return receipt requested to the PARTY's address noted below. Notice shall be deemed to be given upon the date three (3) days after such notice is deposited in the mail. Notices may also be delivered by courier, electronic transmission (including email) or by facsimile transmission and shall be deemed to be delivered when received by the PARTY to whom such notice is directed with a confirmation of receipt. All notices shall be forwarded as follows:

If to CCSS:
Clark County, Department of Social Service
Attn: Director of Social Service
Address: 1600 Pinto Lane
Las Vegas, Nevada 89106

If to ANTHEM:
Anthem Blue Cross and Blue Shield
Attn: Lisa Bogard
Address: 9133 West Russell Road
Las Vegas, Nevada 89148

ENTIRE AGREEMENT

This AGREEMENT represents the entire arrangement and understanding between the PARTIES and supersedes all prior oral and written understandings, representations, and discussions respecting this AGREEMENT.

NO ASSIGNMENT OR MODIFICATIONS

No PARTY to this AGREEMENT may assign, pledge, or otherwise transfer its responsibilities under the scope of work herein except with the prior written consent of the non-assigning PARTY, which consent shall not be unreasonably withheld. This provision does not apply to subcontracting.

This AGREEMENT may not be modified or amended without the written consent of authorized representatives of the PARTIES.

PERMITS AND LICENSES

Each PARTY hereto shall be responsible for securing all necessary licenses and permits required for providing the services for which it is responsible as delineated in this AGREEMENT.

INSURANCE

Each PARTY hereto shall be responsible for providing its own insurance coverage, including general liability, workers compensation, and professional liability (if applicable).

INDEPENDENT CONTRACTORS

The PARTIES to this AGREEMENT are acting as independent contractors and independent employers. Nothing contained in this AGREEMENT shall create or be construed as creating a partnership, joint venture or agency relationship between the PARTIES. No PARTY, nor any PARTY's respective officers, directors, employees or independent contractors, shall be construed to be the partner, employee, agent, or representative of any other PARTY. No PARTY shall have the authority to bind any other PARTY in any respect. No PARTY shall exercise control over the methods or procedures to be utilized by any other PARTY, nor shall any PARTY be responsible for the conduct of any other PARTY.

MISCELLANEOUS

1. Limited Liability
    a. The PARTIES will not waive and intend to assert available NRS chapter 41 liability limitations in all cases. Contract liability of both PARTIES shall not be subject to punitive damages. To the extent applicable, actual contract damages for any breach shall be limited by NRS 354.626.
2. Indemnification
    a. Neither PARTY waives any right or defense to indemnification that may exist in law or equity.
3. Exclusive Benefit of the PARTIES

a. This AGREEMENT is not intended to create any rights, powers, or interest for any PARTY not participating in this AGREEMENT. This AGREEMENT is entered into for the exclusive benefit of the undersigned PARTIES.

4. Interpretation of AGREEMENT
    a. It is agreed that the PARTIES will derive the greatest benefit from this AGREEMENT by promoting the interest of each other, by evaluation, consultation, cooperation, and interpreting the provisions of this AGREEMENT in the manner which shall best promote the interest of the clients served.
5. Non-Discrimination
    a. In providing services under this AGREEMENT, the PARTIES shall not discriminate on the basis of race, color, sex, age, religion, national origin, disability, sexual orientation, or gender identity or expression.
6. Severability
    a. In the event any provision of this AGREEMENT is rendered invalid or unenforceable by any valid act of Congress or the Nevada State Legislature, or declared null and void by any court of competent jurisdiction, the rest and remainder of the provisions of this AGREEMENT shall remain in full force and effect.
7. Waiver
    a. Any waiver of a breach of any provision of this AGREEMENT shall not be deemed a waiver of any other breach of the same or different provision.
8. Governing Law
    a. Nevada law shall govern the interpretation of this AGREEMENT.

IN WITNESS WHEREOF, the PARTIES have caused this AGREEMENT for Shared Services for PROJECT to be executed by their duly authorized representatives on the day and year first written above.

ANTHEM BLUE CROSS AND BLUE SHIELD

By: _____ DATE: Sept 11, 2019

CRAIG SMITH
President, Nevada Medicaid

COUNTY:
CLARK COUNTY, NEVADA

By: _____ DATE: 9-13-19

RANDY REINOSO
Assistant Director of Social Service

APPROVED AS TO FORM:
STEVEN B. WOLFSON
District Attorney

By: _____ DATE: _____

STEVEN SWEIKERT
Deputy District Attorney

AGREEMENT
FOR SHARED SERVICES FOR
HEALTHY LIVING EXPANSION

This AGREEMENT (hereinafter referred to as "AGREEMENT"), is made and entered into this 9th day, of September 2019, by and between the COUNTY of CLARK, DEPARTMENT OF SOCIAL SERVICE (hereinafter referred to as "COUNTY"), and SILVER SUMMIT HEALTH PLAN (hereinafter referred to as "SILVER SUMMIT") for shared services for Healthy Living Expansion collectively hereinafter referred to as PROJECT.

INTRODUCTION

WHEREAS, The PROJECT is a permanent supportive housing project for medically fragile, highly vulnerable households experiencing homelessness. The PROJECT serves medically fragile, highly vulnerable individuals experiencing homelessness, discharged from local hospitals or other medical facilities using a Housing First model. The PROJECT places homeless individuals, and if needed, their families in an affordable housing situation, providing intensive case management and access to addiction and mental health counseling and medical supports;

WHEREAS, there is a need for permanent supportive housing for medically fragile, highly vulnerable individuals and families experiencing homelessness based on data which reflects 100 percent of enrolled clients have special needs in the PROJECT as they all have a disability. Community Management Information System (CMIS) reporting of condition distributions indicate that approximately 88 percent have chronic health conditions, 70 percent have mental illness, 68 percent have physical disabilities, and 53 percent suffer with alcohol and/or substance abuse. The need to coordinate supportive housing post hospital discharge is substantial based on piloted data from the PROJECT;

WHEREAS, the PARTIES to this AGREEMENT believe that the coordination of supportive housing post medical discharge can most effectively be accomplished through the cooperation between the PARTIES through collaboration of case management and housing service provision for the PROJECT to serve more clients utilizing combined resources; and

WHEREAS, it is deemed that the services hereinafter set forth are both necessary and in the best interests of the COUNTY and SILVER SUMMIT;

NOW, THEREFORE, in consideration of the aforementioned premises, the following have been mutually agreed upon by all PARTIES:

PARTICIPANTS

Clark County, Department of Social Service (COUNTY)
Silver Summit Health Plan (SILVER SUMMIT)

TIME FRAME AND ASSOCIATION

This AGREEMENT has been entered into in good faith. This AGREEMENT will remain in effect for four (4) years expiring on September 30, 2024, or until such time as COUNTY and SILVER SUMMIT collectively revise the expiration in writing or if funding is not available. The

AGREEMENT will automatically renew for successive annual terms. Any PARTY may terminate its participation under this AGREEMENT upon not less than sixty (60) days written notice to the other PARTY as provided herein. The AGREEMENT will be reviewed by each PARTY annually.

This AGREEMENT shall not act, nor be construed, to otherwise restrict the PARTIES from participating in similar activities with other public or private agencies, organizations, and individuals.

SPECIFIC ROLES AND RESPONSIBILITIES OF PARTICIPANTS

COUNTY and SILVER SUMMIT have been collaborating since March of 2019 to develop an expansion of the PROJECT which provides intensive case management (ICM) to highly vulnerable, medically fragile individuals experiencing homelessness discharged from local hospitals and other medical facilities;

The grant funds that provide rental assistance to eligible clients are provided by U.S. Department of Housing and Urban Development's (HUD), Continuum of Care Program governed by title IV of the McKinney-Vento Homeless Assistance Act, as amended by S. 896 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 and the Continuum of Care Program regulation 24 CFR 578. Funds for grant year October 1, 2020 – September 30, 2021 are contingent upon receipt of grant funds awarded by HUD to Clark County Social Service;

The Board of County Commissioners (BCC) approved acceptance of the grant award on October 15, 2019;

Direct service is provided through a subcontract with HELP of Southern Nevada which provides outreach, intensive case management, housing placement and supportive services; and

ClarityNet software operating the CMIS is the case management tool of record.

SCOPE OF SERVICES TO BE PROVIDED BY COUNTY:

1. BACKBONE SERVICES: COUNTY will serve as Project Manager for the PROJECT with primary responsibility of organizing meetings and facilitating communication among partnering and contracted agencies.
2. COUNTY will participate as the fiscal agent for the HUD Continuum of Care grant funding to facilitate subcontracts with direct service provider, HELP of Southern Nevada.
3. COUNTY will utilize additional funding resources provided by SILVER SUMMIT to enhance HELP of Southern Nevada's Healthy Living Expansion Intensive Case Management Contract.
4. COUNTY will dedicate a caseload of one (1) case manager at a maximum of fifteen (15) highly vulnerable, medically fragile households experiencing homelessness with supportive housing through rental assistance resources provided by HUD grant Continuum of Care funding for the PROJECT while grant funds are available.

SCOPE OF SERVICES TO BE PROVIDED BY SILVER SUMMIT HEALTH PLAN

1. SILVER SUMMIT will utilize SILVER SUMMIT social work staff at various hospitals to identify presumptively eligible clients who meet the criteria for the PROJECT through the web-based database, ClarityNet Human Services CMIS, which acts as a referral portal, data repository, and case management tool of record for client information.
2. SILVER SUMMIT will follow the admission criteria for the PROJECT to include referring clients who:
   - ❖ Meet the PROJECT's definition of medically fragile, highly vulnerable and homeless.
   - ❖ Have a chronic health condition and/or disabling factors of mental health/substance abuse.
   - ❖ Are independent in performing activities of daily living (ADLs) and medication administration.
   - ❖ Have an acute medical condition with an identifiable end point of care.
   - ❖ Are independent in mobility (individual can ambulate with assistive devices such as walkers, wheelchairs, cane, crutches).
   - ❖ Are willing to see medical and community staff and comply with medical recommendations in accordance with treatment plans (Harm reduction methods will be incorporated with treatment plans).
   - ❖ Are medically and psychiatrically stable; patient must be ready for discharge to independent living and cannot be suicidal or homicidal.
3. Provide $104,520 for year one (1) and three (3) percent increases per year thereafter for services to case manage a maximum of fifteen (15) clients for the PROJECT.
4. Share client level cost benefit data with COUNTY to include, at a minimum, pre-intervention cost six (6) months prior to enrollment and six (6) months post enrollment to evaluate program intervention cost.
5. Share client level information with PROJECT case manager pertinent to providing individualized holistic services.

COLLECTIVE RESPONSIBILITY

The PARTIES shall engage in continuous communication which will allow for a consistent and honest platform where concerns will be addressed and ideas discussed between organizations. This communication method will support common language, a foundation for support, a common agenda, an agreement of common targets, and monitoring of results.

The PARTIES shall participate in regular meetings and conference calls for PROJECT and be responsible for respective data entry, reporting, and processes for using data to improve service delivery and coordination.

The PARTIES understand that nothing contained in the AGREEMENT shall require any PARTY to refer any individual or clients to any other PARTY, or to any affiliate or subsidiary of any PARTY.

