



California  
Health Care  
Foundation

# HOME- LESSNESS RESPONSE

# 101

FOR HEALTH CARE PROVIDERS  
AND STAKEHOLDERS

# WHAT TO EXPECT FROM THESE MATERIALS

The following pages contain foundational information for health care providers about how homeless assistance works at the local level, with particular focus on two critical components: Continuum of Care (CoCs) and Coordinated Entry (CE).

Additionally, you will find practical, action-oriented suggestions on how to participate in your community's response to homelessness.



## What's included

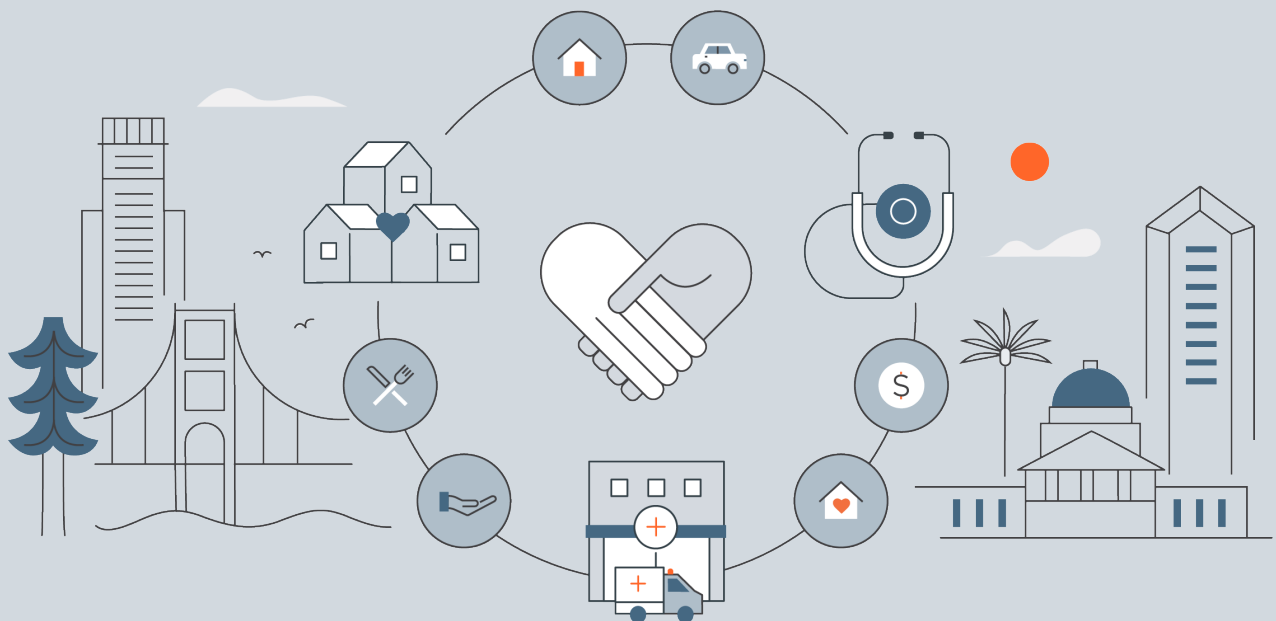
Just enough information and suggested actions to empower and encourage health care providers and other stakeholders to take the first steps to engage and collaborate with their communities' homeless response systems. Specifically:

- The case for collaboration
- Homeless assistance in a nutshell: CoCs and CE
- Opportunities for participation in CE
- Examples of successful homeless assistance and health care partnerships (including those with hospitals, health plans, and other health care providers)
- Basic information about how to connect with your local CoC(s)



## What's not included

A lot of technical details about homeless assistance programs, systems, operations, and funding that often vary from one community to another.



# WHY CROSS-SYSTEM COLLABORATION IS NEEDED

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Just as the health care system is not designed or equipped to address patients' housing needs, homeless assistance programs and systems are not designed or equipped to take care of the often complex medical or behavioral health needs of people experiencing homelessness. Coordination is critical to leverage both systems' resources to better serve people and to improve outcomes for individuals and families as well as the systems designed to support them.

Cross-system collaboration better serves people who are experiencing or at risk of homelessness. It also makes things easier, less costly, and more efficient for both health care and homeless assistance systems overall.

Addressing the health-related needs of people experiencing homelessness is central to ending homelessness. Similarly, stable housing is fundamental to maintaining good health and minimizing the costs of unnecessary emergency department (ED) use and hospital admissions.



## **Housing is a key determinant of health.**

Poor living conditions affect people's vulnerability to illness and disease and their ability to benefit from treatment and manage their conditions. People experiencing homelessness contend with communicable diseases and infections, exposure to extreme weather conditions, malnutrition, stress, lack of running water to maintain cleanliness, and lack of refrigeration for medication and food.



