Abt
ASSOCIATES

Linking Human Services & Housing Assistance for Homeless Families & Families at Risk of Homelessness

Linking Human Services and Housing Assistance for Homeless Families and Families at Risk of Homelessness

Prepared by:

Alvaro Cortes, Ph.D.
Lauren Dunton, M.P.P
Meghan Henry, M.A.
Howard Rolston, Ph.D.
Jill Khadduri, Ph.D.

Contributing Authors:

Tom Albanese, Katherine Dahlem, Emily Holt, Ruby Jennings, Jill Spangler,
Matt White, and Erin Wilson

Table of Contents

Executive Summary

Recent reports have brought national attention to the prevalence of family homelessness[1] and the need to coordinate across all levels of government to prevent and end family homelessness. In June 2011, the U.S. Department of Housing and Urban Development (HUD) released the *2010 Annual Homeless Assessment Report (AHAR)*, the sixth in a series of annual reports on the extent and nature of homelessness nationwide. The report documents a 29 percent increase in sheltered family homelessness between 2007 and 2010. Today, an estimated 168,000 families— 567,000 people—use an emergency shelter or a transitional housing program at some point during the year. The toll of homelessness on children living with their families is troubling. Homelessness can adversely affect children's mental health and behavior, school attendance and educational achievement, cognitive and motor development, and general health.[2]

A year prior to the 2010 AHAR release, the U.S. Interagency Council on Homelessness (USICH) released the nation's first comprehensive strategy to prevent and end homelessness, *Opening Doors*: Federal Strategic Plan to Prevent and End Homelessness. The plan sets an ambitious agenda for addressing homelessness among families and other target groups, stresses governmental collaboration at all levels, and encourages using programs targeted to homeless families and mainstream resources to help families achieve housing stability.

The growing concern about family homelessness has renewed the focus among policymakers, researchers, advocates, and practitioners on using mainstream programs to prevent and end homelessness. The underlying belief is that programs explicitly for homeless people cannot be expected to do the whole job of preventing and ending family homelessness. Indeed, ever since the start of specialized federal funding for homeless people,[3] it has been recognized that mainstream programs such as Housing Choice Vouchers (HCV) and Temporary Assistance for Needy Families (TANF) provide much greater resources than targeted programs for helping families leave homelessness.

It is within this context that the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services (HHS) commissioned a study that focuses on local programs that link human services with housing supports to prevent and end family homelessness. (The

---

[1]   Homeless families are defined by the U.S. Department of Housing and Urban Development as households composed of one or more adults with at least one minor child (age 17 or younger) that are staying in shelter or living in places not meant for human habitation (e.g., abandoned buildings, vehicles, or encampments). With one exception, all of the homeless assistance models described in this report used this definition of homelessness. The model in Decatur, Georgia used the definition by the U.S. Department of Education, which is broader and includes people living in doubled-up situations due to the loss of housing, economic hardship, or a similar reason.

[2]   For a summary, see Rog, Debra and John Buckner. 2007. "Homeless Families and Children." In *Toward Understanding Homelessness: The 2007 National Symposium on Homelessness Research.* The U.S. Department of Health and Human Services and the U.S. Department of Housing and Urban Development; Washington DC.

[3]   Federal funding for homeless families includes programs at HUD, HHS, and the Department of Education explicitly targeted to homeless people—in particular, the Homeless Assistance Programs at HUD, the ARRA Homeless Prevention and Rapid-Re-housing (HPRP) program at HUD, the Healthcare for the Homeless program at HHS, and the Education for Homeless Children and Youth program at the Department of Education (ED).

Department is also engaged in a similar study that focuses on linking housing and services for people who have complex health needs and chronic patterns of homelessness.)

The primary goals of this study are to:

1. Identify programs nationwide that deliberately integrate human services and housing supports for homeless families and conduct site visits to understand how these programs were designed and implemented.
2. Synthesize the information from the site visits into promising practices that facilitated the development, implementation, and sustainability of these programs.

In addition, the study includes the development of an evaluation design document that provides a theoretical framework for rigorously evaluating programs that integrate services and housing supports for the purposes of preventing or ending family homelessness.

More than 80 programs nationwide were considered for the study, and 14 were chosen for study in consultation with a Technical Working Group composed of representatives from HHS, HUD, USICH and the Department of Education. Among the 14 programs, seven had explicit partnerships with the local Public Housing Agencies (PHA) to serve homeless families. These programs were selected to demonstrate how communities partner with PHAs to provide mainstream housing assistance through the HCV program and public housing, for example, to prevent and end homelessness among families.

This report presents the study's results, which are summarized in the next sections. Appendix A describes the study's methodology, and Appendix B describes several design options for evaluating homeless assistance programs. Appendices C through P present short case studies on each of the 14 programs included in the study.

Characteristics of Programs that Link Human Services and Housing Supports

The 14 programs share the mission of assisting homeless families or families at risk of homelessness in obtaining housing, improving their quality of life, and achieving self-sufficiency. The majority of programs (13 of 14) target families who are literally homeless, living in emergency shelters, transitional housing programs, or in places not fit for human habitation. Many of these programs focus on high-needs families who have multiple barriers to housing (e.g., poor rental histories and criminal backgrounds) and face severe personal issues (e.g., mental illness and substance abuse issues). One program in the study is prevention-oriented, assisting families who are facing imminent homelessness or who are doubled-up, temporarily living with family or friends. The families in this program typically have a source of income or sufficient employment skills to obtain a job, but may have experienced an immediate shock such as job loss or medical expense that led to their precarious housing situation.

The programs in the study rely on a variety of organizations to design and implement the various linkage models, including nonprofit organizations, local and state government agencies, public housing agencies, and private companies. Nonprofit organizations are the most common type of collaborating organization, serving as the lead organization in several models, as well as coordinating and providing the case management services that link the human services and housing supports. Local and state government agencies often serve as a funding conduit for the linkage program, but may play a more hands-on role by coordinating program activities between the different partner organizations. Public

housing agencies offer the housing supports and housing management experience, as well as other important resources—such as a process for determining eligibility, applying for assistance, and identifying landlords with eligible units. Private organizations serve in various roles, ranging from individual donors that sponsor family households to business partners that offer employment opportunities to families. The partnership arrangements between these organizations evolve in a variety of ways—some are planned and others are organic—and the formality of the partnership arrangements also vary—some are based on formal memoranda of understanding and others rely on informal relationships.

The 14 linkage models use many different funding sources to support their activities. Many federal programs are used to provide services and housing supports, including programs in HHS, HUD, the U.S. Department of Homeland Security (DHS), the U.S. Department of Education, and the U.S. Department of Agriculture. Several state and local governments use dedicated funding streams to support the linkage programs. Linkage programs also receive financial support from national and regional foundations, banks, and religious organizations. With one exception, the funding models are diffuse and based on a patchwork of funders.

In contrast, families flow through these programs in ways that are basically similar. Families typically are referred by partner organizations or the community's broader network of homeless assistance providers, including local emergency shelters. A few programs receive referrals from other "systems"— mental health, criminal justice and foster care. Upon initial contact with a linkage program, families work with case managers to complete an intake interview and an assessment, often based on a standardized assessment form. Once the assessment process is complete, the case manager works with members of the family to develop an action plan that outlines their goals and the steps needed to accomplish them. Once a family is admitted into the program, it begins to receive the housing and human service supports identified in its action plan.