CONFIDENTIALITY

The PARTIES hereto shall treat as confidential all information relating to any PARTY'S operations or the general business affairs or any of the operations or general business affairs of

the PARTY (including the PARTY'S parent, affiliate, subcontractor for the PROJECT, or subsidiary companies) which any other party may observe or which may be disclosed as a result of the PARTY'S performance under this AGREEMENT. No PARTY shall disclose any such confidential information to third parties or use any such information for any purpose other than the performance under this AGREEMENT, without the prior written consent of the other PARTY.

Additionally, the PARTIES shall abide by all State and Federal laws, rules and regulations, including, but not limited to, 42 C.F.R., Part 2 and the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC § 1320d ("HIPAA"). Specifically, and to the extent applicable to this AGREEMENT and the relationships between the PARTIES, each PARTY shall comply with HIPAA, and any current and future regulations promulgated thereunder, and all the amendments to HIPAA contained in Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), all collectively referred to as "HIPAA Requirements". The PARTIES understand it may be necessary to enter into further agreements to facilitate compliance with HIPAA. Each PARTY shall not use or further disclose any Protected Health Information (as defined in 45 C.F.R. § 132d), other than as permitted by the HIPAA Requirements, including the law enforcement exception to HIPAA.

Any medical information concerning any client or individual that is necessary to share with the COUNTY for the safety of the PROJECT, the client or in furtherance of this AGREEMENT is confidential information and will be protected and not disclosed other than to those who have a need and right to know the information and who is subject to like terms of confidentiality.

NOTICES

Any notices required or permitted to be given pursuant to this AGREEMENT shall be in writing and sent by certified mail, postage prepaid, return receipt requested to the PARTY's address noted below. Notice shall be deemed to be given upon the date three (3) days after such notice is deposited in the mail. Notices may also be delivered by courier, electronic transmission (including email) or by facsimile transmission and shall be deemed to be delivered when received by the PARTY to whom such notice is directed with a confirmation of receipt. All notices shall be forwarded as follows:

If to CCSS: Clark County, Department of Social Service
Attn: Assistant Director of Social Service
Address: 1600 Pinto Lane
Las Vegas, Nevada 89106

If to SILVER SUMMIT: Silver Summit Health Plan
Attn: Nicole Figles
Address: 2500 N Buffalo Drive, Suite 250
Las Vegas, Nevada 89128

ENTIRE AGREEMENT

This AGREEMENT represents the entire arrangement and understanding between the PARTIES and supersedes all prior oral and written understandings, representations, and discussions respecting this AGREEMENT.

NO ASSIGNMENT OR MODIFICATIONS

No PARTY to this AGREEMENT may assign, pledge, or otherwise transfer its responsibilities under the scope of work herein except with the prior written consent of the non-assigning PARTY, which consent shall not be unreasonably withheld. This provision does not apply to subcontracting.

This AGREEMENT may not be modified or amended without the written consent of authorized representatives of the PARTIES.

PERMITS AND LICENSES

Each PARTY hereto shall be responsible for securing all necessary licenses and permits required for providing the services for which it is responsible as delineated in this AGREEMENT.

INSURANCE

Each PARTY hereto shall be responsible for providing its own insurance coverage, including general liability, workers compensation, and professional liability (if applicable).

INDEPENDENT CONTRACTORS

The PARTIES to this AGREEMENT are acting as independent contractors and independent employers. Nothing contained in this AGREEMENT shall create or be construed as creating a partnership, joint venture or agency relationship between the PARTIES. No PARTY, nor any PARTY's respective officers, directors, employees or independent contractors, shall be construed to be the partner, employee, agent, or representative of any other PARTY. No PARTY shall have the authority to bind any other PARTY in any respect. No PARTY shall exercise control over the methods or procedures to be utilized by any other PARTY, nor shall any PARTY be responsible for the conduct of any other PARTY.

MISCELLANEOUS

1. Limited Liability
    a. The PARTIES will not waive and intend to assert available NRS chapter 41 liability limitations in all cases. Contract liability of both PARTIES shall not be subject to punitive damages. To the extent applicable, actual contract damages for any breach shall be limited by NRS 354.626.
2. Indemnification
    a. Neither PARTY waives any right or defense to indemnification that may exist in law or equity.
3. Exclusive Benefit of the PARTIES

a. This AGREEMENT is not intended to create any rights, powers, or interest for any PARTY not participating in this AGREEMENT. This AGREEMENT is entered into for the exclusive benefit of the undersigned PARTIES.

4. Interpretation of AGREEMENT
    a. It is agreed that the PARTIES will derive the greatest benefit from this AGREEMENT by promoting the interest of each other, by evaluation, consultation, cooperation, and interpreting the provisions of this AGREEMENT in the manner which shall best promote the interest of the clients served.
5. Non-Discrimination
    a. In providing services under this AGREEMENT, the PARTIES shall not discriminate on the basis of race, color, sex, age, religion, national origin, disability, sexual orientation, or gender identity or expression.
6. Severability
    a. In the event any provision of this AGREEMENT is rendered invalid or unenforceable by any valid act of Congress or the Nevada State Legislature, or declared null and void by any court of competent jurisdiction, the rest and remainder of the provisions of this AGREEMENT shall remain in full force and effect.
7. Waiver
    a. Any waiver of a breach of any provision of this AGREEMENT shall not be deemed a waiver of any other breach of the same or different provision.
8. Governing Law
    a. Nevada law shall govern the interpretation of this AGREEMENT.

IN WITNESS WHEREOF, the PARTIES have caused this AGREEMENT for Shared Services for Healthy Living to be executed by their duly authorized representatives on the day and year first written above.

SILVER SUMMIT

By: Nicole Figles DATE: 9-12-2019

NICOLE FIGLES
Vice President of Medical Management

COUNTY:
CLARK COUNTY, NEVADA

By: DATE: 9-13-19

RANDY REINOSO
Assistant Director of Social Service

APPROVED AS TO FORM:
STEVEN B. WOLFSON
District Attorney

By: DATE:

STEVEN SWEIKERT
Deputy District Attorney

MEMORANDUM OF UNDERSTANDING FOR SHARED SERVICES FOR HEALTHY LIVING EXPANSION

This AGREEMENT (hereinafter referred to as "AGREEMENT"), is made and entered into this _____ day, of _____ 2020, by and between the COUNTY of CLARK, DEPARTMENT OF SOCIAL SERVICE (hereinafter referred to as "COUNTY"), **and HEALTH PLAN OF NEVADA, INC.** (hereinafter referred to as "HPN") for shared services for Healthy Living Expansion collectively hereinafter referred to as PROJECT.

INTRODUCTION

WHEREAS, The PROJECT is a permanent supportive housing project for medically fragile, highly vulnerable households experiencing homelessness. The PROJECT serves medically fragile, highly vulnerable individuals experiencing homelessness, discharged from local hospitals or other medical facilities using a Housing First model. The PROJECT places homeless individuals, and if needed, their families in an affordable housing situation, providing intensive case management and access to addiction and mental health counseling and medical supports;

WHEREAS, there is a need for permanent supportive housing for medically fragile, highly vulnerable individuals and families experiencing homelessness based on data which reflects 100 percent of enrolled clients have special needs in the PROJECT as they all have a disability. Community Management Information System (CMIS) reporting of condition distributions indicate that approximately 88 percent have chronic health conditions, 70 percent have mental illness, 68 percent have physical disabilities, and 53 percent suffer with alcohol and/or substance abuse. The need to coordinate supportive housing post hospital discharge is substantial based on piloted data from the PROJECT;

WHEREAS, the PARTIES to this AGREEMENT believe that the coordination of supportive housing post medical discharge can most effectively be accomplished through the cooperation between the PARTIES through collaboration of case management and housing service provision for the PROJECT to serve more clients utilizing combined resources; and

WHEREAS, it is deemed that the services hereinafter set forth are both necessary and in the best interests of the COUNTY and HPN;

NOW, THEREFORE, in consideration of the aforementioned premises, the following have been mutually agreed upon by all PARTIES:

PARTICIPANTS

COUNTY
HPN

TIME FRAME AND ASSOCIATION

This AGREEMENT has been entered into in good faith. This AGREEMENT will have a start term upon award of funds from HUD. This AGREEMENT will remain in effect for four (4) years expiring on September 30, 2024, or until such time as COUNTY and HPN collectively revise the expiration in writing or if funding is not available. The AGREEMENT will automatically renew for successive annual terms. Any PARTY may terminate its participation under this AGREEMENT upon not less than sixty (60) days written notice to the other PARTY as provided herein. The AGREEMENT will be reviewed by each PARTY annually.

This AGREEMENT shall not act, nor be construed, to otherwise restrict the PARTIES from participating in similar activities with other public or private agencies, organizations, and individuals.

SPECIFIC ROLES AND RESPONSIBILITIES OF PARTICIPANTS

COUNTY and HPN have been collaborating since March of 2019 to develop an expansion of the PROJECT which provides intensive case management (ICM) to highly vulnerable, medically fragile individuals experiencing homelessness discharged from local hospitals and other medical facilities;

The grant funds that provide rental assistance to eligible clients are provided by U.S. Department of Housing and Urban Development's (HUD), Continuum of Care Program governed by title IV of the McKinney-Vento Homeless Assistance Act, as amended by S. 896 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 and the Continuum of Care Program regulation 24 CFR 578. Funds for grant year October 1, 2020 – September 30, 2021 are contingent upon receipt of grant funds awarded by HUD to Clark County Social Service;

The Board of County Commissioners (BCC) approved acceptance of the grant award on October 15, 2019;

Direct service is provided through a subcontract with HELP of Southern Nevada which provides outreach, intensive case management, housing placement and supportive services; and

ClarityNet software operating the CMIS is the case management tool of record.

SCOPE OF SERVICES TO BE PROVIDED BY COUNTY:

1. BACKBONE SERVICES: COUNTY will serve as Project Manager for the PROJECT with primary responsibility of organizing meetings and facilitating communication among partnering and contracted agencies.
2. COUNTY will participate as the fiscal agent for the HUD Continuum of Care grant funding to facilitate subcontracts with direct service provider, HELP of Southern Nevada.
3. COUNTY will utilize additional funding resources provided by HPN to enhance HELP of Southern Nevada's Healthy Living Expansion Intensive Case Management Contract.
4. COUNTY will dedicate a caseload of one (1) case manager at a maximum of fifteen (15)

highly vulnerable, medically fragile households experiencing homelessness with supportive housing through rental assistance resources provided by HUD grant Continuum of Care funding for the PROJECT while grant funds are available.