## **People who are homeless are at greater risk for poor health.**

The mortality rate among people experiencing homelessness is 3-4 times higher than for the general population. People experiencing homelessness have higher rates of infectious and acute illnesses (skin diseases, tuberculosis, pneumonia, asthma) and chronic diseases (diabetes, hypertension, HIV/AIDS, cardiovascular disease); have higher incidences of mental health issues and/or substance use; and are more likely to be victims of violence.



## **Homelessness is correlated with frequent use of ED and other high-cost health care interventions.**

The high proportion of complex health needs and co-occurring primary and behavioral health conditions increases the number, intensity, and scope of services people experiencing homelessness need. Homelessness inhibits the long-term, consistent care necessary to treat these conditions, aggravating health problems and making them both more dangerous to the individual and more costly to health care systems, especially managed care plans and hospitals. Homelessness also increases the likelihood of excessive ED use, inpatient treatment, and crisis services.






# FUNDAMENTALS OF HOMELESS ASSISTANCE

## FOUNDATIONAL KNOWLEDGE TO EMPOWER HEALTH CARE PROVIDERS TO ENGAGE HOMELESS RESPONSE SYSTEM PARTNERS

Although various types of funding for homeless assistance come from the federal and state governments, homelessness response happens at the local, community level. In California, “community level” most often means the geographic area covered by a single county.

County or city governments provide some homeless assistance, but no single agency or organization administers all resources and services. In almost every community across the country, a myriad of organizations and agencies provide a variety of types of assistance to individuals and families at risk of or experiencing homelessness.

**This assistance may include:**

-  **Emergency shelter**
-  **Temporary or permanent housing**
-  **Transportation assistance**
-  **Necessities like food**
-  **Financial support**  
(one-time assistance or ongoing rental assistance)
-  **Supportive services**  
(e.g., case management, assistance applying for benefits, connections to medical or behavioral health care, help finding or securing housing)

Due to limited resources, the vast majority of housing assistance is prioritized for people living on the street, sleeping in vehicles or tents, or staying in emergency shelters. Communities often further prioritize housing and intensive supportive services for people experiencing “chronic homelessness,” which means those who have a disability and have been homeless for more than a year.

The next few pages will provide an overview of two critical components of local homeless assistance: the **Continuum of Care** and **Coordinated Entry**.

# 5 KEY THINGS TO KNOW ABOUT CONTINUUMS OF CARE

## What is a CoC?

Short for “Continuum of Care,” CoC is the umbrella term for the group of organizations and agencies (including community-based organizations and local government agencies) that collectively coordinates homeless assistance activities and resources in a community. There are currently 44 CoCs in California; most cover a single county, but a few cover a single city or two or more adjacent counties.

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### **A CoC is not a legal entity.**

It is a coalition of organizations and entities that meet regularly to discuss and plan their community's homelessness response.

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### **Each CoC designates an entity to apply for federal funds on its behalf.**

The designated entity, often a local government agency or nonprofit organization, is referred to as the “Collaborative Applicant” or “CoC Lead Agency.” It submits the CoC’s application for homeless assistance grant funds from the U.S. Department of Housing and Urban Development (HUD). CoCs also must have a board comprising representatives from local homeless assistance organizations and at least one person with lived experience of homelessness. A CoC’s board oversees the requirements associated with HUD funding.

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### **HUD awards homeless assistance grant funds to CoCs through an annual competitive process.**

Each CoC runs a local process based on community priorities to determine which organizations should receive funding from HUD’s award and for what purposes. The CoC’s designated Lead Agency uses those determinations to apply for HUD funds on behalf of the community. The primary thing CoCs and CoC-funded organizations use HUD funds for is rental assistance to help people exit homelessness. Some programs combine rental assistance with services for people who need more than financial support to get and maintain stable housing.

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# 5 KEY THINGS TO KNOW ABOUT CONTINUUMS OF CARE

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**The primary purpose of a CoC is to promote a community-wide commitment to end homelessness.**

CoC members attend meetings, participate in community-wide planning, and coordinate with each other. While many agencies that participate in a CoC receive HUD funding, entities that do not receive HUD funding may still participate in the CoC for a variety of reasons: to increase the impact of their own work, to learn more about the different resources available in the community to better serve their clients, to learn strategies and best practices for responding to homelessness, to build relationships with other leaders and organizations with similar missions and values, to better position themselves for future HUD funding, etc.

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**HUD requires CoCs to develop certain processes.**

Because each community has a variety of assistance programs and resources to support people experiencing or at risk of homelessness, HUD requires every CoC to have a process in place to ensure that people who need housing and other supports are connected to local resources in an equitable and coordinated way. This process is called **Coordinated Entry**.

