Table of Contents for Appendices

Definition of Homelessness & Other Key Definitions……..…….Pg 1

Appendix A…….....Pg 6

Appendix B……...Pg 14

Appendix C……...Pg 40

Appendix D……...……...Pg 54

Appendix E……..…….Pg 81

Appendix F……..Pg 118

Appendix G……..Pg 144

Path to a Home
The San Luis Obispo Countywide
10 Year Plan to End Homelessness

Plan Appendix on the Definitions of Homelessness

Developing programs to house and serve homeless people may involve applications for federal and state resources. The following definitions pertain to key funding opportunities.

A. McKinney-Vento Act's Definition of Homeless:

"homeless" or "homeless individual or homeless person" includes –

(1) an individual who lacks a fixed, regular, and adequate nighttime residence; and
(2) an individual who has a primary nighttime residence that is –

(A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
(B) an institution that provides a temporary residence for individuals intended to be institutionalized; or
(C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

U.S.C. § 11302

B. HUD's Definition of "Homeless":

- Living in places not meant for human habitation: cars, parks, sidewalks and abandoned buildings,
- Living in an emergency shelter,
- Living in transitional housing for homeless and originally came from the streets or emergency shelter,
    - In one of the above places, but temporarily (30 days) in an institution
- Being evicted within a week from institution (where a resident for more than 30 days) and no subsequent residences have been identified and lack resources and support network needed to access housing.

C. HUD's Definition of "Chronically Homeless":

- An unaccompanied homeless individual,
- Who has either been continually homeless for a year or more OR has had at least four episodes of homelessness in the past three years,
- With a disabling condition (disabling condition is defined as a "diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.") and
- Must have been sleeping in a place not meant for human habitation (e.g. living on the streets) or in an emergency shelter during that time.

D. Department of Education's Definition of "Homeless children and youth":

- Children and youth who are:
  - Sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason (sometimes referred to as *doubled-up*);
  - Living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations;
  - Living in emergency or transitional shelters;
  - Abandoned in hospitals; or
  - Awaiting foster care placement;

- Children and youth who have a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings;

- Children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

- Migratory children who qualify as homeless because they are living in circumstances described above.

(U.S. Department of Education: Non-Regulatory Guidance, July 2004, Re: Education For Homeless Children and Youth Program, Title VII-B of the McKinney-Vento Homeless Assistance Act, as amended by the No Child Left Behind Act of 2001).

E. The Center for Substance Abuse Treatment's definitions of "Homeless" and "Chronically Homeless":

- "Homeless" persons are those who lack a fixed, regular, adequate nighttime residence, including persons whose nighttime residence is:
    - A supervised public or private shelter designed to provide temporary living accommodations;
    - A time-limited/nonpermanent transitional housing arrangement for individuals engaged in mental health and/or substance use disorder treatment;
    - Or a public or private facility not designed for, or ordinarily used as, a regular sleeping accommodation.
    - "Homeless" also includes "doubled-up" – a residential status that places individuals at imminent risk for becoming homeless – defined as sharing another person's dwelling on a temporary basis where continued tenancy is contingent upon the hospitality of the primary leaseholder or owner and can be rescinded at any time without notice.

- "Chronically Homeless" persons are defined as unaccompanied homeless individuals with:
    - A substance use disorder,
    - Mental disorder,
    - Or co-occurring substance use and mental disorder,
    - Who have either been continuously homeless for a year or more or have had at least four (4) episodes of homelessness in the past three (3) years.

(Center for Substance Abuse Treatment (CSAT). March 31, 2008. Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons Who are Homeless).

Key Definitions

Defining Homelessness

The SLO Countywide 10 Year Plan to End Homelessness defines homelessness as follows:

A. "Homeless" People include those who are:

- An individual or an adult with a minor child or children,
- Who lack a fixed, regular, adequate residence meant for human habitation

OR

o Reside in temporary accommodations meant for human habitation as a step to permanent housing (e.g. shelter, transitional housing, hospital, treatment facility, incarceration),

• Who may suffer from a "disabling condition"
(defined as a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions),

OR

o Become homeless in times of economic hardship.

1. "Chronically Homeless" People

This sub-population could be characterized as the "hard-core" homeless.

Common features of chronically homeless people include:

• A "disabling condition"
(defined as a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions),
• Generally, an older, unaccompanied adult,
• Experiencing long-term unemployment
o Or poverty,
• Utilization of shelters, and other homeless supportive systems, less frequently than other sub-populations but consume more resources
o Each episode of shelter use by a chronically homeless person is likely to last for a long period of time, perhaps years, as they may become entrenched in the system,
o Shelters may be used like long-term housing rather than an emergency solution for the chronically homeless.

2. "Episodically Homeless" People

This sub-population could be described as those who cycle in and out of homelessness.

Common features of episodically homeless people include:

• Repeated contact with institutionalized housing
(e.g., shelter, hospital, treatment facility, incarceration),
• Generally use shelters for a shorter period of time, perhaps for several weeks or months,
• May suffer from a "disabling condition"
(defined as a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or

disability, including the co-occurrence of two or more of these conditions),
- May be unemployed
  - Or in poverty,
- Often younger in age and may be accompanied by a child.

3. “Transitionally Homeless” People

This sub-population could be described as those who make use of a homeless support system and shelters infrequently and as a step towards permanent housing.

Common features include:

- Homelessness resulting from an economic or catastrophic event (i.e., unemployment, separation, death of householder, utility disconnection, fire),
- Generally using shelters for a period of time less than 24 months as a step to permanent housing,
- May include adults with a minor child or children,
- Least likely of the sub-populations to suffer from a “disabling condition”.

(Kuhn, Randall, and Dennis Culhane. 1998. Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization: Results from the Analysis of Administrative Data. American Journal of Community Psychology, Volume 26, Issue 2, April 1998, pgs. 207-232).

Community Safety Net Agencies provide assistance to a broad range of people, but routinely include homeless people. These include the emergency rooms, hospitals, alcohol and drug treatment programs, schools and food pantries.

Homeless Services Coordinating Council (HSCC)

Primary Responders are those whose principal business is responding to housing, services, and treatment needs of extremely low income people, including those who become homeless. They typically include emergency shelters, day centers, the Housing Authorities, the Department of Social Services, Health Department, Health Care for the Homeless, Family Resource Centers and Outreach workers, and non profit housing providers. Primary responders reach out to engage the homeless population and those at immediate risk, assessing needs and creating individual action plans.

Recidivism refers to a tendency to relapse into a previous condition or mode of behavior, in particular a return to criminal behavior.

Appendix A
-Homeless Population-
Enumerating and Projecting Need

Table of Contents

Chart A-1: One Day Count of Homeless People

Chart A-2: One Day Count of Homeless People by Age Group and Gender

Chart A-3: Annual Estimate of Homeless People

Chart A-4: Characteristics of Homeless People

Chart A-5: Service Provider Numbers and other Data "Puzzle Pieces"

Chart A-1: One Day Count of Homeless People

One Day Count of Homeless People				
Homeless Population	**Emergency Shelter**	**Transitional Housing**	**Unsheltered**	**Total**
Number of Families With Dependent Children	22	0	171	193
Number of People in Families	57	0	1003	1060
Number of Households Without Dependent Children	76	54	1218	1295
Number of Single Individuals	76	54	1218	1295
Total Homeless People	133	54	2221	2408

Source: 2007 SLO County Continuum of Care Application, Exhibit 1

Chart A-2: One Day Count of Homeless People by Age Group and Gender

One Day Count of Homeless People			
Age Group		**Frequency**	**Valid Percent**
Valid Data	Children <12	523	22.00%
	Teens 13-21	294	12.40%
	Adults 22-64	1447	60.80%
	Seniors >65	114	4.80%
	Subtotal	2378	100.00%
Age unknown		30	
Total		**2408**	

One Day Count of Homeless People			
Gender		**Frequency**	**Valid Percent**
Valid Data	Male	1015	45.50%
	Female	1371	57.50%
	Subtotal	2386	100.00%
Gender Unknown		22	
Total		**2408**	

Source: SLO County Homeless Enumeration Report, Spring 2006.

Chart A-3: Annual Estimate of Homeless People in San Luis Obispo County

Annual Estimate of Homeless People		
2005 Point In Time Count of Homeless People	**Multiplier**	**Annual Projection of Homeless People**
2368	1.18	2795

This annual projection was created the following formula: A +((B*365/C)*(1-D) = annual projection of homeless count.

A= the homeless count minus people in supportive housing
(40 individual units existed in 2006 per to Exh. 1. 2408 – 40 = **2368**)

B=number of chronically homeless adults and children counted in emergency

C=average length of stay in emergency shelter (**53.5 days**, See below)

D=percentage of people who used emergency shelter more than once (**58%** See below)

2368 + ((149 * 365 / 53.5) * (1-0.58) = 2795

The following data, obtained from EOC and ECHO, was used to generate a figure for C, Average Length of Stay:

EOC: Based on a "typical" group of 20 clients at Maxine Lewis Memorial Shelter in 2007, the average length of stay was 65 days.
ECHO: Average length of stay for 2007 was 42 days
Average of EOC and ECHO = **53.5 days**

The following data, obtained from EOC and ECHO, was used to generate a figure for D, percentage of people who used emergency shelter more than once:

EOC: 80% of clients made repeat visits.
ECHO: 36% of clients made repeat visits
Average of EOC and ECHO = **58%** of clients made repeat visits

The multiplier was calculated by dividing the annual projection (2795) by the point-in-time count (2368).

2795 / 2368 = 1.18

Chart A-4: Characteristics of Homeless People

Group	2005 One-Day Count			
	Point In Time Count for Sheltered People	Projection for all homeless people counted	Multiplier	Annual Unduplicated Projection
Chronically Homeless	115	1247	1.18	1471
Mental Illness	127	1373	1.18	1620
Substance Abuse	76	819	1.18	966
Veterans	14	145	1.18	171
HIV	4	48	1.18	57
Domestic Violence	70	759	1.18	896
Unaccompanied Youth	2	24	1.18	28

Sources: 2006 SLO County Continuum of Care Application, Exhibit 1; Staff Calculations

Group	2007 One-Day Count			
	Point In Time Count for Sheltered People	Projection for all homeless people counted	Multiplier	Annual Unduplicated Projection
Chronically Homeless	15	193	1.18	227
Mental Illness	108	1391	1.18	1641
Substance Abuse	58	747	1.18	881
Veterans	21	270	1.18	319
HIV	2	26	1.18	31
Domestic Violence	37	476	1.18	562
Unaccompanied Youth	0	0	1.18	0

Sources: 2007 SLO County Continuum of Care Application, Exhibit 1; Staff Calculations

Group	Other Methodologies	
	Annual Estimate	Source
Chronically Homeless		
Mental Illness	221	SLO County Consolidated Plan 2005
Substance Abuse	283	SLO County Consolidated Plan 2005
Veterans	248	SLO County Consolidated Plan 2005
HIV	48	SLO County Consolidated Plan 2005
Domestic Violence	792	SLO County Consolidated Plan 2005
Unaccompanied Youth	18	SLO County Consolidated Plan 2005

Chart A-5: Service Provider Numbers and Other Data "Puzzle Pieces"

The following are data from service providers in San Luis Obispo County about how many clients they serve.

Maxine Lewis Memorial Shelter
Individuals Sheltered 2007: 856
Shelter Bed Nights FY 06-07: 25,410
Average Persons Sheltered Nightly: 80
Meals Served 2007: 56626
Individuals Turned Away 2007: 424

Transitions Food and Shelter
Individuals Sheltered FY 06-07: 262
Individuals Sheltered Jan-Feb 2008: 122
Shelter Bed nights FY 06-07: 3619
Shelter Bed nights Jan-Feb 2008: 982

ECHO Shelter
Individuals Sheltered 2007: about 600
Shelter Bed Nights 2007: 8930
Average Persons Sheltered Nightly: 25-30
Meals Served in 2007: 12000+
Unduplicated families served by all EOC Programs in 2007: 2362

Prado Day Center
Individuals Served 2007: 1444
Average Served Daily 2007: 105
Average Meals Served Daily: 85

Homeless Case Management (EOC &TMHA)
Individuals Housed 2007: 314
Individuals Served 2007: 288, including 66 families

Homeless Outreach Program
Individuals Housed FY 06-07: 83
Individuals Served FY 06-07: 92

Womens Shelter Program Inc. of SLO
Capacity: 22 beds

North County Women's Shelter and Resource Center
Capacity: 30 beds

Transitional Mental Health Association
Capacity: 109 beds

Sources: CDBG Applications 2008 Program Year, info received directly from Transitional Food and Shelter, EOC, Homeless Outreach Program AB 2034 and ECHO

Chart A-5: Service Provider Numbers and Other Data "Puzzle Pieces"

The following data, taken from HUD Annual Progress Reports, FY 2007, represent the total clients served by Case Management Supportive Services: South County Case Managemenet (EOC), North County Case Management (EOC) and San Luis Obispo Case Management (EOC and T-MHA). The numbers are totals compiled from all three reports.

	Singles Not In Families	**Adults in Families**	**Children in Families**	**Families**
Number in program on 6/1/2006	57	79	97	58
Number entered during program year	142	112	164	82
Total	**199**	**191**	**261**	**140**
Total Individuals Served=651				
Total Chronically Homeless Adults entering program in FY 07=119 of 390 or 30.5%				

Special Needs of Adults Entering Programs in FY 07 (may be counted in more than one category)

	All	Chronic
Mental Illness	118	83
Alcohol Abuse	46	36
Drug Abuse	44	26
HIV and Related Diseases	2	2
Developmental Disability	18	8
Physical Disability	80	47
Domestic Violence	5	3
Other	1	1

Chart A-5: Service Provider Numbers and Other Data "Puzzle Pieces"

The following charts represent data from two consecutive counts of school-age youth in SLO county. Source: Homeless Enumeration of School Age Youth Summary 2006-2007 & 2007-2008

Grade Level	2006	2007
K	56	54
1	55	73
2	43	58
3	50	62
4	48	55
5	40	63
6	44	48
7	47	40
8	41	40
9	46	53
10	55	43
11	51	60
12	61	46
Total	**637**	**695**

Primary Nighttime Residence	2006	2007
Shelters	40	62
Doubled/ Tripled Up	284	398
Unsheltered	28	33
Hotels or Motels	69	74
Unknown/ Other	216	128
Total	637	695

Appendix B
-Building Blocks of Change-
Inventory of Existing Housing and Services

Profile: **Agency Implementation Schedule to Launch 10 Year Plan Implementation**

Agency
Name:_____

Geographic Area where we will actively house/serve homeless people

- ☐ San Luis Obispo (city)
- ☐ South County
- ☐ North County
- ☐ beaches

Plan Agency Category

- ☐ We are a Primary Responder to Homelessness
- ☐ We are a Community Safety Net Agency

Our Role under the Plan

Given the work we are already immersed in, or had been developing plans to undertake, we are prepared to begin participating in the following:

1. **Mainstream, Coordinated Policy**

   ☐ Creating the Community Services Centers (this is what the Plan calls for in lieu of the "homeless services campus" idea)

   ☐ Creating the Basic Housing Assistance Centers

   ☐ Expanding the Homeless Outreach effort

2. **Housing First Policy**

Our role in housing provision:

- ☐ converting to Interim Housing all emergency shelter
- ☐ converting to Interim Housing all transitional housing
- ☐ expanding Permanent Supportive Housing supply
- ☐ expanding access to Affordable Housing, including increasing supply
- ☐ additional housing subsidies

Our role in services linked to all housing provided:

- ☐ single case plan
- ☐ fast track benefits
- ☐ Work Fast focus

Our initial assessment of what will be required for us to align our work with the Priorities (strategies and action steps) of the 10 Year Plan includes:

Corporate Structure/Governance

- ☐ Reform our agency corporate/governance structure
- ☐ Restructure at Executive Management level

Program Development

- ☐ Design entirely new program components
- ☐ Align existing programs to fit the new directions

Physical Plant

- ☐ Need a new facility
- ☐ Need additional housing units
- ☐ Redesign existing facility

Human Resources

- ☐ Need additional staff
- ☐ Retrain existing staff

Administration and Management

- ☐ Need new procedures
- ☐ Need new protocols
- ☐ Need new/revised assessment tools
- ☐ Need new/revamped data management system

Financial Resources

- ☐ Additional investment in staff will cost approximately:_____
- ☐ Additional physical plant investment might cost:_____
- ☐ Transitional Operations changes require:_____

Timeline

Over 18 months, by Quarters, we could undertake the following:

First Quarter (July-September 2008)

Second Quarter (October –December 2008)

Third Quarter (January-March 2009)

Fourth Quarter (April-June 2009)

Year Two, First Quarter (July-September 2009)

Year Two, Second Quarter (October –December 2009)

Appendix B
-Building Blocks of Change-
Inventory of Existing Housing and Services

Existing housing and services for homeless people will form the foundation of future efforts to develop and expand programs to serve homeless people.

Existing homeless services in San Luis Obispo County can be located on the website of the Homeless Services Coordinating Council:

www.slocounty.ca.gov/HomelessServices.htm

By scrolling down to "To Find Homeless Services" one can click on a link that takes the user to a county map.

On the county map, clicking on any community's name allows the user to view a map of that community with homeless services shown. (Note: Maps may take time to load and require Microsoft Word.)

By clicking in the center of a community map, one can access a list of existing housing and services for homeless people in the area.

This appendix contains the following printouts from the above website:

- Homeless Services Coordinating Council main page
- San Luis Obispo County map
- City of San Luis Obispo map (other cities available on website)
- All listings of housing and services for homeless people

San Luis Obispo County, California

Homeless Services Coordinating Council

HOMELESS SERVICES COORDINATING COUNCIL

Welcome to the website of the Homeless Services Coordinating Council of San Luis Obispo County.

Here you will be able to find maps of the cities and towns in San Luis Obispo County where services for the homeless are provided, as well as information about what time the listed services are available and who can get these services.

How to Use this Website

This website consists of maps and information pages about services for homeless people.

If you are searching for services provided to the homeless, first click on the county map in order to select the city or town in which you need services. You may need to have Microsoft Word open to view the maps.

Once you view the city map you will be able to click on the map to open a page with more information about the services offered in the community that you ave selected. Once on a map, if your cursor is not a hand with a pointing finger (☝), single click two times on the map to change your cursor from an arrow to the hand with a pointing finger and then click again in order to open these links.

The information page has links to the websites of the organization that offers services.

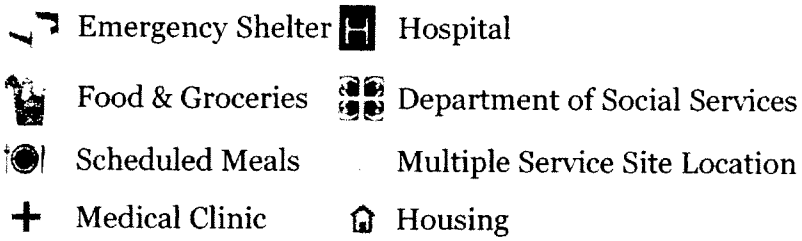
Also, if you click on the address field found on the information page you will open an individual Google street map of the location where services are provided.

If you click on of the border of a map which has a directional arrow (◂), you will go to a map of the nearest community with homeless services beyond the edge of the map you are viewing in the direction of the arrow.

Any of the maps and information pages you view can be printed.

The easiest way to return to a prior page is to click the ⇦**Back** button located on the standard toolbar.

Legend for Maps



To Find Homeless Services

Click here to go to the county map

Homeless Organizations Seeking Volunteers

Click here for a list of organizations that are looking for volunteers to help provide assistance to the homeless.

Organizations that provide Outreach Services

Click here if you are interested in learning more about organizations that provide outreach services for the homeless.

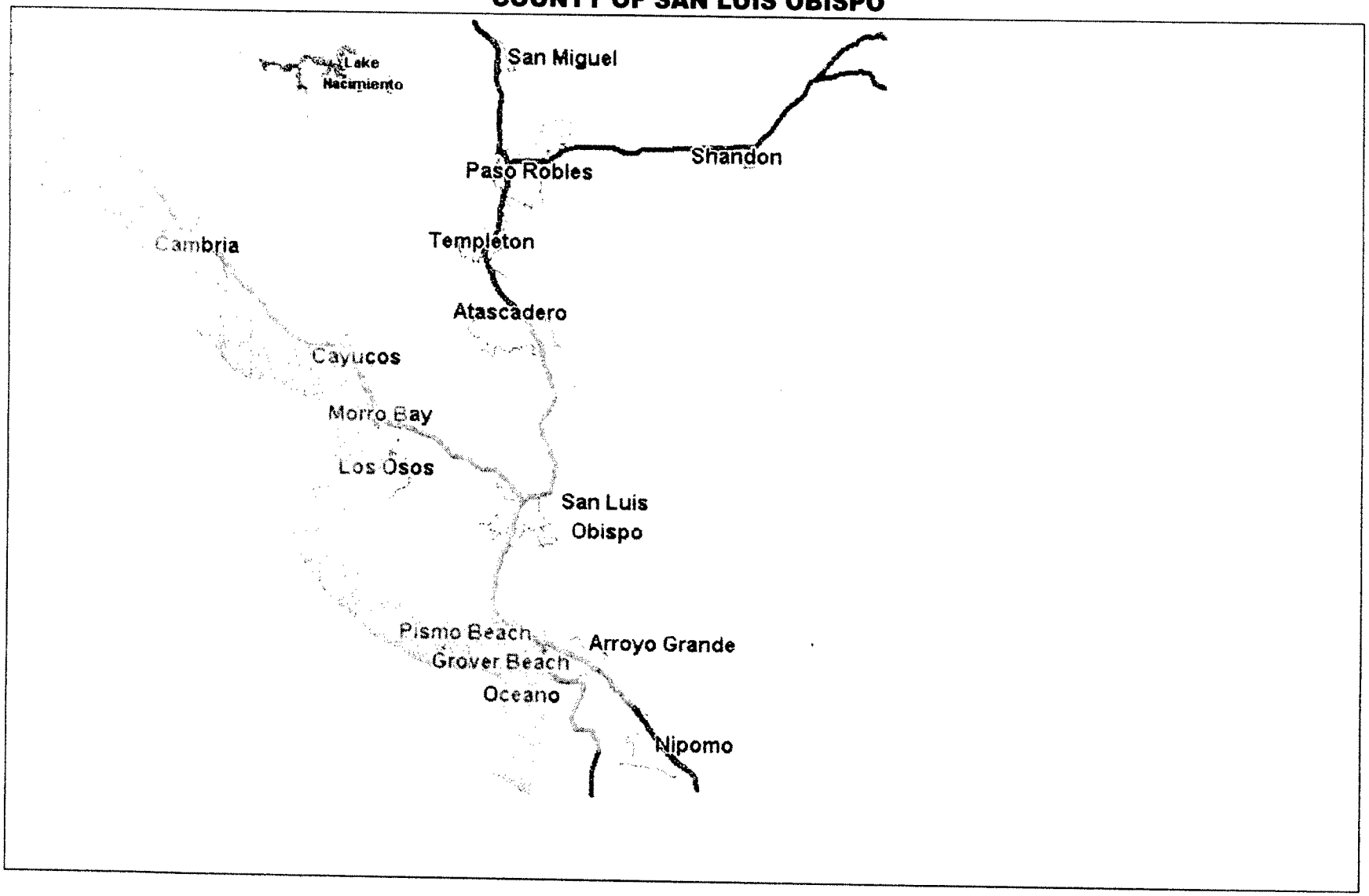
Send us your Feedback

If you are an individual looking for resources for the homeless and have comments or suggestions about this website, please click Contact Us to send us a message

If you are a provider of services to the homeless and have new information or need to correct information found on this website, please click Contact Us to send us a message so that we can keep this site as useful and up-to-date as possible. Thank you.

Ayuda en Español

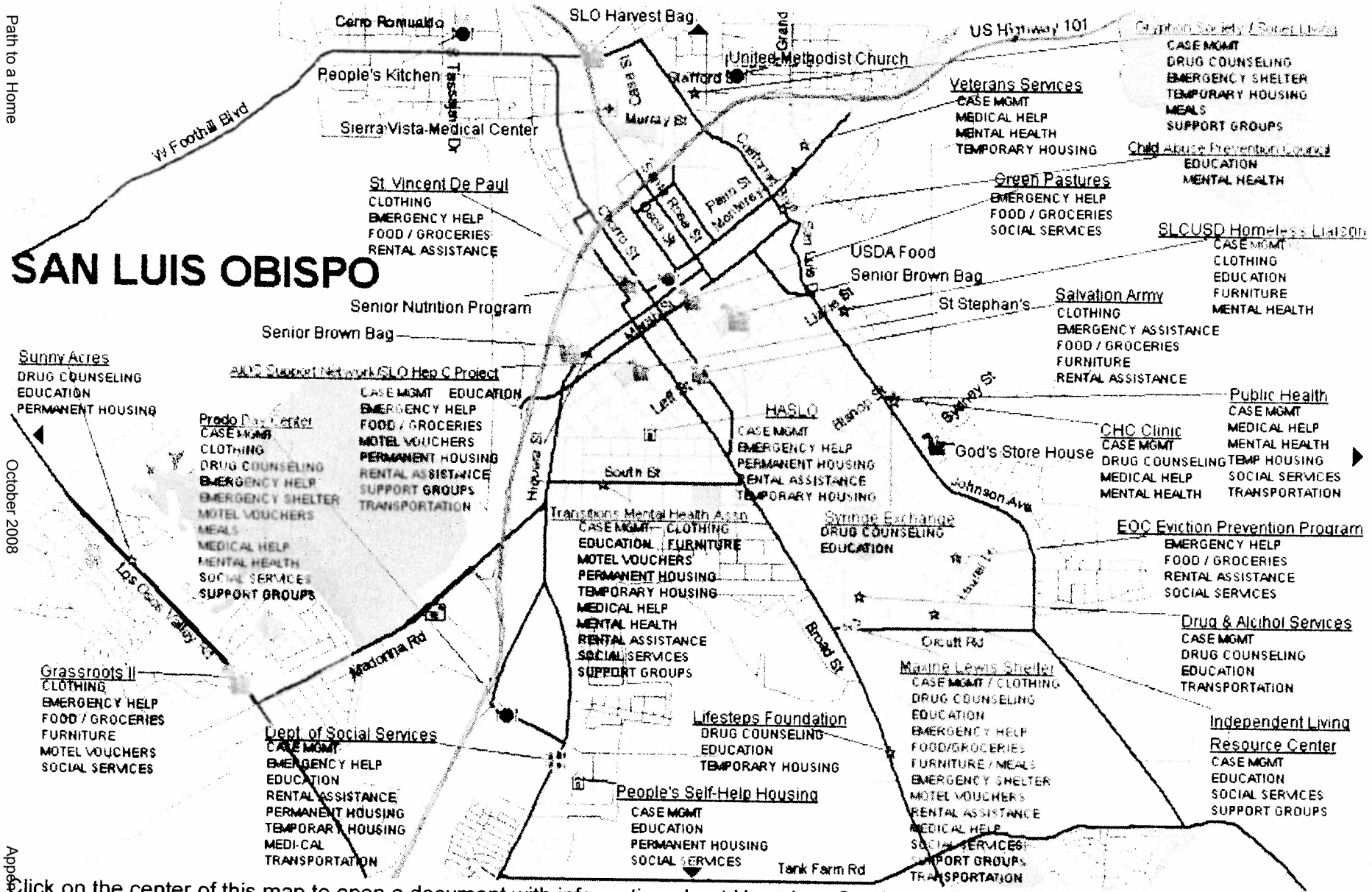
COUNTY OF SAN LUIS OBISPO



Click on the town or city in which you need homeless services.

Click here to return to the Homeless Services front page

CITY OF SAN LUIS OBISPO HOMELESS SERVICES MAP



Click on the center of this map to open a document with information about Homeless Services available in the city of San Luis Obispo. Click close to the edge of the map to go to a map of the nearest sites providing homeless services beyond this map in the direction you select.

Click for a SLO Transit Bus Route Map.

Click here to return to the San Luis Obispo County Homeless Services Map

SERVICES FOR THE HOMELESS IN THE CITY OF SAN LUIS OBISPO

Service Provided	Organization & Website link	Address	Hours	Eligibility Conditions	Telephone
Case Management Services	AIDS Support Network	1320 Nipomo St	M-Th 9-5/F 9-3	HIV Positive	(805) 781-3660
	Behavioral Health Services	2178 Johnson Ave.	M-F 8-5		(805) 781-4700
	Community Health Centers (CHC)	1551 Bishop Street #A160	M-F 8-7, Sat 9-5		(805) 269-1500
	County Office of Education	3350 Education Dr.	M-F 8-5	K-12 children	(805) 782-7209
	Dep. Of Soc. Services - Adult Protection	3433 S. Higuera	24/7	Elderly/disabled	(805) 788-2504
	Department of Social Services	3433 S. Higuera	M-F 8-5	Child Welfare/CalWORKs/Gen. Assistance	(805) 781-1600
	Drug & Alcohol Services	2945 McMillan Av	M-F 8-5		(805) 781-4753
	EOC Homeless Services/Case Management	736 Orcutt Rd	24/7		(805) 541-6351
	Gryphon Society Sober Living	1259 Stafford St	24/7	Drug & alcohol parolees	(805) 550-8140
	Homeless Outreach Program/T-MHA	277 South Street, Suite T	M-F 7-4:30	Homeless / mental illness	(805) 541-5144 x179
	Housing Authority	487 Leff Street			(805) 543-4478
	Independent Living Resource Center	1150 Laurel Lane	M-F 9-12/1-5	Disabled	(805) 593-0667
	Maxine Lewis Shelter	736 Orcutt Rd	5:00 pm - 7:15 am	18+, sober	(805) 781-3993
	Peoples Self Help Housing	3533 Empleo St.			(805) 781-3088
	Prado Day Center EOC	43 Prado Rd	8:30-4:30		(805) 786-0617
	SLCUSD Homeless Liaison	1300 Lizzie St	M-F 8:00 - 4:00	K-12 & families	(805) 549-1219
	SLO Hep C Project	1320 Nipomo	M-F 9-5	HIV, Hep C+	(805) 781-3660
	Transitional Housing - Homeless	277 South St.	M-F 8-5	Homeless/disabled/single	(805) 541-5144 x110
	Transitions Mental Health Association	277 South St.	M-F 8-5		(805) 541-5144
	Veteran's Services Office	601 Grand Av	M-F 9:00-5:00		(805) 781-5766
	Women's Shelter	P.O. Box 125, SLO	24/7	Women & child domestic violence victims	(805) 781-6400
Clothing	Assistance League	1500 Lizzie St	Tu/Th 3-6; Sat.9-12	Referral from DSS	(805) 782-0824
	EOC Homeless Services/Case Management	736 Orcutt Rd	24/7		(805) 541-6351
	Grassroots II	11545 Los Osos Valley Rd	M-F 10-2:00		(805) 544-2333
	Interfaith Coalition for Homeless	P. O Box 1575, SLO			(805) 756-5883
	Maxine Lewis Shelter	736 Orcutt Rd	5:00 pm - 7:15 am	18+, sober	(800) 549-8989
	Prado Day Center EOC	43 Prado Rd	8:30-4:30		(805) 786-0617
	Salvation Army - San Luis Obispo	815 Islay St			(805) 544-2401
	SLCUSD Homeless Liaison	1300 Lizzie St	M-F 8:00 - 4:00	K-12 & families	(805) 549-1219
	St. Vincent De Paul Society	751 Palm St		Homeless	(805) 544-7041
	Transitions Mental Health Association	277 South St.			(805) 541-5144