SCOPE OF SERVICES TO BE PROVIDED BY HPN

1. HPN will utilize HPN social work staff at various hospitals to identify presumptively eligible clients who meet the criteria for the PROJECT through the web-based database, ClarityNet Human Services CMIS, which acts as a referral portal, data repository, and case management tool of record for client information.
2. HPN will follow the admission criteria for the PROJECT to include referring clients who:
   - ❖ Meet the PROJECT's definition of medically fragile, highly vulnerable and homeless
   - ❖ Have a chronic health condition and/or disabling factors of mental health/substance abuse.
   - ❖ Are independent in performing activities of daily living (ADLs) and medication administration.
   - ❖ Have an acute medical condition with an identifiable end point of care.
   - ❖ Are independent in mobility (individual can ambulate with assistive devices such as walkers, wheelchairs, cane, crutches).
   - ❖ Are willing to see medical and community staff and comply with medical recommendations in accordance with treatment plans (Harm reduction methods will be incorporated with treatment plans).
   - ❖ Are medically and psychiatrically stable; patient must be ready for discharge to independent living and cannot be suicidal or homicidal.
3. Provide $313,560 for year one (1) and three (3) percent increases per year thereafter for services to case manage a maximum of forty five (45) clients for the PROJECT.
4. Share client level cost benefit data with COUNTY to include, at a minimum, pre-intervention cost six (6) months prior to enrollment and six (6) months post enrollment to evaluate program intervention cost.
5. Share client level information with PROJECT case manager pertinent to providing individualized holistic services.

COLLECTIVE RESPONSIBILITY

The PARTIES shall engage in continuous communication which will allow for a consistent and honest platform where concerns will be addressed and ideas discussed between organizations. This communication method will support common language, a foundation for support, a common agenda, an agreement of common targets, and monitoring of results.

The PARTIES shall participate in regular meetings and conference calls for PROJECT and be responsible for respective data entry, reporting, and processes for using data to improve service delivery and coordination.

The PARTIES understand that nothing contained in the AGREEMENT shall require any PARTY to refer any individual or clients to any other PARTY, or to any affiliate or subsidiary of any PARTY.

CONFIDENTIALITY

The PARTIES hereto shall treat as confidential all information relating to any PARTY'S operations or the general business affairs or any of the operations or general business affairs of the PARTY (including the PARTY'S parent, affiliate, subcontractor for the PROJECT, or subsidiary companies) which any other party may observe or which may be disclosed as a result of the PARTY'S performance under this AGREEMENT. No PARTY shall disclose any such confidential information to third parties or use any such information for any purpose other than the performance under this AGREEMENT, without the prior written consent of the other PARTY.

Additionally, the PARTIES shall abide by all State and Federal laws, rules and regulations, including, but not limited to, 42 C.F.R., Part 2 and the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC § 1320d ("HIPAA"). Specifically, and to the extent applicable to this AGREEMENT and the relationships between the PARTIES, each PARTY shall comply with HIPAA, and any current and future regulations promulgated thereunder, and all the amendments to HIPAA contained in Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), all collectively referred to as "HIPAA Requirements". The PARTIES understand it may be necessary to enter into further agreements to facilitate compliance with HIPAA. Each PARTY shall not use or further disclose any Protected Health Information (as defined in 45 C.F.R. § 132d), other than as permitted by the HIPAA Requirements, including the law enforcement exception to HIPAA.

Any medical information concerning any client or individual that is necessary to share with the COUNTY for the safety of the PROJECT, the client or in furtherance of this AGREEMENT is confidential information and will be protected and not disclosed other than to those who have a need and right to know the information and who is subject to like terms of confidentiality.

NOTICES

Any notices required or permitted to be given pursuant to this AGREEMENT shall be in writing and sent by certified mail, postage prepaid, return receipt requested to the PARTY's address noted below. Notice shall be deemed to be given upon the date three (3) days after such notice is deposited in the mail. Notices may also be delivered by courier, electronic transmission (including email) or by facsimile transmission and shall be deemed to be delivered when received by the PARTY to whom such notice is directed with a confirmation of receipt. All notices shall be forwarded as follows:

If to CCSS:
Clark County, Department of Social Service
Attn: Assistant Director of Social Service
Address: 1600 Pinto Lane
Las Vegas, Nevada 89106

If to HPN:
Health Plan of Nevada
Attn: Don Giancursio
Address: 2720 N. Tenaya Way
Las Vegas, Nevada 89128

ENTIRE AGREEMENT

This AGREEMENT represents the entire arrangement and understanding between the PARTIES and supersedes all prior oral and written understandings, representations, and discussions respecting this AGREEMENT.

NO ASSIGNMENT OR MODIFICATIONS

No PARTY to this AGREEMENT may assign, pledge, or otherwise transfer its responsibilities under the scope of work herein except with the prior written consent of the non-assigning PARTY, which consent shall not be unreasonably withheld. This provision does not apply to subcontracting.

This AGREEMENT may not be modified or amended without the written consent of authorized representatives of the PARTIES.

PERMITS AND LICENSES

Each PARTY hereto shall be responsible for securing all necessary licenses and permits required for providing the services for which it is responsible as delineated in this AGREEMENT.

INSURANCE

Each PARTY hereto shall be responsible for providing its own insurance coverage, including general liability, workers compensation, and professional liability (if applicable).

INDEPENDENT CONTRACTORS

The PARTIES to this AGREEMENT are acting as independent contractors and independent employers. Nothing contained in this AGREEMENT shall create or be construed as creating a partnership, joint venture or agency relationship between the PARTIES. No PARTY, nor any PARTY's respective officers, directors, employees or independent contractors, shall be construed to be the partner, employee, agent, or representative of any other PARTY. No PARTY shall have the authority to bind any other PARTY in any respect. No PARTY shall exercise control over the methods or procedures to be utilized by any other PARTY, nor shall any PARTY be responsible for the conduct of any other PARTY.

MISCELLANEOUS

1. Limited Liability
    a. The PARTIES will not waive and intend to assert available NRS chapter 41 liability limitations in all cases. Contract liability of both PARTIES shall not be subject to punitive damages. To the extent applicable, actual contract damages for any breach shall be limited by NRS 354.626.
2. Indemnification

a. Neither PARTY waives any right or defense to indemnification that may exist in law or equity.

3. Exclusive Benefit of the PARTIES
    a. This AGREEMENT is not intended to create any rights, powers, or interest for any PARTY not participating in this AGREEMENT. This AGREEMENT is entered into for the exclusive benefit of the undersigned PARTIES.
4. Interpretation of AGREEMENT
    a. It is agreed that the PARTIES will derive the greatest benefit from this AGREEMENT by promoting the interest of each other, by evaluation, consultation, cooperation, and interpreting the provisions of this AGREEMENT in the manner which shall best promote the interest of the clients served.
5. Non-Discrimination
    a. In providing services under this AGREEMENT, the PARTIES shall not discriminate on the basis of race, color, sex, age, religion, national origin, disability, sexual orientation, or gender identity or expression.
6. Severability
    a. In the event any provision of this AGREEMENT is rendered invalid or unenforceable by any valid act of Congress or the Nevada State Legislature, or declared null and void by any court of competent jurisdiction, the rest and remainder of the provisions of this AGREEMENT shall remain in full force and effect.
7. Waiver
    a. Any waiver of a breach of any provision of this AGREEMENT shall not be deemed a waiver of any other breach of the same or different provision.
8. Governing Law
    a. Nevada law shall govern the interpretation of this AGREEMENT.

IN WITNESS WHEREOF, the PARTIES have caused this AGREEMENT for Shared Services for PROJECT to be executed by their duly authorized representatives on the day and year first written above.

HEALTH PLAN OF NEVADA

By: DocuSigned by: Don Giancursio E74FC020EAEC4C3... DATE: 5/15/2020

DON GIANCURSIO
CEO

COUNTY:
CLARK COUNTY, NEVADA

By: DATE: 5-14-20

RANDY REINOSO
Assistant Director of Social Service

APPROVED AS TO FORM:
STEVEN B. WOLFSON
District Attorney

By: Steven Sweikert DATE: 5-14-20

STEVEN SWEIKERT
Deputy District Attorney

Department of Social Service

1600 Pinto Lane • Las Vegas NV 89106
(702) 455-4270 • Fax (702) 455-5950

Timothy Burch, Administrator
Kristin Cooper, Assistant Director • Randy Reinoso, Assistant Director
Margaret LeBlanc, Assistant Director

October 3, 2021

RE: Match Commitment – HL RRH

To Whom It May Concern:

The match commitment of at least 25% will be supported by the State of Nevada contracted managed care organizations (MCOs). Written commitments from Anthem Blue Cross and Blue Shield Healthcare Solutions, and SilverSummit Healthplan, United Health Care / Health Plan of Nevada have been received by CCSS program staff. Due to the in-depth leadership teams of each nationally-based MCO, formal commitments will be made if this project is selected by the Southern Nevada Homelessness Continuum of Care Scoring and Ranking Team for submission as part of the CoC Consolidated Application.

Molina Healthcare, Inc. has recently been awarded a Nevada Medicaid contract and will be included in this project. All MCO partners that have already committed agreed that this new provider should be included in the Healthy Living RRH project. As Molina's contract will be effective January 1, 2022, they have not been asked to provide a letter of commitment at this time. They have expressed verbal interest in the project and are anticipated to join the MCO project partners in their commitment.

Match for this project will consist of all costs related to case management, supportive services, and administrative support. Initial estimates are approximately $850,000 to serve 90 clients annually.

Sincerely,

Brenda Herbstman

Brenda Herbstman, Senior Grants Coordinator
Clark County Social Service
HerbstmB@ClarkCountyNV.gov
(702) 218-3402

silversummit healthplan

2500 N. Buffalo Drive
Suite 250
Las Vegas, NV 89128

October 21, 2021

Clark County Social Services
Fiscal Unit
1600 Pinto Lane
Las Vegas, NV 89106

RE: HEALTHY LIVING RRH PROJECT

To Whom It May Concern:

SilverSummit Healthplan is a Medicaid Managed Care Organization (MCO) in the State of Nevada and seeks to provide a safety net of medical services for the growing community of Southern Nevada. This safety net provides support to low-income, at-risk, and high-risk populations attaining self-sufficiency. The Healthy Living RRH Project seeks to house 100 medically fragile individuals and families experiencing homelessness in supportive housing and wrapping them in intensive case management, medical case management and supportive services to assist them with becoming self-sufficient.

Healthy Living RRH Project is an innovative project for Southern Nevada and will serve as a model for other programs supporting highly vulnerable, medically fragile individuals experiencing homelessness who are seeking permanent housing stability and medical wellness.

SilverSummit Healthplan is dedicated to supporting Healthy Living RRH Project with cash match funds. SilverSummit Healthplan is committing the following amount:

Type	Source	Value	Date of Commitment
Cash	Undisclosed	$250,754	10/1/2022–12/31/2023

For: Intensive case management and supportive services for 25 clients directly linked to the Healthy Living RRH Project.
If you have any questions or require further information, please contact me at Nicole.L.Figles@SilverSummitHealthPlan.com.

Sincerely,

Recoverable Signature

X Nicole Figles

Nicole Figles

Signed by: nicole.l.figles@centene.com

Nicole L. Figles

Lisa J. Bogard
President & CEO

Anthem Blue Cross and Blue Shield Healthcare Solutions
9133 W. Russell Road
Las Vegas, Nevada 89148

October 29, 2021

Anthem

RE: HEALTHY LIVING RRH PROJECT

To Whom It May Concern:

Anthem, Inc. is a Medicaid Managed Care Organization (MCO) in the State of Nevada and seeks to provide a safety net of medical services for the growing community of Southern Nevada. This safety net provides support to low-income, at-risk, and high-risk populations attaining self-sufficiency. The Healthy Living RRH Project seeks to house 100 medically fragile individuals and families experiencing homelessness in supportive housing and wrapping them in intensive case management, medical case management and supportive services to assist them with becoming self-sufficient.