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**Types of stakeholders who participate in a CoC include:**

- nonprofit homeless assistance providers;
- community- and faith-based organizations;
- victim service providers;
- local governments;
- public housing agencies;
- school districts;
- social service providers;
- substance use service organizations and mental health agencies/service organizations;
- local businesses;
- street outreach teams;
- EMT/crisis response teams;
- hospitals;
- affordable housing developers;
- law enforcement agencies and jails;
- community health centers and clinics;
- people with lived experience of homelessness;
- organizations that serve specific populations (e.g., veterans, youth, LGBTQ+ people, people with disabilities); and
- advocates

# COORDINATED ENTRY BASICS

## What is Coordinated Entry?

Coordinated Entry (CE) is the process each CoC sets up to ensure that people experiencing or at risk of homelessness are prioritized for resources based on severity of need, and that people are matched to available resources most suitable to meet their needs. **CE's primary purpose is to allocate housing resources fairly and appropriately.**

## Benefits of Coordinated Entry

Without Coordinated Entry, people experiencing homelessness have to seek out multiple individual organizations that might be able to help them. Not only is this extremely burdensome for people already in crisis, but even those who can successfully find, visit, and apply for help at different agencies often end up on numerous separate waiting lists for housing.

Coordinated Entry removes reliance on individual program waiting lists, which tend to be organized on a first-come, first-served basis rather than taking acuity of need into account. Reducing the use of individual waiting lists and focusing on acuity of need means individuals and families in the most dire circumstances can be housed before those in less severe need. It also means that getting help more quickly or finding out about different types of assistance beyond housing (e.g., benefits, insurance, or employment help) does not depend on the individual case manager someone is assigned (if any) or a person or family's own ability to navigate complicated systems.

## With Coordinated Entry, HUD mandates that each CoC do the following:

- Use a standardized assessment approach with every individual or household that needs housing assistance to determine vulnerability, needs, and eligibility for resources.
- Organize a community-wide waiting list for housing resources that prioritizes individuals and families based on vulnerability/severity of need rather than on a first-come, first-served basis.
- Provide access to housing resources via one intake and referral process.

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The idea behind Coordinated Entry **is similar to emergency room triage**, which ensures that someone having a heart attack is treated before someone with a broken arm, even if the person with the broken arm arrived at the emergency room first and has been waiting for hours. Under Coordinated Entry, this means that higher-acuity people are served before lower-acuity people.

Effective and equitable Coordinated Entry implementation depends on a wide variety of factors, including inclusive and thoughtful client-centered planning; buy-in and engagement at the client, staff, and leadership levels; sufficient and sustainable capacity and resources; and the ability to collect, store, and analyze accurate data to facilitate connection to resources and monitor performance. **The more invested partners who contribute to CE planning and implementation, the better the outcomes are for everyone: CoCs, health care providers and systems, and most important, people experiencing homelessness.**

# 5 KEY THINGS TO KNOW ABOUT COORDINATED ENTRY

A well-functioning CE process ensures that (1) limited housing resources are prioritized to those most in need because of health issues, vulnerability to death or victimization, or the circumstances of their homelessness; and (2) people seeking housing are more likely to be matched with resources that meet their specific needs, regardless of where, when, or how they “show up” seeking assistance.

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### **Coordinated Entry is required.**

Every CoC must operate a CE system as a condition of receiving HUD funding, and every organization that receives HUD’s homeless assistance grant funding must participate in CE. All housing vacancies and rental assistance vouchers funded with HUD’s homeless assistance grant funding must be filled through the CE process.

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### **Key components of Coordinated Entry:**

1. Intake: entry by each person into the CE system;
  2. Assessment of each person;
  3. Prioritization of every assessed person based on vulnerability/severity of need;
  4. A process to match resources to individuals or families as they become available, based on the established prioritization;
  5. Referrals to housing programs that provide the matched resources; and
  6. Placement of people into the housing programs to which they’ve been referred.
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### **CE is open to all organizations that serve people experiencing homelessness.**

Only HUD-funded programs are required to participate, but the goal is for all local organizations with resources for people experiencing homelessness to participate, regardless of funding source.

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# 5 KEY THINGS TO KNOW ABOUT COORDINATED ENTRY

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## **CoCs have flexibility in designing their CE processes.**

Every CoC's CE process must meet certain requirements, but CoCs have flexibility to customize their process. Based on local capacity, needs, and resources, each CoC must plan and design:

1. how and where to identify people in need of homeless assistance;
2. what tool(s) to use to assess each person or family;
3. what factors to include when determining relative vulnerability of those assessed (i.e., the information on which to base prioritization);
4. the process and people involved to match available resources to prioritized people and connect those people to the agencies that hold the resources; and
5. how to evaluate whether the process is working well.