SERVICES FOR THE HOMELESS IN THE CITY OF SAN LUIS OBISPO

Service Provided	Organization & Website link	Address	Hours	Eligibility Conditions	Telephone
Drug Counseling	Community Health Centers (CHC)	1551 Bishop Street #A160	M-F 8-7, Sat 9-5		(805) 269-1500
	Drug & Alcohol Services	2945 McMillan Av	M-F 8:00-5:00		(805) 781-4753
	Friendly Syringe Exchange Program	2191 Johnson Ave	W 5:30-7:30	IV drug user	(805) 235-8044
	Gryphon Society Sober Living	1259 Stafford St	24/7	Drug & alcohol parolees	(805) 550-8140
	Lifesteps Foundation	3450 Broad St	24/7	Moms	(800) 530-5433
	Maxine Lewis Shelter	736 Orcutt Rd	5:00 pm - 7:15 am	18+, sober	(805) 781-3993
	Prado Day Center EOC	43 Prado Rd	8:30-4:30		(805) 786-0617
	Sunny Acres	10340 Los Osos Valley Rd	24/7	Clean & sober	(805) 543-4918
Educational Services	AIDS Support Network	1320 Nipomo St	M-Th 9-5/F 9-3	HIV Positive	(805) 781-3660
	Child Abuse Prevention Council	1110 California Blvd	as needed		(805) 543-6216
	County Office of Education	3350 Education Dr.	M-F 8-5	K-12 children	(805) 782-7209
	Department of Social Services	3433 S. Higuera	M-F 8-5	Child Welfare/CalWORKs/Gen. Assistance	(805) 781-1600
	Drug & Alcohol Services	2945 McMillan Av	M-F 8-5		(805) 781-4753
	EOC Homeless Services/Case Management	736 Orcutt Rd	24/7		(805) 541-6351
	Friendly Syringe Exchange Program	2191 Johnson Ave	W 5:30-7:30	IV drug user	(805) 235-8044
	Homeless Outreach Program/T-MHA	277 South Street, Suite T	M-F 7-4:30	Homeless/mentally ill	(805) 541-5144 x179
	Independent Living Resource Center	1150 Laurel Lane	M-F 9-12/1-5	Disabled	(805) 593-0667
	Lifesteps Foundation	3450 Broad St	24/7	Moms	(800) 530-5433
	Peoples Self Help Housing	3533 Empleo St.	M-F 8-5		(805) 781-3088
	Public Health Department	P.O. Box 1489, SLO	M-F 8-5		(805) 781-5500
	SLCUSD Homeless Liaison	1300 Lizzie St	M-F 8:00 - 4:00	K-12 & families	(805) 549-1219
	SLO Hep C Project	P.O.Box 12158, SLO	M-Th 9-5/F 9-3	Hep. C +	(805) 543-4372
	Sunny Acres	10340 Los Osos Valley Rd.	24/7	Clean & sober	(805) 543-4918
	Transitional Housing - Homeless	277 South St.	M-F 8:00-5:00	Homeless/disabled/single	(805) 541-5144 x110
	Women's Shelter	P.O. Box 125, SLO	24/7	Women & child domestic violence victims	(805) 781-6400
Emergency Assistance	AIDS Support Network	1320 Nipomo St	M-Th 9-5 / F 9-3	HIV Positive	(805) 781-3660
	Catholic Charities	751 Palm St.	M-F 8-5		(805) 541-9110
	Dep. Of Soc. Services - Adult Protection	3433 S. Higuera	24/7	Elderly/disabled	(805) 788-2504
	Department of Social Services	3433 S. Higuera	M-F 8-5	Child Welfare/CalWORKs/Gen. Assistance	(805) 781-1600
	EOC Eviction Prevention Program	1030 Southwood St	M-F 8-5	Eviction Notice	(805) 544-4355
	EOC Homeless Services/Case Management	736 Orcutt Rd	24/7		(805) 541-6351
	Grassroots II	11545 Los Osos Valley Rd	M-F 10-2:00		(805) 544-2333
	Green Pastures	981 Marsh St	W 1:00-3:45		(805) 543-5451
	Housing Authority	487 Leff Street	M-F 8-5		(805) 543-4478
	Maxine Lewis Shelter	736 Orcutt Rd	5:00 pm - 7:15 am	18+, sober	(800) 549-8989
	Prado Day Center EOC	43 Prado Rd	8:30-4:30		(805) 786-0617
	Salvation Army - San Luis Obispo	815 Islay St			(805) 544-2401

Revised 01/15/08

SERVICES FOR THE HOMELESS IN THE CITY OF SAN LUIS OBISPO

Service Provided	Organization & Website link	Address	Hours	Eligibility Conditions	Telephone
	St. Stephans	1344 Nipomo St			(805) 543-7212
	St. Vincent De Paul Society	751 Palm St		Homeless	(805) 544-7041
	Transitional Food & Shelter Program	P.O. Box 1720, SLO			(805) 239-4996
	Women's Shelter	P.O. Box 125, SLO	24/7	Women & child domestic violence victims	(805) 781-6400
	AIDS Support Network	1320 Nipomo St	M-Th 9-5/F 9-3	HIV Positive	(805) 781-3660
	EOC Eviction Prevention Program	1030 Southwood St	M-F 8-5	Eviction Notice	(805) 544-4355
	EOC Homeless Services/Case Management	736 Orcutt Rd	24/7		(805) 541-6351
	God's Store House	1603 Sydney St	11:30 - 1:30 pm. Sat only		(805) 544-8925
	Grassroots II	11545 Los Osos Valley Rd	T-Th 10:00 - 12:00		(805) 544-2333
	Green Pastures	981 Marsh St	W 1:00-3:45		(805) 543-5451
	Interfaith Coalition for Homeless	P. O Box 1575, SLO			(805) 756-5883
Food / Groceries	Salvation Army - San Luis Obispo	815 Islay St	M-Th 9:30 - 1:00	ID & SLO or Avila resident	(805) 544-2401
	Senior Brown Bag	1445 Santa Rosa Ave.	9:00am. 2nd & 4th Tue	Application, Need--based	(805) 238-4664
	Senior Brown Bag	421 Dana St.	9:30 am. 4th Tue	Application, Need--based	(805) 238-4664
	SLO Harvest Bag	1010 Foothill Blvd	9:30 - 10:30. Wed only	Prepay $2.50/bag	(805) 489-4223
	SLO Hep C Project	1320 Nipomo	M-F 9-5	HIV, Hep C+ FD.	(805) 781-3660
	SLO Hep C Project	P.O.Box 12158, SLO	M-Th 9-5/F 9-3	Hep C +	(805) 543-4372
	St. Vincent De Paul Society	751 Palm St.		Homeless	(805) 544-7041
	USDA Food Distribution	1445 Santa Rosa Ave.	8:30 am. 1st Tue	Application, Need--based	(805) 238-4664
	USDA Food Distribution	815 Islay St	9:30am. 1st Mon	Application, Need--based	(805) 238-4664
	EOC Homeless Services/Case Management	736 Orcutt Rd	24/7		(805) 541-6351
	Grassroots II	11545 Los Osos Valley Rd	M-F 10-2:00		(805) 544-2333
Furniture	Salvation Army - San Luis Obispo	815 Islay St			(805) 544-2401
	SLCUSD Homeless Liaison	1300 Lizzie St	M-F 8:00 - 4:00	K-12 & families	(805) 549-1219
	Transitional Housing - Homeless	277 South St.	M-F 8-5	Homeless/disabled/single	(805) 541-5144 x110
	Transitions Mental Health Association	277 South St.			(805) 541-5144
	Women's Shelter	P.O. Box 125, SLO	24/7	Women & child domestic violence victims	(805) 781-6400
	Gryphon Society Sober Living	1259 Stafford St	24/7	Drug & alcohol parolees	(805) 550-8140
Housing - Emergency Shelter	Interfaith Coalition for Homeless	P. O Box 1575, SLO			(805) 756-5883
	Maxine Lewis Shelter	736 Orcutt Rd	5:00 pm - 7:15 am	18+, sober	(800) 549-8989
	Prado Day Center EOC	43 Prado Rd	8:30-4:30		(805) 786-0617
	Women's Shelter	P.O. Box 125, SLO	24/7	Women & child domestic violence victims	(805) 781-6400
	AIDS Support Network	1320 Nipomo St	M-Th 9-5/F 9-3	HIV Positive	(805) 781-3660
Housing - Motel Vouchers	Department of Social Services	3433 S. Higuera	M-F 8-5	Child Welfare/CalWORKs/Gen. Assistance	(805) 781-1600
	EOC Homeless Services/Case Management	736 Orcutt Rd	24/7		(805) 541-6351
	Grassroots II	11545 Los Osos Valley Rd	M-F 10-2:00		(805) 544-2333
	Green Pastures	981 Marsh St	W 1:00-3:45		(805) 543-5451

Revised 01/15/08

SERVICES FOR THE HOMELESS IN THE CITY OF SAN LUIS OBISPO

Service Provided	Organization & Website link	Address	Hours	Eligibility Conditions	Telephone
	Homeless Outreach Program/T-MHA	277 South Street, Suite T	M-F 7-4:30	Homeless/mental illness	(805) 541-5144 x179
	Maxine Lewis Shelter	736 Orcutt Rd	5:00 pm - 7:15 am	18+, sober	(800) 549-8989
	Prado Day Center EOC	43 Prado Rd	8:30-4:30		(805) 786-0617
	Women's Shelter	P.O. Box 125, SLO	24/7	Women & child domestic violence victims	(805) 781-6400
	AIDS Support Network	1320 Nipomo St	M-Th 9-5/F 9-3	HIV Positive	(805) 781-3660
	Department of Social Services	3433 S. Higuera	M-F 8-5	Child Welfare/CalWORKs/Gen. Assistance	(805) 781-1600
	Housing Authority	487 Leff Street	M-F 8-5		(805) 543-4478
Housing - Permanent	Peoples Self Help Housing	3533 Empleo St.		Income	(805) 781-3088
	Sunny Acres	10340 Los Osos Valley Rd	24/7	Clean & sober	(805) 543-4918
	Supportive Housing Consortium	3433 S. Higuera			(805) 772-6460
	Transitions Mental Health Association	277 South St.			(805) 541-5144
	AIDS Support Network	1320 Nipomo St	M-Th 9-5/F 9-3	HIV Positive	(805) 781-3660
	Catholic Charities	751 Palm St.			(805) 541-9110
	Department of Social Services	3433 S. Higuera	M-F 8-5	Child Welfare/CalWORKs/Gen. Assistance	(805) 781-1600
	EOC Eviction Prevention Program	1030 Southwood St	M-F 8-5	Eviction Notice	(805) 544-4355
Housing - Rental Assistance	EOC Homeless Services/Case Management	736 Orcutt Rd	24/7		(805) 541-6351
	Green Pastures	981 Marsh St	W 1:00-3:45		(805) 543-5451
	Housing Authority	487 Leff Street	M-F 8-5		(805) 543-4478
	Salvation Army - San Luis Obispo	815 Islay St			(805) 544-2401
	St. Vincent De Paul Society	751 Palm St.		Homeless	(805) 544-7041
	Transitional Food & Shelter Program	P.O. Box 1720, SLO			(805) 239-4996
	Transitional Housing - Homeless	277 South St.	M-F 8-5	Homeless/disabled/single	(805) 541-5144 x110
	Alpha Academy	P.O. Box 3158, SLO	24/7	Male 18+	(805) 596-0433
	Behavioral Health Services	2178 Johnson Ave.			(805) 781-4700
	Department of Social Services	3433 S. Higuera	M-F 8-5	Child Welfare/CalWORKs/Gen. Assistance	(805) 781-1600
	Gryphon Society Sober Living	1259 Stafford St	24/7	Drug & alcohol parolees	(805) 550-8140
	Homeless Outreach Program/T-MHA	277 South Street, Suite T	M-F 7-4:30	Homeless/mental illness	(805) 541-5144 x179
Housing - Temporary	Housing Authority	487 Leff Street	M-F 8-5		(805) 543-4478
	Lifesteps Foundation	3450 Broad St	24/7	Moms	(800) 530-5433
	Supportive Housing Consortium	3433 S. Higuera			(805) 772-6460
	Transitional Food & Shelter Program	P.O. Box 1720, SLO			(805) 239-4996
	Transitional Housing - Homeless	277 South St.	M-F 8-5	Homeless/disabled/single	(805) 541-5144 x110
	Transitions Mental Health Association	277 South St.	M-F 8-5		(805) 541-5144
	Veteran's Services Office	801 Grand Av.	M-F 8-5		(805) 781-5766

Revised 01/15/08

SERVICES FOR THE HOMELESS IN THE CITY OF SAN LUIS OBISPO

Service Provided	Organization & Website link	Address	Hours	Eligibility Conditions	Telephone
Meals	Gryphon Society Sober Living	1259 Stafford St	24/7	Drug & alcohol parolees	(805) 550-8140
	Interfaith Coalition for Homeless	P. O Box 1575, SLO			(805) 756-5883
	Maxine Lewis Shelter	736 Orcutt Rd	Daily 6:00-7:00 am & pm	18+, sober	(800) 549-8989
	People's Kitchen	539 Cerro Romauldo	Daily 11:30-1:00		(805) 544-8047
	Prado Day Center EOC	43 Prado Rd	12:00 noon daily		(805) 786-0617
	Senior Nutrition Program	955 Monterey Ave	M-F. 11:30 - 12:00	Pre-enroll. Aged 60 + & nutritionally needy	(805) 543-0469
	SLO United Methodist Church	1515 Fredericks St			(805) 544-7302
	Women's Shelter	P.O. Box 125, SLO	24/7	Women & child domestic violence victims	(805) 781-6400
Medical Assistance	Behavioral Health Services	2178 Johnson Ave.	M-F 8-5		(805) 781-4700
	Community Health Centers (CHC)	1551 Bishop Street #A160	M-F 8-7, Sat 9-5		(805) 269-1500
	County Office of Education	3350 Education Dr.	M-F 8-5	K-12 children	(805) 782-7209
	Department of Social Services	3433 S. Higuera	M-F 8-5	Income/disability	(805) 781-1600
	Homeless Outreach Program/T-MHA	277 South Street, Suite T	M-F 7-4:30	Homeless/mental illness	(805) 541-5144 x179
	Maxine Lewis Shelter	736 Orcutt Rd	5:00 pm - 7:15 am	18+, sober	(805) 781-3993
	Prado Day Center EOC	43 Prado Rd	8:30-4:30		(805) 786-0617
	Public Health Department	2191 Johnson Ave.	M-F 8-5		(805) 781-5500
	Sierra Vista Hospital	1010 Murray Av	24/7	Hospitalized	(805) 546-7879
	Veteran's Services Office	801 Grand Av.	M-F 8-5	Veteran	(805) 781-5766
Mental Health Services	Behavioral Health Services	2178 Johnson Ave.	M-F 8-5		(805) 781-4700
	Child Abuse Prevention Council	1110 California Blvd	as needed	Includes post partum depression	(805) 543-6216
	Community Health Centers (CHC)	1551 Bishop Street #A160	M-F 8-7, Sat 9-5		(805) 269-1500
	Homeless Outreach Program/T-MHA	277 South Street, Suite T	M-F 7-4:30	Homeless / mental illness	(805) 541-5144 x179
	Mental Health Services	2178 Johnson Ave	M-F 8-5		(800) 838-1381
	Prado Day Center EOC	43 Prado Rd	8:30-4:30		(805) 786-0617
	SLCUSD Homeless Liaison	1300 Lizzie St	M-F 8:00 - 4:00	K-12 & families	(805) 549-1219
	Transitions Mental Health Association	277 South St.			(805) 541-5144
	Veteran's Services Office	801 Grand Av.	M-F 8-5		(805) 781-5766
Social Services	Alpha Academy	P.O. Box 3158, SLO	24/7	Male 18+	(805) 596-0433
	Catholic Charities	751 Palm St.			(805) 541-9110
	County Office of Education	3350 Education Dr.	M-F 8-5	K-12 children	(805) 782-7209
	Dep. Of Soc. Services - Adult Protection	3433 S. Higuera	24/7	Seniors/disabled	(805) 788-2504
	Department of Social Services	3433 S. Higuera	M-F 8-5	Child Welfare/CalWORKs/Gen. Assistance	(805) 781-1600
	EOC Eviction Prevention Program	1030 Southwood St	M-F 8-5	Eviction Notice	(805) 544-4355
	EOC Homeless Services/Case Management	736 Orcutt Rd	24/7		(805) 541-6351
	Grassroots II	11545 Los Osos Valley Rd	M-F 10-2:00		(805) 544-2333
	Green Pastures	981 Marsh St	W 1:00-3:45		(805) 543-5451
	Homeless Outreach Program/T-MHA	277 South Street, Suite T	M-F 7-4:30	Homeless/mental illness	(805) 541-5144 x179

Revised 01/15/08

SERVICES FOR THE HOMELESS IN THE CITY OF SAN LUIS OBISPO

Service Provided	Organization & Website link	Address	Hours	Eligibility Conditions	Telephone
	Independent Living Resource Center	1150 Laurel Lane	M-F 9-12/1-5	Disabled	(805) 593-0667
	Interfaith Coalition for Homeless	P. O Box 1575, SLO			(805) 756-5883
	Maxine Lewis Shelter	736 Orcutt Rd	5:00 pm - 7:15 am	18+, sober	(805) 781-3993
	Peoples Self Help Housing	3533 Empleo St.			(805) 781-3088
	Prado Day Center EOC	43 Prado Rd	8:30-4:30		(805) 786-0617
	Public Health Department	2178 Johnson Ave.			(805) 781-5500
	Transitional Housing - Homeless	277 South St.	M-F 8-5	Homeless/disabled/single	(805) 541-5144 x110
	Transitions Mental Health Association	277 South St.			(805) 541-5144
	Women's Shelter	P.O. Box 125, SLO	24/7	Women & child domestic violence victims	(805) 781-6400
Support Groups	AIDS Support Network	1320 Nipomo St	M-Th 9-5/F 9-3	HIV Positive	(805) 781-3660
	EOC Homeless Services/Case Management	736 Orcutt Rd	24/7		(805) 541-6351
	Gryphon Society Sober Living	1259 Stafford St	24/7	Drug & alcohol parolees	(805) 550-8140
	Independent Living Resource Center	1150 Laurel Lane	M-F 9-12/1-5	Disabled	(805) 593-0667
	Maxine Lewis Shelter	736 Orcutt Rd	5:00 pm - 7:15 am	Homeless, 18+	(805) 781-3993
	Prado Day Center EOC	43 Prado Rd	8:30-4:30		(805) 786-0617
	SLO Hep C Project	1320 Nipomo	M-F 9-5	HIV, Hep C+	(805) 781-3660
	Transitional Housing - Homeless	277 South St.	M-F 8-5	Homeless/disabled/single	(805) 541-5144 x110
Transportation	AIDS Support Network	1320 Nipomo St	M-Th 9-5/F 9-3	HIV Positive	(805) 781-3660
	Behavioral Health Services	2178 Johnson Ave.	M-F 8-5		(805) 781-4700
	County Office of Education	3350 Education Dr.	M-F 8-5	K-12 children	(805) 782-7209
	Department of Social Services - Adult Protection	3433 S. Higuera	24/7	Elderly/disabled	(805) 788-2504
	Drug & Alcohol Services	2945 McMillan Av	M-F 8-5		(805) 781-4753
	EOC Homeless Services/Case Management	736 Orcutt Rd	24/7		(805) 541-6351
	Maxine Lewis Shelter	736 Orcutt Rd	5:00 pm - 7:15 am	Homeless, 18+, sober	(805) 781-3993
	SLO Hep C Project	1320 Nipomo	M-F 9-5	HIV, Hep C+	(805) 781-3660

Revised 01/15/08

SERVICES FOR THE HOMELESS ON THE NORTH COAST – CAMBRIA, CAYUCOS, MORRO BAY & LOS OSOS

Service Provided	Service Location	Address	Organization	Hours	Eligibility Conditions	Telephone
Case Management Services	Cambria	2515 Main Street, Suite B	Community Health Centers (CHC)	M-T 9-5 F 9-1		(805) 927-5292
	Morro Bay	445 Chorro Creek	Chorro Creek Ranch	24/7	Adults	(805) 772-5815
		660 Harbor Boulevard	Community Health Centers (CHC)	M-W-F 9-6, T&Th 1:30-8:30, Sat 8-12		(805) 771-8489
		1130 D Napa Ave	Dep. Of Soc. Services - Adult Services	M-F 8-5	Elderly/disabled	(805) 781-1704
		1130 D Napa Ave	Department of Social Services	M-F 8-5	CalWORKs/Child Welfare	(805) 772-6495
Drug Counseling	Cambria	2515 Main Street, Suite B	Community Health Centers (CHC)	M-T 9-5 F 9-1		(805) 927-5292
	Morro Bay	660 Harbor Boulevard	Community Health Centers (CHC)	M-W-F 9-6, T&Th 1:30-8:30, Sat 8-12		(805) 771-8489
Educational Services	Morro Bay	1130 D Napa Ave	Department of Social Services	M-F 8-5	CalWORKs/Child Welfare	(805) 772-6495
Emergency Assistance	Morro Bay	1130 D Napa Ave	Dep. Of Soc. Services - Adult Services	M-F 8-5	Elderly/disabled	(805) 781-1704
		1130 D Napa Ave	Department of Social Services	M-F 8-5	CalWORKs/Child Welfare	(805) 772-6495
Food / Groceries	Cambria	950 Main Street	Cambria Anonymous Neighbors	8:00 am. 1st Thur	I.D.	(805) 927-5673
		950 Main Street	USDA Food Distribution	9:00 am. 1st Thur	Application, Need--based	(805) 238-4664
		950 Main Street	Vineyard Christian Fellowship	3:00 - 4:00. 2nd & 4th Thur		(805) 927-5550
	Cayucos	200 S. Ocean	USDA Food Distribution	10:00 am. 1st Thur	Application, Need--based	(805) 238-4664
	Los Osos	1480 Santa Ysabel	Church of the Nazarene	9:30 - 11:00 am Tuesdays	$2.00 donation	(805) 528-0391
	Morro Bay	445 Chorro Creek	Chorro Creek Ranch	24/7	Adults	(805) 772-5815
		540 Quintana	Salvation Army			(805) 772-7062
		209 Surf	Senior Brown Bag	10:00 am. 1st Fri	Application, Need--based	(805) 238-4664
		209 Surff	USDA Food Distribution	10:00 am. 3rd Fri	Application, Need--based	(805) 238-4664
Furniture	Morro Bay	445 Chorro Creek	Chorro Creek Ranch	24/7	Adults	(805) 772-5815
Housing - Emergency Shelter	Morro Bay	445 Chorro Creek	Chorro Creek Ranch	24/7	Adults	(805) 772-5815
Housing - Motel Vouchers	Morro Bay	1130 D Napa Ave	Department of Social Services	M-F 8-5	CalWORKs/Child Welfare	(805) 772-6495
Housing - Permanent	Morro Bay	445 Chorro Creek	Chorro Creek Ranch	24/7	Adults	(805) 772-5815
		1130 D Napa Ave	Department of Social Services	M-F 8-5	CalWORKs/Child Welfare	(805) 772-6495
Housing - Rental Assistance	Morro Bay	1130 D Napa Ave	Department of Social Services	M-F 8-5	CalWORKs/Child Welfare	(805) 772-6495
Housing - Temporary	Morro Bay	445 Chorro Creek	Chorro Creek Ranch	24/7	Adults	(805) 772-5815
		1130 D Napa Ave	Department of Social Services	M-F 8-5	CalWORKs/Child Welfare	(805) 772-6495
Meals	Cambria	2700 Eton	Senior Nutrition Program	M-F 12:00 noon	Pre-enrollment. Over 60 & nutritionally needy	(805) 927-1268
	Los Osos	2180 Palisades	Senior Nutrition Program	M-F 11:45 am	Pre-enrollment. Over 60 & nutritionally needy	(805) 528-6923
	Morro Bay	445 Chorro Creek	Chorro Creek Ranch	24/7	Adults	(805) 772-5815
		1001 Kennedy	Senior Nutrition Program	M-F 11:45 am	Pre-enrollment. Over 60 & nutritionally needy	(805) 772-4422
Medical Assistance	Cambria	2515 Main Street, Suite B	Community Health Centers (CHC)	M-T 9-5 F 9-1		(805) 927-5292
	Morro Bay	660 Harbor Boulevard	Community Health Centers (CHC)	M-W-F 9-6, T&Th 1:30-8:30, Sat 8-12		(805) 771-8489

Revised 01/08/2008

SERVICES FOR THE HOMELESS ON THE NORTH COAST – CAMBRIA, CAYUCOS, MORRO BAY & LOS OSOS

		1130 D Napa Ave	Department of Social Services	**M-F 8-5**	**Income/disability**	(805) 772-6495
		760 Morro Bay Blvd	Public Health Services	**M-F 8-5**		(805) 772-6380
Mental Health Services	Cambria	2515 Main Street, Suite B	Community Health Centers (CHC)	**M-T 9-5 F 9-1**		(805) 927-5292
	Morro Bay	445 Chorro Creek	Chorro Creek Ranch	**24/7**	**Adults**	(805) 772-5815
		660 Harbor Boulevard	Community Health Centers (CHC)	**M-W-F 9-6, T&Th 1:30-8:30, Sat 8-12**		(805) 771-8489
		445 Chorro Creek	Chorro Creek Ranch	**24/7**	**Adults**	(805) 772-5815
Social Services	Morro Bay	1130 D Napa Ave	Dep. Of Soc. Services - Adult Services	**M-F 8-5**	**Seniors/disabled**	(805) 781-1704
		1130 D Napa Ave	Department of Social Services	**M-F 8-5**	**CalWORKs/Child Welfare**	(805) 772-6495

SERVICES FOR THE HOMELESS IN ATASCADERO AND SURROUNDING COMMUNITIES

Service Provided	Service Location	Address & Map link	Organization & Website link	Hours	Eligibility Conditions	Telephone
Case Management Services	Atascadero	6495 Lewis Ave.	Atascadero Community LINK	7:00 - 5:00		(805) 466-5465
		5575 Capistrano Ave.	Community Health Centers (CHC)	M-F 8-7		(805) 792-1400
		9415 El Camino Real	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs/GA	(805) 461-6000
		5575 Hospital Drive	Mental Health Services	M-F 8-5		(805) 461-6060
	Templeton	1050 Las Tablas Road #16	Community Health Centers (CHC)	M-F 9-6	Dental	(805) 434-1038
Drug Counseling	Atascadero	6495 Lewis Ave	Atascadero Community LINK	7:00 - 5:00		(805) 466-5465
		5575 Capistrano Ave.	Community Health Centers (CHC)	M-F 8-7		(805) 792-1400
		8600 Atascadero Ave.	North County Connection	M-F 9:00 to 5:00		(805) 462-8600
	Templeton	1050 Las Tablas Road #16	Community Health Centers (CHC)	M-F 9-6	Dental	(805) 434-1038
Educational Services	Atascadero	9415 El Camino Real	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs/GA	(805) 461-6000
		5575 Hospital Drive	Mental Health Services	M-F 8-5		(805) 461-6060
Emergency Assistance	Atascadero	6495 Lewis Ave	Atascadero Community LINK	7:00 - 5:00		(805) 466-5465
		9415 El Camino Real	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs/GA	(805) 461-6000
		5411 El Camino Real	Loaves & Fishes	M-F 1-3	Photo ID	(805) 238-9896
		5411 El Camino Real	Salvation Army	MWF appt or 12-2:30	I.D.	(805) 466-7201
Food / Groceries	Atascadero	6495 Lewis Ave	Atascadero Community LINK	7:00 - 5:00		(805) 466-5465
		5035 Palma	Harvest Bag		$3.00/bag paid in advance	(805) 489-4223
		5411 El Camino Real	Loaves & Fishes	M-F 1-3	Photo ID	(805) 238-9896
		5035 Palma	Senior Brown Bag	9:00am. 2nd & 4th Wed	Application, Need--based	(805) 238-4664
		5035 Palma	USDA Food Distribution	9:30 am. 1st Wed	Application, Need--based	(805) 238-4664
	California Valley	13080 Soda Lake Rd.	Harvest Bag		$3.00/bag paid in advance	(805) 489-4223
		13080 Soda Lake Rd.	USDA Food Distribution	11:00 am. 1st Fri	Application, Need--based	(805) 238-4664
	Santa Margarita	2201 H St.	Harvest Bag	9:00 am. 2nd & 4th Wed	$3.00/bag paid in advance	(805) 438-5412
		2201 H St.	Senior Brown Bag	10:00 am. 3rd Wed	Application, Need--based	(805) 438-5854
		2201 H St.	USDA Food Distribution	9:30 am. 1st Wed	Application, Need--based	(805) 238-4664
	Templeton	600 Vineyard	Full Life Outreach	By appointment only		(805) 434-5650
Housing - Emergency Shelter	Atascadero	6370 Atascadero Ave.	ECHO	5pm-7:30 am		(805) 462-3662
		8145 El Camino Real	North County Women's Shelter	24/7	Domestic Violence victims	(805) 461-1338
Housing - Motel Vouchers	Atascadero	6495 Lewis Ave	Atascadero Community LINK	7:00 - 5:00	N/A	(805) 466-5465
		9415 El Camino Real	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs/GA	(805) 461-6000
Housing - Permanent	Atascadero	9415 El Camino Real	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs/GA	(805) 461-6000
Housing - Rental Assistance	Atascadero	6495 Lewis Ave	Atascadero Community LINK	7:00 - 5:00		(805) 466-5465
		9415 El Camino Real	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs/GA	(805) 461-6000
		6370 Atascadero Ave.	ECHO	5pm-7:30 am		(805) 462-3662
		5411 El Camino Real	Salvation Army	MWF appt or 12-2:30	ID. Once in a lifetime	(805) 466-7201
Housing -	Atascadero	9415 El Camino Real	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs/GA	(805) 461-6000

Revised 10/05/2007

SERVICES FOR THE HOMELESS IN ATASCADERO AND SURROUNDING COMMUNITIES

Temporary

Meals	Atascadero	6370 Atascadero Ave. ECHO	**M-F 5:00 - 6:30pm.**		(805) 462-3663
		5905 C East Mall Senior Nutrition Program	**M-F 11:30 am**	**Pre-enrollment, over 60 & nutritionally needy**	(805) 466-2317
	Santa Margarita	2201 H St. Senior Nutrition Program	**M-F 12:00 noon**	**Pre-enrollment, over 60 & nutritionally needy**	(805) 438-5854
Medical Assistance	Atascadero	5575 Capistrano Ave. Community Health Centers (CHC)	**M-F 8-7**		(805) 792-1400
		9415 El Camino Real Department of Social Services	**M-F 8-5**	**Income/disability**	(805) 461-6000
		6370 Atascadero Ave. ECHO	**5pm - 7:30 am**		(805) 462-3662
	Templeton	1050 Las Tablas Road #16 Community Health Centers (CHC)	**M-F 9-6**	**Dental**	(805) 434-1038
Mental Health Services	Atascadero	6495 Lewis Ave Atascadero Community LINK	**7:00 - 5:00**		(805) 466-5465
		5575 Capistrano Ave. Community Health Centers (CHC)	**M-F 8-7**		(805) 792-1400
		5575 Hospital Drive Mental Health Services	**M-F 8-5**		(805) 461-6060
		8145 El Camino Real North County Women's Shelter	**24/7**	**Domestic Violence victims**	(805) 461-1338
	Templeton	1050 Las Tablas Road #16 Community Health Centers (CHC)	**M-F 9-6**	**Dental**	(805) 434-1038
Social Services	Atascadero	6495 Lewis Ave Atascadero Community LINK	**7:00 - 5:00**		(805) 466-5465
		9415 El Camino Real Department of Social Services	**M-F 8-5**	**Child Welfare/CalWORKs/GA**	(805) 461-6000
		8145 El Camino Real North County Women's Shelter	**24/7**	**Domestic Violence victims**	(805) 461-1338
Support Groups	Atascadero	8600 Atascadero Ave North County Connection	**See website**		(805) 462-8600

Revised 10/05/2007

SERVICES FOR THE HOMELESS IN NORTHERN SAN LUIS OBISPO COUNTY – SAN MIGUEL & SHANDON

Service Provided	Service Location	Address	Organization & website link	Hours	Eligibility Conditions	Telephone
Food / Groceries	San Miguel	801 Mission	San Miguel Old Mission	Call first	Call first	(805) 467-3256
		601 12th St	Senior Brown Bag	9:00am. 3rd Thur	Application, Need--based	(805) 238-4664
		601 12th St	USDA Food Distribution	10:00 am. 1st Thur	Application, Need--based	(805) 238-4664
	Shandon	105 2nd St	Senior Brown Bag	10:30 - 11:30. 3rd Friday	Application, Need--based	(805) 238-0378
		105 2nd St	USDA Food Distribution	10:30 - 11:30 am. 1st Thur	Application, Need--based	(805) 238-4664
Meals	San Miguel	1383 Mission	Casa San Miguel	M-F 8:00-10:30 am.		(805) 467-2606
		601 12th St	Senior Nutrition Program	M-F 12:00 noon	Pre-enrollment. Over 60 & nutritionally needy	(805) 467-3445
	Shandon	101 W Center	Senior Nutrition Program	M-F 12:00 noon	Pre-enrollment. Over 60 & nutritionally needy	(805) 238-4664