Healthy Living RRH Project is an innovative project for Southern Nevada and will serve as a model for other programs supporting highly vulnerable, medically fragile individuals experiencing homelessness who are seeking permanent housing stability and medical wellness.

Anthem, Inc. is dedicated to supporting Healthy Living RRH Project with cash match funds. Anthem, Inc. is committing up to the following amount:

Type	Source	Value	Date of Commitment
Cash	Undisclosed	$250,754	10/1/2022–12/31/2023

For: Intensive case management and supportive services for 25 clients directly linked to the Healthy Living RRH Project.

If you have any questions or require further information, please contact me at (lisa.bogard@anthem.com) +1 702-545-9842 Ext. 757513-1652.

Sincerely,

Lisa J. Bogard

Lisa J. Bogard
President & CEO

October 19, 2021

RE: HEALTHY LIVING RRH PROJECT

To Whom It May Concern:

Health Plan of Nevada (HPN) is a Medicaid Managed Care Organization (MCO) in the State of Nevada and seeks to provide a safety net of medical services for the growing community of Southern Nevada. This safety net provides support to low-income, at-risk, and high-risk populations attaining self-sufficiency. The Healthy Living RRH Project seeks to house 100 medically fragile individuals and families experiencing homelessness in supportive housing and wrapping them in intensive case management, medical case management and supportive services to assist them with becoming self-sufficient.

Healthy Living RRH Project is an innovative project for Southern Nevada and will serve as a model for other programs supporting highly vulnerable, medically fragile individuals experiencing homelessness who are seeking permanent housing stability and medical wellness.

HPN is dedicated to supporting Healthy Living RRH Project with cash match funds. HPN is committing up to the following amount:

Type	Source	Value	Date of Commitment
Cash	undisclosed	$250,754	10/1/2022–12/31/2023

For: Intensive case management and supportive services for 25 clients directly linked to the Healthy Living RRH Program.

If you have any questions or require further information, please contact Rachel Rosensteel (Rachel.Rosensteel@uhc.com).

Sincerely,

Donald J. Giancursio
Chief Executive Officer, UnitedHealthcare
NV, UT, &ID Markets

October 19, 2021

RE: HEALTHY LIVING RRH PROJECT

To Whom It May Concern:

Molina Healthcare of Nevada is a Medicaid Managed Care Organization (MCO) in the State of Nevada and seeks to provide a safety net of medical services for the growing community of Southern Nevada. This safety net provides support to low-income, at-risk, and high-risk populations attaining self-sufficiency. The Healthy Living RRH Project seeks to house 100 medically fragile individuals and families experiencing homelessness in supportive housing and wrapping them in intensive case management, medical case management and supportive services to assist them with becoming self-sufficient.

Healthy Living RRH Project is an innovative project for Southern Nevada and will serve as a model for other programs supporting highly vulnerable, medically fragile individuals experiencing homelessness who are seeking permanent housing stability and medical wellness.

Molina Healthcare of Nevada is dedicated to supporting Healthy Living RRH Project with cash match funds. Molina Healthcare is committing up to the following amount:

Type	Source	Value	Date of Commitment
Cash	Undisclosed	$250,754	10/1/2022–12/31/2023

For: Intensive case management and supportive services for 25 clients directly linked to the Healthy Living RRH Program.

If you have any questions or require further information, please contact Mike Easterday.

Sincerely,

Michael Easterday
President

AGREEMENT
FOR SHARED SERVICES FOR
HEALTHY LIVING RAPID REHOUSING

This AGREEMENT (hereinafter referred to as "AGREEMENT"), is made and entered into this 3rd day, of November 2021, by and between the COUNTY of CLARK, DEPARTMENT OF SOCIAL SERVICE (hereinafter referred to as "COUNTY"), and SILVERSUMMIT HEALTHPLAN (hereinafter referred to as "SILVERSUMMIT") for shared services for Healthy Living Rapid Rehousing collectively hereinafter referred to as PROJECT.

INTRODUCTION

WHEREAS, The PROJECT is a rapid rehousing project for medically fragile, literally homeless households experiencing homelessness discharged from local hospitals or other medical facilities using a Housing First model. The PROJECT places homeless individuals, and if needed, their families in an affordable housing situation, providing intensive case management and access to addiction and mental health counseling and medical supports;

WHEREAS, there is a need for rapid rehousing for medically fragile, individuals and families experiencing literal homelessness based on data which reflects a portion of the clients referred to Healthy Living PSH do not meet the definitions of chronic homelessness and/or a disabling condition. The need to coordinate supportive housing post medical facility discharge is great based on data from the Healthy Living PSH;

WHEREAS, the PARTIES to this AGREEMENT believe that the coordination of supportive housing post medical discharge can most effectively be accomplished through collaborative case conferencing between the PARTIES through the PROJECT to serve more clients utilizing rental assistance savings; and

WHEREAS, it is deemed that the services hereinafter set forth are both necessary and in the best interests of the COUNTY and SILVERSUMMIT;

NOW, THEREFORE, in consideration of the aforementioned premises, the following have been mutually agreed upon by all PARTIES:

PARTICIPANTS

Clark County, Department of Social Service (COUNTY)
SilverSummit Healthplan (SILVERSUMMIT)

TIME FRAME AND ASSOCIATION

This AGREEMENT has been entered into in good faith. This AGREEMENT will remain in effect for four (4) years expiring on September 30, 2026, or until such time as COUNTY and SILVERSUMMIT collectively revise the expiration in writing or if funding is not available. The AGREEMENT will automatically renew for successive annual terms. Any PARTY may terminate its participation under this AGREEMENT upon not less than sixty (60) days written notice to the other PARTY as provided herein. The AGREEMENT will be reviewed by each PARTY annually.

This AGREEMENT shall not act, nor be construed, to otherwise restrict the PARTIES from participating in similar activities with other public or private agencies, organizations, and individuals.

SPECIFIC ROLES AND RESPONSIBILITIES OF PARTICIPANTS

COUNTY and SILVERSUMMIT have been collaborating since March of 2019 on similar programs that offer intensive case management (ICM) to highly vulnerable, medically fragile individuals experiencing homelessness discharged from local hospitals and other medical facilities.

The grant funds that provide rental assistance to eligible clients are provided by U.S. Department of Housing and Urban Development's (HUD), Continuum of Care Program governed by title IV of the McKinney-Vento Homeless Assistance Act, as amended by S. 896 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 and the Continuum of Care Program regulation 24 CFR 578. Funds for each grant year are contingent upon receipt of grant funds awarded by HUD to Clark County Social Service; and are anticipated to be spent between October 1, 2022 and December 31, 2023. Program dates will be agreed upon by all parties.

It is anticipated that the Board of County Commissioners (BCC) will approve acceptance of the grant award on December 21, 2021;

Direct service is provided through a subcontract with HELP of Southern Nevada which provides outreach, intensive case management, housing placement and supportive services; and

ClarityNet software operating the Community Management Information System is the case management tool of record.

SCOPE OF SERVICES TO BE PROVIDED BY COUNTY:

1. BACKBONE SERVICES: COUNTY will serve as Project Manager for the PROJECT with primary responsibility of organizing meetings and facilitating communication among partnering and contracted agencies.
2. COUNTY will participate as the fiscal agent for the HUD Continuum of Care grant funding to facilitate subcontracts with direct service provider, HELP of Southern Nevada.
3. COUNTY will utilize additional funding resources provided by SILVERSUMMIT to enhance HELP of Southern Nevada's Healthy Living Rapid Rehousing Intensive Case Management Contract with additional resources. Staffing for this project will be at the ratio of one (1) case manager per fifteen (15) clients for intensive case management and housing navigation.

SCOPE OF SERVICES TO BE PROVIDED BY SILVERSUMMIT HEALTHPLAN

1. SILVERSUMMIT will utilize SILVERSUMMIT social work staff at various hospitals to identify presumptively eligible clients who meet the criteria for the PROJECT through the web-based database, ClarityNet Human Services CMIS, which acts as a referral portal, data repository, and case management tool of record for client information

2. SILVERSUMMIT will follow the admission criteria for the PROJECT to include referring clients who:
   - ❖ Meet the PROJECT's definition of medically fragile and literal homelessness.
   - ❖ Are independent in performing activities of daily living (ADLs) and medication administration.
   - ❖ Have an acute medical condition with an identifiable end point of care.
   - ❖ Are independent in mobility (individual can ambulate with assistive devices such as walkers, wheelchairs, cane, crutches).
   - ❖ Are willing to see medical and community staff and comply with medical recommendations in accordance with treatment plans (Harm reduction methods will be incorporated with treatment plans).
   - ❖ Are medically and psychiatrically stable, patient must be ready for discharge to independent living and cannot be suicidal or homicidal.
3. Provide $250,754 for year one (1) and three (3) percent increases per year thereafter for services to case manage clients for the PROJECT. In the event that all SILVERSUMMIT funds are not utilized during any year of the PROJECT, all unused funds will be applied to the subsequent year of the PROJECT. Summaries of expenditures related to SILVERSUMMIT members will be provided to SILVERSUMMIT on a regular basis. All charges are based on a per client ratio of costs.
4. Prior to the start of each year, beginning in year two (2) of the PROJECT, an estimate of match including a three (3) percent increase for services to case manage an initial allotment of twenty-five (25) clients for the PROJECT will be provided in writing to SILVERSUMMIT.
5. Share client level cost benefit data with COUNTY to include, at a minimum, pre-intervention cost six (6) months prior to enrollment and six (6) months post enrollment to evaluate program intervention cost.
6. Share client level information with PROJECT case managers pertinent to providing individualized holistic services in housing.

COLLECTIVE RESPONSIBILITY

The PARTIES shall engage in continuous communication which will allow for a consistent and honest platform where concerns will be addressed, and ideas discussed between organizations. This communication method will support common language, a foundation for support, a common agenda, an agreement of common targets, and monitoring of results.

The PARTIES shall participate in regular meetings and conference calls for PROJECT and be responsible for respective data entry, reporting, and processes for using data to improve service delivery and coordination.

The PARTIES understand that nothing contained in the AGREEMENT shall require any PARTY to refer any individual or clients to any other PARTY, or to any affiliate or subsidiary of any PARTY.

The PARTIES understand that in the event that there is not full utilization of the allocated PROJECT spots that they will be offered to additional PROJECT partners and the respective costs will be billed to that partner. Both PARTIES understand that this may happen at any point during the PROJECT and can be initiated by either PARTY. This will be done to ensure full utilization of PROJECT vacancies for the duration of the PROJECT.

CONFIDENTIALITY

The PARTIES hereto shall treat as confidential all information relating to any PARTY'S operations or the general business affairs or any of the operations or general business affairs of the PARTY (including the PARTY'S parent, affiliate, subcontractor for the HL RRH project, or subsidiary companies) which any other party may observe, or which may be disclosed as a result of the PARTY'S performance under this AGREEMENT. No PARTY shall disclose any such confidential information to third parties or use any such information for any purpose other than the performance under this AGREEMENT, without the prior written consent of the other PARTY.