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## **CoCs must evaluate and refine their CE processes to prioritize equity, address disparities, and improve outcomes.**

HUD has mandated CE for only a few years, so CoCs are at different points in implementation. CoCs should regularly make adjustments to ensure that the process is working effectively and equitably. Even in communities with an established CE system, there is always room for discussions, planning, and changes to improve implementation. Stakeholders with diverse perspectives and expertise — including health care providers — are critical to identify issues and blind spots and inform changes.

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The next pages provide additional details about the components of CE and opportunities for health care providers to get involved to (1) ensure patients with housing needs are connected to the homeless assistance system, and (2) help inform and improve how CE works overall.

# KEY COMPONENTS OF COORDINATED ENTRY

Coordinated Entry (CE) is a formal process through which people experiencing or at risk of homelessness access the homeless response system in a streamlined way, have their strengths and needs assessed, and connect to appropriate, tailored housing and mainstream services within the community. The key components of coordinated entry are described below.



## System Entry

Clients seeking housing or services make contact with the community's homeless response system, usually by interacting with an outreach worker, calling 211, or showing up at a service provider's site.



## Assessment

All individuals and families who enter the system are assessed in a consistent manner, using a uniform decision making process and standardized assessment tools.



## Prioritization

Clients are prioritized for housing and community resources based on factors agreed upon by the CoC, ensuring that limited resources are used in the most effective manner and that households most in need of assistance are prioritized for housing and services.



## Matching

As housing resources become available, clients at the top of the community's priority list are given a choice to accept those resources for which they are eligible and which appear to meet their needs.



## Referral

Clients matched with a resource are referred to the program holding that resource, which requires communication between those who made the match decision, the client, and the program providing the resource.



## Placement

Clients are placed into the program and ultimately into housing. This usually entails ensuring that the client is "document ready" and often requires the client, program, and other partners to work together to address various barriers to housing placement and stability.

### More on Assessment

Relevant assessment factors include information about each person's needs, strengths, and preferences; barriers they face to secure housing; length and duration of past and current episodes of homelessness; and characteristics that make them more vulnerable while experiencing homelessness. Most assessment information is self-reported, and people may underreport certain conditions for various reasons.

### More on Prioritization

Prioritization schemes are decided by each community and usually take into account the severity of service needs, considering factors such as risk of illness, death, and/or victimization; history of frequent use of crisis services; and significant physical or mental health challenges, substance use disorders, or functional impairments.

# OPPORTUNITIES FOR HEALTH CARE PROVIDER PARTICIPATION IN COORDINATED ENTRY

Coordinated Entry offers practical and meaningful opportunities for cross-system coordination. By plugging into a community's CE process, health care providers can: (1) **ensure that patients with housing needs connect to the homeless assistance system** in the way most likely to get them assessed, prioritized, and connected to available resources; and (2) **contribute valuable expertise to improve the overall CE process over time**, so housing resources get to those who need them most in an efficient and equitable way.

Each improvement to the CE process and each patient connection to housing resources contribute to improved overall patient outcomes and decreased burdens and costs on the health care system. **The following are examples of ways health care providers can participate in CE and contribute to its improved functioning.**



## System Entry

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- Learn basic eligibility requirements to identify patients to connect to the CE system.
- Know the entry points for your community's system and how to help your patients access them.
- Develop protocols for notifying outreach teams of potentially eligible patients to get them quickly connected to CE.
- Serve as a CE entry point to reduce the burden on patients and increase the likelihood that they will be assessed and prioritized for available resources.



## Assessment

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- Help review, select, and/or develop assessment tool(s) to more accurately capture health-related vulnerability.
- Notify the CE system of patients who should be assessed.
- Provide space for assessments to take place.
- Administer assessments.



## Prioritization

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- Work with the CE system to ensure that critical health considerations are factored into prioritization schemes.
- Participate in case conferences to explain when and how specific health conditions should result in individuals being prioritized more highly than the standard CE protocols suggest.

# OPPORTUNITIES FOR HEALTH CARE PROVIDER PARTICIPATION IN COORDINATED ENTRY



## Matching

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- Participate in matching case conferences to increase the likelihood of appropriate and successful matches for patients.
- Help clients understand their options and how each might impact health care access and outcomes.



## Referral

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- Offer support to housing providers (e.g., provide health care or other services to clients) to increase the likelihood that referred patients are accepted and successful in housing placements.
- Help clients procure necessary eligibility documentation (e.g., disability verification).



## Placement

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- Provide transportation help to get clients to appointments.
- Follow up with housed clients to ensure continued connections to health care needed to support long-term housing stability.