SERVICES FOR THE HOMELESS IN PASO ROBLES

Service Provided	Organization & website link	Address	Hours	Eligibility Conditions	Telephone
Case Management Services	Community Health Centers (CHC)	345 Spring Street	M-W-F 9-6, T&Th 10:30-7:30, Sat 9-5		(805) 238-7250
	Department of Social Services	530 12th St.	M-F 8-5	Child Welfare/CalWORKs/General Assistance	(805) 237-3110
	Mental Health Services	1030 Vine Street	M-F 8-5		(805) 237-3170
	Transitional Food and Shelter Inc.	3770 North River Road			(805) 238-7056
Clothing	Christ's Kitchen / Second Baptist Church	1937 Riverside Ave.	11:30 a.m. - 12:30 p.m.		(805) 238-2011
	Loaves & Fishes	2650 Spring St	M-F 2:00 - 4:00, Thur 5:30 - 7:00		(805) 238-4742
	Salvation Army - Paso Robles	717 Paso Robles St.			(805) 238-9591
	Transitional Food & Shelter Program	1937 Riverside Ave.			(805) 239-4996
Drug Counseling	Community Health Centers (CHC)	345 Spring Street	M-W-F 9-6, T&Th 10:30-7:30, Sat 9-5		(805) 238-7250
Educational Services	Department of Social Services	530 12th St.	M-F 8-5	CalWORKs	(805) 237-3110
	Mental Health Services	1030 Vine Street	M-F 8-5		(805) 237-3170
Emergency Assistance	Department of Social Services	530 12th St.	M-F 8-5	Child Welfare/CalWORKs/General Assistance	(805) 237-3110
	People's Kitchen	1937 Riverside Ave.	5:00 - 6:00 p.m.		(805) 238-4015
	Salvation Army - Paso Robles	717 Paso Robles St.			(805) 238-9591
	Transitional Food and Shelter Inc.	3770 North River Road			(805) 238-7056
Food / Groceries	Food Bank Coalition of SLO County	2212 Golden Hill Road	M-F 8-5		(805) 238-4664
	Harvest Bag	715 24th St.	6:00 pm Wed only	$3.00/bag paid in advance	(805) 226-8181
	Loaves & Fishes	2650 Spring St	M-F 2:00 - 4:00, 3rd Thur 5:30		(805) 238-4742
	Salvation Army - Paso Robles	717 Paso Robles St.			(805) 238-9591
	Senior Brown Bag	3050 Park St	9:00 am. 2nd & 4th Wed	Application, Need--based	(805) 238-4664
	Senior Brown Bag	535 Creston Rd	9:00 am. 2nd & 4th Thur	Application, Need--based	(805) 238-4664
	Twin Cities Vineyard Christian Fellowship	1332 Vendels Circle	6:00 pm. Last 2 Fri of month		(805) 237-7777
	USDA Food Distribution	1937 Riverside Ave.	9:00 am. 1st Thur	Application, Need--based	(805) 238-4664
	USDA Food Distribution - Lake Nacimiento	2085 Gateway Dr.	10:00 am. 1st Tue	Application, Need--based	(805) 238-4664
	USDA Food Distribution	2650 Spring St.	5:30 pm. 3rd Tue	Application, Need--based	(805) 238-4664
Housing - Motel Vouchers	Department of Social Services	530 12th St.	M-F 8-5	Child Welfare/CalWORKs/General Assistance	(805) 237-3110
	Transitional Food & Shelter Program	3770 North River Road			(805) 238-7056
Housing - Permanent	Department of Social Services	530 12th St.	M-F 8-5	Child Welfare or CalWORKs	(805) 237-3110
	People's Kitchen	1937 Riverside Ave.	5:00 - 6:00 p.m.		(805) 238-4015
Housing - Rental Assistance	Department of Social Services	530 12th St.	M-F 8-5	Child Welfare/CalWORKs/General Assistance	(805) 237-3110
	People's Kitchen	1937 Riverside Ave.	5:00 - 6:00 p.m.		(805) 238-4015
	Salvation Army - Paso Robles	717 Paso Robles St.			(805) 238-9591
Housing - Temporary	Department of Social Services	530 12th St.	M-F 8-5	Child Welfare/CalWORKs/General Assistance	(805) 237-3110
	Transitional Food and Shelter Inc.	3770 North River Road			(805) 238-7056
Meals	Christ's Kitchen / 2nd Baptist Church	1937 Riverside Ave.	11:30 a.m. - 12:30 p.m.		(805) 238-2011
	Senior Nutrition Program	270 Scott St.	M-F 11:30 am	60 +/ nutritional needy. Pre-enrollment	(805) 238-4831
	United Methodist Church	1344 Oak St.	Sat only 12:00-1:00pm		(805) 238-2006
Medical Assistance	Community Health Centers (CHC)	345 Spring Street	M-W-F 9-6, T&Th 10:30-7:30, Sat 9-5		(805) 238-7250

Revised 01/08/2008

SERVICES FOR THE HOMELESS IN PASO ROBLES

	Department of Social Services	530 12th St.	M-F 8-5	Income/disability	(805) 237-3110
	Public Health Services	723 Walnut Dr.	M-F 8-5		(805) 237-3050
Mental Health Services	Community Health Centers (CHC)	345 Spring Street	M-W-F 9-6, T&Th 10:30-7:30, Sat 9-5		(805) 238-7250
	Mental Health Services	1030 Vine Street	M-F 8-5		(805) 237-3170
	Transitional Food and Shelter Inc.	3770 North River Road			(805) 238-7056
Social Services	Department of Social Services	530 12th St.	M-F 8-5	Child Welfare/CalWORKs/General Assistance	(805) 237-3110
	Food Bank Coalition of SLO County	2212 Golden Hill Road	M-F 8-5		(805) 238-4664
	Transitional Food & Shelter Program	3770 North River Road			(805) 238-7056
Transportation	Transitional Food & Shelter Program	3770 North River Road			(805) 239-4996

SERVICES IN THE FIVE CITIES AREA – ARROYO GRANDE, OCEANO, GROVER BEACH, PISMO BEACH & SHELL BEACH

Service Provided	Service Location	Address	Organization & website link	Hours	Eligibility Conditions	Telephone
Case Management Services	Arroyo Grande	336 S. Halcyon	Community Health Centers (CHC)	M-F 8-7 Coastal Medical Center		(805) 481-3652
		1057 Grand Ave	Community Health Centers (CHC)	M-F 9-6 The Doctors Office		(805) 481-7220
		1086 Grand Ave	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 474-2000
		1106 East Grand Ave.	Drug & Alcohol Services	M-F 8-5		(805) 473-7080
		602 Orchard	Lucia Mar School District	M-F 8-5	Homeless children	(805) 474-3000 x4719
		1092 East Grand Ave	Mental Health Services	M-F 8-5		(805) 473-7060
		1086 Grand Ave	South County SAFE	M-F 8-5	Child Welfare	(805) 477-2037
	Grover Beach	815 West Grand Ave	Captive Hearts	24/7		(805) 481-4500
		383 S. 13th St	Casa Solana	24/7	Female addicts, ages 18-72	(805) 481-8555
		710 S. 13th St	Healthcare for Homeless Project	M-F 1:30 - 5:00		(805) 473-7970
	Oceano	1981 Cienaga Street	Community Health Centers (CHC)	M-F 9-6		(805) 270-0025
Clothing	Arroyo Grande	1086 Grand Ave	Department of Social Services	M-F 8-5	Income	(805) 474-2000
		602 Orchard	Lucia Mar School District	M-F 8-5	Homeless children	(805) 474-3000 x4719
		1086 Grand Ave	SAFE (AG/Nipomo/Oceano)	M-F 8-5		(805) 477-2037
	Grover Beach	815 West Grand Ave	Captive Hearts	24/7		(805) 481-4500
		710 S. 13th St	Healthcare for Homeless Project	M-F 1:30 - 5:00		(805) 473-7970
Drug Counseling	Arroyo Grande	336 S. Halcyon	Community Health Centers (CHC)	M-F 8-7 Coastal Medical Center		(805) 481-3652
		1057 Grand Ave	Community Health Centers (CHC)	M-F 9-6 The Doctors Office		(805) 481-7220
		1106 East Grand Ave.	Drug & Alcohol Services	M-F 8-5		(805) 473-7080
	Grover Beach	815 West Grand Ave	Captive Hearts	24/7		(805) 481-4500
		383 S. 13th St	Casa Solana	24/7	Female addicts, ages 18-72	(805) 481-8555
	Oceano	1981 Cienaga Street	Community Health Centers (CHC)	M-F 9-6		(805) 270-0025
Educational Services	Arroyo Grande	1086 Grand Ave	Department of Social Services	M-F 8-5	CalWORKs	(805) 474-2000
		1106 East Grand Ave.	Drug & Alcohol Services	M-F 8-5		(805) 473-7080
		1092 East Grand Ave	Mental Health Services	M-F 8-5		(805) 473-7060
	Grover Beach	815 West Grand Ave	Captive Hearts	24/7		(805) 481-4500
Emergency Assistance	Arroyo Grande	1086 Grand Ave	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 474-2000
	Grover Beach	710 S. 13th St	Healthcare for Homeless Project	M-F 1:30 - 5:00		(805) 473-7970
Food / Groceries	Arroyo Grande	1086 Grand Ave	SAFE (AG/Nipomo/Oceano)	M-F 8-5		(805) 474-2037
		501 Fair Oaks Ave.	St. Patricks Catholic Church	4:00-5:00 Tue, Wed, Thur.	South county resident + interview	(805) 489-2680
	Grover Beach	192-B South 9th St.	5-Cities Christian Woman's Food Ministry	2:00-4:00 M-F except holidays	ID & Five Cities resident. 2x/month max.	(805) 473-3368
		815 West Grand Ave	Captive Hearts	24/7		(805) 481-4500
		383 S. 13th St	Casa Solana	24/7	Female addicts, ages 18-72	(805) 481-8555
		710 S. 13th St	Healthcare for Homeless Project	M-F 1:30 - 5:00		(805) 473-7970

Revised 01/08/2008

SERVICES IN THE FIVE CITIES AREA – ARROYO GRANDE, OCEANO, GROVER BEACH, PISMO BEACH & SHELL BEACH

		1197 Highland	Salvation Army	Tue, Wed, Thur 9-2	ID & Five Cities resident	(805) 481-0278
	Oceano	1820 Railroad	Food Bank Coalition of SLO County	M-F 8-5		(805) 481-4652
		1580 Railroad	Harvest Bag	9:00 - 10:00 1st Thurs only	$2.50/bag paid in advance	(805) 481-7886
		1866 Beach	Salvation Army	Tue, Wed, Thur 9-2	ID & Five Cities resident	(805) 481-0278
		1580 Railroad	Senior Brown Bag	9:00 am. 2nd & 4th Thur	Application, Need--based	(805) 481-7886
		1580 Railroad	USDA Food Distribution	9:00 am. 1st Thur	Application, Need--based	(805) 238-4664
	Arroyo Grande	602 Orchard	Lucia Mar School District	M-F 8-5	Homeless children	(805) 474-3000 x4719
Meals	Grover Beach	815 West Grand Ave	Captive Hearts	24/7		(805) 481-4500
		383 S. 13th St	Casa Solana	24/7	Female addicts, ages 18-72	(805) 481-8555
		946 Rockaway	People's Kitchen	M-Sat. 12-1:00, Sun 12:30-2:00		(805) 489-2150
	Oceano	1580 Railroad	Senior Nutrition Program	M-F 11:30 am	60 +/ nutritional needy. Pre-enrollment	(805) 489-5149
	Arroyo Grande	336 S. Halcyon	Community Health Centers (CHC)	M-F 8-7 Coastal Medical Center		(805) 481-3652
		1057 Grand Ave	Community Health Centers (CHC)	M-F 9-6 The Doctors Office		(805) 481-7220
Medical Assistance		1086 Grand Ave	Department of Social Services	M-F 8-5	Income/disability	(805) 474-2000
	Grover Beach	710 S. 13th St	Healthcare for Homeless Project	M-F 1:30 - 5:00		(805) 473-7970
		286 S. 16th St.	Public Health Services	M-F 8-5		(805) 473-7050
	Oceano	1981 Cienaga Street	Community Health Centers (CHC)	M-F 9-6		(805) 270-0025
	Arroyo Grande	336 S. Halcyon	Community Health Centers (CHC)	M-F 8-7 Coastal Medical Center		(805) 481-3652
		1057 Grand Ave	Community Health Centers (CHC)	M-F 9-6 The Doctors Office		(805) 481-7220
Mental Health Services		1092 East Grand Ave	Mental Health Services	M-F 8-5		(805) 473-7060
		1086 Grand Ave	SAFE (AG/Nipomo/Oceano)	M-F 8-5		(805) 477-2037
	Grover Beach	710 S. 13th St	Healthcare for Homeless Project	M-F 1:30 - 5:00		(805) 473-7970
	Oceano	1981 Cienaga Street	Community Health Centers (CHC)	M-F 9-6		(805) 270-0025
Motel Vouchers	Arroyo Grande	1086 Grand Ave	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 474-2000
Permanent Housing	Arroyo Grande	1086 Grand Ave	Department of Social Services	M-F 8-5	Child Welfare or CalWORKs	(805) 474-2000
	Grover Beach	710 S. 13th St	Healthcare for Homeless Project	M-F 1:30 - 5:00		(805) 473-7970
Rental Assistance	Arroyo Grande	1086 Grand Ave	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 474-2000
	Arroyo Grande	1086 Grand Ave	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 474-2000
Social Services		602 Orchard	Lucia Mar School District	M-F 8-5	Homeless children	(805) 474-3000 x4719
		1086 Grand Ave	SAFE (AG/Nipomo/Oceano)	M-F 8-5		(805) 477-2037
	Grover Beach	710 S. 13th St	Community Health Centers (CHC)	see website		(805) 473-7974
		710 S. 13th St	Healthcare for Homeless Project	M-F 1:30 - 5:00		(805) 473-7970
Temporary Housing	Arroyo Grande	1086 Grand Ave	Department of Social Services	M-F 8-5	CalWORKs/Child Welfare	(805) 474-2000
	Grover Beach	815 West Grand Ave	Captive Hearts	24/7		(805) 481-4500
		383 S. 13th St	Casa Solana	24/7	Female addicts, ages 18-72	(805) 481-8555

Revised 01/08/2008

SERVICES IN THE FIVE CITIES AREA – ARROYO GRANDE, OCEANO, GROVER BEACH, PISMO BEACH & SHELL BEACH

		710 S. 13th St	Healthcare for Homeless Project	M-F 1:30 - 5:00		(805) 473-7970
Transportation	Arroyo Grande	602 Orchard	Lucia Mar School District	M-F 8-5	**Homeless children**	(805) 474-3000 x4719

SERVICES FOR THE HOMELESS IN NIPOMO AND SANTA MARIA

Service Provided	Service Location	Address	Organization & website link	Hours	Eligibility Conditions	Telephone
Case Management Services	Nipomo	150 Tejas Place	Community Health Centers (CHC)	M-F 8-6, Sat 8-4		(805) 929-3254
	Nipomo	681 W. Tefft Street	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 931-1800
	Santa Maria	401 W. Morrison	Good Samaritan Shelter	24/7		(805) 347-3338
Clothing	Nipomo	681 W. Tefft Street	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 931-1800
	Santa Maria	401 W. Morrison	Good Samaritan Shelter	24/7		(805) 347-3338
Drug Counseling	Nipomo	150 Tejas Place	Community Health Centers (CHC)	M-F 8-6, Sat 8-4		(805) 929-3254
	Santa Maria	401 W. Morrison	Good Samaritan Shelter	24/7 Detox.		(805) 347-3338
Educational Services	Nipomo	681 W. Tefft Street	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 931-1800
	Santa Maria	800 S College Dr.	Allan Hancock College Human Services	M-F 9-9	College enrollment	(805) 922-6966 X 3293
Emergency Assistance	Nipomo	681 W. Tefft Street	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 931-1800
Food / Groceries	Nipomo	726 W. Tefft St	Salvation Army	M-F 10-:00 - 1:00	ID & Nipomo resident	(805) 929-2388
	Nipomo	200 E. Dana	Senior Brown Bag	9:00 am. 2nd & 4th Thur	Application, Need--based	(805) 238-4664
	Nipomo	298 S. Thompson Ave.	USDA Food Distribution	9:00 - 10:00 am. 2nd Tue	Application, Need--based	(805) 238-4664
Housing - Emergency Shelter	Santa Maria	401 W. Morrison	Good Samaritan Shelter	24/7		(805) 347-3338
Housing - Motel Vouchers	Nipomo	681 W. Tefft Street	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 931-1800
Housing - Permanent	Nipomo	681 W. Tefft Street	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 931-1800
Housing - Rental Assistance	Nipomo	681 W. Tefft Street	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 931-1800
Housing - Temporary	Nipomo	681 W. Tefft Street	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 931-1800
	Santa Maria	401 W. Morrison	Good Samaritan Shelter	24/7		(805) 347-3338
Meals	Nipomo	200 E. Dana	Senior Nutrition Program	M-F 12:00 noon	60 +/ nutritional needy. Pre-enrollment	(805) 929-1066
	Nipomo	298 S. Thompson Ave.	St. Joseph's Church	4:00-5:00 2nd & 4th Thur	Nipomo only	(805) 929-1922
Medical Assistance	Nipomo	150 Tejas Place	Community Health Centers (CHC)	M-F 8-6, Sat 8-4		(805) 929-3254
	Nipomo	681 W. Tefft Street	Department of Social Services	M-F 8-5	CalWORKs	(805) 931-1800
	Santa Maria	401 W. Morrison	Good Samaritan Shelter	24/7		(805) 347-3338
Mental Health Services	Nipomo	150 Tejas Place	Community Health Centers (CHC)	M-F 8-6, Sat 8-4		(805) 929-3254
	Santa Maria	401 W. Morrison	Good Samaritan Shelter	24/7		(805) 347-3338
Social Services	Nipomo	681 W. Tefft Street	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 931-1800
	Nipomo	681 W. Tefft Street	Department of Social Services	M-F 8-5	Child Welfare/CalWORKs	(805) 931-1800
	Santa Maria	800 S College Dr.	Allan Hancock College Human Services	M-F 9-9	College enrollment	(805) 922-6966 X 3293
	Santa Maria	401 W. Morrison	Good Samaritan Shelter	24/7		(805) 347-3338

Appendix C
-Resource Needs for Housing and Services-
What do we need and what will it cost?
What are we spending now?

1. Housing for All, San Luis Obispo County Housing Trust Fund -- *Rental Housing is "Out of Reach"*
2. Number of Housing Units Needed
3. Local Share for Capital Costs (Construction/Acquisition)
4. Estimate of Number of Homeless Households
5. Estimate of Case Management Costs
6. Summary of Selected Sources of Public Funding for Homeless Programs in SLO County
7. Continuum of Care Funds: San Luis Obispo County
8. Common Sources of Housing Funding
9. Mainstreaming the Response to Homelessness

Housing for All

San Luis Obispo County Housing Trust Fund

Rental housing is "Out of Reach"

According to a recent report from the National Low Income Housing Coalition, a family in California needs to earn at least $24.01/hour - working 40 hours a week, 52 weeks a year - to be able to afford rent and utilities in California's housing market. This represents an increase of 44.3% since 2000.

California is the second most expensive state in the nation for renters. The typical renter in California earns $16.67, which is $7.34 short of what's needed to afford a modest apartment.

"Throughout the state, we are hearing stories of families who are becoming homeless because their paychecks aren't keeping pace with rental costs," said Julie Spezia, Executive Director of Housing California, a statewide advocacy group. "This report clearly illustrates why we need to build more apartments that working families can afford."

The situation for renters in San Luis Obispo County is even worse. While a modest two-bedroom unit only requires a $20.67 per hour job in this county, the average renter only earns $10.88 per hour. This leaves a much larger gap of almost $10 per hour.

A minimum wage earner in this county would need to work 103 hours per week to afford a modest two-bedroom unit. To be affordable for a minimum wage earner, rent and utilities must not exceed $416 per month. For a senior or disabled person who receives SSI, an affordable rent would be $246, including utilities.

The San Luis Obispo County Homeless Enumeration of 2006 found that 30.9% of those surveyed became homeless because they were unable to pay their rent or mortgage.

The report, Out of Reach 2007-2008, was prepared by the National Low Income Housing Coalition (NLIHC) and provides rent and wage data for every state and county in the country. It is available at www.nlihc.org/oor/oor2008.

Support Inclusionary Housing on May 22

The San Luis Obispo County Planning Commission will hold its final hearing on the adoption of an inclusionary housing ordinance on May 22 at 8:30 in the County Supervisors Chambers at 1055 Monterey Road. The hearing may be continued to May 29, if necessary.

Please come to show your support for affordable housing at this hearing. Encourage the Planning Commission to adopt a balanced inclusionary housing ordinance that:

- Provides density bonuses and other incentives to offset the cost of providing affordable housing.
- Allows builders to choose how they will comply with the ordinance — build units on- or off-site, donate land or pay in-lieu fees.
- Phase in the inclusionary requirements over four years to account for the current poor economy.

(See page 4 for link to a website.)

Inside the Apr-May 2008 Issue

New Study: Inclusionary Zoning	**2**
HTF Funding Updates	**2**
Short Notes	**3**
Items of Interest...	**4**
Loan Funds Available	**4**
Board of Directors	**4**

C-2: NUMBER OF HOUSING UNITS NEEDED

- San Luis Obispo County is typical of nationwide data.
- Nationwide on average 1% of the population is homeless. 0.2% is chronically homeless.
- SLO County's Population is estimated at 275,000
- San Luis Obispo's Homeless Population is conservatively estimated at 2,750 persons (1% of 275,000)[1]

    - Chronic homeless = 550 persons (.2% of 275,000)
    - Episodic or Transitional Homeless = 2,200 persons

Note: There are other, widely varying estimates of the proportion of chronically homeless persons in SLO County. Given these, the above estimate of 0.2% is a reasonable figure.

- 2005 point-in-time count: Chronically Homeless = 0.51% of total population
- 2007 point-in-time count: Chronically Homeless = 0.008% of total population

- To determine the number of housing units needed over the next 10 years it is necessary to make assumptions about household size.

    - The 2006 SLO County Homeless Enumeration Report counted the number of homeless persons, but did not quantify the number of total households for housing unit purposes. However, it did note that 34% of the homeless persons counted were children or teens (817 of the 2,408 homeless persons counted).

    - We make the following assumption about the average homeless household size in SLO County

        - Chronic Homeless - average size = 1.25 persons
        - Episodic/Transitionally Homeless. - average size = 2.5 persons

- A total of 1,320 permanent housing units for the homeless will be needed over the next 10 years (132 annually). This number may need adjustment over the 10 year period to account for population changes. A breakdown follows:

    - 440 Chronic Homeless Units/ 44 annually. (550 persons divided by 1.25 Ave HH size)

    - 2,200 Episodic & Transitionally Homeless Units/ 88 annually. (880 persons divided by 2.5 Ave HH size)

[1] The above calculations do not take into account population growth, which was projected at .9% countywide for calendar year 2006 and 1% for 2007 according to the San Luis Obispo County Economic Outlook 2007, published by the UC Santa Barbara Economic Forecast Project. A steady population growth of 1% over 10 years would result in a a greater need for housing and services than predicted here.

C-3: LOCAL SHARE FOR CAPITAL COSTS (CONSTRUCTION/ACQUISITION)

1. $100,000 is the estimated average local contribution per housing unit necessary for construction and/or acquisition of housing units for the homeless. This is a one-time cost, and results in a permanent affordable housing unit. The local share amount is based upon recent financial analysis conducted by the County, as well as historical trends on actual affordable projects. NOTE: The local share funds only a portion of the housing. Typically ½ to 2/3's of the total cost is paid for by outside sources that are leveraged with this local contribution. These outside sources include federal and state affordable housing tax credits, State Dept of Housing Proposition 1C funds, and Federal Home Loan Bank Affordable Housing Program Funds.

2. This local contribution amount equates to $13,200,000 annually (132 units needed annually x $100,000/unit), and $132 million over the life of the Ten Year Plan. Traditionally, local housing capital contributions have come from federal HOME and CDBG funds, Redevelopment Agency Low/Mod Housing Funds, and In-Lieu Fees collected under Inclusionary Housing Ordinances.

3. An initial focus on the Chronically Homeless might require fewer capital dollar outlays.
    a. 44 Chronic Homeless Units Annually x $100,000 = $4.4 million annual outlay for capital costs ($44 million over 10 years).

4. It is assumed that rents collected from these homeless housing units will be sufficient to pay all normal housing operating costs (but not social service/supportive staff costs). Normal housing operating costs include insurances, common area utilities, property management, audit reporting, deposits to long-term capital replacement reserves. These would be expected to run approximately $350 per unit per month.

    a. If the homeless family income was insufficient to pay the basic housing operating costs, then a pool of operating subsidy dollars would need to be made available. HUD Section 8 Housing Vouchers are one resource that could be looked at to provide these operating subsidies.

5. Leasing: Leasing of existing units could also be incorporated into the strategy. It is estimated that the 10 year leasing cost would be at least $ 56 million dollars, without adjusting for inflation. However, this outflow of cash would result in no permanent housing asset after the 10 years.

6. Supportive Services and Case Management are essential to ensure success of homeless households in the housing. The basic housing operating cost referred to in #4 above do not include Supportive Service costs. A separate budget would need to be established for these costs. The staffing levels would vary depending the intensity of services required, which typically is categorized as High, Medium or Low Intensity. **For Chronic Homeless only, it is estimated that the 10 Year Cost would be at least $8.9 million without adjusting for inflation.**

Chart C-4: Estimate of Number of Homeless Householes

	# Homeless Persons	Ave HH Size	# Homeless Households/Housing Units Needed	Annually for 10 Years	
TOTAL	**2,750**				
Episodic	2,200	2.5	880	88	
Chronic	550	1.25	440	44	
TOTAL	**2,750**		**1,320**	**132**	
Capital Cost					
$100,000	Per Unit Capital Cost	(Local Share)			
13,200,000	Annual Capital Cost				
132,000,000	10 Year Capital Cost				
Master Lease Alternative					
Total Rent	$1,000	Ave Rent/Unit			
Tenant Share	$350				
Program Cost/unit	**$650**	**$7,800**	Annual Per Unit		
Annual Units	132				
Monthly Cost	85,800				
Annual Cost	1,029,600				
10 Year Cost	10,296,000				
	Annual Cost	**Number of Units**			
Year 1	1,029,600	132			
Year 2	2,059,200	264			
Year 3	3,088,800	396			
Year 4	4,118,400	528			
Year 5	5,148,000	660			
Year 6	6,177,600	792			
Year 7	7,207,200	924			
Year 8	8,236,800	1,056			
Year 9	9,266,400	1,188			
Year 10	10,296,000	1,320			
TOTAL 10 YEARS	**$56,628,000**				
Year 11	10,296,000				
Year 12	10,296,000				
Year 13	10,296,000				
Year 14	10,296,000				
Year 15	10,296,000				
TOTAL 15 Years	108,108,000.0	No Inflation Factor			

Chart C-5: Estimate of Case Management Costs for Chronically Homeless Persons

Services						Yr 1	Yr 2	Yr 3	Yr 4-10	**TOTAL CASE MANAGEMENT STAFF**	
Year	**Year 1 Chronic**	Ongoing **Year 2**	Ongoing **Year 3**	Ongoing **Year 4-10**	**TOTAL**	Staff @ **1:10**	Staff @ **1:25**	Staff @ **1:40**	Staff @ **0.0833333**		**Annual Cost**
1	44				44	4.40	0.00	0.00	0.00	4.40	$440,000
2	44	44			88	4.40	1.76	0.00	0.00	6.16	$616,000
3	44	44	44		132	4.40	1.76	1.10	0.00	7.26	$726,000
4	44	44	44	44	176	4.40	1.76	1.10	0.73	7.99	$799,333
5	44	44	44	88	220	4.40	1.76	1.10	1.47	8.73	$872,667
6	44	44	44	132	264	4.40	1.76	1.10	2.20	9.46	$946,000
7	44	44	44	176	308	4.40	1.76	1.10	2.93	10.19	$1,019,333
8	44	44	44	220	352	4.40	1.76	1.10	3.67	10.93	$1,092,667
9	44	44	44	264	396	4.40	1.76	1.10	4.40	11.66	$1,166,000
10	44	44	44	308	**440**	4.40	1.76	1.10	5.13	12.39	$1,239,333
										10 Year Cost	**$8,917,333**

Case Management Staff

Average Cost

$50,000 Base Salary
2 Taxes, Benefits, Overhead factor
$100,000

Summary of Selected Sources of Public Funding for Homeless Programs in SLO County

Funding for Homeless Programs by Year	2008	2007	2006	2005
CDBG				
City of Arroyo Grande - SLO Homeless Shelter	4,746	-	-	
City of Arroyo Grande - Shelter for Medically Fragile Homeless	941	-	-	
City of Atascadero - Homeless Shelther by ECHO	15,000	15,000	10,500	
City of Paso Robles - Homeless Facility 2nd Baptist	-	11,106	-	
City of Paso Robles - Rehab of Women's Shelter	-	17,000	-	
City of Paso Robles - Homeless Shelter by ECHO	5,000	4,000	-	2,000
City of Paso Robles - Motel Voucher by Transitional Food & Shelter		21,000	20,503	24,000
City of Paso Robles - Shelter for Medically Fragile Homeless	21,373			
City of SLO - SLO and NC Case Mgt	93,025	96,886	96,887	107,824
City of SLO - Homeless Services Planning	-	7,343	14,583	3,074
County - SLO Homeless Shelter (Maxine)	91,540	91,634	100,737	120,265
County - Prado Homeless Day Center in SLO	21,985	26,181	25,000	26,500
HOME				
SLO Women's Shelter Building Rehab	-	34,000		
Transitions-Mental Health Building Rehab	-	-	-	116,000
Supportive Housing Program (SHP)*				
North County Case Management by EOC	163,091	163,091	163,091	163,091
South County Case Management by EOC	211,149	211,149	211,150	211,150
SLO Case Mgt & Transitional Hsg Program by EOC & Transitions	473,981	473,981	473,981	473,981
Emergency Shelter Grant				
SLO Homeless Shelter Op & NC Case Mgt	35,356	35,515	43,393	43,671
Prado Homeless Day Center in SLO	20,826	20,920	14,654	14,751
Domestic Violence Shelter by SLO Women's Shelter	7,136	7,168	7,547	7,595
Domestic Violence Shelter by NC Women's Shelter	13,867	13,929	18,869	18,994
Homeless Shelter by El Camino Homeless Org (ECHO)	14,888	14,955	7,336	7,385
General Fund Support				
County - SLO Homeless Shelter (Maxine)	65,795	50,770	68,000	68,000
County - SLO Prado Homeless Day Center in SLO	38,291	43,850	22,000	22,000
County - North County Women's Shelter	26,244	21,870	30,000	30,000
County - SLO Women's Shelter	13,500	11,250	14,000	14,000
County - Transitional Food & Shelter (Paso)	8,000		8,000	8,000
County - ECHO (Atascadero)	28,170	22,260	8,000	8,000
City of SLO - SLO Homeless Shelter (Maxine)	42,000	41,113	41,113	50,000
City of SLO - Prado Homeless Day Center	52,600	51,300	50,000	25,000
City of Atascadero - ECHO		4,000		
City of Pismo Beach - SLO Homeless Shelter		2,200		
TOTALS	$ 1,468,504	$ 1,513,471	$ 1,449,344	$ 1,565,281
Notes:				
1. Table includes information for funding administered through Fund Center 290 plus information provided by SLO City for 2005-2008 and by cities of Atascadero and Pismo Beach for 2007.				
2. Direct grants from State of Federal to nonprofits are not included.				
3. Funding provided by County through departments other than Planning and Building is not included.				

Source: SLO County Planning and Building Dept (June 2008)

Continuum of Care Funds : San Luis Obispo County

Year	Pro Rata Need	Hold Harmless Amount (SHP) Awarded by HUD
2008	$710,334	unknown (application to be sent in 2008)
2007	$710,893	$848,222
2006	$699,704	$848,222
2005	$699,700	$848,222
2004	$747,580	$848,222
2003		~$848,222
2002		$163,091*
2001		$163,091*
2000		$163,091*

*More funds may have been received from 2000-2002. This is the County's awarded portion only, and excludes SLO Non-Profit's award of any funds.

Common Sources of Housing Funding

U.S. Department of Health and Human Services (HHS) Programs

- **Transitional Living Program (TLP)**
    - Allocates funding for organizations and shelters that provide living accommodations, skill-building, educational opportunities, employment assistance, and health and mental care to runaway, homeless, missing and sexually exploited young adults
    - Funds also support maternity group homes, designed for young mothers and their children.

U.S. Department of Housing and Urban Development (HUD) Programs

- **Supportive Housing Program (SHP) Funds**
    - SHP funds may be used to develop transitional and permanent housing. Eligible uses include new construction, acquisition, rehabilitation and leasing of buildings. SHP funds may also be used to provide supportive services that will help people transition from homelessness and move to independence.
    - Funds are awarded through an annual competition that requires communities to engage in a coordinated strategic planning process and to submit a comprehensive Continuum of Care plan to address homelessness.

- **Shelter Plus Care (S+C)**
    - S+C funds provide rental assistance for permanent housing for hard-to-serve homeless people with disabilities. Dollar-for-dollar matching by the grantee from federal, state, local or private sources is required in order to provide supportive services linked to the housing.
    - Funds are awarded through an annual competition that requires communities to engage in a coordinated strategic planning process and to submit a comprehensive Continuum of Care plan to address homelessness.

- **Section 8 Moderate Rehabilitation Single Room Occupancy (SRO)**

    - Section 8 SRO funds can be used for rental assistance in single-room-occupancy dwellings.

    - Funds are awarded through an annual competition that requires communities to engage in a coordinated strategic planning process and to submit a comprehensive Continuum of Care plan to address homelessness.

    - Funds are distributed by local public housing agencies.

- **Community Development Block Grant (CDBG)**

    - HUD program that funds local community development activities such as affordable housing, anti-poverty programs, and infrastructure development Subject to less federal oversight and largely used at the discretion of the state and local governments and their subgrantees.

    - Its funds are allocated to more than 1,100 local and state governments on a formula basis at $4.7 billion in FY2005. Funds can also be used for preservation and restoration of historic properties in low-income neighborhoods.

- **Home Investment Partnerships Program**

    - HOME provides formula grants to States and localities that communities use-often in partnership with local nonprofit groups-to fund a wide range of activities that build, buy, and/or rehabilitate affordable housing for rent or homeownership or provide direct rental assistance to low-income people.

U.S. Department of Veterans Affairs (VA) Programs

- **Domiciliary Care for Homeless Veterans**

    - Provides funds to VA medical centers to support the delivery of health, mental health, substance abuse, and other social services in residential treatment settings for veterans who are homeless.