Five types of housing supports are offered by the linkage programs in the study: transitional housing, permanent supportive housing, time-limited rental assistance, HCV, and public housing.   The length of housing assistance varies from short-term (3-6 months) to permanent assistance, depending on the type of housing support. While participating in a linkage program, families receive case management services, the main mechanism for linking human services with housing supports. Case managers appear to be well-positioned to integrate services and housing supports because they have established rapports with their clients, understand clients' service needs and housing preferences, and have relationships with organizations throughout the community that can provide the appropriate services and supports. Families receive a broad array of human services, including: mental and physical health services, substance abuse treatment, transportation, child care, adult and child education, employment and vocational training, financial literacy, and assistance with applying for mainstream benefits.

Although these programs successfully designed and implemented innovative approaches to linking human services and housing supports, they face challenges that impose limits on their ability to serve families and may affect their long-term sustainability. The demand for many programs exceeds their current capacity, and funding constraints mean that none of the programs is positioned to expand its services. Furthermore, client turnover in these programs is very slow, due both to a lack of affordable housing in the community and to the severity of families' needs. Thus programs can assist few new families and are grappling with the reality that some families may never exit the program. Lastly,

maintaining current levels of funding has proven a challenge for several linkage programs, especially those that tapped into temporary funding streams created by the American Recovery and Reinvestment Act of 2009.

Promising Practices in the Field

Based on the 14 site visits and discussions with program staff within each community, ten promising practices were identified. These practices appear to have facilitated the development, implementation and sustainability of the programs, and program staff often said they believed the practices led to improved outcomes for families. However, this study was not designed to measure the impact of these practices on client outcomes, and thus the study is unable to draw any conclusions about the effect of these practices on the goal of preventing and ending family homelessness.

The ten promising practices are:

1. *Creating a logical program structure with services tied directly to goals*. The programs in the study developed structures with: a) objectives that were within reach of the target population, b) service interventions that were tailored to the target population, and c) partners that were best suited to provide those services.

2. *Developing lasting partnerships*. Programs that laid a solid foundation for future collaborations were built on three pillars: a) program missions that advanced the goals of each partner, b) deliberate coordination processes that fostered accountability, and c) capitalizing on established collaborative environments.

3. *Utilizing nontraditional community resources*. The constellation of partners went beyond the traditional network of social service providers and government agencies, indicating that thinking creatively when looking for partners can add value to the service interventions.

4. *Forging relationships between program staff and local landlords to increase housing options*. The relationships among case managers, housing specialists, and local landlords were designed to be mutually beneficial: case managers and housing specialists were able to place homeless families into decent affordable housing, and landlords were reassured by the ongoing program support offered to tenants and by the promise of a stable source of rent.

5. *Using case managers to link human services and housing supports*. Case managers served as the focal point for linking services and housing supports, and the strongest linkages were created intentionally by staff, informed by a thorough assessment of client needs, and intensive—meeting purposefully and frequently.

6. *Tapping a breadth of funding sources*. Communities used a diverse patchwork of funding streams to support their programs, and most had a decentralized funding model in which each organization used its own funding resources to participate in the program.

7. *Using standardized intake and assessment forms and data-sharing systems to improve program operations*. Many programs used standardized client intake and assessment tools which streamlined program operations, eliminated duplicative assessments, improved service delivery, and provided common metrics for gauging progress.

The report also describes three practices that are specific to the participation of PHAs that administer federal housing assistance:

8. *Developing a "continuum of housing" that uses locally funded housing supports as a gateway to federal supports.* Several programs in the study partnered with their local public housing agency to develop a continuum of housing that provided temporary or transitional housing assistance to homeless families with integrated case management services until the families transitioned to a permanent housing opportunity—e.g., HUD's HCV program or public housing developments.

9. *Streamlining the PHA lease-up process (i.e., identifying, inspecting, and renting an appropriate housing unit) through a review and retooling of PHA administrative procedures and using program partners for some housing functions.* The most common strategy was to utilize program partners, most often case managers, to assist with program applications, housing search, and unit inspection activities.

    Creating supportive housing environments by integrating intensive case management and services with mainstream housing supports, allowing mainstream housing programs to be used by families with high barriers to housing. The housing subsidy was typically a tenant- or project-based voucher, public housing, or tax credit unit, and the services were supported by intensive, structured case management.

1. Introduction

1.1   Prevalence of Family Homelessness

Each year the federal government releases two estimates of family homelessness[4] in the United States: Point-in-Time (PIT) counts and longitudinal 12-month estimates. The PIT counts estimate the number of homeless families—both sheltered *and* unsheltered—on a single night in January. According to the 2011 PIT estimates, there were about 236,000 adults and children in 77,000 homeless families, or roughly 37 percent of all homeless people in the country.[5]

The longitudinal estimates describe homeless families in shelter, which includes both emergency shelters and transitional housing programs, during a 12-month period, from October 1 through September 30 of the following year. Approximately 567,000 people in 168,000 families stayed in a shelter at some point over the course of 2010, the last year for which these data are available.[6] The number of family households in shelter has increased by about 29 percent (up from 131,000) since 2007.

This sizable increase in family homelessness during the economic recession probably reflects the fragility of the networks of family and friends on whom families in crisis rely. In 2010, 43 percent of families in shelter became homeless after wearing out their welcome with friends and family.[7] Their presence may have led to overcrowded living arrangements, lease violations, and friction among household members that hastened their path toward homelessness. Many of these families are already living below the poverty line or in deep poverty (less than 50 percent of the poverty line). Because they are already financially vulnerable, any type of financial disruption—such as a job loss, an unexpected medical expense or a change in household composition—may cause a precariously housed household to become homeless.

The profile of homeless families differs considerably from that of the general population. About three-fifths (59 percent) of people who are homeless in families are children under age 18, and a majority of adults in those families are age 30 or younger. Homeless adults in families are likely to be women (78 percent) and to identify themselves as minorities (69 percent). The data on sheltered homeless families identify only 15 percent of adults as having a disability.[8]

Despite the disturbing trend, the population of sheltered homeless families still is not large on a national basis, representing only about 2.5 percent of all family households in poverty.[9] Family homelessness is a solvable problem, through effective federal, state and local policies and innovative program designs. Some of these efforts are documented in this report, which focuses on program interventions that purposively link human services with housing supports and tap "mainstream" programs to prevent and end homelessness among families.

---

[4]   A homeless family is a household with at least one adult and at least one minor child (age 17 or younger).
[5]   U.S. Department of Housing and Urban Development. 2011. "The 2011 Point-in-Time Estimates of Homelessness: Supplement to the Annual Homeless Assessment Report." Washington, DC.
[6]   U.S. Department of Housing and Urban Development. 2010. "The Annual Homeless Assessment Report to Congress." Washington, DC.
[7]   *Ibid*, p. 23.
[8]   *Ibid*, p. 20.
[9]   In 2000, there were an estimated 6,620,945 family households in poverty (U.S. Census 2000 Summary File 3 (SF 3) - Sample Data).

1.2   Existing Efforts to Address Family Homelessness

Federal funding for homeless families includes programs at the U.S. Department of Health and Human Services (HHS), the U.S. Department of Housing and Urban Development (HUD) and the Department of Education (ED) explicitly targeted to homeless people—in particular, the Homeless Assistance Programs at HUD, the Homeless Prevention and Rapid-Re-housing (HPRP) program at HUD,[10] the Healthcare for the Homeless program at HHS, and the Education for Homeless Children and Youth program at ED.[11] Ever since the start of specialized federal funding for homeless people, it has been recognized that "mainstream" programs such as Housing Choice Vouchers (HCV) and Temporary Assistance for Needy Families (TANF) provide much greater potential resources than "targeted" programs for helping families leave homelessness. The recent shift in emphasis to preventing rather than managing homelessness exemplified by the HEARTH Act and the new federal Strategic Plan to Prevent and End Homelessness has renewed the focus on mainstream programs. The federal plan calls for the transformation of homeless services to "crisis response systems that prevent homelessness and rapidly return people who experience homelessness to stable housing."[12] The underlying assumption is that programs explicitly for homeless people cannot be expected to do the whole job of preventing and ending family homelessness.