### One more opportunity...

The next page contains basic information about CoC data systems and how health care providers can help support CE operations through data review and analysis.

# BASICS OF HOMELESS MANAGEMENT INFORMATION SYSTEMS

CoC and Coordinated Entry operations generate a lot of data that can be used to evaluate system performance and identify system needs. However, CoCs often don't have the capacity or expertise to identify and address data quality issues, perform meaningful data analysis, or determine the most efficient use of data.

Health care stakeholders can provide invaluable support to CoCs by contributing expertise and time toward (1) regular and ongoing data quality review, (2) metrics development and progress monitoring, and (3) data analysis to identify areas for improvement.

## What is HMIS?

HUD requires each CoC to collect and report certain information about the people they serve. Homeless Management Information Systems (HMIS) are the data systems that communities use to collect and analyze client, service, and housing data. HUD does not mandate that CoCs use a particular software program; each community may select any that can collect the required data elements, comply with HUD's data standards, and support reporting requirements.



### Information contained in HMIS

HUD requires every community to track specific data points and response options for each of various data elements. HUD also publishes data standards that CoCs must meet. Types of required data elements include the following:

- Basic client information, including whether the client has a physical or developmental disability, chronic health condition, HIV/AIDS, mental health issue, or substance use disorder
- Whether the client receives noncash benefits or has health insurance, and if so, what kinds
- Information about client interactions with the homeless response system



### Limitations

Having a single system to collect data about those served by a community's homeless assistance programs is extremely helpful for keeping track of clients, coordinating the connection to housing and

other resources, monitoring client outcomes, and tracking performance metrics at the organizational and system levels. However, the information contained in HMIS can be insufficient for various reasons:

- Only programs that receive HUD funding are required to enter information into a community's HMIS (although additional programs — including health care providers such as managed care plans and hospitals — often also participate with prior agreement and training).
- Inconsistent data entry and data quality and missing information often occur with so many different individuals and providers entering data.
- Client information contained in HMIS is largely self-reported, and clients may refuse to answer questions or may provide incomplete or inaccurate information for a variety of reasons. Clients underreporting their health conditions can result in lower CE prioritization than their actual vulnerability or acuity of need warrants.

# PARTNERSHIP EXAMPLES: PARTICIPATION IN COORDINATED ENTRY

## System Entry

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- Yakima Neighborhood Health Services in Washington State and Heartland Health Outreach in Chicago **serve as Coordinated Entry access points** for their respective CoCs. They identify and complete the CE intake process for people who may be eligible for homeless services.
- Family Health Centers of San Diego operates the city's Housing Navigation Center, which **provides on-site CE intake, assessment, triage, and referrals** for housing opportunities.
- Washington State provided CoC and CE training to state psychiatric hospital discharge planning staff, so the staff could better **identify patients who were eligible for homeless assistance resources**. The discharge planning staff could also **complete a prescreen assessment** to facilitate a patient's entry into their local CE system.
- **Managed care plans** can work with CoCs to **ensure that plan members** experiencing or at risk of homelessness **connect to the CE system** to be assessed and prioritized for housing resources. For example, United Healthcare Medicare plans in multiple communities have engaged with local CoC partners to **match member lists with HMIS data** to coordinate around shared clients in order to improve connections to health and housing resources. Similarly, L.A. Care worked with the Los Angeles CoC on a data match to identify members staying in COVID-19 non-congregate shelter motels and help connect them to needed health services.
- Hospital, clinic, and community health center staff — including social workers, nurses, physicians, and psychiatrists — are often part of **homeless outreach or street medicine teams, which can serve as CE system entry points** for people experiencing unsheltered homelessness.

## Assessment

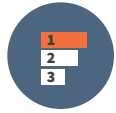
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- Health Care for the Homeless in Baltimore assisted in **building and testing** the Baltimore Decision Assessment Tool, the CoC's **locally created CE assessment tool, and provided training** for CoC staff to use it.
- The Clark County, Nevada, CoC **developed a local CE assessment tool**, and a variety of health care stakeholders participated in the development process.
- Albuquerque Health Care for the Homeless is an **assessment location for the CE system**. Trained Engagement Specialists **complete CE assessments** for clients, so they can be prioritized for and matched to housing resources.
- Valley Homeless HealthCare Program in Santa Clara County, California, has an **outreach team that administers CE assessments**.

# PARTNERSHIP EXAMPLES: PARTICIPATION IN COORDINATED ENTRY

## Prioritization



- Alameda County Health Care for the Homeless and other county and community health care providers participate in an initiative called Home Stretch. This initiative, part of the CoC's CE system, was created to **identify, assess, and**

**prioritize people experiencing chronic homelessness** for programs that provide both housing and intensive supportive services.