Additionally, the PARTIES shall abide by all State and Federal laws, rules and regulations, including, but not limited to, 42 C.F.R., Part 2 and the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC § 1320d ("HIPAA"). Specifically, and to the extent applicable to this AGREEMENT and the relationships between the PARTIES, each PARTY shall comply with HIPAA, and any current and future regulations promulgated thereunder, and all the amendments to HIPAA contained in Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), all collectively referred to as "HIPAA Requirements." The PARTIES understand it may be necessary to enter into further agreements to facilitate compliance with HIPAA. Each PARTY shall not use or further disclose any Protected Health Information (as defined in 45 C.F.R. § 132d), other than as permitted by the HIPAA Requirements, including the law enforcement exception to HIPAA.

Any medical information concerning any client or individual that is necessary to share with the COUNTY for the safety of HL RRH, the client or in furtherance of this AGREEMENT is confidential information pursuant to NRS 179A.100 and will be protected and not disclosed other than to those who have a need and right to know the information and who is subject to like terms of confidentiality.

NOTICES

Any notices required or permitted to be given pursuant to this AGREEMENT shall be in writing and sent by certified mail, postage prepaid, return receipt requested to the PARTY's address noted below. Notice shall be deemed to be given upon the date three (3) days after such notice is deposited in the mail. Notices may also be delivered by courier, electronic transmission (including email) or by facsimile transmission and shall be deemed to be delivered when received by the PARTY to whom such notice is directed with a confirmation of receipt. All notices shall be forwarded as follows:

If to CCSS: Clark County, Department of Social Service
Attn: Director of Social Service
Address: 1600 Pinto Lane
Las Vegas, Nevada 89106

If to SILVERSUMMIT: SilverSummit Healthplan
Attn: Nicole Figles
Address: 2500 N Buffalo Drive, Suite 250

Las Vegas, Nevada 89128

ENTIRE AGREEMENT

This AGREEMENT represents the entire arrangement and understanding between the PARTIES and supersedes all prior oral and written understandings, representations, and discussions respecting this AGREEMENT.

NO ASSIGNMENT OR MODIFICATIONS

No PARTY to this AGREEMENT may assign, pledge or otherwise transfer its responsibilities under the scope of work herein except with the prior written consent of the non-assigning PARTIES, which consent shall not be unreasonably withheld. This provision does not apply to subcontracting.

This AGREEMENT may not be modified or amended without the written consent of authorized representatives of the PARTIES.

PERMITS AND LICENSES

Each PARTY hereto shall be responsible for securing all necessary licenses and permits required for providing the services for which it is responsible as delineated in this AGREEMENT.

INSURANCE

Each PARTY hereto shall be responsible for providing its own insurance coverage, including general liability, workers compensation, and professional liability (if applicable).

INDEPENDENT CONTRACTORS

The PARTIES to this AGREEMENT are acting as independent contractors and independent employers. Nothing contained in this AGREEMENT shall create or be construed as creating a partnership, joint venture or agency relationship between the PARTIES. No PARTY, nor any PARTY's respective officers, directors, employees or independent contractors, shall be construed to be the partner, employee, agent or representative of any other PARTY. No PARTY shall have the authority to bind any other PARTY in any respect. No PARTY shall exercise control over the methods or procedures to be utilized by any other PARTY, nor shall any PARTY be responsible for the conduct of any other PARTY.

MISCELLANEOUS

1. Limited Liability
    a. The PARTIES will not waive and intend to assert available NRS chapter 41 liability limitations in all cases. Contract liability of both PARTIES shall not be subject to punitive damages. To the extent applicable, actual contract damages for any breach shall be limited by NRS 354.626.
2. Indemnification

a. Neither PARTY waives any right or defense to indemnification that may exist in law or equity.

3. Exclusive Benefit of the PARTIES
    a. This AGREEMENT is not intended to create any rights, powers or interest for any PARTY not participating in this AGREEMENT. This AGREEMENT is entered into for the exclusive benefit of the undersigned PARTIES.
4. Interpretation of AGREEMENT
    a. It is agreed that the PARTIES will derive the greatest benefit from this AGREEMENT by promoting the interest of each other, by evaluation, consultation, cooperation and interpreting the provisions of this AGREEMENT in the manner which shall best promote the interest of the clients served.
5. Non-Discrimination
    a. In providing services under this AGREEMENT, the PARTIES shall not discriminate on the basis of race, color, sex, age, religion, national origin, disability, sexual orientation or gender identity or expression.
6. Severability
    a. In the event any provision of this AGREEMENT is rendered invalid or unenforceable by any valid act of Congress or the Nevada State Legislature, or declared null and void by any court of competent jurisdiction, the rest and remainder of the provisions of this AGREEMENT shall remain in full force and effect.
7. Waiver
    a. Any waiver of a breach of any provision of this AGREEMENT shall not be deemed a waiver of any other breach of the same or different provision.
8. Governing Law
    a. Nevada law shall govern the interpretation of this AGREEMENT.

IN WITNESS WHEREOF, the PARTIES have caused this AGREEMENT for Shared Services for Healthy Living RRH to be executed by their duly authorized representatives on the day and year first written above.

SILVERSUMMIT HEALTHPLAN

By: Nicole Figles Digitally signed by Nicole Figles Date: 2021.11.02 14:29:10 -07'00' DATE:

NICOLE FIGLES
Vice President of Medical Management

COUNTY:
CLARK COUNTY, NEVADA

By: Kristin R. Cooper Digitally signed by Kristin R. Cooper Date: 2021.11.02 17:36:32 -07'00' DATE:

KRISTIN COOPER
Assistant Director of Social Service

APPROVED AS TO FORM:
STEVEN B. WOLFSON
District Attorney

By: DATE:

ELIZABETH VIBERT
Deputy District Attorney

AGREEMENT
FOR SHARED SERVICES FOR
HEALTHY LIVING RAPID REHOUSING

This AGREEMENT (hereinafter referred to as "AGREEMENT"), is made and entered into this 3rd day, of November 2021, by and between the COUNTY of CLARK, DEPARTMENT OF SOCIAL SERVICE (hereinafter referred to as "COUNTY"), and ANTHEM BLUE CROSS AND BLUE SHIELD (hereinafter referred to as "ANTHEM") for shared services for Healthy Living Rapid Rehousing collectively hereinafter referred to as PROJECT.

INTRODUCTION

WHEREAS, The PROJECT is a rapid rehousing project for medically fragile, literally homeless households experiencing homelessness discharged from local hospitals or other medical facilities using a Housing First model. The PROJECT places homeless individuals, and if needed, their families in an affordable housing situation, providing intensive case management and access to addiction and mental health counseling and medical supports;

WHEREAS, there is a need for rapid rehousing for medically fragile, individuals and families experiencing literal homelessness based on data which reflects a portion of the clients referred to Healthy Living PSH do not meet the definitions of chronic homelessness and/or a disabling condition. The need to coordinate supportive housing post medical facility discharge is great based on data from the Healthy Living PSH;

WHEREAS, the PARTIES to this AGREEMENT believe that the coordination of supportive housing post medical discharge can most effectively be accomplished through collaborative case conferencing between the PARTIES through the PROJECT to serve more clients utilizing rental assistance savings; and

WHEREAS, it is deemed that the services hereinafter set forth are both necessary and in the best interests of the COUNTY and ANTHEM;

NOW, THEREFORE, in consideration of the aforementioned premises, the following have been mutually agreed upon by all PARTIES:

PARTICIPANTS

Clark County, Department of Social Service (COUNTY)
Anthem Blue Cross and Blue Shield (ANTHEM)

TIME FRAME AND ASSOCIATION

This AGREEMENT has been entered into in good faith. This AGREEMENT will remain in effect for four (4) years expiring on September 30, 2026, or until such time as COUNTY and ANTHEM collectively revise the expiration in writing or if funding is not available. The AGREEMENT will automatically renew for successive annual terms. Any PARTY may terminate its participation under this AGREEMENT upon not less than sixty (60) days written notice to the other PARTY as provided herein. The AGREEMENT will be reviewed by each PARTY annually.

This AGREEMENT shall not act, nor be construed, to otherwise restrict the PARTIES from participating in similar activities with other public or private agencies, organizations, and individuals.

SPECIFIC ROLES AND RESPONSIBILITIES OF PARTICIPANTS

COUNTY and ANTHEM have been collaborating since March of 2019 on similar programs that offer intensive case management (ICM) to highly vulnerable, medically fragile individuals experiencing homelessness discharged from local hospitals and other medical facilities;

The grant funds that provide rental assistance to eligible clients are provided by U.S. Department of Housing and Urban Development's (HUD), Continuum of Care Program governed by title IV of the McKinney-Vento Homeless Assistance Act, as amended by S. 896 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 and the Continuum of Care Program regulation 24 CFR 578. Funds for each grant year are contingent upon receipt of grant funds awarded by HUD to Clark County Social Service; and are anticipated to be spent between October 1, 2022 and December 31, 2023. Program dates will be agreed upon by all parties.

It is anticipated that the Board of County Commissioners (BCC) will approve acceptance of the grant award on December 21, 2021;

Direct service is provided through a subcontract with HELP of Southern Nevada which provides outreach, intensive case management, housing placement and supportive services; and

ClarityNet software operating the Community Management Information System is the case management tool of record.

SCOPE OF SERVICES TO BE PROVIDED BY COUNTY:

1. BACKBONE SERVICES: COUNTY will serve as Project Manager for the PROJECT with primary responsibility of organizing meetings and facilitating communication among partnering and contracted agencies.
2. COUNTY will participate as the fiscal agent for the HUD Continuum of Care grant funding to facilitate subcontracts with direct service provider, HELP of Southern Nevada.
3. COUNTY will utilize additional funding resources provided by ANTHEM to enhance HELP of Southern Nevada's Healthy Living Rapid Rehousing Intensive Case Management Contract with additional resources. Staffing for this project will be at the ratio of one (1) case manager per fifteen (15) clients for intensive case management and housing navigation.

SCOPE OF SERVICES TO BE PROVIDED BY ANTHEM BLUE CROSS AND BLUE SHIELD

1. ANTHEM will utilize ANTHEM social work staff at various hospitals to identify presumptively eligible clients who meet the criteria for the PROJECT through the web-based database, ClarityNet Human Services CMIS, which acts as a referral portal, data repository, and case management tool of record for client information

2. ANTHEM will follow the admission criteria for the PROJECT to include referring clients who:
   - ❖ Meet the PROJECT's definition of medically fragile and literal homelessness.
   - ❖ Are independent in performing activities of daily living (ADLs) and medication administration.
   - ❖ Have an acute medical condition with an identifiable end point of care.
   - ❖ Are independent in mobility (individual can ambulate with assistive devices such as walkers, wheelchairs, cane, crutches).
   - ❖ Are willing to see medical and community staff and comply with medical recommendations in accordance with treatment plans (Harm reduction methods will be incorporated with treatment plans).
   - ❖ Are medically and psychiatrically stable, patient must be ready for discharge to independent living and cannot be suicidal or homicidal.
3. Provide $250,754 for year one (1) and three (3) percent increases per year thereafter for services to case manage clients for the PROJECT. In the event that all ANTHEM funds are not utilized during any year of the PROJECT, all unused funds will be applied to the subsequent year of the PROJECT. Summaries of expenditures related to ANTHEM members will be provided to Anthem on a regular basis. All charges are based on a per client ratio of costs.
4. Prior to the start of each year, beginning in year two (2) of the PROJECT, an estimate of match including a three (3) percent increase for services to case manage an initial allotment of twenty-five (25) clients for the PROJECT will be provided in writing to ANTHEM.
5. Share client level cost benefit data with COUNTY to include, at a minimum, pre-intervention cost six (6) months prior to enrollment and six (6) months post enrollment to evaluate program intervention cost.
6. Share client level information with PROJECT case managers pertinent to providing individualized holistic services in housing.