Establishing links between targeted programs for homeless people and other resources requires that communities coordinate effectively across governmental agencies at all levels and among local homeless service providers. Indeed, one of the missions of the U.S. Interagency Council on Homelessness (USICH) has been to advocate for better coordination among programs at all levels of government.   The Policy Academies sponsored by the HHS Health Resources and Services Administration have brought together state stakeholders to discuss how to integrate systems to address the needs of homeless families and individuals more effectively. The SSI/SSDI Outreach, Access, and Recovery (SOAR) initiative focuses on homeless individuals with disabilities rather than on homeless families, but the models developed under SOAR for protocols and processes to streamline access to benefits may be applicable to families as well. On-the-ground program coordination is hard work: the responses to a recent U.S. Government Accountability Office (GAO) report by both HHS and HUD described the programmatic challenges of working across funding "silos" as a far more important problem than the differing technical definitions of homelessness used to determine eligibility across federal programs.[13]

HHS and HUD have a history of coordinated research on homelessness, recognizing that linkages between housing and services are central to effective program design and implementation. The agencies jointly sponsored two symposia documenting the state of the art of homelessness research, in 1998 and 2007. HHS also has commissioned studies to assess the ability of HHS-funded services to fill

---

[10]   Funded through the American Recovery and Reinvestment Act of 2009.

[11]   Other federal programs are targeted to homeless individuals or to people likely to become homeless as individuals, although some programs (e.g., programs run by the VA) may serve families as well.

[12]   U.S. Interagency Council on Homelessness, *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*, 2010 (Opening Doors), p.7.

[13]   Appendix IV and V to *Homelessness: A Common Vocabulary Could Help Agencies Collaborate and Collect More Consistent Data.* US General Accountability Office, June 2010.

the gap created by the shift of HUD McKinney-Vento funding away from services and to determine which states include questions on homelessness and housing status in TANF and Medicaid administrative data sets. HUD has sponsored studies of the costs of homelessness to both targeted and mainstream systems and of community strategies to enhance access to mainstream benefits.

Overall, coordination among HUD, HHS, and ED programs and research is still evolving, but has been spurred considerably by recent trends in family homelessness and by the federal strategic plan to end homelessness. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) in HHS commissioned this study to focus on community-level programs that deliberately link human services with housing supports to prevent and end family homelessness. ASPE is also engaged in a study of linking housing and services for people (usually individuals) who have complex health needs and chronic patterns of homelessness.

1.3   Goals of the Study

The central goal of this study is to identify and document innovative programs that are integrating housing and human services to better serve homeless or at-risk families at the local level.

Guiding this study are the following research questions:

- Which localities are implementing innovative approaches to provide housing and services to homeless families?
- What are the characteristics of these local programs, including their partnership arrangements and use of federal funding streams?
- What types of human services and housing supports are being integrated within these programs, and what mechanisms are used to forge the linkages?

To address these questions, researchers conducted in-person interviews with program staff in 14 communities, including representatives from the lead agency, key partners, and other local service providers involved in the program (see Exhibit 1-1). To identify the 14 communities and programs, the researchers conducted a nationwide canvass of programs through three avenues: 1) discussions with attendees at HUD's 2010 National Conference for homeless service providers; 2) a general "call for nominations" via several federal email listservs; and 3) consultations with leading researchers in the field of family homelessness and representatives from public housing agency (PHA) membership organizations. Prospective candidates were screened via telephone based on five characteristics of a promising practice:

- *Collaborative*: The program brings a true integration of human services and housing supports to offer a coordinated package of services to homeless families.
- *Implementable*: The program is relatively easy to implement and can be sustained over time.
- *Replicable*: The program can be applied in communities of different sizes and geographies such as large urban cities, mid-sized cities or suburbs, and small towns in rural settings.
- *Measurable*: The program is evidence-based and measures the outcomes associated with participating family members.
- *Cost effective*: The program results in the efficient use of resources.

Table 1-1: Communities in the Study, by PHA Involvement

Community	Program Name
Non-PHA Sites	
1. Boise, ID	Charitable Assistance to Community's Homeless
2. Chicago, IL	Family Assertive Community Treatment Program
3. Decatur, GA	DeKalb KidsHome Collaborative
4. Lawrence, MA	Saunders School Apartments
5. Palm Beach, FL	Adopt-A-Family of the Palm Beaches, Inc.
6. Pittsburgh, PA	Community Wellness Project
7. State of Minnesota	Hearth Connection
PHA Sites	
1. Brattleboro, VT	Pathways to Housing
2. Portland, OR	Bridges to Housing
3. Salt Lake County, UT	Homeless Assistance Rental Program
4. State of Maine	Family Housing Stabilization Program
5. State of New Mexico	Linkages Program
6. Washington, DC	Permanent Supportive Housing Program
7. Yakima, WA	Serving Families and Individuals to End Serious Trouble through Agencies' Support

More than 80 programs were considered for the study, and 14 were selected for study in consultation with a Technical Working Group composed of representatives from HHS, HUD, USICH and ED. Among the 14 programs, seven had explicit partnerships with the local PHA to serve homeless families. These programs were selected to demonstrate how communities partner with PHAs to provide mainstream housing assistance such as HCV and public housing to prevent and end homelessness among families. The full methodology used to conduct the research is provided in Appendix A.

1.4   This Report

The report proceeds as follows:

Chapter 2 describes the structure of the linkage programs. The chapter provides an overview of the programs, focusing on their mission, target population, eligibility criteria, program structure, and partnership and funding arrangements. The chapter also describes the ways in which clients flow through the programs and the types of human services and housing supports the families receive.

Chapter 3 provides a summary of the promising practices that emerged from the programs.[14] The promising practices appeared to facilitate the development, implementation, and sustainability of these programs.

---

[14] The chapter summarizes the information described in the study's research brief (Linking Human Services and Housing Supports to Address Family Homelessness: Promising Practices in the Field) that was released in November 2011 and is available on HHS' website: http://aspe.hhs.gov/hsp/11/FamilyHomelessness/rb.shtml

Appendices A though P provide the study's methodology (Appendix A), design options for evaluating programs that serve homeless families (Appendix B), [15]and short case studies for each of the 14 programs that were part of the study (Appendices C through P).

---

[15]   The appendix synthesizes the information provided in the study's Memo on Evaluation Design Options for the Linking Human Services Study submitted to HHS in November 2011.

---

2. Structure of the Linkage Programs

This chapter explores the structure of the 14 programs included in the study. The chapter begins by providing an overview of the programs, including their mission and goals, the target populations they serve, and eligibility criteria required to participate in the programs. The chapter then reviews the key components of the programs' structure, such as types and roles of collaborating organizations and funding approaches. This section also describes the program processes, from referrals to service provision and program exit. The chapter concludes by examining the types of human services and housing supports provided by the programs and the mechanism for linking those program components together. It also briefly discusses several implementation challenges faced by the linkage programs in the study.

2.1   Overview of the Programs

2.1.1   Mission and Goals

All of the 14 linkage programs[16] have the basic goal of helping families overcome or prevent homelessness and, therefore, all have housing stability as an explicit or implicit goal. Many programs also have a goal characterized as "self-sufficiency," which often means having sufficient income to afford housing without a subsidy, but for some programs—for example, programs that serve families with long histories of homelessness or complex health and behavioral health needs—self-sufficiency can mean the ability to live in stable subsidized housing and be as self-supporting as possible.   The programs differ in the extent to which they focus on outcomes other than housing—for example, whether they focus on addressing behavioral health issues as a central purpose of the program and whether services related to employment are central to the program model.   A few programs focus on outcomes for children related to education and child development goals.   Exhibit 2-1 provides the name and location of each of the 14 programs and shows the mission and goals of each.