- **HUD-VA Supported Housing Program**

- Administered jointly with HUD, provides permanent supportive housing and ongoing treatment services to veterans with serious mental illnesses and substance use disorders who are homeless.

- HUD designates a portion of Section 8 Vouchers for chronically homeless mentally ill veterans, and VA staff provide outreach, clinical care, and case management services

- **Loan Guarantee Program for Multifamily Transitional Housing**

  - Provides loan guarantees for transitional housing projects for veterans that provide supportive services including job counseling and require that residents seek and maintain employment, pay reasonable rent and maintain sobriety as a condition of occupancy.

  - Loan guarantees may be for cover construction, renovation of existing property, and refinancing of existing loans, facility furnishing or working capital.

  - http://www1.va.gov/homeless/page.cfm?pg=8

- **The Homeless Providers Grant and Per Diem Program**

  - The Grant and Per Diem program is offered annually (as funding permits) by the VA to fund community-based agencies providing transitional housing or service centers for homeless veterans.

  - It has two components:

    I. Under the Capital Grant Component, the VA may fund up to 65% of the costs for the construction, acquisition, or renovation of facilities or to purchase van(s) to provide outreach and services to homeless veterans.

    II. The Per Diem component is available to recipients of the capital grants to help off-set operational expenses. Programs serving veterans who have not received a capital grant may apply for Per Diem funding under a separate announcement, when published in the Federal Register, announcing the funding for "Per Diem Only.

  - http://www1.va.gov/homeless/page.cfm?pg=3

Other Federal Resources

- **Low-Income Housing Tax Credit**

- A tax credit created under TRA86 that gives incentives for the utilization of private equity in the development of affordable housing aimed at low-income Americans. The tax credits are more attractive than tax deductions as they provide a dollar-for-dollar reduction in a taxpayer's federal income tax, whereas a tax deduction only provides a reduction in taxable income.

- LIHTC provides funding for the development costs of low-income housing by allowing a taxpayer (usually the partners of a partnership that owns the housing) to take a federal tax credit equal to a large percentage of the cost incurred for development of the low-income units in a rental housing project. Development capital is raised by "syndicating" the credit to an investor or, more commonly, a group of investors. The amount of the credit is based on (i) the amount of credits awarded to the project in the competition, (ii) the actual cost of the project, (iii) the tax credit rate announced by the IRS, and (iv) the percentage of the project's units that are rented to low income tenants.

- **Federal Home Loan Banks**

  - Source of stable, low-cost funds to financial institutions for home mortgage and small business

  - Affordable Housing Program (AHP) – provides grants twice a year through financial institutions for investment in low- or moderate-income housing initiatives. Member banks partner with developers and community organizations to finance the purchase, construction, or rehabilitation of owner-occupied or rental housing. Grants can also be used to lower the interest rate on loans or cover down payment and closing costs. The program is flexible so that AHP funds can be used in combination with other programs and funding sources, ensuring a project's feasibility.

California State Programs

- **Emergency Housing and Assistance Program Operating Facility Grants (EHAP)**

  - Provides facility operating grants for emergency shelters, transitional housing projects, and supportive services for homeless individuals and families.

  - Each county receives a formula grant allocation. 20% of the total allocation is available to non-urban counties, and eighty percent to urban counties.

- Provides direct client housing, including facility operations and administration, residential rent assistance, leasing or renting rooms for provision of temporary shelter, capital development activities of up to $20,000 per site, and administration of the award (limited to %).

- **California Multifamily Housing Program (MHP)**

  - Assists the new construction, rehabilitation and preservation of permanent and transitional rental housing for lower income households.

  - Applications are invited through the issuance of Notices of Funding Availability (NOFAs).

  - http://www.hcd.ca.gov/fa/mhp/

- **Proposition 1C - Housing and Emergency Shelter Trust Fund Act of 2006**

  - Allocates $2.85 billion in general obligation bonds to be paid over 30 years "for the purpose of providing shelters for battered women and their children, clean and safe housing for low-income senior citizens; homeownership assistance for the disabled, military veterans, and working families; and repairs and accessibility improvements to apartments for families and disabled citizens."

- **California Mental Health Services Act (MHSA)**

  - Increases funding, personnel, and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families.

  - Increases the taxes of high income individuals. MHSA will be funded by imposing an additional one percent tax on individual, but not corporate, taxable income in excess of one million dollars.

MAINSTREAMING THE RESPONSE TO HOMELESSNESS

Effective Use of Mainstream Resources to
Prevent and End Homelessness
March 7, 2003
Elihu Harris State Building
Oakland, CA

Sponsored by
U.S. Dept. of Housing and Urban Development, Community Planning and Development Office, California State Office and the State of California, Department of Housing and Community Development, Community Affairs Division

For a compendium of Resource Information, please see the HomeBase Website at:
http://homebaseccc.org/pages/Hot_Topics/mainstreaming.html

Appendix D
-Facilitating Access to Affordable Housing to Put an End to Homelessness-
Program & Practice Examples and Research Knowledge

Table of Contents

PART 1: Program and Practice Examples

I. Housing Linked With Comprehensive, Wraparound Services For People Who Are Chronically Homeless

Project Coming Home, Contra Costa County, CA

II. Continuum of Care Approach: Emergency Services & Shelter, Permanent Supportive Housing (including Safe Haven) and Clinical & Other Support Services Provided Through a Single Agency

Downtown Emergency Service Center (DESC), Seattle, WA

III. Centralized Housing Assistance Agency: Housing Search Assistance, Prevention Services, Short-Term Rental Assistance, Housing Subsidies, and Stabilization Services

HomeStart, Boston, MA

IV. Computerized Listings & Databases for Affordable Housing

Community Technology Alliance (CTA), Santa Clara, CA

V. Housing First For Families

Beyond Shelter, Los Angeles, CA

VI. Housing Sponsorship for Homeless Families from Businesses and Faith-Based Organizations, with Supportive Services

Charitable Assistance to Community's Homeless (C.A.T.C.H.), Boise, ID

VII. Housing First: Replacing Emergency Shelters with Permanent Housing

A. South Middlesex Opportunity Council (SMOC) Housing Corporation, Framingham, MA
B. Cambridge Shelter Inc., Cambridge, MA

VIII. Reducing Reliance on Emergency Shelters: Prevention, Rapid Exit and Targeting

Family Homeless Prevention and Assistance Program (FHPAP), Hennepin County, MN

IX. Third Party Rent Vendor Payment System

Tenderloin Housing Clinic, Modified Payment Program, San Francisco, CA

PART 2: Research Knowledge

I. PERMANENT SUPPORTIVE HOUSING HELPS PEOPLE WHO ARE CHRONICALLY HOMELESS TO ACHIEVE LONG-TERM RESIDENTIAL STABILITY, IMPROVES THEIR HEALTH AND WELL-BEING, AND PRODUCES COST SAVINGS FOR COMMUNITIES

II. THE HOUSING FIRST MODEL OF SUPPORTIVE HOUSING IS EFFECTIVE EVEN WITH PEOPLE WHO HAVE SERIOUS DISABILITIES AND HAVE BEEN HOMELESS FOR EXTENDED TIME PERIODS

III. HOUSING FIRST'S RAPID REHOUSING APPROACH IS ALSO EFFECTIVE FOR HOMELESS FAMILIES, HELPING THEM TO QUICKLY RESTABILIZE AND MINIMIZING THE NEGATIVE IMPACTS OF HOMELESSNESS, ESPECIALLY ON CHILDREN

IV. HOUSING SUBSIDIES HELP PREVENT AND END HOMELESSNESS

V. SHORT-TERM AND SHALLOW SUBSIDIES HAVE ALSO BEEN SHOWN TO BE EFFECTIVE IN HELPING PEOPLE REGAIN AND MAINTAIN HOUSING

VI. RESPITE CARE FACILITIES IMPROVE HEALTH OUTCOMES FOR PEOPLE WHO ARE HOMELESS AND BEING DISCHARGED FROM HOSPITALS AND HEALTH CARE FACILITIES.

PART 1: Program & Practice Examples

I. Housing Linked With Comprehensive, Wraparound Services For People Who Are Chronically Homeless

Project Coming Home
Contra Costa County, California

See Strategy 3.1 and Action Steps 1.1.3, 1.2.2, 3.1.8, 3.6.1

Project Coming Home (PCH) provides housing linked with a range of support services to help people who are chronically homeless to leave the streets for the long term. This is accomplished through a multi-agency collaborative that provides outreach, housing, treatment and support services through integrated service teams, composed of staff from homeless, mainstream and veterans services agencies.

Partners:

Contra Costa County Office of Homeless Programs, County Housing Authority, Health, Housing and Integrated Service Network, Contra Costa County Alcohol and Other Drugs Services Division, Contra Costa County Mental Health Services Division, Health Care for the Homeless Program, Mental Health Consumer Concerns, Phoenix Programs, Rubicon Programs, SHELTER, Inc., Department of Veterans Affairs, Neighborhood House of North Richmond, Bi-Bett

Significant Program Design Features:

- **Multi-disciplinary Outreach:** Outreach, assessments, services and linkages occur on the street, in encampments and in other key locations through the multi-disciplinary HOPE outreach team, using a modified Assertive Community Treatment model. Staff utilize an **"any door is the right door"** to service approach and maintain contact with clients from pre-engagement through treatment, until client is able to access permanent housing.

- **Housing Assistance:** Project Coming Home clients are housed in scattered site one-bedroom units through Shelter Plus Care grants or assisted in accessing other appropriate and affordable housing. PCH uses a **"housing first"** approach that seeks to help clients enter housing as soon as possible.
- **Treatment on Demand:** PCH clients have access to **dedicated residential detoxification and treatment beds** through community-based providers contracted through the County Department of Alcohol and Other Drugs Services.

- **Wraparound Supportive Services Linked With Housing:** PCH clients living in housing receive ongoing support and assistance from the Health, Housing, and

Integrated Services Network (HHISN) **Integrated Service Teams (ISTs)**. The ISTs are multi-disciplinary involving staff from both mainstream and homeless agencies. They provide **intensive case management** and either directly provide or actively link clients with health care, mental health care, substance use management counseling based on a harm reduction philosophy, money management and life skills counseling, benefits and employment assistance, peer support and any other needed services or support.

- **Special Focus On Outreach To Homeless Veterans With Fast-Track Services:** A Veteran's Outreach Worker works with the HOPE outreach team and the HHISN integrated service team, facilitating assessment and linkage of veterans with Veterans Administration (VA) financial and medical benefits and creating a fast track for access to non-emergency VA health and mental health services.

- **Special Focus on Assisting Clients in Obtaining SSI/SSDI Benefits:** Clients are actively assisted by staff in applying for SSI/SSDI benefits, including filling out applications, gathering necessary supplementary materials, keeping appointments and acting as a liaison and advocate with eligibility staff. In addition, clients are assisted in accessing psychological and cognitive assessments to prove their disability.

- **Enhanced Interagency Collaboration:** Close relationships have been forged between the outreach team and the county hospital, mental health department, and various police departments. When a chronically homeless person enters the hospital, the emergency room at the county hospital contacts the outreach team. Police departments regularly call the outreach team when they encounter a chronically homeless person in need of services. Members of the county mental health assessment team attend the Project Coming Home Project Management meetings and are working with the PCH partners resulting in enhanced quality of mental health care. A PCH partner, County Public Health, opened new homeless ambulatory care clinics in different parts of the county.

Outcomes

- 72% of clients maintain permanent housing for at least one year[1]
- 78% of clients receive all the services identified as needed in their assessments[2]
  - 98% of those with mental health needs receive services
  - 100% of those with substance abuse needs receive services
- Total average health care costs (medical/dental, mental health and substance abuse) per person over a three month period dropped dramatically from $9,757 to $4,450[3]

[1] PCH housing retention data as of May 2007.
[2] Summary of PCH Clients, Contra Costa County Homeless Program, as of 9/26/2006.
[3] Mares, A.S. and Rosenheck, R. A, HUD/HHS/VA Collaborative Initiative to Help End Chronic Homelessness, National Performance Outcomes Assessment, Preliminary Client Outcomes Report, Northeast Program Evaluation Center, February 2007.

II. Continuum of Care Approach: Emergency Services & Shelter, Permanent Supportive Housing (including Safe Haven) and Clinical & Other Support Services Provided Through a Single Agency

Downtown Emergency Service Center (DESC)
Seattle, Washington

See Action Steps 1.1.3 &1.5.1

The Downtown Emergency Service Center (DESC) is a multi-service center serving disabled and vulnerable homeless adults; it is one of the largest such centers in the Northwest. It serves over 5,000 people annually, providing emergency shelter and survival services, clinical programs and supportive housing. DESC has been recognized by HUD and others both for the quality of care it provides and for the effective integration of its services. The care provided by DESC is both comprehensive and seamless, offering clients a full "continuum of care" within the agency.

PROGRAMS

1. Emergency Services and Overnight Shelter Program: The Emergency Shelter Program serves more than 4,000 men and women each year. It provides safe, secure **shelter, hot meals, and a day-time safe haven** from the streets. It is also central to DESC's outreach efforts as it helps people access a wide range of programs (both at DESC and elsewhere) to help them stabilize their lives, and ultimately get permanent housing. Services available at DESC include hygiene facilities, mail and phone services, information and referral, emergency clothing, and on-site medical care, mental health counseling and chemical dependency treatment. A bi-weekly dermatology clinic is also available.

2. Supportive Housing Program: DESC follows a **Housing First model** and operates under the belief that clinical stabilization of mentally ill, addicted, and homeless people will occur more quickly if housing is provided first. To this end, DESC has developed a variety of **supportive housing** options, all of which include case management and/or on-site coordination of support services to facilitate long-term tenancy. DESC´s supportive housing consists of the following programs:

- *The Union Hotel* - At The Union, 52 formerly homeless, disabled tenants live in their own apartments. The building is staffed 24-hours a day, and an on-site Service Coordinator maintains close contact with tenants and coordinates their access to supportive services.

- *The Lyon Building* - The Lyon Building has 64 units of permanent housing for homeless adults with multiple disabilities, including HIV/AIDS, mental illness and chemical dependence. Project staff, including four clinical specialists, provide intensive support and coordination to ensure that residents' service needs are met and housing is successfully maintained.

- ♣ *Kerner-Scott House* – This is the site of a DESC shelter for mentally-ill women, and it contains 40 units of housing. Twenty-five units provide **"Safe Haven" housing** for homeless mentally ill people who are not currently receiving services. The units themselves serve as tools to help engage clients into receiving services. The residential setting helps facilitate clients' movement toward permanent housing and increased self-sufficiency. The 15 units located on the top floor are occupied by chemically dependent formerly homeless adults in recovery.

- ♣ *The Morrison* is DESC's largest housing project, containing 190 units of permanent housing for formerly homeless adults with serious disabilities.

- ♣ *1811 Eastlake* – This facility provides supportive housing to 75 men and women with chronic alcohol addiction. Residents benefit from 24 hour - 7 day a week support including mental health and chemical dependency treatment, primary health care, meals and counseling assistance. The project aims to improve the lives of its residents through reduced alcohol consumption, better health care, and increased stability.

- ♣ *Scattered Site Housing* – DESC also has **housing subsidies** which case managers use to place their clients into rental properties throughout Seattle. Using HUD Supportive Housing Program leasing funds, DESC leases units directly from private property owners and in turn subleases to its residents at 30% of their income. Case management services are integrated with the housing to provide the necessary support for people to succeed and stabilize.

3. Clinical Programs: DESC provides mental health and chemical dependency treatment services to address the needs of mentally ill homeless people, the majority of DESC's clients. It provides services through a continuum of care that includes street outreach and engagement, case management, and short- and long-term care. These services are delivered through the following four components:

- ♣ *Homeless Outreach Stabilization and Transition (HOST):* HOST case managers conduct outreach and provide intensive case management on the streets, in shelters, hospitals, jails, libraries, and other facilities, seeking out people who are mentally ill and homeless. DESC's drop-in center allows people to proceed at their own pace and become familiar with the environment. When they are ready, case managers help identify their underlying issues and service needs, facilitate access to services (whether at DESC or with other service providers), help achieve clinical and social stabilization, secure housing, and transition into long-term case management.

- ♣ *Support, Advocacy and Growth Enhancement (SAGE): SAGE* is the ongoing comprehensive case management component of DESC's mental health program. SAGE case managers work with clients to help them obtain and maintain housing,

improve clinical and social stability, and enrich and enhance their level of independence and self-sufficiency.

- ♣ *Chemical Dependency Treatment:* Chemical dependency clients usually have a sustained and/or complicated substance abuse history, while many also suffer from a co-occurring mental disorder. DESC provides integrated mental health and substance abuse treatment – substance abuse counselors work in coordination with mental health case managers in both the emergency shelter and in supportive housing projects, so that services meet clients at their current level and offer support for change.

- ♣ *Crisis Respite Program (CRP):* The Crisis Respite Program (CRP) **provides shelter and case management for severely mentally ill homeless adults emerging from a recent crisis or jail.** CPR helps them to stabilize in safe, secure and supportive surroundings and to connect with ongoing services and housing.

In addition to these programs, DESC operates a thrift store to provide vocational opportunities for clients, and is in the process of developing a more comprehensive vocational program.

Additional Information: www.desc.org

III. Centralized Housing Assistance Agency: Housing Search Assistance, Prevention Services, Short-Term Rental Assistance, Housing Subsidies, and Stabilization Services

HomeStart
Boston, Massachusetts

See Action Step 1.2.1

HomeStart offers people who are homeless or at-risk a comprehensive package of housing services to help people obtain and maintain housing. These services include:

- Housing Search: Housing Search Advocates assist homeless adults and families at more than 50 shelters and programs in Greater Boston with the complicated process of **locating affordable permanent housing**. People are assisted one-on-one with obtaining private apartments, government subsidized housing, and rooming house units.

- Stabilization: Once placed in housing, the most vulnerable participants, such as those with histories of substance abuse, mental illness, and long-term homelessness, are referred for **stabilization services**. Stabilization Advocates help each participant integrate into the community, maintain successful housing, and break the cycle of chronic homelessness.

- Homelessness Prevention: Our Prevention Program utilizes a combination of HomeStart's **housing and stabilization knowledge, mediation techniques, and flexible monetary funds** to help high-risk households retain their housing and avoid shelter. Prevention Team Members are also dedicated to developing sound housing strategies with low-income households all over Greater Boston.

- Housing First: The Housing First Program helps homeless disabled individuals **move directly from the streets and into permanent housing**. HomeStart provides these clients with **wrap-around support services** as they obtain the living skills, financial benefits, and health and mental health treatment they need to successfully stay in housing.

- Money Management Services: The Money Management program provides **Representative Payee and financial literacy** services to homeless and formerly homeless adults in Boston and Cambridge. The representative payee services are available to individuals with disabilities whose disabilities interfere with their ability to manage their money.

- Training and Technical Assistance: HomeStart runs a monthly group that brings together housing advocates and case managers from around the region for

information sharing, training, and networking. HomeStart also offers a Housing Search Training Series to teach new housing advocates and other providers of homeless services successful housing search strategies.

- Rental Assistance: HomeStart's Rental Fund helps participants **overcome the financial barriers to obtaining permanent housing**. It is most often used toward move-in costs such as first month's rent or security deposit. HomeStart also runs the New Frontiers Program, which provides both monthly stipends toward rent and budgeting workshops for one year. HomeStart Advocates work with clients to match them with appropriate HomeStart resources.

- Housing Subsidies: HomeStart has become a leading provider of special **housing subsidies** for the homeless disabled. HomeStart staff members match eligible participants with these subsidies, helps them locate housing, and provides them with follow-up supportive services.

- Vacancy Clearinghouse: In partnership with the City of Boston's 10% homeless set-aside program, HomeStart operates a **vacancy clearinghouse** that matches people who are homeless with government-funded housing units in Boston. HomeStart conducts outreach to property management companies, streamlines the tenant application process, matches tenants to units, and provides tenants with follow-up support services.

Brief Overview of Fiscal Year 2007 Accomplishments
(October 1, 2006 through September 30, 2007)

- HomeStart placed 396 homeless individuals and families into permanent, affordable housing.
- Over the past eleven years, more than 3100 people have moved from homelessness to housing.
- The Homelessness Prevention Program helped 197 at-risk households stay in their housing and avoid homelessness.
- HomeStart provided stabilization services to 377 individuals and families.
- 92% of stabilization participants served maintained housing throughout the year.
- The Housing Voucher Program provided much needed rental subsidies to 163 disabled individuals.
- HomeStart's Housing First program, which provides services to homeless disabled individuals living on the streets – in alleys, under bridges, etc. – , assisted 24 individuals in obtaining and maintaining permanent housing and a warm place to live.

Additional information: http://www.homestart.org/services.htm

IV. Computerized Listings & Databases for Affordable Housing

Community Technology Alliance (CTA)
Santa Clara, CA

See Action Step 1.2.1

Partner Agencies:

- Housing for Independent People (HIP)
- Community Voicemail
- Hundreds of homeless and housing service providers

Significant Program Design Features:

- CTA provides the technical infrastructure for easy and clear accessibility to affordable housing and service information on their two websites: www.helpscc.org and www.housingscc.org. They do not provide direct service.
- CTA information is **only published online**. This is a "very conscious choice", because it is too difficult to update print material in a timely manner and maintain accuracy. CTA does print bookmarks with contact information for those without computer knowledge or access. CTA receives about two calls a day from such people.
- Communication is key to successful organizing with agencies – CTA has a reputation of being a neutral entity in the process, which is "a big key to successful maintenance of an infrastructure".

www.housingscc.org includes:

- Search engines that allow the user to determine their income eligibility, find available housing in the area (according to income, maximum monthly rent, unit size and more), and check the status of wait lists at specific subsidized properties.
- Information on properties that are currently under construction, with details on when construction beings, ends and when it is expected to be available for occupancy.
- "Shelters at a Glance" directory of area shelters.
- A partnership between CTA and Housing for Independent People (HIP) for the maintenance of data. To date, HIP has been in charge of updating and managing the data being stored on the site. Housing and property developers each have access to their own properties on the database and are responsible for updating their personal records. CTA provides the technical infrastructure behind the websites. Due to recent management changes at HIP, new arrangements may be made to manage website content.

www.helpscc.org includes:

- Information about health and human services. The health services are broken down by expertise. 19 experts have access to the database and update it frequently.

Outcomes:

- www.housingsccc.org consistently gets 40,000 hits annually
- Many service providers and different city's Departments of Housing use the site as a tool, as well as individuals

Costs/Funding:

- CTA is grant-funded
- Sustaining money comes from bundled grant proposals called TECH SCC proposals – Tools to End Chronic Homelessness in Santa Clara County. These tools include www.housingscc.org, www.helpscc.org, Community Voicemail – everything excluding HMIS.

V. Housing First For Families

Beyond Shelter
Los Angeles, California

See Action Step 1.3.1

Beyond Shelter's Housing First Program helps homeless **families move directly into affordable rental housing in residential neighborhoods** as quickly as possible, and then provides six months to one year of **individualized, home-based social services** support "after the move" to help each family transition to stability. Their approach is implemented through four stages:

- Crisis Intervention & Short-Term Stabilization: helping families access emergency shelter services and/or short-term transitional housing and address crisis needs.
- Screening, Intake and Needs Assessment: development of an action plan for clients with short- and long-term goals and objectives with concrete action steps.
- Provision of Housing Resources: addressing any housing barriers and assisting families in moving into permanent, affordable housing in a safe neighborhood.
- Provision of Case Management: before the move into permanent housing, case management services to identify family needs and ensure that sources of income through employment and/or public benefits are in place, and after the move, time-limited case management services to help families solve problems that may arise and connect them with community services to meet longer-term needs.

Program Outcomes include:

- 88% of the over 2,500 Los Angeles families enrolled in Beyond Shelter's Housing First Program from 1989-2001 have been relocated to and stabilized in permanent housing.
- An evaluation of 185 families enrolled in this program found that over 80% of adults were attached to the labor force through employment, and others were enrolled in job training programs. Only 2.3% of those who entered the program with reported substance abuse problems had relapsed and only .4% of domestic violence survivors had returned to a dangerous relationship.

Additional information:
http://www.beyondshelter.org/aaa_initiatives/ending_homelessness.shtml

VI. Housing Sponsorship for Homeless Families from Businesses and Faith-Based Organizations, with Supportive Services

Charitable Assistance to Community's Homeless (C.A.T.C.H.)
Boise, ID

See Action Step 1.1.3 and 1.3.1

Partner Agencies:

- The United Way of Treasure Valley
- Housing Authority
- Boise State University
- Multiple local businesses & faith congregations

Significant Program Design Features:

- CATCH aims to first house homeless families and afterwards offer supportive services to address the issues that contributed to their homelessness. The goal is to have families reach self-sufficiency through a Housing First model.
- Families are housed in market rate units that are scattered around the Boise community by way of sponsorship from local businesses or faith congregations. Confidentiality of the families is respected.
- Sponsors are acquired through an annual awareness meeting, for which the mayor sends out invitations. Word of mouth also has resulted in a few congregations/companies approaching CATCH.
- 100% of families are referrals from shelters
- A lease is drawn up for a term of six months and is signed by the family and a landlord. Typically they range in market value from $500-$800. The sponsor pays the lease for those 6 months.
- Services offered after families are housed include case management, life skills, employment/educational training, treatment, social security benefits, counseling, Section 8, and both mental and physical healthcare.
- Transferable skills analysis often applied to clients to help them find jobs they are well suited for.
- After the lease is up, a family goes through an evaluation process. Graduating successfully from the program means that a family is able to pay their own rent. They are not required to move from the unit since they are market place listings, but can if they so desire. They can still talk to the social workers if they need help, but are no longer held responsible to them.
- If a family is not self-sufficient after 6 months, CATCH has the flexibility depending on the situation and sponsor, to continue to help the family with rental assistance
- Mountain West Bank recently initiated CATCH Match, a program that matches dollar for dollar the money that families save while in the CATCH program. MWB contributed an initial $7,500 and will solicit additional funding from other sources to help grow the program.

- A fundraising initiative called CATCH 22 seeks to capture more community attention and resources. It seeks personal donations of $22 or more in recognition that “families experiencing homelessness understand the meaning of CATCH 22 as they daily face dilemmas and obstacles on their way to self-sufficiency”.

Outcomes:

- The first year’s goal to serve 10-15 families was met in the first 4 months of the program and an additional social worker was added to the staff to keep up with the demand
- To date CATCH has handled 27 families, 22 of which have graduated successfully.

Costs/Funding:

- All of CATCH’s administrative costs are covered by the City of Boise, with the Mayor’s support
- 100% of sponsorship donations go directly to families
- Additional grants from various sources (United Way, Key Bank, Wells Fargo, Idaho Power) support the program.

VII. Housing First: Replacing Emergency Shelters with Permanent Housing

South Middlesex Opportunity Council (SMOC)
Framingham, MA

See Action Step 1.3.2

SMOC Housing Corporation was created in 1986 in order to address the need for safe, decent and affordable housing for low-income families, individuals and disabled adults. It is a full-service real estate agency that also incorporates human services. SMOC Housing Corporation uses commercial lending to purchase, renovate and develop properties, which they use to appropriately house the variety of clients they serve.

SMOC has recently adopted a "Housing First" approach and supported the closing of two shelters in favor of permanent housing options: Common Ground Overflow Shelter in Framingham has been replaced with the Common Grounds Resource Center, which is an access point for permanent housing placements. SMOC is now in "phase two" of shutting down the Rowland's House in Marlborough and providing clients with permanent housing options.

<u>Significant Program Design Features:</u>

- Policy choice to shift focus from providing emergency shelter, which did not appear to reduce client needs long-term, to providing permanent housing ("Housing First" model)
- Pilot program to test permanent housing solutions with 14 individuals from the Common Ground Shelter sober housing unit. Additional funding sought from the Department of Mental Health Care to help cover costs.
- Staff went through intensive harm and trauma reduction training, discussion, and research prior to the pilot program
- Pilot program clients from the Common Ground Shelter were individually assessed and placed in permanent housing according to service needs. Housing offered was mostly SROs with some studios and one-bedroom apartments.
- Sobriety was eliminated as a requirement for the pilot program, as part of the "harm reduction model". In the Common Ground emergency shelter a relapse would have resulted in a discharge from the shelter.
- Following the pilot program, the Common Ground Shelter was repurposed as the Common Ground Resource Center, where clients can walk in and receive assistance and referrals.
- Referral and acceptance into the housing program has been modified: the previous walk-in shelter model has been replaced with a "Morning Team" comprised of area shelter employees, behavioral health specialists and others. The team meets daily to assess potential clients for housing placement. Service providers can refer clients and walk-ins are still welcome. The team considers

client's location needs, why the person has been homeless, client's housing preferences, etc.
- The morning team may refer clients to SMOC's other services including: SMOC's behavioral health clinic, with outpatient treatment focusing on relapse prevention; mental health programs with group and or individual therapy; Voices Against Violence that deals with domestic and sexual abuse, etc. SMOC also has a Career Center which helps clients with their resumes and job search, along with a temporary employment office that aids clients in finding immediate, entry-level jobs.
- SMOC also aids clients in finding market rate apartments in the community, depending on their desires/needs. There is a separate program for families seeking shelter, as they are required to be screened through welfare and must meet income eligibility.

Outcomes:

- Via commercial lending, SMOC has secured an inventory of 115 buildings, which creates housing for over 1,200 individuals.
- Of the 14 individuals that participated in the Common Grounds pilot program 6 are still with SMOC.

Costs/Funding:

- SMOC's funding for this initiative is a combination of grants, private market lending, and federal home loans.

Heading Home (formerly known as Cambridge Shelter Inc.)
Cambridge, MA

See Action Steps 1.3.1 & 1.3.2

Cambridge Shelter Inc. aims to end homelessness by providing affordable, permanent housing for both families and individuals in small home-like communities, all of which are backed by a intensive network of services. The organization has shifted its focus from emergency shelter to the development of permanent supportive housing. Their goal is to have a ratio of 1 case manager per 10 permanently housed clients.

Significant Program Design Features:

Their strategic plan incorporates the following priorities:

- Expand services to individuals and families regardless of public funding priorities
- Focus on creating permanent housing for both individuals and families
- Increase private fundraising to meet goals

Outcomes:

Shelter Inc. has added over 100 site units serving chronically homeless individuals.

Costs/Funding:

- Receives 70% of its funding from government sources (HUD & Department of Transitional Assistance)
- The rest is from donations and funding from the private sector
- 84% of donations go directly towards services to end homelessness. The remainder covers administrative fees

VIII. Reducing Reliance on Emergency Shelters: Prevention, Rapid Exit and Targeting

Family Homeless Prevention and Assistance Program (FHPAP)
Hennepin County, Minnesota

See Action Step 1.5.1

The Family Homeless Prevention and Assistance Programs seeks to prevent first time shelter stays, reduce the length of shelter stays, and eliminate shelter reentry.

Hennepin County developed a **shelter screening and diversion system** to limit access to shelters to families which need the most help. Pregnant and parenting teems, families with more than two children or with infants, and families receiving SSI have priority for shelter space. Within 1-3 days after entry to the shelter, families meet with the rapid exit coordinator for an in-depth assessment that focuses on housing barriers. The family is then referred to a **rapid exit program where a case worker works with the family to develop a housing stabilization plan**. Continued stay in the shelter is contingent on the family cooperating with the case manager and case plan. The case worker focuses on helping the family find housing and coordinates with other providers to address other needs. Followup continues for 6 months after the family leaves the shelter.

Prevention services are targeted to those families who are threatened with housing loss for non-payment of rent, but for whom a resolution to the crisis is possible. Case works assess the amount of rent owed, the family's credit history, resources and other circumstances and determine the amount of assistance the program can provide. Followup assistance is provided for up to 6 months on budgeting and other issues.

FHPAP's screening system and prevention services have reduced the average duration of shelter stays by half and reduced the daily census of families by 63%. 88% of families served in the rapid exit component did not return to shelter within 12 months. The average cost per family was $800. 95% of the families served in the prevention component did use shelter within 12 months. The average cost per family was $472.[4]

[4] Burt and Pearson. Strategies for Preventing Homelessness, U.S. Department of Housing and Urban Development, May 2005.

IX. Third Party Rent Vendor Payment System

Tenderloin Housing Clinic, Modified Payment Program
San Francisco, CA

See Action Step 1.1.3

The Tenderloin Housing Clinic provides permanent housing for single adults leaving shelters and currently serves over 3,000 clients each year. In order to participate clients must (1) have an income (can be either SSI income from employment or veteran's benefits) and (2) be referred by a city-approved emergency shelter, the County Adult Assistance Program (CAAP), or a community-based organization that has been approved by the Human Services Agency.

Partner Agencies: Housing and Urban Health Clinic

Significant Program Design Features:

- The Modified Payment Program (MPP) is a system of payment designed to help tenants who are already receiving benefits with money management.
- Clients must be referred to the program.
- After referral, a client's benefit checks are mailed directly to the THC, where the tenant contribution towards rent is automatically deducted and paid to the landlord. Depending on the benefit, clients on SSI pay $493 monthly rent, whereas GA clients only pay for part of that. Whatever money is left is given to the client to use as necessary. MPP thus assures timely and complete rent payment, reducing the likelihood of having THC tenants become homeless again.
- MPP also offers representative-payee services to its participants. Three women from THC collect client checks biweekly and help with money management, specifically for bills (i.e. phone, internet, etc.)