COLLECTIVE RESPONSIBILITY

The PARTIES shall engage in continuous communication which will allow for a consistent and honest platform where concerns will be addressed, and ideas discussed between organizations. This communication method will support common language, a foundation for support, a common agenda, an agreement of common targets, and monitoring of results.

The PARTIES shall participate in regular meetings and conference calls for PROJECT and be responsible for respective data entry, reporting, and processes for using data to improve service delivery and coordination.

The PARTIES understand that nothing contained in the AGREEMENT shall require any PARTY to refer any individual or clients to any other PARTY, or to any affiliate or subsidiary of any PARTY.

The PARTIES understand that in the event that there is not full utilization of the allocated PROJECT spots that they will be offered to additional PROJECT partners and the respective costs will be billed to that partner. Both PARTIES understand that this may happen at any point during the PROJECT and can be initiated by either PARTY. This will be done to ensure full utilization of PROJECT vacancies for the duration of the PROJECT.

CONFIDENTIALITY

The PARTIES hereto shall treat as confidential all information relating to any PARTY'S operations or the general business affairs or any of the operations or general business affairs of the PARTY (including the PARTY'S parent, affiliate, subcontractor for the HL RRH project, or subsidiary companies) which any other party may observe, or which may be disclosed as a result of the PARTY'S performance under this AGREEMENT. No PARTY shall disclose any such confidential information to third parties or use any such information for any purpose other than the performance under this AGREEMENT, without the prior written consent of the other PARTY.

Additionally, the PARTIES shall abide by all State and Federal laws, rules and regulations, including, but not limited to, 42 C.F.R., Part 2 and the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC § 1320d ("HIPAA"). Specifically, and to the extent applicable to this AGREEMENT and the relationships between the PARTIES, each PARTY shall comply with HIPAA, and any current and future regulations promulgated thereunder, and all the amendments to HIPAA contained in Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), all collectively referred to as "HIPAA Requirements." The PARTIES understand it may be necessary to enter into further agreements to facilitate compliance with HIPAA. Each PARTY shall not use or further disclose any Protected Health Information (as defined in 45 C.F.R. § 132d), other than as permitted by the HIPAA Requirements, including the law enforcement exception to HIPAA.

Any medical information concerning any client or individual that is necessary to share with the COUNTY for the safety of HL RRH, the client or in furtherance of this AGREEMENT is confidential information pursuant to NRS 179A.100 and will be protected and not disclosed other than to those who have a need and right to know the information and who is subject to like terms of confidentiality.

NOTICES

Any notices required or permitted to be given pursuant to this AGREEMENT shall be in writing and sent by certified mail, postage prepaid, return receipt requested to the PARTY's address noted below. Notice shall be deemed to be given upon the date three (3) days after such notice is deposited in the mail. Notices may also be delivered by courier, electronic transmission (including email) or by facsimile transmission and shall be deemed to be delivered when received by the PARTY to whom such notice is directed with a confirmation of receipt. All notices shall be forwarded as follows:

If to CCSS:
Clark County, Department of Social Service
Attn: Director of Social Service
Address: 1600 Pinto Lane
Las Vegas, Nevada 89106

If to ANTHEM:
Anthem Blue Cross and Blue Shield
Attn: Lisa Bogard
Address: 9133 West Russell Road
Las Vegas, Nevada 89148

ENTIRE AGREEMENT

This AGREEMENT represents the entire arrangement and understanding between the PARTIES and supersedes all prior oral and written understandings, representations, and discussions respecting this AGREEMENT.

NO ASSIGNMENT OR MODIFICATIONS

No PARTY to this AGREEMENT may assign, pledge or otherwise transfer its responsibilities under the scope of work herein except with the prior written consent of the non-assigning PARTIES, which consent shall not be unreasonably withheld. This provision does not apply to subcontracting.

This AGREEMENT may not be modified or amended without the written consent of authorized representatives of the PARTIES.

PERMITS AND LICENSES

Each PARTY hereto shall be responsible for securing all necessary licenses and permits required for providing the services for which it is responsible as delineated in this AGREEMENT.

INSURANCE

Each PARTY hereto shall be responsible for providing its own insurance coverage, including general liability, workers compensation, and professional liability (if applicable).

INDEPENDENT CONTRACTORS

The PARTIES to this AGREEMENT are acting as independent contractors and independent employers. Nothing contained in this AGREEMENT shall create or be construed as creating a partnership, joint venture or agency relationship between the PARTIES. No PARTY, nor any PARTY's respective officers, directors, employees or independent contractors, shall be construed to be the partner, employee, agent or representative of any other PARTY. No PARTY shall have the authority to bind any other PARTY in any respect. No PARTY shall exercise control over the methods or procedures to be utilized by any other PARTY, nor shall any PARTY be responsible for the conduct of any other PARTY.

MISCELLANEOUS

1. Limited Liability
    a. The PARTIES will not waive and intend to assert available NRS chapter 41 liability limitations in all cases. Contract liability of both PARTIES shall not be subject to punitive damages. To the extent applicable, actual contract damages for any breach shall be limited by NRS 354.626.
2. Indemnification

a. Neither PARTY waives any right or defense to indemnification that may exist in law or equity.

3. Exclusive Benefit of the PARTIES
    a. This AGREEMENT is not intended to create any rights, powers or interest for any PARTY not participating in this AGREEMENT. This AGREEMENT is entered into for the exclusive benefit of the undersigned PARTIES.
4. Interpretation of AGREEMENT
    a. It is agreed that the PARTIES will derive the greatest benefit from this AGREEMENT by promoting the interest of each other, by evaluation, consultation, cooperation and interpreting the provisions of this AGREEMENT in the manner which shall best promote the interest of the clients served.
5. Non-Discrimination
    a. In providing services under this AGREEMENT, the PARTIES shall not discriminate on the basis of race, color, sex, age, religion, national origin, disability, sexual orientation or gender identity or expression.
6. Severability
    a. In the event any provision of this AGREEMENT is rendered invalid or unenforceable by any valid act of Congress or the Nevada State Legislature, or declared null and void by any court of competent jurisdiction, the rest and remainder of the provisions of this AGREEMENT shall remain in full force and effect.
7. Waiver
    a. Any waiver of a breach of any provision of this AGREEMENT shall not be deemed a waiver of any other breach of the same or different provision.
8. Governing Law
    a. Nevada law shall govern the interpretation of this AGREEMENT.

IN WITNESS WHEREOF, the PARTIES have caused this AGREEMENT for Shared Services for Healthy Living RRH to be executed by their duly authorized representatives on the day and year first written above.

ANTHEM BLUE CROSS AND BLUE SHIELD

By: Lisa A Bogard DATE:

LISA BOGARD
Operations Director

COUNTY:
CLARK COUNTY, NEVADA

By: Kristin R. Cooper Digitally signed by Kristin R. Cooper Date: 2021.11.03 08:32:09 -07'00' DATE:

KRISTIN COOPER
Assistant Director of Social Service

APPROVED AS TO FORM:
STEVEN B. WOLFSON
District Attorney

By: DATE:

ELIZABETH VIBERT
Deputy District Attorney

AGREEMENT
FOR SHARED SERVICES FOR
HEALTHY LIVING RAPID REHOUSING

This AGREEMENT (hereinafter referred to as "AGREEMENT"), is made and entered into this _____ day, of _____ 2021, by and between the COUNTY of CLARK, DEPARTMENT OF SOCIAL SERVICE (hereinafter referred to as "COUNTY"), and HEALTH PLAN OF NEVADA (hereinafter referred to as "HPN") for shared services for Healthy Living Rapid Rehousing collectively hereinafter referred to as PROJECT.

INTRODUCTION

WHEREAS, The PROJECT is a rapid rehousing project for medically fragile, literally homeless households experiencing homelessness discharged from local hospitals or other medical facilities using a Housing First model. The PROJECT places homeless individuals, and if needed, their families in an affordable housing situation, providing intensive case management and access to addiction and mental health counseling and medical supports;

WHEREAS, there is a need for rapid rehousing for medically fragile, individuals and families experiencing literal homelessness based on data which reflects a portion of the clients referred to Healthy Living PSH do not meet the definitions of chronic homelessness and/or a disabling condition. The need to coordinate supportive housing post medical facility discharge is great based on data from the Healthy Living PSH;

WHEREAS, the PARTIES to this AGREEMENT believe that the coordination of supportive housing post medical discharge can most effectively be accomplished through collaborative case conferencing between the PARTIES through the PROJECT to serve more clients utilizing rental assistance savings; and

WHEREAS, it is deemed that the services hereinafter set forth are both necessary and in the best interests of the COUNTY and HPN;

NOW, THEREFORE, in consideration of the aforementioned premises, the following have been mutually agreed upon by all PARTIES:

PARTICIPANTS

Clark County, Department of Social Service (COUNTY)
Health Plan of Nevada (HPN)

TIME FRAME AND ASSOCIATION

This AGREEMENT has been entered into in good faith. This AGREEMENT will remain in effect for four (4) years expiring on September 30, 2026, or until such time as COUNTY and HPN collectively revise the expiration in writing or if funding is not available. The AGREEMENT will automatically renew for successive annual terms. Any PARTY may terminate its participation under this AGREEMENT upon not less than sixty (60) days written notice to the other PARTY as

provided herein. The AGREEMENT will be reviewed by each PARTY annually.

This AGREEMENT shall not act, nor be construed, to otherwise restrict the PARTIES from participating in similar activities with other public or private agencies, organizations, and individuals.

SPECIFIC ROLES AND RESPONSIBILITIES OF PARTICIPANTS

COUNTY and HPN have been collaborating since March of 2019 on similar programs that offer intensive case management (ICM) to highly vulnerable, medically fragile individuals experiencing homelessness discharged from local hospitals and other medical facilities.

The grant funds that provide rental assistance to eligible clients are provided by U.S. Department of Housing and Urban Development's (HUD), Continuum of Care Program governed by title IV of the McKinney-Vento Homeless Assistance Act, as amended by S. 896 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 and the Continuum of Care Program regulation 24 CFR 578. Funds for each grant year are contingent upon receipt of grant funds awarded by HUD to Clark County Social Service; and are anticipated to be spent between October 1, 2022 and December 31, 2023. Program dates will be agreed upon by all parties.

It is anticipated that the Board of County Commissioners (BCC) will approve acceptance of the grant award on December 21, 2021;

Direct service is provided through a subcontract with HELP of Southern Nevada which provides outreach, intensive case management, housing placement and supportive services; and

ClarityNet software operating the Community Management Information System is the case management tool of record.