Almost all of the programs follow what has come to be called a "housing first" approach to serving families who are homeless or at risk of homelessness. This means that identifying and securing housing happens early in the program and is considered a first step in addressing the issues that may have led to the family's homelessness. If those issues include mental illness or substance abuse, the program may attempt to follow a "harm reduction" model, in which discontinuing harmful activity is not a condition of housing placement. This is closely related to the program's target population, also shown on Exhibit 2-1.

The mission of the program may reflect the way in which it was created. For example, the DeKalb KidsHome Collaborative in Decatur, GA was formed by four organizations that had come together in an ad hoc manner to assist a family in crisis. These organizations formalized their partnership and began targeting families in crisis and at risk of sliding into homelessness that can be stopped with minimal services. The intent of the program is to help families who are homeless because of a short-term economic crisis and in need of temporary assistance in order to return to stable housing.

---

[16]   The terms "program," "model," and "initiative" and are used synonymously throughout the report, except where the context makes it clear we are making a distinction.

Exhibit 2-1: Overview of Linkages Program Models

Location of Program and Name	Mission/Goals of Program	Target Population	Number of Family Households Served[1]
Programs with no PHA involvement			
Boise, ID: Charitable Assistance to Community's Homeless (CATCH) Program	Help families achieve economic self-sufficiency and maintain their housing stability	Homeless families staying in local homeless shelters	136 households
Chicago, IL: Family Assertive Community Treatment (FACT) Program	Assist families in achieving self-sufficiency using the ACT model and a harm reduction approach	Homeless mothers ages 18-25 with a diagnosed severe mental illness and a child under the age of 5	69 households
Decatur, GA: DeKalb KidsHome Collaborative	Assist families in securing housing and income stability, as well as addressing children's school needs	Homeless families that have a child attending school in the DeKalb County School District	90 households
Lawrence, MA: Saunders School Apartments	Provide stable, affordable housing for families while assisting them in achieving self-sufficiency	Homeless families from the Lawrence area	16 households
Palm Beach, FL: Adopt-A-Family (AAF) of the Palm Beaches	Reduce use of hotel/motel vouchers	Homeless families in Palm Beach County coming from emergency shelters or hotel/motels	124 households
Pittsburgh, PA: Allegheny County Community Wellness Project	Link homeless and formerly homeless with employment, training, and social service benefits	Families and individuals residing in HUD-funded transitional housing and permanent supportive housing	360 households
State of Minnesota: Hearth Connection	End long-term homelessness by providing permanent supportive housing	Families, singles, and unaccompanied youth who have experienced long-term homelessness	180 households
Programs with PHA Involvement			
Brattleboro, VT: Pathways to Housing	Help homeless households find and maintain stable housing	Individuals and families who are homeless or at risk of homelessness who have or soon will have a stable source of income; families that receive TANF; youth aging out of foster care; women being discharged from prison and their children	27 households

Location of Program and Name	Mission/Goals of Program	Target Population	Number of Family Households Served[1]
Portland, OR: Bridges to Housing	Stabilize families, move them to greater safety, and improve the well-being of children	High-needs homeless families facing multiple barriers to stability and with chronic patterns of homelessness	558 households
Salt Lake County, UT: Homeless Assistance Rental Program (HARP)	Stabilize families by providing housing and supportive services	Individuals or families who are homeless or at risk of homelessness; individuals or families interacting with the criminal justice system	117 households
State of Maine: Family Housing Stabilization Program (FHSP)	Stabilize families at risk of homelessness	TANF-eligible families with a child under 21 years of age at imminent risk of homelessness	203 households
State of New Mexico: Linkages Program	Stabilize individuals and families and help them address behavioral health issues	Homeless individuals and families with severe mental illness; non-reservation Native Americans	39 households
Washington, DC: Permanent Supportive Housing Program (PSHP)	Help individuals and families to become self-sufficient and maintain stable housing	The "hardest to serve" homeless individuals and families	150 households
Yakima, WA: Serving Families and Individuals to End Serious Trouble through Agencies' Support Program (FIESTAS)	Aid families in Yakima County, Washington in becoming self-sufficient	Homeless families in Yakima County with moderate and high needs	52 households

[1] The total number of households served since program inception is reported by program staff as of the date of the research team's site visit. All site visits were conducted in July and August 2011, with the exception of the FACT, HEARTH, and Community Wellness Project programs, which were conducted in April 2011.

2 This program provides services to people already residing in transitional housing (TH) or permanent supportive housing (PSH).

In contrast, the Linkages Program in New Mexico evolved from an existing service collaboration focused on people with severe mental illness. The 13 partner organizations in the New Mexico Behavioral Health Purchasing Collaborative were already pooling their health service resources from the state and saw an opportunity to leverage this partnership to serve homeless families and individuals with severe mental illness.

2.1.2   Target Population

A majority of the programs target families who are literally homeless—that is, staying in emergency shelters, in transitional housing programs, or in places not fit for human habitation. One program in the study, the Family Housing Stabilization Program (FHSP) in Maine, is prevention-oriented and is designed

only to provide assistance to families who are doubled up, living with family or friends, precariously housed or facing imminent homelessness.

Several linkage programs target further to specific subpopulations of homeless families. Examples include ex-offenders, single mothers with young children, families coping with severe mental illness, Native American families, and families receiving TANF. These subpopulations are prioritized for admission either because of local need or because the collaborating service organizations themselves have focused on them historically.

Five programs in the study are designed to assist the highest-barrier, hardest-to-serve homeless families: the Family Assertive Community Treatment (FACT) Program in Chicago, Hearth Connection in Minnesota, Permanent Supportive Housing Program (PSHP) in Washington DC, Bridges to Housing in Portland, OR, and the Linkages Program in New Mexico. Families in these programs often have experienced long periods of extreme poverty, and family members may have multiple physical and mental health problems. These families typically face additional barriers to attaining self-sufficiency, including criminal records, poor housing references, or no credit history. High-barrier families require intensive, long-term case management and may need permanent supportive housing. For example, the PSHP in Washington, DC uses an index, the Vulnerability Assessment for Homeless Families, to identify the most vulnerable and hardest-to-serve families. Eligible families are assessed, and families with the highest index value on the assessment are housed first. Many of the families entering the program have had chronic patterns of homelessness such as long-term stays in shelter or repeated episodes of homelessness.

Four of the linkage programs target their assistance to already-homeless, low-barrier families or to families at imminent risk of homelessness: the Charitable Assistance to Community's Homeless (CATCH) Program in Boise, ID, the DeKalb KidsHome Collaborative in Decatur, GA, Adopt-A-Family (AAF) of the Palm Beaches, and Pathways to Housing in Brattleboro, VT. Families served by these programs may be: 1) recently homeless due to an abrupt economic shock (e.g., job loss or medical expense); 2) not yet literally homeless, but living in a doubled-up situation that is unsustainable; or 3) in their own home but at imminent risk of homelessness, facing foreclosure or eviction. Many are in short-term economic crises, and the programs believe that with the appropriate assistance the families can quickly achieve self-sufficiency. These linkage programs assisting low-barrier families often provide families with prevention assistance, rapid rehousing assistance or short-term rental assistance paired with case management services.