### The Effect of the Pandemic on People Experiencing Homelessness and CoCs

People experiencing homelessness are among those most vulnerable to severe COVID-19 illness and death for numerous reasons. Because CE's primary purpose is to prioritize people based on vulnerability, CoCs across the country adjusted their prioritization schemes to incorporate COVID-19 risk factors, working with public health departments, local Health Care for the Homeless programs, and other health system stakeholders. Centers for Disease Control and Prevention (CDC) guidance and local health care provider expertise have been critical to inform the adjustments CoCs made to their systems, particularly their CE prioritization decisions.

## Matching, Referral, Placement



- Daily Planet Health Services in Richmond, Virginia, and Hennepin County Health Care for the Homeless in Minneapolis, Minnesota, **each participate in case conferencing to help match prioritized individuals and families** to available housing resources and monitor and advance their progress toward securing housing.
- Houston's Coordinated Entry system partners with three Health Care for the Homeless programs to **refer clients** to health clinics, dental health services, mental health services, HIV services, and housing.
- Oahu's hospitals and Medicaid health plans participate in Coordinated Entry in a variety of ways. Participating

health care providers identify and triage patients with housing needs to enter the CE system, can request special prioritization for patients with complex needs, and help patients prioritized for housing to **gather the documentation necessary to demonstrate eligibility** for certain housing programs.

- Valley Homeless HealthCare Program in Santa Clara County, California, helps clients who are prioritized for Permanent Supportive Housing **collect the documentation needed to complete the referral and placement process.**

# NEXT STEPS: LOCATE + LEARN ABOUT + REACH OUT TO LOCAL CONTINUUMS OF CARE

There's no one way to collaborate with a CoC or participate in a Coordinated Entry system that applies across the board. Each CoC has different things to offer and needs different things from potential health care partners. Specific opportunities to participate in Coordinated Entry vary across CoCs as well, and there may be opportunities to partner other than participating in CE (e.g., by colocating health services at emergency shelters or housing sites, or by partnering on a medical respite/recuperative care program).

The best way to engage with your local CoC(s) in a mutually beneficial way is to connect with and begin to build a relationship with representatives from key CoC stakeholders, such as the Lead Agency, CoC chair, or Coordinated Entry operator. Speaking with CoC and CE leaders is a great way to learn about the health needs of people who engage with your local homeless response system, share insights about your and your patients' needs, and discuss opportunities for cross-system collaboration and partnership to address those needs.

**The following pages contain a list of California CoCs by the geographic region they cover and includes the current website for each of them, to help you take the first step toward a cross-system partnership.**



# CALIFORNIA CONTINUUMS OF CARE

| Geographic Region Covered | Name of CoC  | CoC Website   |
|---------------------------|--|---|
| Alameda County            | Oakland, Berkeley/Alameda County CoC   | <a href="https://everyonehome.org/about/committees/hud-coc-committee/">https://everyonehome.org/about/committees/hud-coc-committee/</a>   |
| Alpine County             | Alpine, Inyo, Mono Counties CoC  | <a href="https://www.imaca.net/">https://www.imaca.net/</a>   |
| Amador County             | Amador, Calaveras, Mariposa, Tuolumne Counties CoC (Central Sierra CoC)                      | <a href="https://www.centralsierracoc.org/">https://www.centralsierracoc.org/</a>   |
| Butte County              | Chico, Paradise/Butte County CoC   | <a href="https://www.buttecaa.com/">https://www.buttecaa.com/</a>   |
| Calaveras County          | Amador, Calaveras, Mariposa, Tuolumne Counties CoC (Central Sierra CoC)                      | <a href="https://www.atcaa.org/">https://www.atcaa.org/</a>   |
| City of Glendale          | Glendale CoC   | <a href="https://www.glendaleca.gov/government/departments/community-services-parks/homeless-services">https://www.glendaleca.gov/government/departments/community-services-parks/homeless-services</a> |
| City of Long Beach        | Long Beach CoC   | <a href="http://www.longbeach.gov/health/services/directory/homeless-services/">http://www.longbeach.gov/health/services/directory/homeless-services/</a>   |
| City of Pasadena          | Pasadena CoC   | <a href="https://pasadenapartnership.org/coc-program/">https://pasadenapartnership.org/coc-program/</a>   |
| Colusa County             | Colusa, Glenn, Trinity Counties CoC (Dos Rios CoC)   | <a href="http://cgtcap.org/dosrios/default.aspx">http://cgtcap.org/dosrios/default.aspx</a>   |
| Contra Costa County       | Richmond/Contra Costa County CoC   | <a href="https://cchealth.org/h3/coc/council.php">https://cchealth.org/h3/coc/council.php</a>   |
| Del Norte County          | Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC) | <a href="https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care">https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care</a>                                 |
| El Dorado County          | El Dorado County CoC   | <a href="https://www.edcgov.us/Government/HumanServices/Housing/pages/continuum_of_care.aspx">https://www.edcgov.us/Government/HumanServices/Housing/pages/continuum_of_care.aspx</a>                   |
| Fresno County             | Fresno City and County/Madera County CoC   | <a href="http://fresnomaderahomeless.org/">http://fresnomaderahomeless.org/</a>   |
| Glenn County              | Colusa, Glenn, Trinity Counties CoC (Dos Rios CoC)   | <a href="http://cgtcap.org/dosrios/default.aspx">http://cgtcap.org/dosrios/default.aspx</a>   |
| Humboldt County           | Humboldt County CoC  | <a href="https://humboldt.gov/2512/Humboldt-Housing-Homeless-Coalition">https://humboldt.gov/2512/Humboldt-Housing-Homeless-Coalition</a>   |
| Imperial County           | Imperial County CoC  | <a href="https://www.imperialvalleycontinuumofcare.org/">https://www.imperialvalleycontinuumofcare.org/</a>   |
| Inyo County               | Alpine, Inyo, Mono Counties CoC  | <a href="https://www.imaca.net/">https://www.imaca.net/</a>   |
| Kern County               | Bakersfield/Kern County CoC  | <a href="https://bkrhc.org/">https://bkrhc.org/</a>   |
| Kings County              | Visalia/Kings, Tulare Counties CoC   | <a href="https://www.kthomelessalliance.org">https://www.kthomelessalliance.org</a>   |
| Lake County               | Lake County CoC  | <a href="https://www.lakecoc.org">https://www.lakecoc.org</a>   |
| Lassen County             | Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC) | <a href="https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care">https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care</a>                                 |