Outcomes: >90% retention rate; 1500 units of housing

Costs/Funding: Most costs are covered by the tenants' rent. Funding comes mostly from the San Francisco Human Services Agency with the rest covered by the county.

PART 2: Research Knowledge

I. PERMANENT SUPPORTIVE HOUSING HELPS PEOPLE WHO ARE CHRONICALLY HOMELESS TO ACHIEVE LONG-TERM RESIDENTIAL STABILITY, IMPROVES THEIR HEALTH AND WELL-BEING, AND PRODUCES COST SAVINGS FOR COMMUNITIES.

See Action Step 1.3.1

- Residential Stability: Studies of permanent supportive housing programs which provide affordable, independent housing linked with an array of support services show that about **three quarters of residents stay for at least two years, and about half retain the housing for three to five years.**[5]

- Cost Savings Through Reduced Usage of Emergency Services: A study of a program in New York City documented a **reduction in service use of $16,281 per housing unit per year** by homeless people with severe mental health disabilities who are placed in supportive housing. More than 85% the savings resulted from reduced usage of emergency and inpatient health and mental health services.[6] Importantly, the **reduced costs from lower service utilization cover 95% of the cost of developing and operating supportive housing**.

  In Portland, Oregon, an evaluation of the Community Engagement Program found **annual per person savings of over $16,000 from reduced costs for health care and incarceration for people in supportive housing[7]**. Likewise, a study of two programs in San Francisco serving people who are chronically homeless found that those in supportive housing have lower service costs, with a **57% reduction in emergency room visits and a 45% reduction in inpatient admissions[8].** Other communities report similar positive outcome data for people in their first year in supportive housing:

  - Emergency room use in Baltimore dropped by over 75%
  - Medicaid costs per treated individual in Connecticut dropped by 42%
  - Emergency detoxification days in Minnesota dropped by 84%

[5] Wong YI, Hadley TR, Culhane DP, Poulin SR, Davis MR, Cirksey BA, Brown JL. Predicting Staying or Leaving in Permanent Supportive Housing that Serves Homeless People with Serious Mental Illness. U.S. Department of Housing and Urban Development, Office of Policy Development and Research, Washington DC. March 2006. and Lipton, F.R., Siegel, C., Hannigan, A., et al. Tenure in supportive housing for homeless persons with severe mental illness. Psychiatric Services 51(4): 479-486, 2000.

[6] Culhane, Dennis P., Metraux, Stephen and Hadley, Trevor. (2002). Public Service Reductions Associated With Placement of Homeless Persons With Severe Mental Illness in Supportive Housing. *Housing Policy Debate* Vol 13, Issue 1, pp 107-163. Fannie Mae Foundation.

[7] Moore, T.L. 2006. Estimated Cost Savings Following Enrollment in the Community Engagement Program: Findings From a Pilot Study of Homeless Dually Diagnosed Adults. Portland, OR. Central City Concern.

[8] Martinez T and Burt M. Impact of Permanent Supportive Housing on the use of Acute Health Care Services by Homeless Adults. Psychiatric Services, Vol.57, No. 7, July 2006.

- Mental health hospitalizations in Seattle dropped by 89%, while
- arrests and incarcerations dropped by 93%[9].

- Improved Health & Well-Being: Enhanced health and well-being can be inferred from the reduction of use of emergency health, mental health and substance abuse services. In addition, these same studies document increased use of outpatient services, most likely due to clients having better access to preventative and other non-emergency health care services. In New York City, **use of Medicaid-reimbursed outpatient services increased by 76%** among people placed in supportive housing[10]. Likewise, in Denver, **costs for outpatient care increased by 50%** for people placed in supportive housing (although overall total health care costs declined 45% due to reduced inpatient hospitalization and emergency room usage)[11]. In addition, an evaluation of the HUD-VA Supported Housing program found **increased use of mental health services by residents as well as greater satisfaction with housing, larger social networks and reduced problems related to the use of alcohol and other drugs.**

[9] National Alliance to End Homelessness, "ToolKit for Ending Homelessness, Featuring the Ten Essentials for Ending Homelessness in Your Community", p. 10, http://www.endhomelessness.org/content/article/detail/1223
[10] Culhane, Metraux and Hadley, 2002.
[11] Perlman, J, and Parvensky, J. Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report, Colorado Coalition for the Homeless: Denver, CO, December 2006.

II. THE HOUSING FIRST MODEL OF SUPPORTIVE HOUSING IS EFFECTIVE EVEN WITH PEOPLE WHO HAVE SERIOUS DISABILITIES AND HAVE BEEN HOMELESS FOR EXTENDED TIME PERIODS.

See Action Step 1.3.2

- Housing Retention: A HUD-sponsored study of three Housing First programs [New York City's Pathways to Housing, Seattle's Downtown Emergency Services Center (DESC) and San Diego's Reaching Out and Engaging to Achieve Consumer Health (REACH)] serving people who are chronically homeless and have a mental illness or a co-occurring disorder found that **84% of clients were still housed after 12 months**[12].
  A comparison of outcomes from this type of low demand/no prerequisites housing with the outcomes of housing contingent on sobriety found that people with a serious mental illness, a 6-month history of homelessness and recent street living who were placed in the low demand, housing first model spent more time stably housed than those placed in the higher demand type of housing[13].

- Needed Services Accessed: In addition, despite the fact that services are often not required in these programs, clients still access assistance that addresses their needs. An evaluation of the Closer to Home Initiative found that **81% of tenants were receiving health care services, 80% mental health treatment, 56% substance abuse treatment, 65% money management, 51% benefits assistance, and 41% employment services**.[14]

- Cost-Savings: In Seattle, Washington, results from two separate studies released in January 2008 document the cost savings of the Housing First model for chronically homeless individuals. An analysis of outcome data for two programs 1811 Eastlake and Plymouth on Stewart, show that **the programs are saving the City an estimated $3.2 million in reduced emergency social and health services costs.** The following is a summary of the outcomes achieved.

  - *1811 Eastlake*[15]: This is a "wet housing" program allowing residents to consume alcohol in their homes. However, residents reported a one third reduction in the number of days spent drinking to intoxication, and researchers found an almost total elimination of the use of the sobering center by the building's residents, a decline of more than 5,000 visits per year.

[12] [12] Locke, G, Khadduri, J and O'Hara, A. *Housing Models.* Discussion Draft for the 2007 National Symposium on Homelessness Research. p. 14.
[13] Tsemberis, S, Gulcer, L and Nakae, M. Housing first, consumer choice and harm reduction for homeless individuals with a dual diagnosis. American Journal of Public Health. 94(4), 651-656, 2004.
[14] Barrow S, Soto G, Cordova p, Final Report on the Evaluation of the Closer to Home Initiative, Corporation for Supportive Housing, 2004.
[15]Source: Downtown Emergency Service Center, preliminary data on one-year outcomes, Nov. 28, 2007

Client use of Services	One Year Prior To Admission	One Year Post Admission	% Change
Harborview Medical Center visits	891	596	-33%
EMS paramedic interventions	540	432	-20%
County jail bookings	123	59	-52%
County jail days	1,233	678	-45%
Sobering Center admissions	5,549	222	-96%
Aggregate reduction in cost of services used	-$1.7 million		

- *Plymouth on Stewart*[16]: Resident's medical costs were reduced by 75% or 1.2 million from the year prior to admission. In addition, residents reported that the program had improved their housing situation, helped them deal more effectively with daily problems, improved their physical health, and helped them reduce drug use.

Client use of Services	One Year Prior To Admission	One Year Post Admission	% Change
Medical Respite Days	1,107 days	0 days	-100%
Harborview Medical Center Inpatient	329 days	56 days	-83%
Harborview Emergency Dept.	191 incidents	50 incidents	-74%
County jail bookings	5 bookings	7 bookings	40%
County jail days	123 days	101 days	-18%
Sobering Center admissions	349 visits	11 visits	-97%
Income support and employment	3 residents shifted from GAU to SSI. No employment income.		
Resident self-reported satisfaction measures	Residents agreed with statement: "I deal more effectively with daily problems." "I am not using drugs as much." "I am better able to control my life." "My physical health is improved." "I am getting along better with my family."		
Aggregate reduction in cost of svs used	-$1.5 million		

[16] Source: Debra Srebnik, Ph.D, King County Mental Health and Chemical Abuse and Dependency Services Division, One Year Outcomes Report for Plymouth on Stewart "Begin at Home" Program, Oct. 15, 2007.

III. HOUSING FIRST'S RAPID REHOUSING APPROACH IS ALSO EFFECTIVE FOR HOMELESS FAMILIES, HELPING THEM TO QUICKLY RESTABILIZE AND MINIMIZING THE NEGATIVE IMPACTS OF HOMELESSNESS, ESPECIALLY ON CHILDREN.

See Action Step 1.3.2

- Families: A two-year evaluation of Beyond Shelter's Housing First program, which helps homeless families move directly into affordable rental housing in residential neighborhoods as quickly as possible, and then provides six months to one year of individualized, home-based social services support to help each family transition to stability, found that 90% of mothers graduating from the program after 6 months in permanent housing had **achieved program goals relating to increased residential stability, improved mental health functioning, reduced drug and alcohol use and increased trauma recovery. More than 80% of adults were employed and others were enrolled in job training. 80% of children were enrolled in school and 77% were attending regularly.** Only 2.3% of those who entered with a substance abuse problem has relapsed and less than 1% of domestic violence survivors had returned to a dangerous relationship[17].

[17] Locke, G, Khadduri, J and O'Hara, 2007, p. 14.

IV. HOUSING SUBSIDIES HELP PREVENT AND END HOMELESSNESS.

See Action Steps 1.4.1 & 1.4.2

- Housing subsidies have been identified as a key factor in preventing and ending homelessness for poor women and children.

  - Data indicate that even the most troubled families can escape homelessness and maintain their housing when they receive a housing subsidy, regardless of whether or not they receive services[18].

  - A study in the Boston area found that nearly **90% of families that exited homelessness with a housing subsidy remained stably housed 6-12 months later.**[19] Similarly, a study of homeless families in New York City found that those who left homeless shelters with a housing subsidy were **21 times more likely to be stably housed five years** later than other formerly homeless families without housing subsidies[20].

  - In addition, housing subsidies are linked with **success by families in finding and retaining employment.** Possible reasons for this are that subsidies help to stabilize families' living situation and free up funds to cover work-related expenses such as childcare and transportation[21].

- Subsidies help prevent homelessness even for people with serious mental illness and substance abuse disorders.[22]

---

[18] Rog, D. J., & Gutman, M. (1997). The homeless families program: a summary of key findings. In Isaacs & J. R. Knickman (Eds.) *To improve health and health care: The Robert Wood Johnson Foundation anthology.* [209-231]. San Francisco: Jossey-Bass Publishers and Rog, D. J., Gilbert-Mongelli, A. M., & Lundy, E. (1998). *The Family Unification Program: Final Evaluation Report.* Washington, DC: CWLA Press.

[19] Friedman, D.H., Meschede, T. and Hayes, M. (2003). Surviving against the odds: Families' journeys off welfare and out of homelessness. *Cityscape: A journal of Policy Development and Research, 6(2),* 187-206.

[20] Shinn, M., Weitzman, B. C., Stojanovic, D., Knickman, J. R., Jimenez, L., Duchon, L, James, S. & Krantz, D. H. (1998). Predictors of homelessness among families in New York City: from shelter request to housing stability. *American Journal of Public Health, 88*(11): 1651-1657.

[21] Center On Budget And Policy Priorities, "The Increasing Use of TANF and State Matching Funds to Provide Housing Assistance to Families Moving from Welfare to Work.", February 2000.

[22] Shinn, M and Baumohl, J. Rethinking the prevention of homelessness. In Fosburg, L.B., Dennis, D.L. (eds), *Practical Lessons.* Washington, DC: HHS & HUD, 1999.

V. SHORT-TERM AND SHALLOW SUBSIDIES HAVE ALSO BEEN SHOWN TO BE EFFECTIVE IN HELPING PEOPLE REGAIN AND MAINTAIN HOUSING.

See Action Steps 1.4.1 & 1.4.2

- The Transitions to Housing Program in Portland, Oregon has provided short term emergency rental assistance to over 1,300 individuals and families who are newly housed after homelessness or at-risk of becoming homelessness. Twelve-month estimates show that **71 percent of households retained permanent housing free of rent assistance, and the latest figures show that households, on average, have increased their monthly income by almost 35 percent.**[23]

- In Massachusetts, three pilot programs were implemented to test alternative approaches to family emergency shelter which had become very costly (average annual cost of providing shelter to a family was $47,000 in 2004). The Rental Assistance for Families in Transition (RAFT) program provided flexible funding for first/last month's rent, security deposits and utility payments. 436 families were assisted at an average household cost of $1,365. Similar assistance was provided to 476 eligible families through the State's TANF emergency assistance program to help them shorten a shelter stay or avoid homelessness. The average cost per family was $3,080. 207 families were assisted under the Shelter to Housing pilot with a one-time subsidy of $6,000 to cover rent and some stabilization services. **Two years later 80% of the families were still housed. In addition, these three programs were able to significantly reduce costs, housing 1,119 families for the same cost as 63 shelter rooms.**[24]

[23] National Alliance to End Homelessness, "A New Vision: What is in Community Plans to End Homelessness?", November 2006, p. 27.
[24] One Family. *Housing First: An Unprecedented Opportunity,* Fall 2006. http://www.onefamilyinc.org/cgi-script/csArticles/uploads/466/PolicyPaperFINAL.pdf

VI. RESPITE CARE FACILITIES IMPROVE HEALTH OUTCOMES FOR PEOPLE WHO ARE HOMELESS AND BEING DISCHARGED FROM HOSPITALS AND HEALTH CARE FACILITIES.

Patients who received respite care had a **49% reduction in hospital admissions** compared to similar patients who received usual care. The average daily cost of respite care was $706, about **half the cost of a day of hospital care**.[25]

[25]Buchanan D, Doblin B, Sai T, Garcia P. The Effects of Respite Care for Homeless Patients: A Cohort Study, American Journal of Public Health, July 2006.

Appendix E
-Stopping Homelessness Before It Starts Through Prevention and Effective Intervention- Program & Practice Examples

Table of Contents

I. Data Tracking System coordinated with Cal OMS

II. Re-entry Planning, In-Reach Services & Post-Release Services

A. Project Choice, Oakland, CA

B. Montgomery County Correctional Facility (MCCF), Reentry Collaborative, Case Management Group (CCM), and Projects for Assistance in Transition from Homelessness (PATH) – Montgomery County, MD

C. Department of Corrections, Tennessee Bridges, Genesis Transition Program, Change Is Possible, TN

D. Massachusetts Department of Corrections, Re-entry Housing Program

E. Ridge House, Reno NV

III. Programs that provide Discharged Inmates with government-approved Identification Cards

A. Community Reentry Identification Card System, Montgomery County, MD

B. Indiana Department of Corrections

IV. Forensic Teams: Community–Based, Multi-Disciplinary Teams that Work to Prevent Homelessness & Recidivism to the Corrections System

V. Criminal Justice Diversion: Treatment In Lieu of Incarceration

Serial Inebriates Program San Diego, CA

VI. Homeless Court Programs

VII. Discharge Planning for People Released From Hospital ERs

New Directions Program, Santa Clara County, CA

VIII. Programs that Provide Respite Care for Those Discharging From Hospitals

A. The Cincinnati Center for Respite Care (CRC). Cincinnati OH

B. Hennepin County Health Care for the Homeless Respite Care Program, Minneapolis, MN

C. The Medical Respite Care Program Colorado Coalition for the Homeless (CCH), Denver, CO

IX. Housing Advocacy and Cash Assistance for Youth Aging Out of Foster Care: Youth Housing Assistance Program, IL

X. Transitional Housing for Youth Aging Out of Foster Care

A. A First Place for Youth, Oakland, CA
B. Larkin Street Youth Services LEASE Program, San Francisco CA

XI. Short-term Rental, Move-In & Mortgage Assistance

A. SHARE/Homeless Intervention Program, Prince William County, VA
B. Tri-Valley Housing Scholarship Program, Pleasanton and Livermore, CA
C. Echo Housing, San Francisco Bay Area, CA

Program & Practice Examples

I. Data tracking system coordinated with Cal OMS

See Action Step 2.1.1 & 2.1.2

The first goal of creating discharge planning policies and protocols is to end homelessness for clients entering SLO County jail and prisons, mental health institutions and drug and alcohol treatment programs. This means identifying clients who are homeless or whose housing is not stable and gathering information to help develop a plan to help the client access adequate housing and the supports necessary for ongoing stability. In order to succeed, intake workers must identify entering clients as "homeless." Staff must follow an intake protocol that includes performing a housing assessment. For clients identified as homeless, the housing assessment should be the first step in a protocol that links the client to housing and services.

A second goal of creating discharge planning policies and procedures is to determine the level of success of those policies and protocols. Therefore protocols must be established for collecting housing information at intake and at discharge in order to accurately track and report the housing status of clients entering *and* exiting a facility or program. As SLO County prepares to implement its HMIS, it is important to coordinate the data collection with CalOMS, described below, to enhance service providers' ability to track homeless persons' needs.

All licensed Narcotic Treatment Programs and other programs licensed or certified by the California Department of Alcohol and Drug Programs (ADP) that receive public alcohol or drug treatment funding must track and report outcome data for their clients in a database called California Outcomes Measurement System (CalOMS). Data *must* be collected at admission, at discharge or administrative discharge from the program, and annually as an annual update for clients in treatment for over twelve months.

The CalOMS data includes two pieces of homeless/housing-related information: 1) the client's zip code at their current residence with an option to enter "homeless" as a value and 2) his/her current living arrangements, also with an option to enter "homeless" as a value.[1] The CalOMS system also includes a data element titled "Discharge Status" where programs may track where a client intends to live after treatment, e.g. residential treatment, permanent housing, transitional housing, etc.

[1] CalOMS Data Dictionary, Version 1.02, California Department of Alcohol and Drug Programs, August 10, 2005. http://www.adp.ca.gov/caloms/pdf/CalOMS_Data_Dictionary_V1_01_Final_8_10_05.pdf.pdf

In the SLO discharge data collection protocol, the following questions must be asked two separate times, at intake and again at discharge, and recorded in HMIS data fields corresponding to the CalOMS system:

1) "Where do you live and with whom?" The case manager might clarify by asking, "Where have you been sleeping?" The goal is to ask questions that uncover the nature of the client's living situation, as some people are embarrassed to admit they are homeless. "Homeless" shall be entered into the "Current Living Arrangements" data field if the case manager determines that the client is, in fact, homeless as per the HUD definition.
2) "What is your current zip code?" If the client is homeless, "homeless" shall be entered into that data field.
3) "Where will you live when you leave here?" This corresponds to the CalOMS system includes a data element titled, "Discharge Status," recording where a client intends to go upon discharge the facility or program.

II. Re-Entry Planning, In-Reach Services & Post-Release Services for Inmates in Correctional Facility

Note: The California Department of Corrections is designing a series of reentry facilities to house prisoners in their last 6-12 months of incarceration. If constructed, the facilities will be located in the counties where the prisoners will be released. A facility has been proposed for SLO County and planned programming includes housing placement. Since the project is still in a planning phase, there may be opportunities for input or collaboration. See http://www.cdcr.ca.gov/News/Secure_Reentry.html for more information. See also Part 2: Research Knowledge (App. E, pg. 36).

A. Project Choice
Oakland, California

See Action Steps 2.1.3 and 2.1.4

Project Choice addresses the service needs of returning ex-offenders through **re-entry planning, service provision prior to parole, and post-release services** for young (14-29 year old) male offenders incarcerated at the California Department of Corrections and Youth Authority facilities nearest to Oakland (San Quentin State Prison, two CDC community reentry center and CYA's northern California Youth Correctional Center in Stockton).

Partners: City of Oakland, Oakland Police Department, Oakland Community Action Agency, Oakland Private Industry Council, Oakland Workforce Investment Board, Alameda County Probation Department, Alameda County Behavioral Health, California Department of Corrections, California Youth Authority, California Youth Authority Parole, California Parole, Police and Corrections Team, California Employment Development Department, San Quentin State Prison, Building Opportunities for Self Sufficiency, Allied Fellowship, Allen Temple Baptist Church, Walden House, West Oakland Youth Opportunity Program, and various education institutions

Significant Program Design Features:

- Comprehensive assessment to inform a LifePlan prescribing intensive services and supervision bridging the institutional, transitional and long-term support phases
- A multi-disciplinary team approach to reentry planning and support
- Dedicated caseworkers called "coaches" with small caseloads who begin to work with exoffenders prior to release and serve as "parole agent extenders" post-release

- Parole agencies and coaches brokering services though a network of public, private and faithbased service providers to meet ex-offenders' multiple and varied needs
- Graduated incentives and sanctions to encourage parolee success and a step-down to less intensive supervision over time
- Availability of continued support after parole has ended

PHASE I – SERVICES WHILE INSTITUTIONALIZED

- Comprehensive assessment at least 12 months prior to release, reassessments 30-90 days pre-release
- Educational, vocational, behavioral health, victim awareness, reentry preparation
- Initiate case management 6-12 months pre-release

PHASE II – TRANSITION

- Intensive supervision and support, including periodic re-evaluations of supervision level and service needs
- Educational services (basic academic, remedial, special education) including tutoring and mentoring
- Vocational, college and career counseling
- Vocational training
- Job placement
- On-the-job support geared toward job retention
- Substance abuse treatment and prevention services
- Mental health counseling and support, including life skills, anger management training
- Housing support
- Community service and restitution

PHASE III – LONG TERM SUPPORT

- Lower intensity supervision and case management, including periodic re-evaluations of supervision/service needs
- Education and vocational training
- Job placement and employment support
- Substance abuse and mental health services
- Housing support
- Restitution

B. Montgomery County Correctional Facility (MCCF)
Reentry Collaborative Case Management Group (CCM) and
Projects for Assistance in Transition from homelessness (PATH)
Montgomery County, Maryland

See Action Steps 2.1.3 & 2.1.4

CCM Partners

MCCF case managers, treatments staff, and social worker; Montgomery County Police, Parole and Probation; 40+ Health and Human Services agencies, local non-profits and faith-based organizations

CCM Significant Program Design features

- CCM is an effort for the MCCF Reentry Unit to reach "beyond the walls" and provide a continuum of services that begins during incarceration and continues after release
- CCM is a group that meets bi-weekly to do reentry planning for each inmate who has accepted reentry services. The group is comprised of corrections reentry staff, law enforcement and parole staff, and 40+ community-based service providers. Together they decide who will take each inmate's case and plan transitional services.
- Reentry services are offered to all inmates 90-120 days prior to release. An MCCF reentry social worker holds orientation meetings in every unit. Inmates can accept or deny reentry services. Those who accept reentry services are then assigned an MCCF Reentry Caseworker.
- The Reentry Caseworker establishes links with the community-based service providers who will assist the inmate directly upon release, e.g. housing and homeless service providers, substance abuse treatment, employment training, etc. In some cases, the service providers meet with the inmate prior to release and begin services while the inmate is incarcerated.
-The MCCF Reentry Benefit Specialist is available to assist inmate and family with benefits enrollments
- There is also a one-stop career center located inside the correctional facility where inmates can view job posting, prepare resumes and apply for jobs online.

PATH Significant Program Design Features

-provides services to inmates who are homeless and severely and persistently mentally ill in the MCCF Crisis Intervention Unit
-serves both pre-trial and adjudicated inmates
-refers clients to co-occurring disorders treatment services and residential partial hospital programs
-focus on mental health medication and treatment engagement
-provides assistance with benefits applications, linkages to housing and vocational programs
-case management continues until client is stable in the community

PATH Outcomes
-in FY05, 196 clients were referred from Correctional Behavioral Services, and 153 were admitted to PATH

C. Department of Corrections, Tennessee
Tennessee Bridges, Genesis Transition Program and Change *Is* Possible

See Action Steps 2.1.3 & 2.1.4

Partners
Tennessee Dept. of Corrections, Project Return, Inc.

The Tennessee Department of Corrections releases about 12,000 people a year. Project Return interacts with roughly 5,000 clients per year, including 1,400 new clients.

Bridges Significant Program Design Features
Tennessee Bridges was a pilot reentry program for high-risk male offenders, to prepare them at pre-release for reentry and to continue to assist them post-release with case management. Participants were selected by the parole board--for example, repeat offenders who had not succeeded in other programs--and paroled to the Bridges program.

The two-year program had three phases:

1) 1st 6 months: Programmatic phase, inmate still incarcerated
    - cognitive skills training
    - substance abuse treatment
    - job readiness preparation
    - other pre-release services
2) 2nd 6 months: Work-Release, Inmate incarcerated but working in the community
    - paying a percentage of income for to state for prison housing
    - mandatory savings to help prepare for future housing needs
3) last 12 months: Release and Reentry
    - continued case management from Bridges case manager, including housing placement
    - those unable to find housing while on work release received assistance from case managers for placement in transitional housing—halfway houses--and, if needed, a loan to cover the first week's deposit
    - participants mandated to stay in halfway houses for at least 3 months to stabilize the reentry process
    - after the 90 days stay, continued assistance from case manager to access housing

- Single parole officer assigned to program participants in each district. Monthly group parole meetings, which facilitated the parole process.

Bridges Outcomes
-recidivism rate of 46.6% as opposed to 71% in 3 control groups.

Due to changes in funding allocation, Tennessee Bridges was replaced by the Genesis Transition Program, a 9-month 3-phase program for men and the Change *Is* Possible program for women. These programs incorporate the programmatic and educational portion of the Bridges program. They also include case management and discharge planning, but only until the date of release.

Genesis Transitions and Change is Possible Significant Program Design Features

- Case Manager and offender together draw up Offender Release Plan as far in advance of release date as possible
- Case manager locates housing options in area where offender will be paroled
- In some cases, houses or housing organizations send a representative to interview and accept the offender prior to release
- Offenders who secure housing prior to release may in some cases receive a waiver on the requirement to secure employment within 60 days of parole
- Case managers assist offender to obtain legal identification while incarcerated, including birth certificate and social security card

Additional features of Genesis
Program Attributes

- Modified therapeutic community
- Assessment of criminogenic issues, addiction severity, employment, vocational training, and socialization & relationships
- Drug testing
- Community service
- Focus on employment retention
- Fees assessed to off-set costs

Program Services Offered

- Employment readiness and placement assistance
- Relapse prevention planning
- Victim impact awareness
- Cognitive behavioral therapy
- Discharge planning
- Community service
- Parole preparation

- Mentoring services

Additional Features of Change *Is* Possible

- 2-phase pre-release program specifically designed to meet the needs of female offenders
- 3 individual assessments to help individualize services: risk of re-offending, life skills, vocational skills

1st Phase, Life Skills, involves 10 weeks of daily life skills classes, 4.5 hours a day. Classes include:

- financial skills
- survival skills for women such as health, nutrition, child management, legal rights, etc
- Critical thinking and decision-making;
- GED classes required for all those lacking a high school diploma; math and reading assistance for all others
- Health and exercise classes

2nd Phase, Reentry, includes:

- Structured therapeutic community model, including daily half-hour meetings, cognitive-behavioral therapy, outside speakers
- Social learning for reentry curriculum
- Work release/workline jobs to help build work history
- Life Action Plan written by each participant with staff help. Identifies long and short-term goals and barriers to achieving them, with specific strategies for overcoming barriers. Identifies services needs and specific resources to address them.

D. Massachusetts Department of Corrections, Reentry Housing Program Massachusetts

See Action Steps 2.1.3 & 2.1.4

Partners

Massachusetts Department of Corrections, South Middlesex Opportunity Council (SMOC)

Significant Program Design Features

The Reentry Housing Program is intended to ensure that inmates discharge into secure housing. Non-violent offenders at risk of homelessness and with substance abuse problems receive discharge planning during incarceration and wraparound services, including housing stabilization, for up to a year post-release. The Department of Corrections contracts with SMOC for housing placement services.

The Department of Corrections provides:

- One or more case managers/reentry counselors in each of 17 Department of Corrections facilities
- the “first tier” in a two-tiered system
- reentry planning, beginning a year before each offender's release to locate the services the offender will need upon reentry, including housing. Some reentry services, such as GED prep begin earlier, following risk assessment at the inmate reception center.
- Monthly triage meetings involving DOC caseworkers, correctional program officers, medical and mental health staff, inmate liaisons, etc. to assess who is at risk of homelessness upon release. Inmates are assessed at least 6 months prior to release.
- Referrals to a SMOC housing specialist for non-violent offenders at risk of homelessness and with substance abuse problems, up to six months prior to release
- For offenders who do not meet criteria for a SMOC referral but are at-risk of homelessness, DOC staff find a housing placement for the inmate
- Other reentry services include employment training, GED preparation, and mental health services

SMOC provides:

- the voluntary “second tier” in a two-tiered system
- 7 mobile housing specialists working out of regional offices located in Boston, Fall River, Lowell, Springfield and Worcester
- “in-reach” to all 17 correctional facilities
- an in-person intake interview in the prison to identify client’s preferred release region, financial situation, family support, as well as medical, mental health and/or substance abuse issues.
- housing specialist works with client to secure an appropriate housing placement prior to release and picks client up on day of release to transport him or her to housing
- placements may include SMOC’s properties in Framingham, Fall River, Springfield, Lowell, and Wooster. SMOC owns 113 buildings--867 units of affordable housing in 14 communities--include emergency housing, reentry housing, sober housing, low rent apartments, and even some home-ownership properties.
- continued housing stabilization services and other wrap-around services for up to a year post-release

<u>Outcomes:</u>
Program nationally recognized by the U. S. Interagency Council on Homelessness as a model that decreases the likelihood of offenders releasing to shelters

Funding:
Massachusetts Department of Corrections, with $1,000,077 from the Department of Justice

E. Ridge House
Reno, Nevada

See Action Step 2.1.3

Partners
Ridge House, Nevada Department of Parole and Probation. KAIROS prison ministry

Significant Program Design Features
Ridge house is a faith-based program that operates six residential facilities in Reno, housing seven clients each: two houses for women, three for men, and one transitional living facility for those not needing full residential care. A seventh house, which is relatively small and new, is located in Las Vegas.

-designed specifically for ex-offenders or people involved in the criminal justice system struggling with substance abuse/addiction
-95% of clients are former inmates. Most applicants either write from prison requesting an application, or a prison case manager applies for the inmate. Applicants are then interviewed on the phone or in prison so the person can discharge directly into the program.
-residential programs, operated from home, with a live-in house manager
-average stay of 3 months
-3-phase approach with re-entry skills taught at each phase
-structured group and individual counseling / mental health treatment
-family style meals
-family reunification assistance
-life skills
-money management training
-computer training
-free HIV and TB testing available as well as STD education

The 3 phases
1) Stabilization: clients are asked to sign a contract at intake outlining certain milestones they must meet, including finding employment within seven working days, paying for room and board, and contributing to household chores. Participants receive support from staff, including instruction on some of the necessary skills for self-responsibility.

2) Habilitation: participants are provided with substance abuse treatment, GED classes, vocational training, parenting classes, and life-skills training.

3) Re-entry phase, staff builds on earlier programming to ensure that clients have addressed their substance abuse issues and have built a strong supportive network.

All Ridge House residents work 40 hours a week, day shift, and pay sliding-scale "service fees" in lieu of rent. The goal is for clients to save up for housing during their stay and prepare for a permanent housing situation upon release. After completing the program, clients are transferred to the Ridge House Aftercare component, which involves 6-8 months of outpatient group and individual counseling. Patients who are not yet ready to live independently may be moved to the Transitional Living house for up to 6 months.

Outcomes

-since 1991, less than 30% of Ridge House clients recidivated within three years of release

-The Statewide Ridge House Collaborative (two Ridge House programs located at opposite ends of the state) had a 20 percent rate of recidivism at the end of 2001

III. Programs that provide inmates discharging from correctional facilities with government-approved ID cards

Inmates discharging from jails and prisons face numerous barriers to reentry when they lack proper identification upon discharge. Government-approved photo identification is necessary for people exiting correctional facilities to access housing, employment, medical care and numerous other services required for successful reintegration into the community. However, a great number of inmates lose their identification during the course of their incarceration.

A. Community Reentry Identification Card System Montgomery County, Maryland

See Action Step 2.1.4

Partners

Montgomery County Department of Correction and Rehabilitation, Montgomery County Correctional Facility, Maryland State Department of Motor Vehicles, Federal Department of Homeland Security, County Council, County Executive

Significant Program Design Features

The Community Reentry Identification Card System provides a 60-day temporary identification card to inmates exiting Montgomery County correctional facilities. It enables cardholders to access services that require identification immediately upon release and to apply for jobs. It creates a 2-month window for former prisoners to apply for a permanent state ID card, and serves as a secondary proof of identification for the issuing of that permanent ID. (A birth certificate or social security card is still required for obtaining the permanent ID, and the correctional facility does not assist ex-offenders in obtaining the latter.)

An inmate may request an ID card from his or her regular case manager 30 days or more before release. The case manager, after verifying the inmate's eligibility for the identification, can schedule the card's production within two weeks of the release date. The inmate receives the card upon release. The card functions as a valid county-issued temporary ID, and meets the federal standards for employment identification. It also serves as a temporary public transit pass, helping the ID-holder meet all parole/probation obligations and seek other services. Additionally, it serves as a temporary library card, allowing free access to the internet for employment searches.