SCOPE OF SERVICES TO BE PROVIDED BY COUNTY:

1. BACKBONE SERVICES: COUNTY will serve as Project Manager for the PROJECT with primary responsibility of organizing meetings and facilitating communication among partnering and contracted agencies.
2. COUNTY will participate as the fiscal agent for the HUD Continuum of Care grant funding to facilitate subcontracts with direct service provider, HELP of Southern Nevada.
3. COUNTY will utilize additional funding resources provided by HPN to enhance HELP of Southern Nevada's Healthy Living Rapid Rehousing Intensive Case Management Contract with additional resources. Staffing for this project will be at the ratio of one (1) case manager per fifteen (15) clients for intensive case management and housing navigation.

SCOPE OF SERVICES TO BE PROVIDED BY HEALTH PLAN OF NEVADA

1. HPN will utilize HPN social work staff at various hospitals to identify presumptively eligible clients who meet the criteria for the PROJECT through the web-based database,

ClarityNet Human Services CMIS, which acts as a referral portal, data repository, and case management tool of record for client information

2. HPN will follow the admission criteria for the PROJECT to include referring clients who:
   - ❖ Meet the PROJECT's definition of medically fragile and literal homelessness.
   - ❖ Are independent in performing activities of daily living (ADLs) and medication administration.
   - ❖ Have an acute medical condition with an identifiable end point of care.
   - ❖ Are independent in mobility (individual can ambulate with assistive devices such as walkers, wheelchairs, cane, crutches).
   - ❖ Are willing to see medical and community staff and comply with medical recommendations in accordance with treatment plans (Harm reduction methods will be incorporated with treatment plans).
   - ❖ Are medically and psychiatrically stable, patient must be ready for discharge to independent living and cannot be suicidal or homicidal.
3. Provide $250,754 for year one (1) and three (3) percent increases per year thereafter for services to case manage clients for the PROJECT. In the event that all HPN funds are not utilized during any year of the PROJECT, all unused funds will be applied to the subsequent year of the PROJECT. Summaries of expenditures related to HPN members will be provided to HPN on a regular basis. All charges are based on a per client ratio of costs.
4. Prior to the start of each year, beginning in year two (2) of the PROJECT, an estimate of match including a three (3) percent increase for services to case manage an initial allotment of twenty-five (25) clients for the PROJECT will be provided in writing to HPN.
5. Share client level cost benefit data with COUNTY to include, at a minimum, pre-intervention cost six (6) months prior to enrollment and six (6) months post enrollment to evaluate program intervention cost.
6. Share client level information with PROJECT case managers pertinent to providing individualized holistic services in housing.

COLLECTIVE RESPONSIBILITY

The PARTIES shall engage in continuous communication which will allow for a consistent and honest platform where concerns will be addressed, and ideas discussed between organizations. This communication method will support common language, a foundation for support, a common agenda, an agreement of common targets, and monitoring of results.

The PARTIES shall participate in regular meetings and conference calls for PROJECT and be responsible for respective data entry, reporting, and processes for using data to improve service delivery and coordination.

The PARTIES understand that nothing contained in the AGREEMENT shall require any PARTY to refer any individual or clients to any other PARTY, or to any affiliate or subsidiary of any PARTY.

The PARTIES understand that in the event that there is not full utilization of the allocated PROJECT spots that they will be offered to additional PROJECT partners and the respective costs will be billed to that partner. Both PARTIES understand that this may happen at any point during

the PROJECT and can be initiated by either PARTY. This will be done to ensure full utilization of PROJECT vacancies for the duration of the PROJECT.

CONFIDENTIALITY

The PARTIES hereto shall treat as confidential all information relating to any PARTY'S operations or the general business affairs or any of the operations or general business affairs of the PARTY (including the PARTY'S parent, affiliate, subcontractor for the HL RRH project, or subsidiary companies) which any other party may observe, or which may be disclosed as a result of the PARTY'S performance under this AGREEMENT. No PARTY shall disclose any such confidential information to third parties or use any such information for any purpose other than the performance under this AGREEMENT, without the prior written consent of the other PARTY.

Additionally, the PARTIES shall abide by all State and Federal laws, rules and regulations, including, but not limited to, 42 C.F.R., Part 2 and the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC § 1320d ("HIPAA"). Specifically, and to the extent applicable to this AGREEMENT and the relationships between the PARTIES, each PARTY shall comply with HIPAA, and any current and future regulations promulgated thereunder, and all the amendments to HIPAA contained in Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), all collectively referred to as "HIPAA Requirements." The PARTIES understand it may be necessary to enter into further agreements to facilitate compliance with HIPAA. Each PARTY shall not use or further disclose any Protected Health Information (as defined in 45 C.F.R. § 132d), other than as permitted by the HIPAA Requirements, including the law enforcement exception to HIPAA.

Any medical information concerning any client or individual that is necessary to share with the COUNTY for the safety of HL RRH, the client or in furtherance of this AGREEMENT is confidential information pursuant to NRS 179A.100 and will be protected and not disclosed other than to those who have a need and right to know the information and who is subject to like terms of confidentiality.

NOTICES

Any notices required or permitted to be given pursuant to this AGREEMENT shall be in writing and sent by certified mail, postage prepaid, return receipt requested to the PARTY's address noted below. Notice shall be deemed to be given upon the date three (3) days after such notice is deposited in the mail. Notices may also be delivered by courier, electronic transmission (including email) or by facsimile transmission and shall be deemed to be delivered when received by the PARTY to whom such notice is directed with a confirmation of receipt. All notices shall be forwarded as follows:

If to CCSS: Clark County, Department of Social Service
Attn: Director of Social Service
Address: 1600 Pinto Lane
Las Vegas, Nevada 89106

If to HPN: Health Plan of Nevada
Attn: Don Giancursio
Address: 2720 N. Tenaya Way
Las Vegas, Nevada 89128

ENTIRE AGREEMENT

This AGREEMENT represents the entire arrangement and understanding between the PARTIES and supersedes all prior oral and written understandings, representations, and discussions respecting this AGREEMENT.

NO ASSIGNMENT OR MODIFICATIONS

No PARTY to this AGREEMENT may assign, pledge or otherwise transfer its responsibilities under the scope of work herein except with the prior written consent of the non-assigning PARTIES, which consent shall not be unreasonably withheld. This provision does not apply to subcontracting.

This AGREEMENT may not be modified or amended without the written consent of authorized representatives of the PARTIES.

PERMITS AND LICENSES

Each PARTY hereto shall be responsible for securing all necessary licenses and permits required for providing the services for which it is responsible as delineated in this AGREEMENT.

INSURANCE

Each PARTY hereto shall be responsible for providing its own insurance coverage, including general liability, workers compensation, and professional liability (if applicable).

INDEPENDENT CONTRACTORS

The PARTIES to this AGREEMENT are acting as independent contractors and independent employers. Nothing contained in this AGREEMENT shall create or be construed as creating a partnership, joint venture or agency relationship between the PARTIES. No PARTY, nor any PARTY's respective officers, directors, employees or independent contractors, shall be construed to be the partner, employee, agent or representative of any other PARTY. No PARTY shall have the authority to bind any other PARTY in any respect. No PARTY shall exercise control over the methods or procedures to be utilized by any other PARTY, nor shall any PARTY be responsible for the conduct of any other PARTY.

MISCELLANEOUS

1. Limited Liability
    a. The PARTIES will not waive and intend to assert available NRS chapter 41 liability limitations in all cases. Contract liability of both PARTIES shall not be subject to punitive damages. To the extent applicable, actual contract damages for any breach shall be limited by NRS 354.626.
2. Indemnification
    a. Neither PARTY waives any right or defense to indemnification that may exist in law or equity.
3. Exclusive Benefit of the PARTIES
    a. This AGREEMENT is not intended to create any rights, powers or interest for any PARTY not participating in this AGREEMENT. This AGREEMENT is entered into for the exclusive benefit of the undersigned PARTIES.
4. Interpretation of AGREEMENT
    a. It is agreed that the PARTIES will derive the greatest benefit from this AGREEMENT by promoting the interest of each other, by evaluation, consultation, cooperation and interpreting the provisions of this AGREEMENT in the manner which shall best promote the interest of the clients served.
5. Non-Discrimination
    a. In providing services under this AGREEMENT, the PARTIES shall not discriminate on the basis of race, color, sex, age, religion, national origin, disability, sexual orientation or gender identity or expression.
6. Severability
    a. In the event any provision of this AGREEMENT is rendered invalid or unenforceable by any valid act of Congress or the Nevada State Legislature, or declared null and void by any court of competent jurisdiction, the rest and remainder of the provisions of this AGREEMENT shall remain in full force and effect.
7. Waiver
    a. Any waiver of a breach of any provision of this AGREEMENT shall not be deemed a waiver of any other breach of the same or different provision.
8. Governing Law
    a. Nevada law shall govern the interpretation of this AGREEMENT.

IN WITNESS WHEREOF, the PARTIES have caused this AGREEMENT for Shared Services for Healthy Living RRH to be executed by their duly authorized representatives on the day and year first written above.

HEALTH PLAN OF NEVADA

By: _____ DATE: _____
Don Giancursio
CEO

COUNTY:
CLARK COUNTY, NEVADA

By: _____ DATE: _____
KRISTIN COOPER
Assistant Director of Social Service

APPROVED AS TO FORM:
STEVEN B. WOLFSON
District Attorney

By: _____ DATE: _____
ELIZABETH VIBERT
Deputy District Attorney

AGREEMENT
FOR SHARED SERVICES FOR
HEALTHY LIVING RAPID REHOUSING

This AGREEMENT (hereinafter referred to as "AGREEMENT"), is made and entered into this _____ day, of _____ 2021, by and between the COUNTY of CLARK, DEPARTMENT OF SOCIAL SERVICE (hereinafter referred to as "COUNTY"), and MOLINA HEALTHCARE OF NEVADA (hereinafter referred to as "MOLINA") for shared services for Healthy Living Rapid Rehousing collectively hereinafter referred to as PROJECT.

INTRODUCTION

WHEREAS, The PROJECT is a rapid rehousing project for medically fragile, literally homeless households experiencing homelessness discharged from local hospitals or other medical facilities using a Housing First model. The PROJECT places homeless individuals, and if needed, their families in an affordable housing situation, providing intensive case management and access to addiction and mental health counseling and medical supports;

WHEREAS, there is a need for rapid rehousing for medically fragile, individuals and families experiencing literal homelessness based on data which reflects a portion of the clients referred to Healthy Living PSH do not meet the definitions of chronic homelessness and/or a disabling condition. The need to coordinate supportive housing post medical facility discharge is great based on data from the Healthy Living PSH;

WHEREAS, the PARTIES to this AGREEMENT believe that the coordination of supportive housing post medical discharge can most effectively be accomplished through collaborative case conferencing between the PARTIES through the PROJECT to serve more clients utilizing rental assistance savings; and

WHEREAS, it is deemed that the services hereinafter set forth are both necessary and in the best interests of the COUNTY and MOLINA;

NOW, THEREFORE, in consideration of the aforementioned premises, the following have been mutually agreed upon by all PARTIES:

PARTICIPANTS

Clark County, Department of Social Service (COUNTY)
Molina Healthcare of Nevada (MOLINA)

TIME FRAME AND ASSOCIATION

This AGREEMENT has been entered into in good faith. This AGREEMENT will remain in effect for four (4) years expiring on September 30, 2026, or until such time as COUNTY and MOLINA collectively revise the expiration in writing or if funding is not available. The AGREEMENT will automatically renew for successive annual terms. Any PARTY may terminate its participation under this AGREEMENT upon not less than sixty (60) days written notice to the other PARTY as

provided herein. The AGREEMENT will be reviewed by each PARTY annually.