2.1.3   Eligibility Criteria

Program eligibility criteria vary across the study sites, although there are two criteria that are shared across the programs. A common eligibility criterion is that families' housing status must be documented as homeless or at-risk of homelessness. Nearly all programs that serve families who are already homeless use HUD's definition: those in emergency shelters, transitional housing, or in places not fit for human habitation.[17] A family's housing status is typically verified by the referring agency. The other common criterion for participation is that the family must have resided within the service catchment area prior to program entry.

---

[17]   The exception is the DeKalb KidsHome Collaborative, which uses the Department of Education's definition that includes families residing in doubled-up living arrangements.

The eligibility criteria that are specific to the programs in the study are shaped by the target populations. Programs that serve high-need families have metrics for assessing families' needs through well-crafted client assessment forms, which typically gauge families across several key indicators of need—e.g., housing needs, physical and behavioral health, and employment and income. Other programs require specific demographic characteristics. For example, in the Linkages Program in New Mexico, some of the program slots are reserved for Native American applicants, a designated target population for the program.

The programs with PHA involvement typically use eligibility restrictions that align with PHA program requirements to ensure that participating families are eligible to receive a HCV, either because the HCV is the housing support offered by the linkage program or because of an assumed post-program transition to the HCV program. To be eligible for most PHAs' HCV programs, adult members of the applicant household must complete a background check to confirm that they do not have a conviction for:

- sexual assault or molestation;
- a violent crime within the past five years;
- the manufacturing of drugs in public housing;
- assault and battery with a dangerous weapon; or
- distribution or trafficking of illegal drugs.[18]

Some programs also screen for *any* history of physical violence, substance use and arson.

Programs that use a prevention approach, providing financial assistance to at-risk families to help them stabilize in their homes, often have income or employment requirements. These requirements ensure that after a short period of assistance, families will be able to sustain the rent or mortgage payments on their own. For example, to be eligible for the DeKalb KidsHome Collaborative Program in Decatur, GA, families are required to have an employed adult member of the household or an adult member who is able to maintain employment, so the family can quickly return to stable housing with minimal assistance.

2.2   Program Structure and Client Workflow

2.2.1   Types and Roles of Collaborating Organizations

To successfully combine an array of human services with housing supports into a single assistance program that meets local needs, lead agencies in the linkage models partner with a variety of organizations located throughout their communities. The involvement of multiple organizations produces two key benefits. First, programs are able to leverage the special knowledge and expertise of each partner to enhance their service package and inform their service delivery approach. Participating organizations learn from each other and refine their own program operations accordingly. Second, involving different types of organizations expands the number and types of potential funding streams. As discussed below in more detail, the programs in the study use an enormous variety of funding streams to support their activities.

---

[18]   Some of these screening criteria are required by law, while others are not, and HUD guidance has varied. Most PHAs apply all of these criteria.

Exhibit 2-2 provides an overview of the types of partner organizations involved in each of the linkage programs. Nonprofit organizations are the most common type of collaborating organization, included in 12 of the 14 linkage programs. The number of nonprofits involved per model varies considerably. Hearth Connection in Minnesota partners with more than two dozen nonprofit organizations through three multi-county collaboratives. In contrast, the HARP program in Salt Lake County has only two nonprofit partners. In most programs, the nonprofit organizations are responsible for providing and coordinating case management, but they may also serve as direct providers of human services.

For example, the FACT Program in Chicago is led by a nonprofit organization that collaborates with another nonprofit partner to provide human services. The lead agency is Beacon Therapeutic, an organization with extensive experience working with children and dealing with an array of social, behavioral, and emotional challenges and risks, including homelessness. Heartland Alliance, another established nonprofit with experience in housing, tenant advocacy, and housing assistance, serves as the program's fiscal agent and provides case management and permanent housing for the participating families.

Nine of the linkage programs involve local government entities as a principle collaborator, including city and county departments of health and human services, mental health, substance abuse, and criminal justice services, mayors' offices, and school districts. In several programs, local or city government entities have an operational role in the program, facilitating the connections between other organizations, as well as providing funding for housing and human service supports. For instance, the CATCH Program in Boise was founded by a Community Planning Department staff member and initially championed by the mayor, who hosted meetings with faith-based groups and the business community to secure funding support and partnership. The CATCH program is now operated by the City of Boise's Community Planning Department.

Private entities are partners in seven of the linkage programs. They include religious institutions, private universities, banks, restaurant groups, and private donors. The roles of private partners range from donations that provide direct support to family households to the development and management of housing units that are used by homeless or at-risk families. The Saunders Apartments project in Lawrence, MA has several private companies as partner organizations, led by Peabody Properties, a private housing developer and manager of affordable housing. For the Saunders Apartment project, Peabody partnered with two local companies, Little Sprouts, a local early childhood development program, and Salvatore's, a chain of Italian restaurants that provides subsidized employment training for program participants. Both Little Sprouts and Salvatore's offer employment opportunities to program participants in an effort to improve the Lawrence community and give families a pathway to self-sufficiency.

Exhibit 2-2: Types of Collaborating Organizations Involved in Linkage Programs

Location and Name of Program	Type of Organization				
	Local Government[1]	State Government[2]	Public Housing Authority	Nonprofit	Private[3]
Programs without PHA Involvement					
Boise, ID: CATCH Program	●			●	●
Chicago, IL: FACT Program				●	●
Decatur, GA: DeKalb KidsHome Collaborative	●			●	●
Lawrence, MA: Saunders School Apartments		●		●	●
Palm Beaches, FL: AAF of the Palm Beaches	●			●	
Pittsburgh, PA: The Community Wellness Project	●	●			●
State of Minnesota: Hearth Connection				●	
Programs with PHA Involvement					
Brattleboro, VT: Pathways to Housing	●	●	●	●	●
Portland, OR: Bridges to Housing	●	●	●	●	●
State of Maine: FHSP		●	●		
State of New Mexico: Linkages Program		●	●	●	●
Washington DC: PSHP	●		●	●	
Salt Lake County, UT: HARP	●		●	●	
Yakima, WA: FIESTAS	●	●	●	●	●

[1] Local government partners are usually city and county government departments such as departments of human services.

[2] State government partners are typically the state mortgage finance authority and departments of health and human services.

[3] Private entities include religious institutions, private universities, banks, restaurant groups, and private donors.

State government agencies are partners in several linkage programs. Four programs have a state government representative actively engaged in the design, implementation, and operation of the program. Similar to local and city governments, the involvement of state governments in programs is primarily to facilitate coordination between different partner organizations and to provide access to

funding streams for human service and housing supports. Sometimes the state agencies are in the lead. For example, Maine's FHSP is a joint effort of two state agencies, Maine's Department of Health and Human Services (DHHS) and the Maine State Housing Authority (MaineHousing). The two agencies worked together to combine two programs funded by the American Recovery and Reinvestment Act of 2009 (ARRA), HUD's HPRP and HHS's TANF Emergency Contingency Fund. MaineHousing designed the FHSP and implemented it in partnership with DHHS.

In the seven programs that were selected for the study because the local PHA is actively involved, PHAs contributed in three fundamental ways: 1) they provide actual housing units in public housing or other housing developments they own or control; 2) they administer rental subsidies through HCVs or another program; and/or 3) they provide expertise in local housing markets and potentially available housing units. Four of the linkage programs use HCVs as their housing support, including the FIESTAS Program in Yakima, WA, Bridges to Housing in Portland, OR, the Saunders School Apartments in Lawrence, MA, and the PSHP in Washington, DC. PHA staff determine the homeless families' eligibility for housing assistance, calculate the subsidy payments based on families' incomes and units' rents, inspect the units to ensure the HCV program's quality standards are met, and provide information on local landlords.