In order to qualify for the temporary ID card, an inmate needs to be able to provide a verifiable address where he or she will live after release. This can be a private home or a shelter that has already agreed to accept the inmate. Inmates who do not have housing plans may enter the reentry services program and receive discharge planning.

Outcomes
"During the first year, results indicate a significant positive effect on the successful reintegration of ex-offenders in gaining employment, securing permanent identification to conduct basic commerce (e.g. cash checking, renting) and establishing a lawful existence in the community." --Warden Robert Green

From October, 2005 through January, 2008, 483 Community Reentry ID Cards were issued. More continue to be issued.

The temporary ID has been successfully used by jail-based social workers and Income Assistance Program Specialists to secure Medicaid and Medicare benefits.

Costs
$7,424 in startup costs for cameras, printers, card inventory and software, which was generated from telephone and canteen proceeds. Funds were taken from the Inmate Advisory Council Budget; no county funds were used. Additional annual cost is approximately $1,485.

B. Indiana Department of Corrections

See Action Step 2.1.4

Partners
Indiana Department of Corrections, Indiana Bureau of Motor Vehicles (BMV), Indiana State Department of Health (IDOH)

Significant Program Design Feature
The Department of Corrections is in the process of establishing a BMV office at every correctional facility, so that offenders can be issued permanent state identification cards upon release. There are currently BMV offices at the "heavy release" correctional facilities, with plans for further construction at all remaining correctional facilities.

When an inmate enters a correctional facility without identification, the intake unit immediately orders a birth certificate for him or her from the State Department of Health, as long as the inmate will be in the facility for at least 30 days. When the birth certificate arrives, the Department then applies for a social security card for the inmate. The DOC then submits the birth certificate and the social security card to the BMV so that upon release, the offender receives his or her permanent state-issued ID card or driver's license. Thus, an offender returning to the community is able to access all services and benefits requiring legal identification from the moment of his or her release.

Inmates at Plainfield Reentry and Educational Facility are able to obtain limited-use checking accounts and debit cards for use in the facility. They are also assisted in obtaining a bank account upon release. The Department is also in the process of setting up a pre-release application process for Medicaid. A committee has been formed which includes individuals representing necessary human services, along with entities such as Vocational Rehabilitation, Child Support and Paternity, Medicare and Mental Health and Addiction. Eligibility criteria have been identified for these benefits and services in an attempt to provide guidance to IDOC staff. See http://www.in.gov/idoc/reentry/

In addition to identification cards reentry services for inmates include the creation of an electronic Reentry Accountability Plan, which can be accessed by an inmate's parole officer once the inmate is released. Prior to release, the inmate is required to complete a pre-release training course for a minimum of 65 hours. A variety of outside organizations come into teach pre-release classes. These include: Banks that teach about checking, employers that talk about job opportunities, educators that teach about financial aid, health providers, transitional housing providers, substance abuse counselors, people from the VA administration, etc. Other pre-release services include computer skills classes and mock job interviews for those who have served extended sentences, as well as resume preparation. All of an inmate's work experience during his or her incarceration is incorporated into the resume. Department of Corrections case managers can also schedule appointments for inmates prior to release, for example with doctors or substance abuse programs, and include an appointment card reminder for the inmate in his release packet.

Funding

Funding for the construction of BMV offices comes from the Department of Corrections budget. Offenders pay for their birth certificates out of their recreation funds.

IV. Forensic Teams: Community-Based, Multi-Disciplinary Teams That Work To Prevent Homelessness & Recidivism To The Corrections System

AB 2034
California

See Action Step 2.1.6

AB 2034 was a state program that funded localities to provide comprehensive services to adults with serious mental illness who were homeless, recently released from a county jail or state prison, or who were untreated, unstable, and at significant risk of incarceration or homelessness unless provided with treatment. At the height of the program, AB 2034 funded 53 programs, operating in 34 counties, serving over 4,500 people, through the state. Due to the flexibility of its funding, counties were able to provide a comprehensive array of services, including assertive community outreach, supportive housing and other housing assistance, employment, substance abuse, and mental and physical healthcare.

AB2034 programs were effective in meeting client needs, as documented by the following outcomes:

- Hospital use decreased: number of clients hospitalized decreased 42.3%, hospital admissions decreased 28.4%, and the number of hospital days decreased 55.8%
- Incarceration in prison and jails decreased: number of clients incarcerated decreased 58.3%, number of incarcerations decreased 45.9%, and the number of incarceration days decreased 72.1%
- Income levels increased: number of SSI recipients increased by 93.1% and the number of people receiving wages from employment increased by 279.8%
- Homelessness by clients decreased: overall number of homeless days experienced by clients decreased by 67.3%

V. Criminal Justice Diversion: Treatment In Lieu Of Incarceration

Serial Inebriates Program
San Diego, California

See Action Step 2.1.6

The Serial Inebriates Program (SIP) is an intervention and treatment program which offers homeless chronic inebriates **alcohol treatment and wraparound services with transitional living and permanent housing placement assistance in lieu of jail time**. SIP's goal is to reduce the number of people cycling through detoxification centers, County jail, local emergency rooms and treatment.

Partners

County, City and nonprofit stakeholders in systems which "serve" chronic inebriates: City of San Diego City Council, City of San Diego Police Department, City of San Diego Fire Department/Emergency Medical Services, San Diego City Attorneys Office, San Diego Office of Public Defender, County of San Diego Alcohol and Drug Services, County of San Diego Sheriff's Department Detention Facilities, County of San Diego Superior Court, San Diego Inebriate Reception Center (Detox), San Diego Health and Human Services, Medi-Coast Counseling Services, Mental Health Services, Inc., One Day at a Time Sober Living Homes, and St. Vincent de Paul Village

Significant Program Design Features

JUSTICE SYSTEM PROCESSES

- Individuals found to be drunk in public are arrested and transported to Detox
- If records indicate chronic use of the facility, the offender is booked into jail; otherwise Detox accepts the offender.
- Police department booking procedures changed so offenders were no longer released after 4 hours; offenders remained in jail until arraignment
- All in-custody arrest reports were sent to the City Attorney with SIP stamped on front for special handling; City Attorney brought all cases meeting the elements of drunk in public to trial
- Upon conviction, the court offers an option of rehabilitation; the offender must volunteer to be assessed to determine eligibility
- Mid-Coast Counseling Services performed in-custody assessments to determine willingness to enter treatment
- If accepted the Court releases the offender to treatment; if the offender refuses the treatment program or is determined ineligible, s/he remains in jail and ordered to attend an in-custody alcohol treatment program

- Based on first year's experience, in year 2 of program, the City Attorney issued "notify warrants" to SIP for drunk in public arrests when the offender was admitted into the emergency room

TREATMENT AND HOUSING

- Mid-Coast Counseling Services provides treatment sessions and case management: medical treatment, employment and education services, referrals
- One Day at a Time Sober Living Homes provide housing
- Participants can stay in the program for up to 9 months; the average stay is 6 months
- Once a participant has income, s/he pays 1/3 for program expenses, 1/3 into a savings account for emergencies and permanent housing

Outcomes

Since 2000, the participant outcomes include the following:

- 32% completed treatment
- EMS contacts were reduced 88%
- Emergency room visits decreased 92%
- Hospital costs decreased 80%
- Arrests decreased 58%.

VI. Homeless Court Programs

See Action Step 2.1.6 & 3.1.8

The Issue: People experiencing homelessness often receive citations for public nuisance offenses and then fail to appear in court. Homeless defendants fail to appear in traditional courts, not because of a disregard for the court system, but due to their status and condition. For many homeless people, their day is consumed with a search for food, clothing and shelter. Most homeless persons are not in a position to fight the procedural or substantive issues a case presents. The homeless are aware that the court also requires a decent appearance. Not wanting to make a bad first impression, a homeless person with poor hygiene or without a place to store belongings may choose not to appear in court at all. Many homeless people are reluctant to attend court given the uncertainty of court proceedings and the threat of custody. Unresolved legal issues can ultimately preclude homeless people from accessing desperately needed services such as employment, housing, public assistance and treatment programs.

The Solution: Homeless courts are special court sessions for homeless defendants to resolve outstanding misdemeanor offenses and warrants. Several jurisdictions in California have instituted Homeless Court Programs, including Contra Costa County, Alameda County, and Santa Clara County. San Diego County began the first homeless court program in the country in 1989.

Homeless court programs reduce court and jail costs, build community collaboration, improve access to court, and assist homeless people in accessing vital services and jobs. Access to court for people who are homeless is improved by bringing the court to the community. Court sessions are held at local shelters or agencies that serve this population. Many homeless people have received multiple citations for public disturbance offenses such as illegal lodging, drinking in public, and loitering. This frequent contact with police perpetuates the cycle of homelessness.

Homeless courts build on partnerships between the court, local shelters and service agencies, and the prosecutor and public defender. It attempts to resolve the problems that homelessness represents with practical solutions. Initial referrals to homeless courts originate in shelters and service agencies. The prosecution and defense review the cases before the court hearing, both to make sure the offense is eligible for disposition through the homeless court program, and to create appropriate alternative sentencing. Alternative sentencing substitutes participation in agency programs for fines and custody. Homeless court programs are designed for efficiency: cases are heard and resolved, and people are sentenced, in one hearing.

To counteract the effect of criminal cases pushing homeless defendants further outside society, this court combines a progressive plea bargain system, alternative sentencing structure, assurance of "no custody" and proof of program activities, to address a full range of misdemeanor offenses and bring them back into society. Alternative sentencing substitutes participation in agency programs for fines and custody. These activities include: life-skills, chemical dependency or AA/NA meetings, computer or English literacy classes, training or search for employment, counseling or volunteer work. Defendants are 'sentenced to' and given credit for time 'served' in educational activities, substance abuse rehabilitation programs, medical care, volunteer and paid work, and other life-building steps. The court agreement of "no custody" acknowledges the participant's efforts in their program activities to satisfy court requirements. Local homeless shelters and agencies are the gateway for participants to enter this court. Homeless persons who want to appear before this court must sign up through one of a number of local shelters and/or service providers. Prospective participants work with a shelter caseworker to design a plan to move towards self-sufficiency. The shelter representatives write advocacy letters for each client. The advocacy letter is symbolic of the relationship between the client and the agency while including a description of the program, the client's start date, and accomplishments, programs completed and insight into the client's efforts.

Benefits of the Homeless Court Program: Homeless Courts expand access to justice and reduce the number of hearings necessary to successfully complete court orders by integrating the shelter system into the "currency" participants present for sentencing. Advanced preparation and fewer hearings translate into efficiency during courtroom hours and reduced court costs.

Shelters and service agencies save precious resources when clients move toward self-sufficient lives with cleared criminal cases. Without homeless court programs, a client might successfully complete the agency program only to be incarcerated on an outstanding criminal case and, afterward, return to homelessness. When cases are resolved through the homeless court the homeless service providers do not have to redouble their efforts. The shelters address the underlying problems homelessness represents. Holding court in the shelter gives judges and attorneys easy access to a defendant's character witnesses and others who can describe the individual's commitment to change. It allows homeless people to participate at a less stressful level than a formal court hearing room fosters. Perhaps most important, though, it illustrates the extent to which the justice system is capable of reaching out to disenfranchised citizens and creating avenues back into the community.

For participants, the Court hearing is an opportunity to separate the past, as represented by the cases before the Court, from the present (and future) by presenting the accomplishments described in the advocacy letters, along with plans for future improvement. The strongest recommendation for creating a

homeless court program is that it is a key element in reintegrating into our society people who have lived long in its shadows. Anecdotes and statistics show that 'graduates' of the homeless court program in San Diego have the confidence, skills and 'clean slate' that enables them to look for permanent housing (46%), apply for a driver's license (39%) and seek employment (38%).

Homeless courts help the community by engaging homeless people in gainful activity, thereby removing them from doorways, parks and gathering places where they are unwanted and susceptible to arrest. It helps homeless people move back into productive lives by addressing the legal issues that often create barriers to accessing employment, housing, public assistance and treatment programs.

The benefits to a county that has instituted a successful homeless court program are extraordinary. Homeless courts bring about significant reductions in the number of hearings necessary to resolve cases. Homeless courts lower costs associated with homeless misdemeanants, and significantly raise rates of successful completion of sanctions without incarceration. Recidivism is much lower, and the bulk of the cases handled by an HCP (80% to 90%) are dismissed.

HCP provides a cost-benefit to the criminal justice system, although the actual cost savings may be difficult to calculate monetarily. HCP participants indicated they would not have voluntarily surrendered themselves to the court for prosecution unless the police detained them and then booked them into custody. Thus, the cost of law enforcement booking the defendants into jail (average daily cost in San Diego: $72.84) does not happen, and the cost of housing a defendant in jail for several days is not incurred. In addition, resolving a large number of cases for multiple defendants in one setting reduces the number of court appearances and therefore reduces court cost and court time.

Homeless Courts are presently operating in the following jurisdictions:

Alameda County, CA
Ann Arbor, MI
Bakersfield, CA
Bernalillo County, Albuquerque, NM
Contra Costa, CA
Denver, CO
Fresno County, CA
Houston, TX
Humboldt, CA
Kern County, CA
Los Angeles, CA
Maricopa County, AZ
Phoenix, AZ
Pima County/Tucson, AZ
Sacramento, CA
Salt Lake City, UT
San Bernardino, CA
San Diego, CA
San Joaquin, CA
Santa Clara, CA
Santa Maria, CA
Sonoma County, CA
Vancouver, WA
Ventura County, CA

For More Information: This summary is based on two very helpful tools on homeless courts: “The Homeless Court Program: Taking the Court to the Streets," documents San Diego's successful Homeless Court Program and "Homeless Courts Conference Coursebook," contains the materials circulated at the American Bar Association (ABA) National Conference on Homeless Courts on October 8, 2004 in San Diego. Both of these resources can be found at http://www.abanet.org/homeless/homeless_courts.shtml. The ABA Commission on Homelessness & Poverty has been instrumental in establishing homeless courts across the country. The Commission has developed a number of educational resources and routinely provides technical assistance. The ABA has also approved policies related to homeless courts, including basic principles for homeless court programs.

VII. Discharge Planning For People Released From Hospital Emergency Rooms

New Directions Program
Santa Clara County, California

See Action Step 2.2.1

Santa Clara County's New Direction Program provides a **comprehensive range of discharge and transition planning services** to help frequent users of hospital emergency rooms to achieve greater health and housing stability and to reduce their use of hospital emergency services. Services, including housing assistance, benefits advocacy, health care, mental health, drug and alcohol treatment, employment and training, budgeting and other life skills, are provided through an interdisciplinary service team using an intensive case management approach and interagency case conferencing to effectively coordinate care.

Partners: County, City, Hospitals and Nonprofit Agencies, including: Santa Clara Valley Medical Center, San Jose Medical Center, Saint Louise Regional Hospital, Regional Medical Center of San Jose, O'Connor Hospital, Santa Clara County Department of Alcohol and Drug Services, Santa Clara County Department of Public Health, Santa Clara County Social Services Agency, Santa Clara County Department of Mental Health, Santa Clara County Office of Affordable Housing, Community Health Partnership, Catholic Charities, Corporation for Supportive Housing, EHC LifeBuilders, Gardner Family Health Network, InnVision, San Jose Police Department, Santa Clara Family Health Plan, Valley Homeless Health Care Program, and Valley Transportation Authority

Significant Program Design Features:

INTENSIVE CASE MANAGEMENT

- Assertive case management model (build trust, flexible client-specific supports, 'whatever it takes')
- Focuses on helping clients achieve stability in key areas (for example, medical, behavioral, housing, food)
- Establishes the case manager as a continuous point of contact and support
- Emphasizes gradual transition to increased independent self-care and employment
- Low case loads
- Provides:
  - Assistance with furnishing and moving into apartments
  - Assistance and advocacy in maintaining good tenant-landlord relationships

- Assistance with budgeting and other life skills
- Access to financial assistance and health insurance
- Assistance and advocacy obtaining mainstream benefits, including SSI, GA, Food Stamps, Medicare and MediCal.
- Assistance in accessing employment and training services
- Assistance with accessing and using transportation
- Group programs in decreasing stress & anxiety, increasing coping mechanisms,
- managing money, and other topics as needed

INTERDISCIPLINARY AND INTER-AGENCY CASE CONFERENCING

- Multidisciplinary team that includes members from the Mental Health Department, Alcohol and Drug Services, and Primary Medical Care
- Enables coordination of care across providers and facilitates timely access to needed services at the right location
- Team members assist in reviewing cases and finding solutions and options for clients with difficult issues.
- Team makes recommendations for changes in systems that create barriers to services for this population.
- New Directions also works with a community collaborative formed specifically for the New Directions program, including members from Public Health, Mental Health, Alcohol and Drug Services, hospitals in the community, several housing organizations, transportation systems, community health clinics, primary health care providers, and community based support organizations. All of these members provide services needed by this population and work actively with New Directions on issues and barriers to services for this population.

LINKAGE TO PRIMARY CARE AND CONTINUITY OF PHYSICIAN

- Access to primary and specialty medical care with a specific primary care physician assigned
- Advocacy to move through barriers to service and health care access
- Assistance in accessing medical care including escorting participants to medical appointments and providing follow-up after appointments
- Assistance in filling prescriptions and compliance with medication schedules
- Assistance in accessing mental health and substance abuse programs

A note on housing: New Directions soon recognized that lack of permanent housing is the biggest barrier to success for this population. Even when the client is motivated, it is very difficult without stable housing to make improvements in chronic health conditions, mental illness, or substance abuse. Therefore the project formed a partnership with a local homeless housing provider to develop

permanent supportive housing, using a Housing First model, to provide permanent units for New Directions' clients.

New Direction Outcomes:

- 31% reduction in emergency department visits
- 53% decrease in inpatient hospital days for clients
- Almost 50% reduction in cost of emergency department, inpatient, and outpatient clinic services provided to clients after just one year of enrollment, with greater reductions for clients who completed two years of enrollment

VIII. Programs that provide respite care for individuals discharging from hospitals

Respite care refers to recuperative or convalescent services for those who may not meet criteria for hospitalization, but who are too sick or vulnerable to be discharged to the streets. Respite programs provide medical services, including a minimum of daily nursing care.

Respite care for individuals who are homeless offers numerous benefits. Respite care provides a safe, recuperative environment for a person to heal, and offers supportive medical, nursing and case management services. Respite care serves as an entry point for homeless individuals to benefit from multiple services that may be available in the community (including those provided through the HCH and PATH programs), while encouraging the building of trusting therapeutic relationships with medical and social service providers. In so doing, respite care provides an opportunity to minimize harm to persons unable to advocate for themselves who are at high risk for serious health complications resulting from fragmented systems of care.

A. The Cincinnati Center for Respite Care (CRC) Cincinnati, OH

See Action Step 2.2.3

Summary: A 14-bed facility for homeless people who are either too sick to be in a shelter or have been recently discharged from a hospital and need a safe place for recuperation. Located downtown near the largest homeless shelter, the respite facility is open 24 hours a day, 7 days a week.

Services: The CRC provides basic short-term medical and recuperative care, as well as social services for sick, homeless people while they recover. Key elements of the program include: 1) initial diagnostic medical assessment and development of a plan of care for patients upon admission, 2) implementation of the plan of care, 3) coordination of care with a primary care physician and/or hospital staff, 4) application for entitlement programs or coordination of plan with outside case manager, 5) referrals to community housing and job placement services, 6) referrals to appropriate medical agencies for ongoing care and substance abuse/mental health services as needed, and 7) discharge placement to stable housing or treatment facilities.

Patients: Patients are referred from area hospitals or are admitted directly from homeless shelters by medical staff.

Collaborative partners: The Health Resource Center of Cincinnati, Inc.; the Health Care for the Homeless Program through the Cincinnati Health Network,

Inc.; three major hospital networks (The Health Alliance of Greater Cincinnati, TriHealth, and Mercy Health Partners); The Health Foundation of Greater Cincinnati; the University of Cincinnati Department of Family Medicine; and The Drop Inn Center emergency shelter.

Funding: Funding comes from local hospitals, government grants, foundations, individuals, and faith-based organizations.

B. Hennepin County Health Care for the Homeless Respite Care Program Minneapolis, MN

See Action Step 2.2.3

Summary: A 15-bed medical respite program primarily based in an existing shelter that receives on-site HCH clinic services.

Patients: Patients are homeless adults residing in a local shelter or recently released from area hospitals who are recovering from acute medical problems.

Services: The program provides on-site clinic HCH services. One full-time public health nurse (PHN) serves as lead Respite Nurse for the HCH project and provides care coordination and medical case management to respite clients. The Respite Nurse conducts a health and social needs assessment of each client entering the respite program and works with the client to develop a plan of care and follow up strategies. Initially the sole respite service provider, she now heads a respite team, which also includes a part-time PHN, a nurse practitioner, a financial worker, and a social worker.

Funding: Funding is provided by an HCH grant, supplemented by a small grant from the State of Minnesota to cover a portion of the lead PHN's salary.

C. The Medical Respite Care program Colorado Coalition for the Homeless (CCH) Denver, CO

See Action Step 2.2.3

Summary: This program is one branch of medical services provided through Stout Street Clinic, a designated Health Care for the Homeless clinic in downtown Denver. The respite program collaborates with three different facilities to provide respite beds and services throughout the city. Respite staff are based in a shelter where 15 of the total 33 beds are located.

Patients: Referrals to the program are made by area hospitals, clinics, shelters, churches, VA programs, Adult Protective Services, and detox facilities.

Services: The Respite Care Program provides nursing care, medical treatment, case management including assistance with benefits application and discharge planning, medication monitoring, 24-hour staff supervision, meals, a laundry facility, housekeeping, and referrals and transportation to other needed care. Staffing for the program includes a full-time program coordinator who is a registered nurse, a clinical case manager (.65 FTE), two additional registered nurses (.75 FTE), and an administrative assistant (.5 FTE). Clients admitted to the respite program meet with both nursing and case management staff to identify specific needs and goals to address while they reside in this temporary housing program.

Funding: HCH grant.

IX. Housing Advocacy and Cash Assistance for Youth Aging Out of Foster Care

Youth Housing Assistance Program
Illinois

See Action Step 2.3.1

Illinois' Youth Housing Assistance Program targets youth at high risk of becoming homeless who are approaching emancipation or who have already emancipated from the foster care system**. Housing advocacy** is provided for youth between the ages of 17 1/2 and 21 and **cash assistance** is provided to youth between the ages of 18 and 21.

Services

- Housing Advocacy -- service to help youth locate housing
- Budget counseling
- Linkage with community resources and social services.
- Start-up Grants to assist youth in moving into housing at the time of emancipation. Youth can receive up to $800 ($1200 if youth is parenting, pregnant, or disabled) to cover start up costs including deposits, furniture, appliances, etc.
- Partial Housing Subsidy -- If youth's housing cost exceeds 30% of their income, their landlord will receive up to $100 per month for up to 12 months following the youth's emancipation. The monthly subsidy is designed to be large enough to provide a cushion for young people learning to live on their own for the first time, but small enough to discourage youth from becoming dependent on the subsidy.
- Cash assistance -- Cash assistance may be used for housing security deposits, rent, partial rental subsidies, furniture, appliances, utilities, and other item required for youth to avoid or manage a crisis. Youth are provided up to $2000 per 12- month period following emancipation to help them stabilize after a crisis. If any employed youth loses a job and needs to pay rent before another job is secured, youth is eligible for $600 one-time exception. Lifetime limit for all types of cash assistance is $4000.
- Follow-up services for a minimum of three months after the client secures appropriate housing.

X. Transitional Housing for Youth Aging Out of Foster Care

A. First Place for Youth
Oakland, CA

See Action Step 2.3.1

Partners
Affordable Housing Associates, East Bay Asian Local Development Corporation, Citizen's Housing Corporation, Jubilee Restoration

Significant Program Design Features
First Place for Youth provides housing for transitional youth ages 18-24 who "age out" of or otherwise exit the foster care system. First Place provides affordable housing to roughly 130 former foster youth from four Bay Area counties at any given time, as well as supportive services. First place provides transitional youth with safe, stable housing for up to 2 years, along with practical tenancy training, comprehensive case management and housing advocacy.

My First Place
The My First Place supportive housing program offers youth an opportunity to live independently, with important subsidies and services. In order to access a First Place apartment, participants must complete an independent living skills course and be employed or working towards employment. Having met these requirements, participants can move into a shared 2-bedroom apartment where they begin by paying 10% of their income in rent. Over time, the rent burden is increased toward the fair market rent, so that at the end of the 2-year program, the participant is fully independent and pays his or her whole rent.

The My First Place program incorporates services, including move-in assistance and a stipend, peer pressure/peer support for loan repayment, life skills training, youth advocate counseling sessions, and goal-setting in the areas of education, financial management, employment, health, and relationships. First Place employs a cohort model, where groups of 8-10 youths enter the program at the same time and meet weekly throughout the 24-month duration of their stay with First Place.

My First Place emphasizes education and health care. First Place provides academic tutoring and counseling so that all youth receive their high school diploma or GED. Post-secondary education is strongly encouraged. Health care services include wellness workshops, case management, access to MediCal, and encouragement of preventive health measures. Pregnant youth or youth

with children are connected to prenatal and pediatric medical care, as well as parenting classes.

PATH

In 2007, First Place launched its Permanent Avenues Toward Home (PATH) project with support from the San Francisco County Department of Human Services. PATH participants live with a caring, permanent adult of their choosing, who is willing to house them in their home for up to two years. For youth preparing to age out of the foster care system, the PATH program can prevent them from discharging into homelessness.

To participate in the program, youth must be under 25 and identify an appropriate adult that is able to house them. The adult must complete a rigorous screening and assessment, including an interview, background check, home visit, and house meetings with the youth. This process takes about 3-4 weeks. Simultaneously, the youth must attend an orientation and assessment, as well as a "Step It Up" independent living skills class, for which he or she is paid $10/hour and up to $25 in transportation assistance.

There is usually a waitlist for housing. The timeline for accessing the PATH program is roughly 3-4 weeks for the adult to be certified and the youth to graduate from "Step It Up," plus 2 weeks to move into housing if there is no waitlist. Once the youth is housed with the adult, the adult receives a $500 stipend to defray housing costs. The adult and the youth decide together if the youth should make additional contributions for food. The youth does not pay rent, but is required to save money in a First Place savings account. The savings contribution begins at 10% of $500 per month and increases by 10% every 3 months until the youth is saving $500 per month at the end of 2 years. The youth receives all savings plus interest upon leaving the program.

Outcomes

-98 percent of all program participants avoided homelessness after entering First Place services

-80 percent of youth in the My First Place Program maintain safe, permanent housing after exiting the program

(see http://firstplaceforyouth.org/about/impact/)

Funding

Oakland Fund for Youth and Children, United Way Foster Youth Initiative, California Wellness Foundation, Walter S. Johnson Foundation, Ashoka Foundation

B. Larkin Street Youth Services, LEASE Program
San Francisco, CA

See Action Step 2.3.1

Partners

Significant Program Design Features

The Larkin Extended Aftercare for Supported Emancipation (LEASE) program is a supportive housing program for youth who have aged out of foster care or otherwise exited the system, ages 18-21. The program places former foster youth in studios or shared apartments scattered in San Francisco and the East Bay, while providing supportive services in the form of and case management, counseling, employment training, and referrals. An emphasis is placed on developing life skills – managing money, retaining employment, and living independently. LEASE accepts mothers with one child and provides parenting classes to women. All participants in the LEASE program receive education counseling and most attend college on a part-time or full-time basis.

LEASE program participants are screened and referred by Independent Living Skills Program (ILSP), an organization which facilitates transitions for recently emancipated foster youth. There are 3 intake screenings by LEASE—an initial contact, an interview with an employment specialist, and a final walk-through intake to determine if the youth will enter the program. Youths must be employed to enter the program.

Case managers at LEASE focus on preparing program participants for stable permanent housing after age 21. This discharge planning for housing after LEASE begins when the youth enters the program. LEASE program participants are responsible for paying 30% of their income in rent, with LEASE paying the remainder of their rent. Over time, LEASE helps youth obtain higher-paid full-time jobs to better prepare them to pay market-rate rent upon graduation. Upon graduation, the youth's entire rent contribution is returned to them. Youth exiting the program typically move into roommate situations, section 8 housing, their own apartments, or a family living situation.

There are currently 58 youth in LEASE.

Funding

LEASE is funded in part by the State of California's Transitional Housing Plus Supportive Services program

C. Bill Wilson Center
Santa Clara, CA

See Action Step 2.3.1

Partners
Choices for Children childcare, NOVA employment services, Center for Employment Training, Second Harvest Food Bank, Wilson Adult Education, RISE scholarships for job training and education

Significant Program Design Features
-Youth are referred by word of mouth or from a variety of agencies
-12 month transitional housing program with supportive services for single homeless youth aged 18-24. Legally emancipated youths ages 16-17 are also eligible.
-Intake process involves an initial interview and information session, followed by an application. Accepted youth are placed on a waiting list and admitted as space becomes available. Case management and supportive services are available to youth waiting to receive a housing placement.
-Youth live rent-free in supervised shared apartments and houses for up to 12 months. Each house has a live-in adult house monitor and a case manager who does not live in the house. The 3 apartments share a house monitor and case manager.
-Some units are specifically for homeless youth parents with 1-2 children. They receive weekly parenting classes through BWC's Medical program. They also receive subsidized childcare, provided by Choices for Children. In most cases, the youth enter with no income and therefore have no copayments.
-Weekly case management meeting focused on self-direction and self-determination
-Other supportive services include independent living skills, job readiness, mental health services, drug abuse counseling, financial planning assistance
-case managers work with clients to secure permanent housing prior to their graduation from the program. In some cases this means renting a room, in others it may mean a return to a family home.
-rental subsidies are available for 6 months after graduation up to $600/month, depending on a youth's income. Monthly case management and maintaining employment are required.
-further aftercare services include rental subsidy, aftercare group, case management and counseling, and crisis intervention such as gas and grocery cards

Outcomes
-roughly 12 youth per year graduate into permanent housing and maintain permanent employment

-One or two youth per year maintain plan of attending community college and transferring to a 4-year college

Funding
HUD, Dept. of Health and Human Services

XI. Short-Term Rental, Move-In & Mortgage Assistance

A. SHARE/Homeless Intervention Program
Prince William County, Virginia

See Action Step 2.5.1

The SHARE/Homeless Intervention Program is a state funded program that provides **interest-free loans for temporary rental, mortgage, and security deposit payments** for those who meet program criteria.

Program Criteria:

- Income of 80% of AMI or less and all other resources must be exhausted before such assistance can be used
- Use is limited to once-in-a-lifetime
- Housing counseling is also included in the program, including budgeting classes and credit counseling in order to facilitate long-term financial independence
- Applicants must be homeless or in imminent threat of becoming homeless, and this must be verifiable
- The family or individual must have an "unavoidable crisis," such as an illness, lay-off from employment, loss of transportation to a job, etc., and this crisis must be temporary and not chronic
- The family or individual must have been self-sufficient prior to the crisis and be able to be self-sufficient after receiving the assistance (self-sufficiency is defined as steady employment, a stable rental/mortgage history, & timely bill payment)
- Applicants must have current, verifiable income

B. Tri-Valley Housing Scholarship Program
Pleasanton and Livermore, California

See Action Step 2.5.1

The City of Pleasanton, in collaboration with the City of Livermore and Allied Housing, Inc., provides limited **temporary rental assistance to participants in job training** programs. This program, which was begun in 1998, provides monthly rent subsidies to households that are homeless or at risk of being homeless. Subsidies are provided while the head of household is undergoing job training and are gradually phased out after employment is secured.

C. Echo Housing
San Francisco Bay Area, California

See Action Step 2.5.1

Echo Housing provides a limited Rental Assistance Program (RAP) that provides **assistance with move-in costs or helps residents with delinquent rent** due to a temporary financial setback. ECHO helps by arranging a **guaranteed repayment contract** between the tenant and the landlord.