# CALIFORNIA CONTINUUMS OF CARE, CONTINUED

| Geographic Region Covered   | Name of CoC  | CoC Website   |
|---|--|---|
| Los Angeles County<br>(except the cities of Glendale, Long Beach, and Pasadena) | Los Angeles City and County CoC  | <a href="https://www.lahsa.org/">https://www.lahsa.org/</a>   |
| Madera County   | Fresno City and County/Madera County CoC   | <a href="http://fresnomaderahomeless.org/">http://fresnomaderahomeless.org/</a>   |
| Marin County  | Marin County CoC   | <a href="https://www.marinhhs.org/homelessness-marin">https://www.marinhhs.org/homelessness-marin</a>   |
| Mariposa County   | Amador, Calaveras, Mariposa, Tuolumne Counties CoC (Central Sierra CoC)                      | <a href="https://www.atcaa.org/">https://www.atcaa.org/</a>   |
| Mendocino County  | Mendocino County CoC   | <a href="https://www.mendocinocounty.org/government/health-human-services-agency/adult-aging-services/mendocino-county-homeless-services-continuum-of-care">https://www.mendocinocounty.org/government/health-human-services-agency/adult-aging-services/mendocino-county-homeless-services-continuum-of-care</a> |
| Merced County   | Merced City and County CoC   | <a href="https://www.co.merced.ca.us/848/Homeless-Assistance">https://www.co.merced.ca.us/848/Homeless-Assistance</a>   |
| Modoc County  | Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC) | <a href="https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care">https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care</a>   |
| Mono County   | Alpine, Inyo, Mono Counties CoC  | <a href="https://www.imaca.net/">https://www.imaca.net/</a>   |
| Monterey County   | Salinas/Monterey, San Benito Counties CoC  | <a href="https://chsp.org/">https://chsp.org/</a>   |
| Napa County   | Napa City and County CoC   | <a href="https://www.countyofnapa.org/1036/Napa-Continuum-of-Care">https://www.countyofnapa.org/1036/Napa-Continuum-of-Care</a>   |
| Nevada County   | Nevada County CoC  | <a href="https://www.hrcscoc.org/">https://www.hrcscoc.org/</a>   |
| Orange County   | Santa Ana, Anaheim/Orange County CoC   | <a href="https://www.ochealthinfo.com/homeless_serv/coc/2021">https://www.ochealthinfo.com/homeless_serv/coc/2021</a>   |
| Placer County   | Roseville, Rocklin/Placer County CoC   | <a href="https://www.hrcscoc.org/">https://www.hrcscoc.org/</a>   |
| Plumas Count  | Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC) | <a href="https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care">https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care</a>   |
| Riverside Count   | Riverside City and County CoC  | <a href="http://dpss.co.riverside.ca.us/homeless-programs/housing-and-homeless-coalition">http://dpss.co.riverside.ca.us/homeless-programs/housing-and-homeless-coalition</a>   |
| Sacramento County   | Sacramento City and County CoC   | <a href="https://sacramentostepsforward.org/">https://sacramentostepsforward.org/</a>   |
| San Benito County   | Salinas/Monterey, San Benito Counties CoC  | <a href="https://chsp.org/">https://chsp.org/</a>   |
| San Bernardino County   | San Bernardino City and County CoC   | <a href="https://wp.sbcounty.gov/dbh/sbchp/">https://wp.sbcounty.gov/dbh/sbchp/</a>   |
| San Diego County  | San Diego City and County CoC  | <a href="https://www.rtfhsd.org/">https://www.rtfhsd.org/</a>   |