2.2.2   Partnership Arrangements

The partnerships are based on a variety of arrangements, forged by different local contexts. Several of the partnerships, including the Linkages Program in New Mexico, the Saunders Apartments in Lawrence, MA, Hearth Connection in Minnesota, and the Allegheny County Community Wellness Partnership in Pittsburgh, are built on relationships among staff at the various organizations who have collaborated in the past. The strength of these partnerships is found in the established trust between staff, including confidence that clients will be treated well by program partners and that all referred families will be properly assessed before they are sent to a program partner.

In metropolitan Portland, community leaders sought to build upon the area's successful regional transportation planning efforts that led to the creation of the Tri-Met public transportation system to address the issue of affordable housing in the region. Three Oregon counties – Multnomah, Washington, and Clackamas – worked with officials from Clark County, Washington to form a regional housing group, funded by a HUD Economic Development Initiative grant. This regional housing group, facilitated by the local nonprofit Neighborhood Partnerships, eventually formed the Bridges to Housing program to provide housing opportunities for chronically homeless families.

Some of the partnerships formed in an ad hoc manner, resulting from an existing working relationship between service organizations or a shared mission—for example, the DeKalb KidsHome Collaborative in Decatur, GA. Other linkage partnerships were created explicitly to assist the growing number of homeless families in specific geographic regions. In response to a 30 percent increase in family homelessness between 2007 and 2009, the Palm Beach County Department of Housing and Community Development sought alternative ways to serve this population that did not entail providing expensive hotel and motel vouchers. The county partnered with the AAF Program of the Palm Beaches, which aims to stabilize and rehouse families within 30 days of their becoming homeless and was able to use HPRP funds granted to the county.

One of the linkage programs is based on a public-private partnership that allows the program to access considerable private funding and to increase the visibility of the program by promoting it through

multiple public and private networks. The CATCH program is a partnership between the City of Boise and a group of local faith-based organizations and private businesses. The City Department of Community Planning manages, operates, and provides the human service component of the program, while rental assistance funding is provided by donations made by private businesses and local faith-based groups.

A few programs partner with research organizations to gain a better understanding of the program's ability to help homeless families obtain housing and gain self-sufficiency. The HARP program in Salt Lake County collaborates with the University of Utah to conduct an evaluation of the program, designed to understand whether the program reduces families' interaction with the county's criminal justice, substance abuse treatment, and mental health systems, as well as whether the program is cost-effective. Similarly, the Bridges to Housing program in Portland partners with Portland State University to evaluate its program.

To formalize the partnerships between multiple organizations, the linkage programs implement different types of partnership agreements. The level of formality differs by programs: some have signed memoranda of understanding (MOUs) that explicitly describe the roles and responsibilities of partners; others rely on inter-governmental agreements to secure the involvement of government agencies and external organizations; and still other programs used do not have formal arrangements between the partner organizations, instead relying on their informal existing working relationships.

To facilitate communication and coordination, most of the linkage programs schedule regular meetings with staff from partner organizations to monitor and manage the programs. Staff used these meetings to discuss the progress of families, address any emerging issues, train staff on eligibility requirements for mainstream services, and exchange information.

2.2.3   Types of Funding and Funding Approaches

Each of the 14 linkage programs has a different funding strategy. As illustrated in Exhibit 2-3, federal resources represent a significant source of funding. However, each program identified and secured a unique combination of federal, state, and local government funding, and sometimes also private and foundation supports. Exhibit 2-4 lists the key funding streams for each of the 14 programs in the study from all sources, shown separately for the human services and housing components of the linkage program.

Exhibit 2-3: Federal Programs Used for Linkage Program Funding

Federal Agency	Federal Program
U.S. Department of Health and Human Services	• Community Service Block Grants • Medicaid • Healthcare for the Homeless • Temporary Assistance to Needy Families and the TANF Emergency Contingency Fund
U.S. Department of Housing and Urban Development	• Community Development Block Grant Program • Emergency Shelter Grants • HOME Program Tenant-Based Rental Assistance • Homelessness Prevention and Rapid Re-housing Program • Housing Choice Voucher Program • HUD McKinney-Vento Shelter Plus Care • HUD McKinney-Vento Supportive Housing Program • HUD - Veterans Affairs Supportive Housing • Neighborhood Stabilization Program • Public housing
U.S. Department of the Treasury	• Low-Income Housing Tax Credit Program
U.S. Department of Homeland Security	• FEMA Emergency Food and Shelter Grant
U.S. Department of Education	• McKinney-Vento Education for Homeless Children and Youth • Title I Program
U.S. Department of Agriculture	• USDA Rural Development Rental Assistance Program
U.S. Department of Labor	• Workforce Investment Act

Program funding from HHS is used by at least seven linkage programs.[19] Funding streams that support mental and behavioral health services and case management include TANF, Medicaid, and the Community Service Block Grant (CSBG). Six linkage programs use federal/state Medicaid funds, while four programs use TANF funding. In the Linkage Program in New Mexico, the New Mexico Behavioral Health Purchasing Collaborative pools health services money from the state and then contracts with OptumHealth New Mexico as a single statewide entity to provide mental health and other behavioral services to state residents through local organizations. Through this funding structure, the Linkages program receives Medicaid reimbursement for case management and behavioral health services for participating families. These services are part of the state's existing Medicaid plan.

---

[19]   The program partner staff interviewed for the study often were not able to say whether local or state funding for services came from a federal source.

Exhibit 2-4: Funding Sources for Linkage Programs

Location and Name of Program	Program Component	
	Human Services[1]	**Housing Supports**
Programs without PHA Involvement		
Boise, ID: CATCH Program	• City of Boise • United Way	• Private donations
Chicago, IL: FACT Program	• Hilton Foundation's Strengthening At-Risk and Homeless Mothers and Children Initiative • McCormick Foundation • Medicaid • Polk Brothers Foundation	• Chicago Low Income Housing Trust Fund • HUD Housing Choice Voucher Family Reunification Program • HUD McKinney-Vento Supportive Housing Program • HUD-Veterans Administration Supportive Housing
Decatur, GA: DeKalb KidsHome Collaborative	• FEMA Emergency Food & Shelter Grant • Fulton County Department of Human Services • HUD Community Development Block Grant • HUD Emergency Shelter Grant • United Way • U.S. Department of Education, Education for Homeless Children and Youth Program • U.S. Department of Education Title I Program	• HUD Homelessness Prevention and Rapid Re-housing Program • HUD McKinney-Vento Supportive Housing Program
Lawrence, MA: Saunders School Apartments	• Community Service Block Grant • HUD Homelessness Prevention and Rapid Re-housing Program • HHS Temporary Assistance to Needy Families	• Low Income Housing Tax Credits • Federal and Commonwealth historic tax credits • HUD Home Investment Partnership Program funds • HUD Housing Choice Voucher program HUD Neighborhood Stabilization Funds • State affordable housing trust fund
Palm Beach, FL: AAF of the Palm Beaches	• Local community foundations • United Way • Palm Beach County ad valorem property taxes	• HUD Homelessness Prevention and Rapid Re-housing Program
Pittsburgh, PA: The Community Wellness Project	• Allegheny County Department of Human Services Children & Youth Funds • Allegheny County Department of Human Services PA-EARN (TANF) • Medicaid • Pennsylvania Behavioral Health • Workforce Investment Act	• HUD McKinney-Vento Supportive Housing Program • Local Housing Trust Fund • Pennsylvania Housing Assistance Program Funds • Private foundations