Appendix F
-Ending and Preventing Homelessness Through Integrated, Comprehensive, Responsive Supportive Services- Program & Practice Examples and Research Knowledge

Table of Contents

PART 1: Program and Practice Examples

I. Homeless Action & Response Team (HART), Norfolk, VA

II. Skid Row Collaborative, Los Angeles, CA

III. Human Services Campus, Maricopa County, AZ

IV. YWCA Family Center, Columbus, OH

V. Volunteer-Led Community Meetings to Provide Services for Homeless People and Forge Partnerships Between Homeless People, Service Providers, and the Community

A. Project Homeless Connect, Multiple Locations
B. Stand Down, Multiple Locations including San Luis Obispo County

VI. Customized Employment

A. Homeless Opportunity Providing Employment (LA HOPE) Los Angeles, CA.
B. Hope House, San Francisco, CA

VII. Work First or Work Fast

VIII. Sources of Funding for Supportive Services and Employment: Social Enterprises

A. The Greyston Bakery, Yonkers, NY
B. Pioneer Human Services, Seattle, WA
C. Rubicon Programs Inc., Richmond, CA

PART 2: Research Knowledge

I. COMPREHENSIVE, INTEGRATED SERVICES ARE EFFECTIVE IN MEETING THE NEEDS OF HOMELESS PEOPLE, ESPECIALLY THOSE WITH MULTIPLE NEEDS

II. OUTREACH WHETHER IN SHELTERS OR ON THE STREETS IS EFFECTIVE AT ENGAGING HARD-TO-REACH CLIENTS

III. INTENSIVE CASE MANAGEMENT, SUCH AS ASSERTIVE COMMUNITY TREATMENT (ACT), HELPS CLIENTS ACCESS AND REMAIN ENGAGED WITH SERVICES

IV. THE DURATION AND INTENSITY OF SERVICES CAN BE TAILORED TO THE CLINICAL NEEDS OF CLIENTS

V. INTEGRATED MENTAL HEALTH AND SUBSTANCES ABUSE TREATMENT IS EFFECTIVE IN TREATING CO-OCCURING DISORDERS

VI. EMPLOYMENT SERVICES ARE EFFECTIVE IN HELPING PEOPLE WHO ARE HOMELESS TO ACCESS PAID EMPLOYMENT

VII. BENEFITS ADVOCACY SIGNIFICANTLY INCREASES HOMELESS ACCESS TO ENTITLEMENT PROGRAMS, AND RECIPT OF BENEFITS IMPROVES CLIENT QUALITY OF LIFE

PART 1: Program & Practice Examples

I. Coordinating Existing Services Through Single Point of Entry Using Centralized Assessment and Data Collection Tool

Homeless Action & Response Team (H.A.R.T.)
Norfolk, VA

See Action Steps 3.1.3, 3.1.4 and 3.2.1

Partners:

- Local service providers
- Community programs
- Interns from local universities

Significant Program Design Features:

- HART's mission is to align existing resources, coordinate all area service providers, and create a single point of contact for homeless families -- the Norfolk Family Hotline.
- The new system has required no new staffing, it is simply an innovative structural strategy, though volunteers and support from shelters are essential to handle call volume.
- Norfolk Family Hotline operates 24/7. It is staffed Mon-Fri, 7am - 7pm by full-time social workers, interns or volunteers. Outside of these hours, the hotline is staffed by a rotating schedule of shelter staff and volunteers.
- The hotline offers information and screening for shelter placement, assessment for service needs, and connection to the appropriate providers.
- HART serves both families facing imminent homelessness (notice to quit, 72 hour notice) and families that have been evicted and have no identifiable place to stay. Both are invited for intake in-office.
- Service needs are assessed using the Structured Decision-Making tool. It helps to identify critical decision making points, increases consistency an accuracy of decision-making, and targets resources to families most at risk. This is combined with research and clinical judgment.
- HART representatives meet with two of the shelters each week to check up on families.
- HART also has a physical location within the Department of Human Services in downtown Norfolk. Walk-ins are welcome.
- HART uses HMIS to keep track of data
- Partnerships were with service providers were easily forged, as most are active participants in the homeless consortium.
- Newest development is the Housing Broker Team. It aims to expand the capacity of the existing supply of affordable housing to accommodate families leaving or being diverted from the service system. Their long-term goal is to

merge and manage all city-wide housing resources with all landlord contacts. Currently the team consists of two housing specialists.

Outcomes:

- Community based providers found that they were more easily able to target appropriate families, and noticed improved performance outcomes (more families exiting into permanent housing)
- Decrease in the administrative burden of the intake process with an improvement in the quality of data gathered
- To date HART has decreased the number of homeless families being placed in hotels to zero, decreased the number of families turned away from shelters, and significantly decreased the length of stays in such shelters
- In FY07 HART saw 4,567 families and assisted 689 with permanent housing. They also placed 354 families in shelters
- To date the Housing Broker Team has contacted 100 new landlords, identified over 2,200 affordable rental units in Norfolk, placed 100 families into affordable housing, and handled over 235 housing related referrals.

Costs/Funding:

- Funding for staff is from Federal, State, and local benefits and child welfare funding streams. No new funds were allocated.
- The Housing Broker Team was developed through the collaborative partnership, which then identified a single entity, The Planning Council, to make application for local and philanthropic grant opportunities.

II. Integrated Service Teams Providing Outreach & Wraparound Services Linked To Housing

Skid Row Collaborative
Los Angeles, California

See Action Step 3.2.1

The Skid Row Collaborative is a community-wide strategy that addresses the needs of chronically homeless and disabled individuals with a collaborative approach to resolving the problems of Los Angeles' most vulnerable citizens. The Collaborative aims to provide chronically homeless individuals with stable housing, mental health and substance abuse services, primary healthcare and veterans' services using an **integrated multidisciplinary team.**

Partners: A partnership of 12 public and private non-profit agencies: Skid Row Housing Trust, Lamp Community, County of LA Dept. of Mental Health, JWCH Institute, Housing Authority of the City of Los Angeles, Homeless Healthcare Los Angeles, Behavioral Health Services, Clinica Oscar Romero, GLA Veterans Healthcare System, Corporation for Supportive Housing, Los Angeles Homeless Services Authority, New Directions, Inc.

Significant Program Design Features:

- **Integrated Services Team (IST)**

The IST is composed of a mental health specialist, substance abuse specialist, peer advocate, psychiatric and medical staff, and property management staff. Services provided include: psychiatric treatment, recovery services, housing placement and case management. A management structure is used for the IST to support staff integration, flexible and responsive services, resource sharing and necessary system change.

- **Housing First**

A "Housing First" approach is used in which clients do not have to graduate through a continuum of housing to be "ready" for permanent housing. Instead, clients are helped to access housing appropriate to their needs, as quickly as possible. Housing options include: low demand Safe Haven, community enriched project-based or scattered site housing.

- **Wraparound Support Services**

On site services include: case management, drug/alcohol recovery, health screening, medication management, mental health assessment and treatment, benefits advocacy, money management/rep-payee, individual and group counseling, crisis intervention, recreation, educational and cultural activities, and transportation. In-patient or off-site

services include: health care, employment support, psychiatric treatment, and detox and drug and alcohol treatment.

III. Co-Located Services / One Stop Access

Human Services Campus
Maricopa County, Arizona

See Action Step 3.2.1

The 14 acre Human Services Campus (HSC) in downtown Phoenix integrates service provision by **co-locating numerous services in one place thereby providing "One Stop" access to services.** The HSC opened its doors in 2005 and provides emergency shelter, health and dental care, counseling, employment training and job search assistance, meals and a day resource center. It is designed to help people exit homelessness and regain maximum self-sufficiency.

The Human Services Campus is the first component of a regional plan to serve the estimated 14,000 homeless men, women and children in Maricopa County. Approximately 700 of those individuals congregate at any given time in downtown Phoenix to access services that were previously spread out and in dilapidated facilities. Homeless individuals were required to travel in different directions using public transportation to receive the various services they needed. In the face of such difficulties, many either never sought needed services or only received partial and insufficient care. Through the HSC, **access to services is now both centralized and simplified**, resulting in improved quality and effectiveness of care, especially for those with multiple needs.

The Human Services Campus anchor agencies provide emergency shelter, dining/food services, and medical, mental health and dental services. The Lodestar Day Resource Center acts as the campus gateway, co-locating staff from a broad range of agencies to facilitate a coordinated assessment and response to people's needs. The Day Resource Center offers behavioral health screening and referral, eligibility for health care and other entitlements, housing referral, a homeless court, and job training and placement among other services. Current agencies that are located on the campus include the Central Arizona Shelter Services (CASS), Maricopa County Healthcare for the Homeless, Society of St Vincent de Paul, NOVA Safe Haven and St Joseph the Worker.
For more information: http://www.hscampus.org

IV. Single Point of Entry To Homelessness System

YWCA Family Center
Columbus, Ohio

See Action Step 3.2.1

The YWCA Family Center provides a **single point of entry** to the family sheltering system center, quickly assessing families and referring them to appropriate services. Some families are referred to prevention services, including financial assistance and case management, and others enter the shelter where they are assisted in finding permanent housing as quickly as possible and referred to appropriate services. Some are linked with short-term case management to help them stabilize in their housing after exiting emergency shelter. No families needing shelter are turned away, and a recent point in time count found no unsheltered families in the city.

V. Volunteer-Led Community Meetings to Provide Services for Homeless People and Forge Partnerships Between Homeless People, Service Providers, and the Community

A. Project Homeless Connect (PHC)
Multiple Locations

See Action Step 3.2.1

Partner Agencies:
Local governments and government agencies, housing providers, service providers, volunteers, law enforcement, corporate and community partners

Significant Program Design Features:

- Project Homeless Connect (PHC) holds one-day events that offer homeless people immediate access (not just referrals) to housing, employment, and quality of life services such as dental and medical care, meals, haircuts, massage and foot care, phone calls, eyeglasses, entertainment, wheelchair repair and more.
- PHC is led by the city or community and is designed to be highly consumer-centric
- Services include medical, mental health, substance abuse, housing, dental, benefits, legal, free eyeglasses, California ID, food, clothing, wheelchair repair and more.
- Events are coordinated by a planning team. Planning teams usually consist of a director that is affiliated with the lead city/county and a small core group that is accountable to the director.
- The event involves the creation of a temporary community resource center with a large variety of services available on-site
- PHC sites are usually large, centrally-located indoor areas known to the community, but not previously associated with homelessness.
- PHC events are focused on **immediate** service with clearly posted signage, floor plans and maps. Mobile Hospitality Volunteers (MHV's) are provided to escort the consumers to and from meal and service tables. The MHV follows and remains with the consumer through every meeting. A 1:1 volunteer-to-consumer ratio is ideal.
- PHC promotional materials are distributed to and by police, direct service providers, and consumers.
- Data collection is another critical outcome of a PHC event; each resource provider at the event should be required to keep track of and report data on the *same day* of the event.

Outcomes:

- Adopted as a model to end homelessness by 106 cities across the U.S. as well as Canada, Australia, and Puerto Rico
- In Dec, 2006 the Contra Costa County PHC served 509 consumers with 266 volunteers. Services included sheltering 24 individuals and 4 families, providing access to 3 detox beds, hearing 69 homeless court cases, completing 24 social security applications, 20 GA applications, and 24 food stamp applications, and providing 36 medical exams, 65 dental exams and cleanings, and 97 flu shots.
- Over 1,000 volunteers participate in San Francisco's PHC every month
- As of February 2007, 18,486 volunteers have provided services to 18,217 homeless San Franciscans
- The most recent PHC in San Francisco included 958 volunteers who provided services to 2,394 homeless individuals (including 89 families and 21 children) and 92 individuals who were living on the street were placed in a combination of shelters and stabilization rooms.

Costs/Funding:

- Most PHC's are supported by jurisdictional, corporate funding, or grants
- Donations are critical

B. Stand Down
Multiple Locations including San Luis Obispo County

See Action Step 3.2.1

Partner Agencies:

- California Department of Veterans Affairs (CDVA)
- United States Department of Veterans Affairs (VA)
- California Employment Development Department
- National Coalition for Homeless Veterans (NCHV)

Significant Program Design Features:

- Stand Down is a collaborative community-based event that brings a variety of services, such as food, shelter, clothing, medical screenings, housing, employment, and substance abuse treatment, to one central location, providing easy access for homeless veterans.
- There is no specific formula for staging a Stand Down. A community generally must create a committee specifically geared towards organizing the event. A group of dedicated volunteers is essential.
- Stand Downs range in length from one to four days, and are generally held outside in wide-open spaces such as football fields or parks. Typically, only

veterans and their immediate family members and significant others are welcome.
- Afterwards data is reported to the NCHV in the form of a standardized After Action Report. All After Action reports are then used to create an annual Stand Down report.

Outcomes:

- In San Luis Obispo, the third-ever Stand Down was held on March 29, 2008 at the Veterans Memorial building. Project partners included the Kenny Nickelson Foundation, HelpAmerica Foundation, the Employment Development Department, Americorps, and other agencies. Hundreds of veteran and civilian clients received services. SLO County is home to about 26,000 veterans of whom 367 are estimated to be homeless.

Costs/Funding:

- Grants
- Volunteers
- Donations

VI. Customized Employment

A. Homeless Opportunity Providing Employment (LA HOPE) Los Angeles, California

See Action Step 3.4.1

The Los Angeles Homeless Opportunity Providing Employment (LA HOPE) is a consortium of Los Angeles agencies working to integrate the permanent housing, mental health and workforce development programs serving the chronically homeless mentally ill population. The Community Development Department, on behalf of the City's Workforce Investment Board, was awarded a grant from the Department of Labor to develop customized employment programs.

Customized employment is a best practice for serving people who are chronically homeless. It involves individualizing the employment relationship to meet the needs of the job seeker and the employer. Under this model, job development begins from the individual job seeker's perspective rather than the labor market perspective. The first step in customized employment is to get to know the job seeker for the purpose of developing a "blueprint," of the job that will be custom tailored to them. The job developer negotiates a unique employment relationship based upon the parameters identified as conditions of employment for the person and the individual's contributions and meshing these with the needs of the employer, rather than looking for job openings. Support is provided to the job seeker and employer during the course of the employment relationship toward successful job retention and promotion.

Partners: A consortium of Los Angeles agencies representing the public and private, community-based and faith-based sectors: The City of Los Angeles Community Development Department (WIB), Housing Authority of the City of Los Angeles, Goodwill Southern California, Inc. (Goodwill), Los Angeles County Department of Mental Health, Los Angeles Homeless Services Authority, Portals House, Inc., San Fernando Valley Community Mental Health Center, Inc. (SFVCMHC), Shelter Partnership, Inc., South Central Health and Rehabilitation Program (SCHARP)

Significant Program Design Features:

ENROLLMENT THROUGH OUTREACH AT SHELTERS

Outreach workers from Portals, SCHARP and SFVCMHC identify LA HOPE's participants at three of the region's continuously operated overnight emergency shelters.

HOUSING AND SUPPORTIVE SERVICES

Participants enrolled are referred to the partners' existing wrap-around AB 2034 programs to stabilize their mental health issues and address other issues that they are experiencing (e.g. substance abuse, physical health issues, etc.).

Housing specialists from these agencies help the participant's immediately secure permanent, affordable housing with supportive services in the private market using their federal housing certificate to pay the rent. Additionally, upon enrollment, LA HOPE participants receive mental health services, including medication support, 24/7 crisis counseling, case management, and move-in assistance.

CUSTOMIZED EMPLOYMENT

Once the participant is living in their own apartment and has exhibited evidence of their readiness to work, Goodwill's staff, in partnership with their case-manager, will begin implementing their customized job plan. Goodwill will assess the participant's job readiness, work skills, work history, and areas of interest in relation to employment. The Goodwill job developer will begin to work with employers to secure meaningful employment commitments for LA HOPE participants once they are able to seek competitive employment.

Funding is available to provide both wages for paid supported employment as well as vocational training for the participants. Business service reps work with employers to find food service, retail, and administrative positions that will fit the population.

B. Hope House
San Francisco, California

See Action Step 3.4.1

Under the leadership of the Private Industry Council of San Francisco, Inc., Hope House, a "vocationalized housing" program, provides housing, case management and employment program services to chronically homeless people. This effort seeks to better combine and coordinate the multiple services and agencies that deliver vocationalized housing in an effort to improve both the involvement of the area's workforce development system, including the area One-Stop Career Centers, and the employment options for the chronically homeless.

Partners: A Collaborative of nonprofit, community and government partners: San Francisco Department of Human Services, Housing and Homeless Programs Division and Workforce Development Division, United Council of Human Services, Young Community Developers, Southeast Career Link One Stop, Corporation for Supportive Housing and Private Industry Council

Significant Program Design Features:

HOUSING

- 70 units of permanent housing
- scattered sites, multi-bedroom homes
- private bedrooms and shared common areas
- services provided on-site and at other neighborhood locations

CASE MANAGEMENT

- Supportive services to assist with housing stability and promote increased self-sufficiency.

EMPLOYMENT PROGRAM

- Customized employment opportunities for chronically homeless adults focused on individual needs and skills and creating a culture of work with the hope of ending the cycle of chronically homeless individuals.

Outcomes:

- 15 clients have found full-time jobs
- 25 clients have found part-time jobs
- Average Hourly Wage $10.39
- Minimum Hourly Wage $6.75
- Maximum Hourly Wage $15.38
- Types of jobs found: Food Preparation, Labor, Janitorial, Driving, Warehouse, Receptionist, Sales, Self-Employment

VII. Employment Programs for People Experiencing Chronic Homelessness

Work First or Work Fast

See Action Step 3.4.1

The combination of political forces at work today including: the focus on ending chronic homelessness, the push for HUD Homeless Assistance funds to provide permanent supportive housing rather than supportive services, and the continuing threats to cash benefits from entitlement programs, has caused renewed focus on employment strategies for people who are chronically homeless.

For example, in 2003, HUD and DOL collaborated to fund an initiative in five U.S. communities to help individuals who have been chronically homeless obtain housing and employment through the workforce development system. In San Francisco, a program, Hope House, was funded to provide Housing First/Work First services using scattered site HUD supportive housing to implement "vocationalized" housing to a representative group of individuals that were formerly chronically homeless. The program was designed (a) to coordinate service delivery, including among employment staff, housing case managers, vocational rehabilitation staff, a general assistance worker and One-Stop Career Center staff, and (b) to improve the workforce development system, including the One-Stop Career Centers, and employment options for this population.

People who are chronically homeless face a number of different hurdles to employment. Work Fast or Work First, one employment policy strategy, like Housing First, is designed to meet people where they are. Work First, paired with Housing First at the Hope House project, requires strong, integrated services and supports for consumers from outreach until long into the housing experience. These services include mental health services, substance use services, and other types of support.

Work Fast programs are client-driven and emphasize choice for the consumers. Each consumer has different needs and preferences, so the program requires significant flexibility. Many homeless people are already working in some capacity to create some income stream, so Work Fast also proposes redefining what is "job ready," what is "work," and further, what is "success." Work Fast recognizes the skills and strengths that consumers bring and allows for a lot of flexibility and customization.

Customized employment means individualizing the employment relationship between employer and employee to meet the needs of both. This strategy involves determining the strengths, requirements and interests of a person with a complex life. Customized employment builds on strategies like supported employment and self-employment, and pairs them with services and support. It begins with an in-depth job seeker- led assessment process, and may be followed by a negotiating process with an employer, that could involve job carving (that is, individualized job design), negotiating a job description, job creation and job sharing, job supports or flexibility in hours and location of job.

The Work Fast approach improves self-esteem and confidence, facilitates motivation to change, creates a sense of stability and establishes trust in self and others.

Outreach for Work Fast begins with talking with the consumer about his or her likes or dislikes and listening to his or her stories to start the consumer thinking about possibilities. From the beginning, the program should provide a standing offer of work, or in-house jobs, as not every moment is a competitive job placement moment (e.g., because the consumer may not be able to pass a drug test). To make this work, the whole organization must support and assume employability. The program must find internal and external partners and the employment process should not require lengthy prerequisites or training. The program should have a variety of jobs for people with different needs or interests.

Many consumers may feel hopeless, have negative experiences with employment, think of the jobs historically available to them as being boring or stifling, be experiencing depression or other dampers to their motivation, or have concerns about effects of employment on his or her benefit. Nonetheless, when staff focus on motivation as something that can change, act as an ally, and encourage recovery, change and growth, work may become more interesting to them. Staff should be supportive without being demanding or judgmental, or over-involved. Making work opportunities visible and available helps, with activities and resources to support employment.

The six principles of Work Fast are that:

- competitive employment is the ultimate goal,
- eligibility is based on consumer choice,
- employment services are integrated with mental health treatment and other services,
- the job search process starts immediately after the consumer expresses an interest,
- support continues for employed consumers, and
- choice.

Work Fast requires assertive engagement and outreach, integration with other services, choice and individuality, flexibility and support.

Resources for Additional Information

- Housing First/Work Fast PATH Audio Presentation, Ann Denton and Gary Shaheen from Advocates for Human Potential, September 5, 2006.
- Ending Chronic Homelessness Through Employment & Housing, A Leadership Dialogue, January 25, 2006.
- Ending Chronic Homelessness Through Employment and Housing: Brief Project Descriptions, Chronic Homelessness Employment Technical Assistance Center, June 2006.
- *"Work as a Priority"*- http://mentalhealth.samhsa.gov/publications/allpubs/SMA03-3834/default.asp

- *"Creating Change: Pushing Workforce Systems to Help Participants Achieve Economic Stability and Mobility"*-Annie Casey Foundation-July 2002 http://www.aecf.org/
- *"Economic Engagement: An Avenue to Employment for Individuals with Disabilities"* - Institute for Community Inclusion-2004 www.communityinclusion.org
- *"Innovative Methods for Providing Vocational Rehabilitation Services to Individuals with Psychiatric Disabilities"*- RSA/George Washington University - http://www.gwu.edu/~iri/psg.htm
- "Profiles of One Stop Career Centers Serving Homeless Persons" at www.csh.org/CHETA

Resources on the Web

- www.dol.gov/odep
- http://www.psych.uic.edu/eidp/eidptoolkit.htm
- www.samhsa.gov

VIII. Sources of Funding for Supportive Services and Employment: Social Enterprises

A. The Greyston Bakery, Yonkers, New York

See Action Step 3.5.1

Greyston Bakery is a for-profit subsidiary of the Greyston Foundation. The Greyston Foundation is a community development organization, providing low-income housing, childcare, health care, and technology education.

The bakery, a for-profit corporation, operates in the Bronx, providing gourmet products for retail and wholesale (the bakery supplies all the brownies for Ben & Jerry's brownie ice cream). The business hires individuals “chronically unemployed” due to lack of skills and education, as well as histories of homelessness, drug addiction and incarceration. According to its CEO, “We don’t hire people to bake brownies. We bake brownies to hire people.”

Greyston Bakery generated a 4% profit on $6 million in 2006 revenues. Its recently completed state-of-the-art production facility and cafe won the Institute of Architects award for Top 10 Green Projects and FastCompany's 2006 Social Capitalist award.

B. Pioneer Human Services, Seattle, Washington

See Action Step 3.5.1

Pioneer helps "people on the margins of society" stay out of prison and off the streets through an integrated combination of services, including job training and placement, youth and family counseling, housing, and chemical-dependency treatment. To fund its programs, it runs profitable businesses such as precision sheet-metal fabrication, aerospace machining, and retail cafés. With each contract, it trains and employs "at risk" people. Its operating budget of $60 million is generated almost entirely (99%) from earned-income.

Pioneer’s businesses include:

- Manufacturing: Pioneer Industries, a precision sheet metal manufacturer with over 100,000 square feet of manufacturing space in two facilities, is a complete manufacturer offering laser and water jet cutting, CNC punching, shearing, forming, welding, hardware insertion, assembly, wet paint and powder coat finishing, and silk-screening.

- Construction & Maintenance: Pioneer Construction Services provides construction and maintenance services to properties owned and operated by the Real Estate Services division of Pioneer, and to residential homeowners and commercial property owners.

- Wholesale Food Distribution: Food Buying Service sells canned and dry grocery products to nonprofit and government organizations such as food banks, school districts, correction facilities and daycares, located in seven western states.

- Catering & Cafés: Pioneer's four retail concepts, operated under the trademark name of Mezza Café, serve retail and corporate customers in Seattle and Bellevue.

- Institutional Food Services: Pioneer Food Services operates an institutional kitchen serving hospitals, extended care facilities, day nutrition centers, and work releases in King County.

- Contract Packaging: Pioneer Distribution Services provides assembly, packaging, and warehousing for several major national and international corporations. It has a core group of 13 employees and also employs on a seasonal basis up to 200 additional temporary workers, hired through referrals and recovery centers. In addition to basic work and life skills which are taught at Pioneer Distribution Services, a forklift certification program and English as a Second Language program are offered.

C. Rubicon Programs, Inc., Richmond, CA

See Action Step 3.5.1

Rubicon was founded in 1973 to assist individuals who are living in poverty, homeless, unemployed or disabled to lead independent lives. With its headquarters in Richmond, California, one of the most economically depressed cities in the San Francisco Bay Area, Rubicon provides services to residents of Contra Costa, Alameda and San Francisco Counties. To further its mission, Rubicon operates social enterprises that employ and train economically disadvantaged individuals.

Revenue from these enterprises funds over half of Rubicon's $17 million dollar budget for social programs and integrated services that help people find housing and jobs, handle their finances, obtain legal advice and manage mental illness.

Rubicon employs approximately 80 people in its two enterprises at any given time:

- Bakery: At Rubicon Bakery, employees make gourmet desserts that are sold in upscale markets and restaurants and on the Internet.

- Landscape Services: Rubicon Landscape Services provide grounds maintenance and installation services for commercial properties, cities and developers.

Rubicon is working to launch a nationally scaled social enterprise. The "Rubicon National Social Innovations" program will select one or more businesses for national scaling after an assessment process and then secure funding support for a full launch of the endeavor.

PART 2: RESEARCH KNOWLEDGE

I. COMPREHENSIVE, INTEGRATED SERVICES ARE EFFECTIVE IN MEETING THE NEEDS OF HOMELESS PEOPLE, ESPECIALLY THOSE WITH MULITPLE NEEDS.

See Action Step 3.1.8

- California's AB 2034 Program provided comprehensive services to adults with serious mental illness who were homeless, recently released from a county jail or state prison, or at significant risk of incarceration or homelessness unless provided with treatment. Meeting the multiple needs of this client population required integration of services within and across agencies, including outreach, supportive housing and other housing assistance, employment, substance abuse, mental health and health care services.

  AB 2034 outcomes include:

  - Reduction in Prison and Jail Incarceration: number of clients incarcerated decreased 58.3%, number of incarcerations decreased 45.9%, and the number of incarceration days decreased 72.1%

  - Decreased Homelessness: overall number of homeless days experienced by clients decreased by 67.3%

  - Decreased Hospital Use: number of clients hospitalized decreased 42.3%, hospital admissions decreased 28.4%, and the number of hospital days decreased 55.8%

  - Increased Income Levels: number of SSI recipients increased by 93.1% and the number of people receiving wages from employment increased by 279.8%[1]*

- A study of two supportive housing projects using interagency integrated service teams found high rates of residential stability, with 81% of clients remaining in their housing for a year and 62% for two years. In addition, after one year, client use of emergency rooms fell by 58%; use of hospital inpatient beds fell by 57%; and use of residential mental health programs disappeared.[2]

[1] Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness, Report to the Legislature 2003. California Department of Mental Health, Stephen W. Mayberg, Ph.D. Director. May 2003. pp. 9-13. www.dmh.cahwnet.gov/AOAPP/Int_Services/docs/Leg_Report_2003.pdf

[2] Proscio, Tony. (2000). "Supportive Housing and Its Impact on the Public Health Crisis of Homelessness", Corporation for Supportive Housing. pp. 7 and 15-18.

- The evaluation of the ACCESS (Access to Community Care and Effective Services and Supports) demonstration program concluded that systems that are better integrated have significantly better client housing outcomes.[3]

- An evaluation that looked at nine National Institute on Alcoholism and Alcohol Abuse (NIAAA) demonstration projects to foster increased cooperation among alcohol treatment, drug treatment, and housing and other supportive services, found that individuals served in sites with more inter-program cooperation and formal linkages were significantly more likely to report improvement than comparison clients in most other sites.[4]

- An evaluation of the joint initiative between the Social Security Administration and the Veterans Administration to increase applications and awards for disability benefits for entitled homeless veterans found that veterans at sites with co-located mental health and benefits services were almost twice as likely to apply for benefits and receive awards as those in comparison sites.[5]

[3] Goldman, H.H.; Morrissey, J.P.; Rosenheck, R.A.; Cocozza, J.; Blasinsky, M.; Randolph, F.; and the ACCESS National Evaluation Team. *Lessons From the Evaluation of the ACCESS Program.* Psychiatric Services, August 2002 Vol. 53 No. 8, pp. 967-969. http://psychservices.psychiatryonline.org

[4] Orwin, R. G., Goldman, H. H., Sonnefeld, L. J., Ridgely, M. S., Garrison-Mogren, R., & O'Neill, E. (1994). Alcohol and Drug Abuse Treatment of Homeless Individuals: Results From the NIAAA Community Demonstration Program. *Journal of Health Care for the Poor and Underserved, 5*(4): 326-352.

[5] Rosenheck, R., Frisman, L., & Kasprow, W. (1998). Improving Access to Disability Benefits among Homeless Persons with Mental Illness: An Agency-Specific Approach to Services Integration. Cited in Dennis, D. etal. What Do We Know About Systems Integration and Homelessness? In Fosburg, L. and Dennis, D. (eds), Practical Lessons: The 1998 National Symposium on Homelessness Research. http://aspe.hhs.gov/progsys/homeless/symposium/12-Sysintg.htm

II. OUTREACH WHETHER IN SHELTERS OR ON THE STREETS IS EFFECTIVE AT ENGAGING HARD-TO-REACH CLIENTS IN SERVICES.

See Action Step 3.1.8

- Street Outreach: Studies show that even individuals with the most severe disorders and who are the most reluctant to accept treatment will enroll in services and **show improved outcomes when served by an outreach team**.[6] A study of outreach to homeless people with substance abuse disorders found that nearly half of those contacted though the outreach team enrolled in services.[7]

- Shelter-Based Outreach: A study of shelter-based outreach involving a psychiatric social worker and weekly visits by a psychiatrist found that individuals receiving the intervention were **more likely to participate in substance abuse treatment services**.[8]

[6] Lam, J.A., Rosenheck, R. (1999). Street outreach for homeless persons with serious mental illness. *Medical Care* 37(9): 894-907.
[7] Tommasello, A.C., Myers, C.P., Gillis, L., Treherne, L.L., Plumhoff, M. Effectiveness of Outreach to Homeless Substance Abusers. *Evaluation and Program Planning* 22(3): 295-303, 1999.
[8] Bradford et al. , Can shelter-based interventions improve treatment engagement in homeless individuals with psychiatric and/or substance misuse disorders? Medical Care 43:763-768, 2005.

III. INTENSIVE CASE MANAGEMENT, SUCH AS ASSERTIVE COMMUNITY TREATMENT (ACT), HELPS CLIENTS ACCESS AND REMAIN ENGAGED WITH SERVICES.

See Action Step 3.1.8

- Studies show that intensive case management models **reduce hospitalization, decrease substance uses and psychiatric symptoms, and increase community tenure** for people who are homeless.[9] A study comparing outcomes for traditional "broker" case management and for ACT intensive case management found that ACT produced superior outcomes for resource utilization, symptomatology and client satisfaction.[10]

[9] SAMHSA. Blueprint for Change: Ending Chronic Homelessness for Persons With Mental Illnesses and/or Co-Occurring Substance Use Disorders, 2003.
[10] Morse et al. An experimental comparison of the types of case management for homeless mentally ill persons. Psychiatric Services 48:497-503, 1997.

IV. THE DURATION AND INTENSITY OF SERVICES CAN BE TAILORED TO THE CLINICAL NEEDS OF CLIENTS.

See Action Step 3.1.8

- An analysis of the outcomes of clients receiving ACT services found that clients could be discharged from the program to less intensive case management without losing gains in mental health status, control of substance use, housing stability or employment.[11]

- Another study found that while persons with high psychiatric severity and high substance abuse disorder achieved better outcomes with a comprehensive housing program that included housing, support services and case management, those with low to medium symptom severity and minimal alcohol and drug use did just as well in a program that offered case management alone.[12]

[11] Rosenheck, RR and Dennis, D.Time-limited assertive community treatment for homeless persons with severe mental illness. Arch Gen Psychiat 58:1073-1080, 2001.
[12] Clark C and Rich AR. Outcomes of homeless adults with mental illness in a housing program and in case management only, Psychiatric Services 54:78-83, 2003.

V. INTEGRATED MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT IS EFFECTIVE IN TREATING CO-OCCURRING DISORDERS.

- Studies show that integrated treatment for homeless people with co-occurring disorders has been found to be effective in **engaging and retaining clients in services and in reducing alcohol and drug use, homelessness and the severity of mental health symptoms**.[13] (Drake, et al.,1998 and Drake et al., 1997).