## CALIFORNIA CONTINUUMS OF CARE, CONTINUED

| Geographic Region Covered | Name of CoC  | CoC Website   |
|---------------------------|--|---|
| San Francisco County      | San Francisco CoC  | <a href="https://hsh.sfgov.org/committees/lhcb/">https://hsh.sfgov.org/committees/lhcb/</a>   |
| San Joaquin County        | Stockton/San Joaquin County CoC  | <a href="http://www.sanjoaquinoc.org/">http://www.sanjoaquinoc.org/</a>   |
| San Luis Obispo County    | San Luis Obispo County CoC   | <a href="https://www.slocounty.ca.gov/Departments/Social-Services/Homeless-Services.aspx">https://www.slocounty.ca.gov/Departments/Social-Services/Homeless-Services.aspx</a> |
| San Mateo County          | Daly City/San Mateo County CoC   | <a href="https://hsa.smcgov.org/san-mateo-county-continuum-care">https://hsa.smcgov.org/san-mateo-county-continuum-care</a>   |
| Santa Barbara County      | Santa Maria/Santa Barbara County CoC   | <a href="https://www.countyofsb.org/housing/continuumprogram.sbc">https://www.countyofsb.org/housing/continuumprogram.sbc</a>   |
| Santa Clara County        | San Jose, Santa Clara City and County CoC  | <a href="https://www.sccgov.org/sites/osh/ContinuumofCare">https://www.sccgov.org/sites/osh/ContinuumofCare</a>   |
| Santa Cruz County         | Watsonville/Santa Cruz City and County CoC   | <a href="http://homelessactionpartnership.org/">http://homelessactionpartnership.org/</a>   |
| Shasta County             | Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC) | <a href="https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care">https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care</a>       |
| Sierra County             | Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC) | <a href="https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care">https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care</a>       |
| Siskiyou County           | Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC) | <a href="https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care">https://www.co.shasta.ca.us/index/housing-community/norcal-continuum-of-care</a>       |
| Solano County             | Vallejo/Solano County CoC  | <a href="http://www.housingfirstsolano.org/">http://www.housingfirstsolano.org/</a>   |
| Sonoma County             | Santa Rosa, Petaluma/Sonoma County CoC   | <a href="https://sonomacounty.ca.gov/CDC/Homeless-Services/Continuum-of-Care/">https://sonomacounty.ca.gov/CDC/Homeless-Services/Continuum-of-Care/</a>                       |
| Stanislaus County         | Turlock, Modesto/Stanislaus County CoC   | <a href="http://www.stancoha.org/coc/">http://www.stancoha.org/coc/</a>   |
| Sutter County             | Yuba City and County/Sutter County CoC   | <a href="https://www.syhomelessconsortium.org/">https://www.syhomelessconsortium.org/</a>   |
| Tehama County             | Tehama County CoC  | <a href="http://www.tehamacoc.org/">http://www.tehamacoc.org/</a>   |
| Trinity County            | Colusa, Glenn, Trinity Counties CoC (Dos Rios CoC)   | <a href="http://cgtcap.org/dosrios/default.aspx">http://cgtcap.org/dosrios/default.aspx</a>   |
| Tulare County             | Visalia/Kings, Tulare Counties CoC   | <a href="https://www.kthomelessalliance.org">https://www.kthomelessalliance.org</a>   |
| Tuolumne County           | Amador, Calaveras, Mariposa, Tuolumne Counties CoC (Central Sierra CoC)                      | <a href="https://www.atcaa.org/">https://www.atcaa.org/</a>   |
| Ventura County            | Oxnard, San Buenaventura/Ventura County CoC  | <a href="https://www.venturacoc.org/">https://www.venturacoc.org/</a>   |
| Yolo County               | Davis, Woodland/Yolo County CoC  | <a href="http://www.y3c.org/home1.aspx">http://www.y3c.org/home1.aspx</a>   |
| Yuba County               | Yuba City and County/Sutter County CoC   | <a href="https://www.syhomelessconsortium.org/">https://www.syhomelessconsortium.org/</a>   |