Location and Name of Program	Program Component	
	Human Services[1]	Housing Supports
State of Minnesota: Hearth Connection	• Medicaid • Minnesota Department of Human Services, Long-Term Supportive Services Fund (LTSSF) • HHS Block Grant for Prevention and Treatment of Substance Abuse • HHS Temporary Assistance to Needy Families	• Minnesota Department of Human Services, Long-Term Supportive Services Fund • HUD McKinney-Vento Shelter Plus Care • HUD McKinney-Vento Supportive Housing Program funds
Programs with PHA Involvement		
Brattleboro, VT: Pathways to Housing	• HHS Temporary Assistance to Needy Families[2]	• Vermont Agency of Human Services General Fund
Portland, OR: Bridges to Housing	• Bill and Melinda Gates Foundation • Paul G. Allen Family Foundation • Meyer Memorial Trust • Clark County, WA; Multnomah, Clackamas and Washington Counties, OR	• HUD Housing Choice Voucher program • HUD McKinney-Vento Shelter Plus Care • Low Income Housing Tax Credit program • State (WA and OR) housing assistance
Salt Lake County, UT: HARP	• Salt Lake County General funds • Medicaid	• HUD Home Investment Partnership Program Tenant-Based Rental Assistance • Salt Lake County general funds
State of Maine: FHSP	• Temporary Assistance to Needy Families Emergency Contingency Fund • HUD Homelessness Prevention and Rapid Re-housing Program	• Temporary Assistance to Needy Families Emergency Contingency Fund • HUD Homelessness Prevention and Rapid Re-housing Program
State of New Mexico: Linkages Program	• Healthcare for the Homeless • Medicaid	• New Mexico Department of Human Services
Washington, DC: PSHP	• Federal funding for the District of Columbia • Washington, DC funding	• Federal funding for the District of Columbia • HUD Housing Choice Voucher program
Yakima, WA: FIESTAS	• Washington Families Fund • Yakima County Department of Social and Health Services • Triumph Treatment Services • YWCA • Yakima Neighborhood Health Services • Medicaid	• HUD Housing Choice Voucher program • USDA Rural Development Rental Assistance Program • HUD McKinney-Vento Supportive Housing Program

[1] The program partner staff interviewed for the study often were not able to say whether local or state funding for services came from a federal source.

[2] Funding for case management services was provided by each organization's funding streams, and interviewees were unable to identify each source separately.

Eleven of the linkage models utilize HUD programs as a key housing resource.   These programs include the HCV program, HOME Tenant-Based Rental Assistance (TBRA), HUD/Veterans Administration

Supportive Housing (VASH), the Community Development Block Grant (CDBG) program, the Emergency Shelter Grant (ESG) program, and the HUD McKinney Vento Homeless Assistance Grants programs, Shelter Plus Care (S+C) and the Supportive Housing Program (SHP). Some linkage programs were able to use recent and temporary HUD programs created as part of ARRA to fund their programs. Four programs used either the Neighborhood Stabilization Program (NSP) or HPRP to fund housing or human service supports for participating families.

Other federal funding sources include ED McKinney-Vento and Title I funds that are used by one linkage program, and the FEMA Emergency Food and Shelter Grant program used by another program to provide human services to participants. The FIESTAS program, located in Yakima, WA, provides housing for participating families using the U.S. Department of Agriculture (USDA) Rural Development Rental Assistance Program.

Foundation support is another major funding source for some of the programs in the study. Initially, three programs, the Bridges to Housing Program in Portland, OR, the FIESTAS program in Yakima, WA, and the FACT program in Chicago, IL, had significant support from local, regional, and/or national foundations. Foundation funding often has few restrictions and can be used to fund multiple aspects of program services that may be ineligible under federal programs. In the Bridges to Housing program, a group of foundations—including the Bill and Melinda Gates Foundation, the Paul G. Allen Family Foundation, and the Meyer Memorial Trust—provided $20 million for a variety of tasks, including program implementation, technical assistance, case management, and evaluation.

Other funding sources for linkage programs include state or local housing trust funds for housing supports and local government funds for human service supports.

Approaches to accessing and securing funding vary by linkage program. Many linkage programs leverage funds from individual organizations for case management to access housing support funding from another source such as the HCV program. The FHSP in Maine combines two funding sources made available through ARRA: TANF Emergency Contingency Fund and HPRP.

Some linkage programs are supported by a dedicated state or city funding stream: the Pathways to Housing program in Brattleboro, VT, the Linkages program in New Mexico, and the PSHP in Washington, DC. Securing line-item funding in a local or state budgets allows the program to have a consistent, fairly reliable funding stream. However, in the current economic climate, some of the programs have faced cuts in, or total elimination of, these funding streams as local and state governments look for ways to balance their budgets. Other linkage programs received one-time funding allocations to design and implement their programs. PSHP in Washington, DC received a one-time federal appropriation of $17 million and 350 federal HCVs to initiate the program. Because this one-time appropriation has been spent down, the program is attempting to identify new funding sources.

2.2.4   Client Workflow Process

The linkage programs implement similar client workflow processes. This section describes the general referral process used by linkage programs, including the intake and assessment procedures.

Referrals. Families are referred to linkage programs in a variety of ways. While the majority of programs have multiple referral points, including partner agencies, local emergency shelters, and street outreach teams, one program has a single point-of-entry through which all families must be referred: the DeKalb

KidsHome Collaborative relies on the DeKalb County School District McKinney-Vento Homeless Liaison. In contrast, the Hearth Connection program in Minnesota relies on community partners working with homeless individuals and families across the state, including emergency shelters, drop-in centers, and street outreach workers, to refer potential clients to their program.

Local emergency shelters are a common referral source, as are internal referrals from program partners that operate other programs for low-income and homeless families. A few programs, including the FACT program in Chicago, the Saunders School Apartments in Lawrence, MA, and the Bridges to Housing Program in Portland, OR accept self-referrals, walk-ins, or referrals from the local 211 system, respectively.

Intake, Assessment, and Securing Housing. Most programs require the family to complete an intake interview, either over the phone or in-person, once referred to the program. During this interview, program staff confirms the families' homeless or at-risk status and conducts any necessary background checks, including criminal, credit checks, or rental and eviction history.

Client-needs assessments are conducted shortly after the intake process, although programs that serve high-need clients may conduct the assessment over several days or weeks, as case managers develop a rapport with clients. Program staff complete assessments to determine the level of assistance needed by the family and its individual members. Most programs use a common assessment tool or set of questions, so that multiple referring agencies can gather the same information about applicant families. The assessments cover a broad range of topics, including housing, education, employment, income, and mental and physical health. Several of the linkage programs have created their own assessments modeled from the Arizona Self-Sufficiency Matrix.

The information gathered through the assessment process is then used to develop a service or action plan for the family during its time in the linkage program. Service plans outline the goals of each family member and the agreed upon action steps to achieve them. The plans are used by case managers to track a family's progress toward its goals and self-sufficiency during its time in the program. Many programs require that the plans be updated monthly or quarterly.

Linkage programs that use rental vouchers for their housing support require families to go through a separate housing application process. This is usually the intake process for the HCV program. In addition to the screening for criminal history, HCV programs also verify the family's income in order to determine the portion of the rent that will be covered by the housing support. The PHA may provide help to the family in identifying potential rental units in its community.

Under the HCV program, families are responsible for the ultimate decision on which housing unit to rent. However, in several linkage programs, case managers visit potential rental units and provide guidance to families on the suitability of units based on family size, transportation needs, proximity to social supports, and other characteristics of the location of the unit. Once a unit is identified, PHA staff will make sure that the rent meets the HCV program's Rent Reasonableness standard (the owner is not overcharging for the unit) and that, if the unit rents for more than the program's Payment Standard, the family will not pay more than 30 percent of income for its share of the rent. Additionally, the PHA will inspect the unit to ensure it meets the HCV program's Housing Quality Standards (HQS). Some linkage programs will go beyond the HCV program's requirement that the owner and the family sign a standard rental lease and also require participating families to sign additional agreements outlining the family's

responsibilities as a housing tenant and as a participant in the linkage program. The timeline for completing the entire enrollment process – from initial referral to the linkage program to securing a housing unit – varies from program to program and is largely dependent on a family's specific needs and preferences.