- In California, an evaluation of four integrated services demonstration projects jointly funded by the California State Departments of Mental Health and Alcohol and Drug Programs documented positive outcomes to this approach, including improvements in psychiatric functioning; access to mental health treatment, quality of life, and physical health treatment; and decreases in substance abuse and criminal justice costs.[14]

[13] Drake, R.E., Mercer-McFadden, C., Muser, K.T., et al. (1998). A review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin* 24: 589-608 and Drake, R.E., Yovetich, N.A., Bebout, R.R., et al. (1997). Integrated treatment for dually diagnosed homeless adults. *The Journal of Nervous and Mental Disease* 185(5): 298-305.
[14] California Department of Alcohol and Drug Programs and California Department of Mental Health. (2002). *Final Report of the Dual Diagnosis Projects*. http://www.adp.cahwnet.gov/COD/dualdiag.shtml

VI. EMPLOYMENT SERVICES ARE EFFECTIVE IN HELPING PEOPLE WHO ARE HOMELESS TO ACCESS PAID EMPLOYMENT.

See Action Steps 3.4.1, 3.4.2 & 3.4.3

- Employment services are an integral part of the recovery process, helping people develop the motivation to change, stabilize their psychiatric symptoms, and attain sobriety. Studies document that clients, even those with histories of homelessness and disability, who receive employment services as part of an integrated package of care are able to access employment.[15]

- Analysis of data from the ACCESS demonstration program suggests that **use of vocational services is significantly associated with increased likelihood of paid employment**.[16] In addition, receipt of vocational and rehabilitation services delivered through case management has been found to be associated with a **lower probability of shelter reentry** after termination of ACCESS services.[17]

- In New York City, The Doe Fund's, Ready Willing and Able employment program assists homeless people to secure housing and personal stability through employment. **56% of all clients who completed the program obtained employment**, either outside the Doe Fund or within it. 86% of the employed clients kept their jobs for at least 90 days, 57% for at least one year and 44% for two years.[18]

[15] Cook, J.A., Pickett-Schenk, S.A., Grey, D., Banghart, M., Rosenheck, R., and Randolph, F. Vocational outcomes among formerly homeless individuals with severe mental illness in the ACCESS program. *Psychiatric Services* 52(8):1075-1080, 2001 and Trutko, J.W., Barnow, B.S., Kessler-Beck, S., et al. Employment and Training for America's Homeless: Final Report of the Job Training for the Homeless Demonstration Program. Washington, DC: U.S. Department of Labor, 1997.
[16] Pickett-Shenk et al (2002) Employment history of homeless persons with mental illness, Community Mental Health Journal, 38(3):199-211.
[17] Nin, Wong and Rothbard. Outcomes of shelter use among homeless adults with serious mental illness. Psychiatric Services, 56:172-178, 2005.
[18] The Doe Fund, Inc.'s *Ready, Willing and Able* Program Client Profile and Outcomes 1999 – 2001. Prepared March 2003 by Mika'il DeVeaux of Phillber Research Associates. http://www.doe.org/programs/program_eval.cfm

VII. BENEFITS ADVOCACY SIGNIFICANTLY INCREASES HOMELESS ACCESS TO ENTITLEMENT PROGRAMS, AND RECEIPT OF BENEFITS IMPROVES CLIENT QUALITY OF LIFE.

See Action Steps 3.6.1, 3.6.2 & 3.6.3

- The federal SOAR (SSI/SSDI Outreach, Access and Recovery) Project's training and technical assistance in 24 states and the County of Los Angeles have dramatically improved homeless access to this important benefit. SSI/SSDI application **approval rates increased from 10-15% to 49-100%** and the length of time for an application decision decreased from an average of more than 120 days to an average of less than 96 days. In addition, fewer follow-up consultative exams are being requested by DDS, evidence of better disability documentation in the applications.[19]

- A study of mentally-ill homeless veterans who applied for SSI or SSDI found that three months after the award decisions, those awarded benefits had significantly higher incomes and reported higher quality of life. They spent more on housing, food, clothing, transportation and tobacco products, but not on alcohol or illegal drugs.[20]

[19] Preliminary Outcomes from the SOAR Technical Assistance Initiative, http://www.prainc.com/SOAR/about/SOARPreliminaryOutcomes.pdf

[20] Long, D, Rio, J and Rosen, J. *Employment and Income Supports for Homeless People*. Discussion Draft for the 2007 National Symposium on Homelessness Research. pp. 21-22.

Appendix G
-Coordinating A Solid Administrative & Financial Structure To Support Effective Plan Implementation-
Program & Practice Examples and Research Knowledge

Table of Contents

Introduction

I. AN OVERVIEW AND BACKGROUND INFORMATION ON STRUCTURES THAT COMMUNITIES AROUND THE COUNTRY HAVE UTILIZED TO ADMINISTER THEIR EFFORTS TO PREVENT AND END HOMELESSNESS

II. AN OVERVIEW OF STRATEGIES THAT COMMUNITIES HAVE USED TO FUND IMPLEMENTATION OF THEIR TEN YEAR PLANS AND OTHER EFFORTS TO ADDRESS HOMELESSNESS

Program and Practice Examples

I. Oversight, Coordinating Structures
- A. Joint Powers Authority, Los Angeles, CA
- B. Independent Non-Profit, Washington, DC
- C. Local Council of Governments, UT
- D. Inter-Jurisdictional Community Wide Collaborative, Santa Barbara, CA
- E. Two Tier Leadership Groups, Sacramento, CA

II. Centralized Funding for Administration and Coordination
- A. Contra Costa County
- B. Santa Clara County
- C. City of San Jose
- D. San Francisco

III. Funders Group, Seattle/King County, WA

IV. City and County Investment in Housing and Services
- A. Santa Clara County, CA
- B. San Jose, CA

V. City and County Investment in Housing and Services: Focus on Uses of California Mental Health Services Act Funding
- A. Santa Clara County Department of Mental Health
- B. San Diego Mental Health Services

VI. Project Coming Home

VII. Miami-Dade Homeless and Domestic Violence Food and Beverage Tax, Miami-Dade County, FL

VIII. Using Medicaid to Finance Supportive Services in Housing

IX. Using Medi-Cal to Finance Supportive Services in Housing

X. Supportive Housing for Persons with Disabilities Program and Supportive Housing for the Elderly, HUD.

XI. Funding Sources for Housing-Linked Services for People Living with HIV/AIDS

A. Ryan White Comprehensive AIDS Resources Emergency Act (CARE), U.S. Department of Health and Human Services
B. Housing Opportunities for persons with AIDS (HOPWA), HUD
C. Dream Homes Community Center, Danbury, CT

I. The following is an overview and background information on structures that communities around the country have utilized to administer their efforts to prevent and end homeless.

Model A. Joint Powers Authority

See Action Step 4.1.1

A Joint Powers Agreement (JPA) is an agreement between two or more local government agencies or bodies to collectively provide a service to a community. California Government Code section 6500 grants authority to local governing bodies to join together to provide any service that either of them could provide on their own. To form a JPA, participating government agencies must mutually agree to specific conditions and terms that may limit each agency's ability to act independently, but it does not alter the basic structure of each agency's decision-making processes. Common examples of JPAs include: a sheriff's department agreeing to provide police services to a city, a county and a city agreeing to jointly run an emergency dispatch center, or multiple jurisdictions running a transit authority.

JPAs are designed to have separate boards of directors. The boards have the same power of the participating agencies. It is within the purview of participating agencies to limit the powers granted. As such, the powers can be general or specific, the term of the authority can be designated, and general administrative requirements can be made. Funding typically flows from the participating agencies. The JPA may have its own staffing and legal entity.

Model B. Independent Nonprofit to Host All Efforts

See Action Step 4.1.1

Several communities have created a lead nonprofit organization to implement homelessness planning. These nonprofits can either operate as stand-alone organizations or in concert with a joint powers authority.

Under the existing federal McKinney Vento homelessness assistance program, communities are not eligible for funding unless the community has created what is known as a Continuum of Care. The structure of the Continua of Care vary from region to region. Some Continua are nonprofits with 501(c)(3) designation, while others are government agencies. New legislation is currently under consideration that might replace the Continua of Care with a new body known as the Collaborative Applicant. The Collaborative Applicant will not be too unlike a nonprofit entity, which may make a nonprofit model a more attractive way to implement the Plan.

Model C. Collaborative Body Model to Include Jurisdictions, Providers, Homeless People and Advocates

See Action Steps 4.1.1 & 4.2.3

This structure is the most commonly chosen. Many of the local communities organize their bodies that direct planning to address homelessness in this way.

Key considerations when selecting the structure for your community include:

- Who should be included / membership?
- Who provides the leadership on homelessness in your community?
- How will it be staffed?
- How will decisions be made?
- What funding exists for these activities?
- What capacity is there for data collection and analysis to guide planning and funding decisions?
- Will the structure control funding allocation decisions?

II. The following is an overview of strategies communities have used to fund implementation of their ten year plans and other efforts to address homelessness.

A. Fair Share Jurisdictional Contributions

1. Per capita
2. Contributing by entitlement jurisdiction
3. Percent of homeless individuals in the jurisdiction
4. Even split across Supervisors' districts (and cities within them)

B. Trust Fund

In the last twenty years, localities have created trust funds as a mechanism to accept funds from various sources. They can be useful because funds contributed to the fun are designated for a particular use and the fund can accept funds according to the budget cycle of the various contributors. Year ago, Alameda and San Francisco set up trust funds to fund the administration and coordination of homeless services, but did not receive the level of funding needed to effect change. Most Trust Funds are established to fund affordable housing by dedicating a revenue source and establishing the Trust Fund as a separate and distinct entity that can receive and disburse funds. They may be overseen or administered by an Advisory Committee.

SOURCE OF FUNDING
The source of these funds could be any of the following:

Taxes

- Local Hotel Tax- a model in Miami uses a 1% hotel tax which funds a homeless trust
- Redevelopment tax increment financing

Non-Tax Dedicated Revenue

- Assessments—Local government can create an assessment area to fund improvements, such as road building, sewer installation, or fire protection. All property owners in the area must pay the assessment along with their property taxes.
- Developer's Fees—Some communities require for-profit developers of housing or other real estate to pay an annual fee for each new unit they build, to offset increased municipal costs for schools, roads, public services, etc.
- Recording Fee—In Washington, a $10 document recording fee (HB2163) on real estate transaction in all counties funds homeless housing and services administered at the local level, with counties as the lead. Essentially any activity that leads to reducing homelessness is eligible if it complies with State and local plan priorities, including technical assistance and capacity building.

Government Debt Mechanism

- Municipal Bonds—Municipal bond financing, which may require voter approval, is often used, along with other funding sources, to nourish a range of government programs from public education to urban redevelopment.
- State Bonds—California may also issue legislature-approved bonds for a variety of purposes.

Existing Federal-State-Local Financing Streams

- Locally Controlled Federal Dollars—Many local jurisdictions use federal block grant funds they control, such as CDBG and HOME, for homeless housing and services.
- Local General Funds—Many local communities regularly spend a portion of general fund dollars to support homeless service and housing projects prioritized by local processes.

Voluntary Sources

- Voluntary Bid Agreement—Under the Business Improvement District model, businesses within the BID area volunteer to pay fees to the BID to provide services.
- Membership Dues—Jurisdictions could be asked to voluntarily pay dues to a regional member organization providing homeless services, planning, and coordination in support of local efforts.

Program & Practice Examples

I. Oversight, Coordinating Structures

A. Joint Powers Authority
Los Angeles, California

See Strategy 4.1

***Name of Group*:** Los Angeles County Homeless Services Authority (LAHSA)

Established: December 1993
- By the L.A. County Board of Supervisors, L.A. City Mayor, L.A. City Council

Membership
Governing body: 10-member commission with the authority "to make budgetary, funding, planning and program policies."
- 5 L.A. County Board of Supervisors' appointees
  - 1 President/CAO of a social service agency serving homeless
  - 1 developer: V.P. of Community Development at Casden Properties
  - 1 Local gov't leader: Whittier City Council councilman
  - 1 legislative deputy for a Supervisor from the County Board of Supervisors
  - 1 member not appointed
- 5 L.A. City Mayor appointees (L.A. City Council must confirm appointees)
  - 1 lawyer
  - 1 academia: USC Associate Dean of Admin.
  - 1 Financial Institution: V.P./regional manager for corporate giving at Washington Mutual
  - 1 faith-based organization leader
  - 1 non-profit: Executive Director of the ACLU Southern California, ACLU Foundation

Committees: 1 Commissioner on each Committee, non-Commissioner members participate in discussions, but do not vote.
- Committees on Finance, Contracts & Grants Management; Programs, Planning & Policy
- Role: "to handle specific issue tasks and make recommendations to the full Commission"

Mission:
"To support, create and sustain solutions to homelessness in Los Angeles County by providing leadership, advocacy, planning, and management of program funding."

Goals of Group:
LAHSA was created "to address the problems of homelessness on a regional basis"

"LAHSA's primary role is to coordinate the effective and efficient utilization of Federal and local funding in providing services to homeless people throughout Los Angeles City and County."

Staffing:
70 full-time staff

Funding: *City and County each contribute to admin and operating costs.*

Number of Homeless in Area: 152,261 (2007 estimate)

JPA as organizational structure.
A JPA is an agreement between two or more local government bodies to collectively provide a service to the community, that either of them could have provided on their own. To form a JPA, participating government agencies must mutually agree to specific conditions and terms, that may limit each agency's ability to act independently, but it does not alter the basic structure of each agency's decision making processes. JPAs are designed to have separated Boards of Directors. Powers granted a JPA can be general or specific, the term of authority can be designated, and general administrative requirements spelled out in agreement. Funding typically flows from the participating agencies. A JPA may have its own staffing and legal entity.

Other Homelessness JPAs:
Solano County, CA

B. Independent Non-Profit
Washington, DC

See Strategy 4.1

***Name of Group*:** The Community Partnership for the Prevention of Homelessness

Established: 1989

Membership:
"The Community Partnership is governed by a diverse Board of Directors with representatives from local government, community foundations, homeless service providers, former consumers of homeless services as well as community residents."

The 15 member Board currently has the following members:

- Non-profit (chair)
- 7 Service providers
    - community action
    - employment
    - education

    - family focused
    - youth focused
    - children focused
    - single adults/chronic homeless focused
- Local government
    - D.C. Housing Finance Agency
    - Health care
- Fed. government
    - Fannie Mae
    - Dept. of Veteran's Affairs
    - SAMHSA

Mission:
"To serve as a focal point for efforts to reduce and ultimately prevent homelessness in the District of Columbia."

Goal of Group:
- "Our goal is to utilize community resources to create innovative strategies that prevent homelessness in our city."
- Functions as the central planning, funding and monitoring entity for all homeless assistance programs.
- Many contracts with service/housing agencies are funneled through TCP, using funds from many government and private sources.

Staffing:
20-23 staff members

Funding:
Contract to DC Health and Human Services

Other Homelessness Administering Agency NonProfit Corporations
- Columbus Ohio (funders pool private and public resources, so providers complete one funding application, meet common outcome measures, and comply with centralized reporting requirements)

- New Orleans, LA

C. Local Council of Governments
Utah

See Strategy 4.1

***Name of Group*:** Local Homeless Coordinating Committee
Adjunct to
State Homeless Coordinating Committee (SHCC)

Established: *State structure mid 90's/revised 2005; local structures 2007*

Membership
State Structure: 17 Governor-appointed members

- Lt. governor (chair)
- the state planning coordinator
- the state superintendent of public instruction
- the chair of the board of trustees of the Utah Housing Corporation
- the executive director of the Department of Human Services
- the executive director of the Department of Corrections
- the executive director of the Department of Community and Economic Development
- the executive director of the Department of Employment security
- the executive director of the Department of Health
- one representative from rural service providers
- one representative from law enforcement
- one representative from financial institutions
- four representatives of advocacy and religious groups that are not applicants for homeless trust funds
- one representative of public housing authorities
- one representative of native Americans
- two private sector representatives
- two homeless or formerly homeless persons
- two members of the general public
- two representatives from local government, one from the Salt Lake City Mayor's office

Also on the committee are representatives from the Salt Lake County, Weber County and Utah County Homeless Coordinating Committees.

Goals of Group:
The SHCC "provides oversight and approves allocations of funding for providers of homeless services. The committee ensures that services provided to the homeless are utilized in a cost-effective manner and works to facilitate a better understanding of homelessness."

- Coordinates all homeless planning, policy
- Recommends policy, regulatory, resource changes needed to accomplish objectives

- Coordinates the State Plan with local government associations

Local Council of Government "Homeless Coordinating Committee"

12 created statewide, with local Association or Council of Governments

Meet bi-monthly
Develop pilot programs, seek funding from state homeless trust fund to implement.

Mission:

- Implement locally the State's ten-year plan to end chronic homelessness and reduce overall homelessness.
- Prioritize and coordinate funding to implement supportive service programs to reduce and prevent homelessness.
- Use Homeless Management Information System to report and manage results.
- Develop a "local pathway" to self-reliance for homeless customers.

Membership

- County commissioner (Chair)
- City councils (each in the area)
- Police department/sheriff
- Department of Corrections/jail
- Adult probation and parole
- Public housing authority
- Department of workforce services
- School district
- Community action program
- Medical Center
- Department of Health
- Mental Health
- Domestic Violence
- Chamber of commerce
- Financial institutions
- United Way
- Board of Realtors
- Churches
- Community at large
- Continuum of care
- HMIS
- State Homeless Task Force

Goals of Group:

Carry out the Homelessness Plan for each county/region

D. Inter-Jurisdictional Community Wide Collaborative

Santa Barbara, California

See Strategy 4.1

***Note: this governing body structure is currently evolving as the plan is being implemented.**

***Name of Group*:** Leadership Council of Bringing Our Community Home

Established: 2006

Membership: *30 seats*

- County Elected officials
- Elected official from each city
- Business leader
- philanthropists
- Faith community leaders
- Homeless service providers
- Formerly homeless persons

Mission:
Form a governing board, to implement the 10 Year Plan

Staffing:
Executive Director
Fund Development Coordinator
Liaison to Continuum of Care staff, MHSA Housing Coordinator

Other Community Wide Collaboratives:
This is the most common structure, with wide variation in actual committee design, staffing, and seat of responsibility within local government.

Contra Costa County, CA

Continuum of Care Board and Homeless Inter-Jurisdictional Inter-Departmental Work Group combined and renamed the ***Contra Costa County Inter-Agency Council on Homelessness***

Leadership Team membership

- Consumers
- City representatives
- County agency staff

- Law enforcement
- Faith based organizations
- Community based organizations

Has Committees that implement the 10 Year Plan core strategies, meet needs of the HUD NOFA, Health Care for the Homeless program, military base conversion process, housing development, performance measurement, HMIS, discharge planning, transformation of MSCs to Basic Housing Assistance Centers, culture change to Housing First.

Staffing and Funding:
Health Services Department, Public Health Division
County general funds, admin funds from state and federal grants
6 staff (includes operating general and youth shelter, coordinating Project Homeless Connect, project management for signature strategic programs)

Santa Cruz County, CA

Continuum of Care expanded to handle 10 Yr Plan, renamed ***Homeless Action Partnership.***

Membership
- Faith community
- Business
- Funders
    - Community foundation of Santa Cruz
    - United Way
- Law enforcement
- Community groups
- Neighborhood groups
- County
    - County administrator
    - Human resources agency
    - Health services agency
    - Housing authority
- Santa Cruz city
- Watsonville
- Capitola
- Scotts Valley

Staffing and Funding:
- County Human Resources Agency
- 2 staff
- cost sharing formula among jurisdictions formalized in MOU creating the HAP, for staff and winter shelter operations, etc

E. Two Tier Leadership Groups
Sacramento, California

See Strategy 4.1

***Name of Group*:** Policy Board and Inter-Agency Council

Established: 2007

Policy Board
Provides strategic direction, oversight and advocacy for 10 Year Plan and homeless services

- Mayors (3)
  - Sacramento
  - 2 cities within Sacramento County
- Board of Supervisors (1)
- Foundations: CEO or Board member (2)
- Business (2)
- Faith based leaders
- Civic leaders
- Health care leaders
- Homeless/formerly homeless
- Community based providers
- Criminal justice rep
- Inter-Agency Council rep

Inter-Agency Council
"plans and coordinates service delivery, recommends policy and strategy to the Policy board"

- Government agencies
- Service providers
- County health
- Medical providers
- Housing developers
- Disability community

Has 10 committees on specific issues

Staffing
Housed in Community Services Planning Council, a CBO
(2) Director and Project Coordinator

II. Centralized Funding for Administration and Coordination

See Action Step 4.2.2

A. Contra Costa County

Administration and Coordination is funded by a combination of:

- General funds from the county that flow through the Public Health Department
- Administrative money from McKinney- Vento Continuum of Care awards and
- Other federal and state grants

B. Santa Clara County

Continuum of Care Staff—The Santa Clara Countywide Continuum of Care is called the Santa Clara Collaborative on Affordable Housing and Homeless Issues. The County Homeless Concerns Coordinator is staff to the Continuum of Care. That position is located within the Office of Affordable Housing (which is located within the County Executive's Office) and funded with County General Funds. No part of McKinney-Vento Homeless Assistance Grants administrative funding supports this position. The County is the direct grantee on Shelter Plus Care grants only.

C. City of San Jose

The city of San Jose funds its Homeless Program Manager position, located within its Housing department out of City General Funds.

D. San Francisco

The lead entity of the continuum of care in San Francisco is the Local Homeless Coordinating Board. Housing and Homeless Services funds a staff person for the Board, and other homeless services with city general funds, administrative money from McKinney-Vento grants and other federal and state grants.

III. Coordinated Funding for Special Initiatives

Funders Group
Seattle/King County, WA

See Action Step 4.2.3

The Funders Group was created under the Taking Health Care Home (THCH) initiative to promote system change to facilitate development of PSH called for in the County's Ten Year Plan. This group includes state representatives who later helped get state legislation passed to provide additional resources for homeless housing and services. A Coordinator position within the Department of Community and Human Services was funded by THCH.

In 2002, $24 million was dedicated to homeless prevention, support services, assessment and treatment, emergency shelter, and a variety of transitional and supportive housing programs. Sources of this funding included the Department of Community and Human Services, King County, the city of Seattle, other "pass-through" cities, various federal programs, State mental health and chemical dependency funds, State THOR funds, and others. Community partners in these efforts included the City of Seattle, suburban cities, Healthcare for the Homeless Network, courts, law enforcement, community mental health and substance abuse treatment providers, community based non-profit providers, veterans organizations and providers, and multi-jurisdictional housing groups. In the summer of 2006, the Funders group issued its first request for proposals for PSH development, combining capital, services and operations funding.

IV. City and County Investment in Housing and Services

See Action Step 4.2.3

A. Santa Clara County, CA

Housing Authority of Santa Clara County – prioritizes section 8 vouchers to people who are chronically homeless, including Project-Based Vouchers to use in newly constructed or rehabilitated rental housing.

Mental Health Services Act Funding – some of these funds are dedicated to full-service partnership slots and housing for people who are chronically homeless and to youth who are homeless.

County Affordable Housing Funds - prioritizes funding for housing for people experiencing chronic homelessness. Some of this funding is coupled with MHSA-Full Service Partnership funds.

Housing Trust Fund— The Santa Clara Housing Trust Fund supports housing and services for people who are homeless, affordable housing developments and housing for first-time homeowners buy affordable housing. An endowment of $20 million was targeted and reached, impressively, within two years. Private citizens, employers, the County government and, in a display of solidarity, all of the 15 Santa Clara County towns and cities contributed to the Trust becoming a major funder of affordable housing options.

B. San Jose, CA

City controlled funding that either is dedicated to people who are homeless, or which prioritizes people who are homeless includes:

- The Housing Services Partnership, a collaboration of three community-based organizations that assists clients in maintaining their housing through rental assistance and supportive services.

- New Construction/Adaptive Reuse Construction loans (up to $20 Million) – one target population is individuals who are chronically homeless

- San Jose Housing Trust Fund – Neighborhood-Based Special Needs Housing dollars ($1.5 millions) for new construction of acquisition/rehabilitation of permanent rental housing for chronically homeless people.

- PROGRESS program will provide housing and supportive services to a few chronically homeless people using HOME funds (TBRA).

V. City and County Investment in Housing and Services: Focus on Uses of California Mental Health Services Act Funding

A. Santa Clara County Department of Mental Health

See Action Step 4.2.3

The Department of Mental Health's Jail Aftercare and Recovery Services program provides Full Service Partnership intensive, wrap-around, "whatever it takes" services to homeless adults and youth in need of mental health and/or substance abuse treatment as an alternative to incarceration, as a condition of early release from jail/youth facility detention or upon serving their court ordered sentence. The FSP Teams are charged with acquiring needed levels of housing through use of housing funds managed by the FSP Team.

Transitional Housing
Recognizing that a significant barrier to individuals returning to the community from incarceration is finding immediate stable and safe housing, specialized transitional housing beds are set-aside for those released from jail, and 75 transitional housing units are being developed for FSP-enrollees being released from jail to provide stabilization and the opportunity to develop a plan for employment, education and long-term housing.

The FSP Teams, existing and new transitional housing units, and current and enhanced services available through the PALS and Treatment Courts, are funded through dollars from the Mental Health Services Act, County General Fund, HHS/SAMHSA, Juvenile Justice Crime Prevention Act, MediCal Revenue, Comprehensive Drug Court Implementation (CDCI), Drug Court Partnership (DCP) grants, and two new grants awarded to the County in 2007 through the California Department of Corrections and Rehabilitation's Mentally Ill Offender Crime Reduction Program (MIOCR): $1.5 million for the County's Department of Mental Health's Justice and Recovery Courtroom to Community Partnership and another $1.5 million for its Youth Development Partnership.

Permanent Housing
In addition to the more than $6 million for housing contained in the County's MHSA 3-year plan, an estimated $5 million will be available each year for new housing for the homeless mentally ill. The County Mental Health Department has formed a Housing Advisory Committee to develop the process for partnering with developers to access these funds.

B. San Diego Mental Health Services

See Action Step 4.2.3

The County of San Diego Mental Health Services Act (MHSA) Housing Plan establishes a goal of creating approximately 438 units of affordable housing for individuals with serious mental illness over a six year period. These housing units are to be dedicated for individuals enrolled in MHSA-funded Full Service Partnerships (FSP's) programs that

provide wraparound services to individuals with serious mental illness who also have unmet housing needs.

To implement the plan, the County of San Diego Mental Health Services (SDMHS) sought, and the California Department of Mental Health (State DMH) and the California Housing Finance Agency (CalHFA) allocated approximately $33 million dollars to SDMHS for capital and operating subsidies for the development, acquisition, construction and/or rehabilitation of permanent supportive housing.

In February, 2008, SDMHS then issued a Request for Proposals to allocate those funds. In addition, the County of San Diego Department of Housing and Community Development (HCD) is administering, on behalf of SDMHS, an additional amount of up to $3.24 million for the same purpose – creation of permanent supportive housing. Applicants seek the HCD funds through a separate but coordinated process.

To best meet the housing needs of individuals enrolled in the FSP's, SDMHS set a goal of creating the most housing units feasible given the available funding. The financial model establishes a numerical goal of 438 units for the FSP's.

The MHSA Housing Plan also includes guidance for developers about desirable projects, including certain design and development principles which MHSA projects must meet, or be given waivers through a special review process. This guidance includes minimum unit sizes for studio apartments, a requirement that projects be located near amenities such as transportation and services, and that tenants pay a maximum of 30% of their incomes.

VI. Blending or Coordinating Funding Across Agencies or Programs

Funding to allow for the provision of integrated services can be coordinated or blended across agencies or programs. This allows housing, services and treatment to be provided seamlessly, thus enhancing the likelihood of positive outcomes.

By increasing coordination and integration of service provision, unnecessary duplication can be reduced, poor outcomes improved and resources more efficiently utilized. The resulting cost-savings can be then be applied to other needed housing and services.

Project Coming Home
Contra Costa County, CA

See Full Project Profile in Appendix D – Housing, p. 1

See Action Step 4.2.3

Project Coming Home was initiated through a joint application for funding under the federal Chronic Homelessness Initiative. The application was submitted by the County Office of Homeless Programs in conjunction with 10 partners, including both public agencies and non-profit providers.

VII. Funding Housing-Linked Supportive Services through Local Taxation

Miami-Dade Homeless and Domestic Violence Food and Beverage Tax
Miami-Dade County, FL

See Action Step 4.2.3

The Miami-Dade Homeless and Domestic Violence Food and Beverage Tax collects a one percent tax on all food and beverage sales made by businesses that are licensed by the State of Florida to sell alcoholic drinks. Motels, hotels, and establishments that make under $400,000 in annual receipts are exempt. Money collected funds such services as emergency, transitional, and permanent housing, and supportive services like food assistance, employment, and healthcare. Revenues collected from the Miami-Dade tax raises $6.8 million a year for homeless services alone (National Policy and Advocacy Council on Homelessness, 2004). Since the tax began, Miami-Dade County has collected more private dollars for homelessness than any other city in America. As a result, Miami-Dade attracts more federal dollars as well, thus enabling the community to provide needed assistance to their homeless population (Miami Dade Government Homeless Trust, 2005).

VIII. Using Medicaid to Finance Supportive Services in Housing

See Action Step 4.2.3

Medicaid represents a potentially reliable source of mainstream funding to support many of the health-related services provided in supportive housing. Further, it provides opportunities for states and local communities to leverage additional Federal matching funds for services, permitting a greater portion of HUD resources and private capital to go toward permanent housing. The Corporation for Supportive Housing (CSH) recently examined opportunities to fund services in supportive housing using Medicaid (CSH, 2003). CSH found that while major challenges still exist, many governments and supportive housing providers have succeeded in using Medicaid to finance supportive services in housing (Id.). The use of funds for supportive services has decreased in recent years, as budget cuts have forced states to reduce payouts for long-term care and case management. Between 2003 and 2005, twenty-two states made Medicaid cuts to long-term care and thirty-eight made cuts to case management (Wilensky and McDermott, 2005).

Under Medicaid's rehabilitation option, providers can be reimbursed for services aimed at improving skills and functioning impaired by mental illnesses and, in some states, substance use disorders. The targeted case management option can be used to support goal setting and linkage to health and other social services. Through partnerships with Federally Qualified Health Centers, providers can deliver health, mental health, and substance abuse treatment services to people living in supportive housing.

Additionally, states may use Medicaid waivers to allow funds to be used in more flexible and creative ways to fund supportive services in community-based settings. While these strategies and their implementation vary from one state or community to the next, they offer promise for expanding the use of Medicaid to fund supportive services in housing.

IX. Using Medi-Cal to Finance Supportive Services in Housing

See Action Step 4.2.3

This is how one California County contracts with a community-based organization to provide targeted case management services:

A County health department contracts with a community-based organization for$100,000 from its general fund to provide targeted case management services in a family supportive housing project. Comprehensive case management services are provided by qualified staff to Medi-Cal beneficiaries. If targeted case management is successfully accessed, the federal government will reimburse the County 50% of its $100,000 disbursement, or $50,000. Of this $50,000, the County health department takes 12% off the top to cover the administrative fees of managing the targeted case management. (Note that County health departments establish their own administrative fees and can, if they choose, keep the entire reimbursement). The remaining 88% (or $44,000) in this case is provided to the community-based organization to fund services in supportive housing. Because the County had to spend $100,000 to be reimbursed $50,000, targeted case management funding in this example is considered to be an augmentation, rather than a replacement of one funding source for another.

What	Percentage/Calculation	Amount
County Health Dept. contracts with community-based organization to provide targeted case management services		$100,000
Federal reimburses County Health Dept.	50% of $100,000	$50,000
County Health department takes administrative costs	12% of $50,000	$6,000
Community-based organization receives as service reimbursement	88% of $50,000	$44,000
County Health Department contributes to community-based organization in total	Original $100,000 plus 88% of reimbursement	$144,000

As the case study illustrates, a County health department may enter into an agreement with a contracting community-based organization to provide targeted case management

services under the Community State Plan Amendment. This makes it possible, essentially, for the County health department to ***buy*** more services in supportive housing without expending more funds. However, this scenario is unusual. The County health department is under no mandate to pass on its targeted case management reimbursement to the community-based organization. If it chooses, the County health department can retain any percentage of its reimbursement to cover both the cost of purchasing targeted case management services from the provider as well as the administrative costs of managing targeted case management.

(Excerpted from “Using Medi-Cal to Fund Services”, Corporation for Supportive Housing, 2005)

X. Funding for Housing-Linked Supportive Services for the Elderly

Supportive Housing for Persons with Disabilities Program and Supportive Housing for the Elderly
HUD

See Action Step 4.2.3

Program Description: This program supports the development and operation of supportive housing for people with disabilities and the elderly. Grants are made to nonprofits in the form of no-interest capital advances, which do not have to be repaid for 40 years so long as the housing remains available for persons with disabilities. Funds may be used for new construction, rehabilitation, or acquisition; for project-based rental assistance; and for supportive services to address the health, mental health, or other needs of people with disabilities and the elderly.
Funded by: Funds awarded competitively to community based nonprofit organizations

XI. Funding Sources for Housing-Linked Services for People Living With HIV/AIDS

See Action Step 4.2.3

A. Ryan White Comprehensive AIDS Resources Emergency Act (CARE)
US Dept. of Health And Human Services

Program Description: Funds housing-related services for individuals living with HIV disease in localities that are most severely affected by the HIV/AIDS epidemic. Services include outpatient and ambulatory health services including substance abuse and mental health treatment, outreach, and early intervention services. The Act includes initiatives that specifically target minority and youth populations.

B. Housing Opportunities for Persons with AIDS (HOPWA)
HUD

Program Description: HOPWA supports the provision of both housing and services for low-income people with HIV/AIDS. Funds can be used for a variety of activities, including housing information and coordination assistance; acquisition, rehabilitation, and leasing of property; rental assistance; operating costs; supportive services; and technical assistance (TAC, 1999).
Funded by: Funds are awarded by block grant to states and the most populous city in each eligible "Metropolitan Statistical Area."

Dream Homes Community Center
Danbury, CT

Partner Agencies:

- Housing Authority of the City of Danbury
- The Association of Religious Communities
- We CAHR
- And People First of CT

Significant Program Design Features:

- A collaborative effort of four non-profits to create a single point of entry for the homeless, people seeking rentals, and first-time homeowners.
-

Outcomes:

Costs/Funding:

- The City of Danbury, New Fairfield, New Milford, Redding, and Ridgefield
- McCue Mortgage
- An anonymous donor
- Housing Authority
- We CAHR