This AGREEMENT shall not act, nor be construed, to otherwise restrict the PARTIES from participating in similar activities with other public or private agencies, organizations, and individuals.

SPECIFIC ROLES AND RESPONSIBILITIES OF PARTICIPANTS

COUNTY and MOLINA have been collaborating since March of 2019 on similar programs that offer intensive case management (ICM) to highly vulnerable, medically fragile individuals experiencing homelessness discharged from local hospitals and other medical facilities.

The grant funds that provide rental assistance to eligible clients are provided by U.S. Department of Housing and Urban Development's (HUD), Continuum of Care Program governed by title IV of the McKinney-Vento Homeless Assistance Act, as amended by S. 896 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 and the Continuum of Care Program regulation 24 CFR 578. Funds for each grant year are contingent upon receipt of grant funds awarded by HUD to Clark County Social Service; and are anticipated to be spent between October 1, 2022 and December 31, 2023. Program dates will be agreed upon by all parties.

It is anticipated that the Board of County Commissioners (BCC) will approve acceptance of the grant award on December 21, 2021;

Direct service is provided through a subcontract with HELP of Southern Nevada which provides outreach, intensive case management, housing placement and supportive services; and

ClarityNet software operating the Community Management Information System is the case management tool of record.

SCOPE OF SERVICES TO BE PROVIDED BY COUNTY:

1. BACKBONE SERVICES: COUNTY will serve as Project Manager for the PROJECT with primary responsibility of organizing meetings and facilitating communication among partnering and contracted agencies.
2. COUNTY will participate as the fiscal agent for the HUD Continuum of Care grant funding to facilitate subcontracts with direct service provider, HELP of Southern Nevada.
3. COUNTY will utilize additional funding resources provided by MOLINA to enhance HELP of Southern Nevada's Healthy Living Rapid Rehousing Intensive Case Management Contract with additional resources. Staffing for this project will be at the ratio of one (1) case manager per fifteen (15) clients for intensive case management and housing navigation.

SCOPE OF SERVICES TO BE PROVIDED BY MOLINA HEALTHCARE OF NEVADA

1. MOLINA will utilize MOLINA social work staff at various hospitals to identify

presumptively eligible clients who meet the criteria for the PROJECT through the web-based database, ClarityNet Human Services CMIS, which acts as a referral portal, data repository, and case management tool of record for client information

2. MOLINA will follow the admission criteria for the PROJECT to include referring clients who:
   - ❖ Meet the PROJECT's definition of medically fragile and literal homelessness.
   - ❖ Are independent in performing activities of daily living (ADLs) and medication administration.
   - ❖ Have an acute medical condition with an identifiable end point of care.
   - ❖ Are independent in mobility (individual can ambulate with assistive devices such as walkers, wheelchairs, cane, crutches).
   - ❖ Are willing to see medical and community staff and comply with medical recommendations in accordance with treatment plans (Harm reduction methods will be incorporated with treatment plans).
   - ❖ Are medically and psychiatrically stable, patient must be ready for discharge to independent living and cannot be suicidal or homicidal.
3. Provide $250,754 for year one (1) and three (3) percent increases per year thereafter for services to case manage clients for the PROJECT. In the event that all MOLINA funds are not utilized during any year of the PROJECT, all unused funds will be applied to the subsequent year of the PROJECT. Summaries of expenditures related to MOLINA members will be provided to MOLINA on a regular basis. All charges are based on a per client ratio of costs.
4. Prior to the start of each year, beginning in year two (2) of the PROJECT, an estimate of match including a three (3) percent increase for services to case manage an initial allotment of twenty-five (25) clients for the PROJECT will be provided in writing to MOLINA.
5. Share client level cost benefit data with COUNTY to include, at a minimum, pre-intervention cost six (6) months prior to enrollment and six (6) months post enrollment to evaluate program intervention cost.
6. Share client level information with PROJECT case managers pertinent to providing individualized holistic services in housing.

COLLECTIVE RESPONSIBILITY

The PARTIES shall engage in continuous communication which will allow for a consistent and honest platform where concerns will be addressed, and ideas discussed between organizations. This communication method will support common language, a foundation for support, a common agenda, an agreement of common targets, and monitoring of results.

The PARTIES shall participate in regular meetings and conference calls for PROJECT and be responsible for respective data entry, reporting, and processes for using data to improve service delivery and coordination.

The PARTIES understand that nothing contained in the AGREEMENT shall require any PARTY to refer any individual or clients to any other PARTY, or to any affiliate or subsidiary of any PARTY.

The PARTIES understand that in the event that there is not full utilization of the allocated

PROJECT spots that they will be offered to additional PROJECT partners and the respective costs will be billed to that partner. Both PARTIES understand that this may happen at any point during the PROJECT and can be initiated by either PARTY. This will be done to ensure full utilization of PROJECT vacancies for the duration of the PROJECT.

CONFIDENTIALITY

The PARTIES hereto shall treat as confidential all information relating to any PARTY'S operations or the general business affairs or any of the operations or general business affairs of the PARTY (including the PARTY'S parent, affiliate, subcontractor for the HL RRH project, or subsidiary companies) which any other party may observe, or which may be disclosed as a result of the PARTY'S performance under this AGREEMENT. No PARTY shall disclose any such confidential information to third parties or use any such information for any purpose other than the performance under this AGREEMENT, without the prior written consent of the other PARTY.

Additionally, the PARTIES shall abide by all State and Federal laws, rules and regulations, including, but not limited to, 42 C.F.R., Part 2 and the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC § 1320d ("HIPAA"). Specifically, and to the extent applicable to this AGREEMENT and the relationships between the PARTIES, each PARTY shall comply with HIPAA, and any current and future regulations promulgated thereunder, and all the amendments to HIPAA contained in Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), all collectively referred to as "HIPAA Requirements." The PARTIES understand it may be necessary to enter into further agreements to facilitate compliance with HIPAA. Each PARTY shall not use or further disclose any Protected Health Information (as defined in 45 C.F.R. § 132d), other than as permitted by the HIPAA Requirements, including the law enforcement exception to HIPAA.

Any medical information concerning any client or individual that is necessary to share with the COUNTY for the safety of HL RRH, the client or in furtherance of this AGREEMENT is confidential information pursuant to NRS 179A.100 and will be protected and not disclosed other than to those who have a need and right to know the information and who is subject to like terms of confidentiality.

NOTICES

Any notices required or permitted to be given pursuant to this AGREEMENT shall be in writing and sent by certified mail, postage prepaid, return receipt requested to the PARTY's address noted below. Notice shall be deemed to be given upon the date three (3) days after such notice is deposited in the mail. Notices may also be delivered by courier, electronic transmission (including email) or by facsimile transmission and shall be deemed to be delivered when received by the PARTY to whom such notice is directed with a confirmation of receipt. All notices shall be forwarded as follows:

If to CCSS: Clark County, Department of Social Service
Attn: Director of Social Service
Address: 1600 Pinto Lane
Las Vegas, Nevada 89106

If to MOLINA: Molina Healthcare of Nevada
Attn: Michael Easterday
Address: 6748 Cinnamon Dr.
Sparks, Nevada 89436

ENTIRE AGREEMENT

This AGREEMENT represents the entire arrangement and understanding between the PARTIES and supersedes all prior oral and written understandings, representations, and discussions respecting this AGREEMENT.

NO ASSIGNMENT OR MODIFICATIONS

No PARTY to this AGREEMENT may assign, pledge or otherwise transfer its responsibilities under the scope of work herein except with the prior written consent of the non-assigning PARTIES, which consent shall not be unreasonably withheld. This provision does not apply to subcontracting.

This AGREEMENT may not be modified or amended without the written consent of authorized representatives of the PARTIES.

PERMITS AND LICENSES

Each PARTY hereto shall be responsible for securing all necessary licenses and permits required for providing the services for which it is responsible as delineated in this AGREEMENT.

INSURANCE

Each PARTY hereto shall be responsible for providing its own insurance coverage, including general liability, workers compensation, and professional liability (if applicable).

INDEPENDENT CONTRACTORS

The PARTIES to this AGREEMENT are acting as independent contractors and independent employers. Nothing contained in this AGREEMENT shall create or be construed as creating a partnership, joint venture or agency relationship between the PARTIES. No PARTY, nor any PARTY's respective officers, directors, employees or independent contractors, shall be construed to be the partner, employee, agent or representative of any other PARTY. No PARTY shall have the authority to bind any other PARTY in any respect. No PARTY shall exercise control over the methods or procedures to be utilized by any other PARTY, nor shall any PARTY be responsible for the conduct of any other PARTY.

MISCELLANEOUS

1. Limited Liability
    a. The PARTIES will not waive and intend to assert available NRS chapter 41 liability limitations in all cases. Contract liability of both PARTIES shall not be subject to punitive damages. To the extent applicable, actual contract damages for any breach shall be limited by NRS 354.626.
2. Indemnification
    a. Neither PARTY waives any right or defense to indemnification that may exist in law or equity.
3. Exclusive Benefit of the PARTIES
    a. This AGREEMENT is not intended to create any rights, powers or interest for any PARTY not participating in this AGREEMENT. This AGREEMENT is entered into for the exclusive benefit of the undersigned PARTIES.
4. Interpretation of AGREEMENT
    a. It is agreed that the PARTIES will derive the greatest benefit from this AGREEMENT by promoting the interest of each other, by evaluation, consultation, cooperation and interpreting the provisions of this AGREEMENT in the manner which shall best promote the interest of the clients served.
5. Non-Discrimination
    a. In providing services under this AGREEMENT, the PARTIES shall not discriminate on the basis of race, color, sex, age, religion, national origin, disability, sexual orientation or gender identity or expression.
6. Severability
    a. In the event any provision of this AGREEMENT is rendered invalid or unenforceable by any valid act of Congress or the Nevada State Legislature, or declared null and void by any court of competent jurisdiction, the rest and remainder of the provisions of this AGREEMENT shall remain in full force and effect.
7. Waiver
    a. Any waiver of a breach of any provision of this AGREEMENT shall not be deemed a waiver of any other breach of the same or different provision.
8. Governing Law
    a. Nevada law shall govern the interpretation of this AGREEMENT.

IN WITNESS WHEREOF, the PARTIES have caused this AGREEMENT for Shared Services for Healthy Living RRH to be executed by their duly authorized representatives on the day and year first written above.

MOLINA HEALTHCARE OF NEVADA

By: _____ DATE: _____
Michael Easterday
President

COUNTY:
CLARK COUNTY, NEVADA

By: _____ DATE: _____
KRISTIN COOPER
Assistant Director of Social Service

APPROVED AS TO FORM:
STEVEN B. WOLFSON
District Attorney

By: _____ DATE: _____
ELIZABETH VIBERT
Deputy District Attorney

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