2.3   Human Services and Housing Supports

2.3.1   Types of Human Services

The primary type of human service offered in each of the linkage programs is case management. A majority of linkage programs require that enrolled families engage in case management as a condition of program participation. The PSHP does not mandate that clients utilize case management services, as a District of Columbia law prohibits that the provision of housing to homeless people be made dependent on participation in case management. Most programs require families to start by meeting with case managers once a week. Case management generally continues for the duration of the program, but the number of required case management meetings often decreases if the family continues to make progress toward its goals. Some linkage programs extend case management services beyond program exit, encouraging families to contact their case manager if they are struggling to maintain their housing or with other issues that could threaten their self-sufficiency. The FIESTAS program in Yakima, WA allows all families to receive a third, additional year of case management, to assist with their transition out of the program and into permanent housing.

A primary responsibility of case managers is to connect families with the human services and housing supports that are intended to help them overcome homelessness. In some programs, case managers provide assistance directly, while in others case managers refer families to other service providers identified in their service plan, including local government agencies and nonprofit organizations. Referrals result in clients accessing the following types of services: budgeting/financial literacy; mental health services; substance abuse counseling; transportation assistance; assistance with application to mainstream benefits (e.g. TANF, Medicaid, WIC); employment preparation services; vocational rehabilitation classes; child care services; adult and child education; work experience; and GED and ESL classes.

While some of the linkage programs function primarily as a conduit to services provided outside the partnership, other programs developed explicit arrangements for partners to offer human services to program participants. An example is the Allegheny County (PA) Community Wellness Project, in which a therapist from Duquesne University's Occupational Therapy Department is the Project Specialist for the program, developing linkages to a variety of housing and human service offerings in the region. The therapist visits local homelessness assistance programs to provide her services directly to families. Similarly, the Saunders School Apartments program partnered with two local employers to provide subsidized on-the-job training for program participants.

2.3.2   Types of Housing Supports

Exhibit 2-5 summarizes the different types of housing assistance that the 14 linkage programs provide to homeless families and the length of time for which the housing assistance is available. Seven of the linkage programs included in this report partnered with a PHA. The PHAs may provide the physical housing unit (e.g., public housing) or may manage the housing subsidy (e.g., HCV, HOME TBRA).

Exhibit 2-5: Housing Assistance Offered by Linkage Programs

Program Name	Transitional Housing	Permanent Supportive Housing	Time-Limited Rental Subsidy	Permanent Rental Subsidy	Public Housing	Length of Housing Assistance
Programs without PHA Involvement						
Boise, ID: CATCH Program			●			6 months
Chicago, IL: FACT Program			●			2 years or longer
Decatur, GA: KidsHome Collaborative			●			3 months
Lawrence, MA: Saunders School Apartments				●		Permanent
Palm Beach, FL: AAF of the Palm Beaches			●			13 -18 months
Pittsburgh, PA: The Community Wellness Program[1]	●	●				TH is up to 2 years; PSH is permanent
State of Minnesota: Hearth Connection		●				Permanent
Programs with PHA Involvement						
Brattleboro, VT: Pathways to Housing			●			Up to 2 years
Portland, OR: Bridges to Housing			●	●	●	Permanent
Salt Lake County: HARP			●			2 years
State of Maine: FHSP			●			One-time assistance
State of New Mexico: Linkages Program			●			2 years
Washington, DC: PSHP		●		●		Permanent
Yakima, WA: FIESTAS		●		●		2 years

[1]   The housing is provided by the community's network of homeless assistance providers rather than directly through the Community Wellness Program.

Four linkage programs use the HCV program as the housing support. Families may receive a tenant-based voucher to be used toward market-rate housing in a scattered-site model, or the vouchers may be

project-based, meaning they are attached to a specific unit or building. (PHAs have the authority to project-base a percentage of their HCV program.) The vouchers are not time limited and families can retain the subsidy as long as they are income-eligible. In three of the four programs, the local PHAs are actively involved in the design and implementation of the programs and make use of its infrastructure and expertise to help families in locating and securing housing units. In the other program, the Saunders School Apartments, the HCV is project-based.

Nine programs provide time-limited rental assistance to participating families. Programs using time-limited rental assistance can take various forms. Four programs utilize a "rapid re-housing" model, in which families are placed in housing within 30 days of entering shelter and are provided rental assistance from three to 18 months. Families receive assistance in identifying market-rate rental housing. Families can remain in the unit when the housing assistance concludes if they are able to find other forms of housing assistance or are able to pay for the unit themselves. Three programs, Pathways to Housing (Brattleboro VT), HARP (Salt Lake County, UT), and Linkages (New Mexico), provide time-limited assistance through HCV voucher "look alike" programs. These programs have the same rules and requirements as the HCV program, but are funded by state or local governments from their own revenue or from the HOME program, which permits TBRA to be time-limited. The look-alike programs are "bridge" programs to provide housing assistance from which participants can transition into the HCV program once a voucher becomes available and can be secured by the family. Permanent supportive housing is used by five of the linkage programs. This type of housing is provided to participants who will need long-term support and intensive wrap-around services to maintain stable housing. Permanent supportive housing is not time-limited and is targeted to high-need families.

One program, Bridges to Housing in Portland, OR, uses public housing units as one type of housing support for its families. (This is a large program, serving 558 families with several types of housing support but does not include permanent supportive housing.)

In addition to providing rent subsidies, some linkage programs also offer additional housing-related services including: moving assistance, security deposits for rental units, landlord mediation, and assistance in obtaining home furnishings such as beds, cooking supplies, and cleaning supplies.

2.3.3   Linking of Human Services and Housing Supports

Comprehensive and fairly intensive case management is the main mechanism that programs use to link human services and housing supports across the linkage programs. Case managers appear to be well-positioned to integrate services and housing supports because they have an established rapport with their clients, understand their clients' service needs and housing preferences, and have relationships with staff throughout the community that can provide the appropriate services and supports. But creating these linkages can be challenging and places an enormous burden on case managers. A case manager typically handles 10-15 families, and for any given family the case manager may:

- Conduct the needs assessment, develop a service plan, and routinely monitor progress on the plan through weekly meetings with clients;
- Provide services directly to clients or make appropriate service referrals;
- Help the family find an appropriate housing unit, sometimes by driving clients to view the unit, and then assist them with the lease-up process;

- Assist the family in completing required forms and compiling documentation to apply for income supports such as the Supplemental Nutrition Assistance Program (SNAP), as well as for the housing subsidy;

- Act as mediators between the clients and landlords whenever an issue arises that jeopardizes the client's housing stability;

- Instruct clients about their legal rights as tenants (often in conjunction with a legal staff member from the partnership); and

- Conduct home visits (usually monthly) to ensure that clients are maintaining their rental properties.

The most effective linkages appear to be made when the case management is intensive and deliberately planned based on thorough client assessments. Strong linkages are forged when case managers create well-designed service plans, make appropriate service connections, follow-up regularly with clients to check on their progress, and are willing to physically accompany the client to services and aid with the housing search.

2.4   Major Implementation Challenges

The 14 program in the study were able to design and implement innovative approaches to integrating human services with housing supports to address family homelessness, but they also encountered several challenges that limit their ability to serve homeless families and may even threaten their long-term sustainability.

Excess demand for program assistance. In nearly all the programs, the demand for assistance exceeds the capacity of the program.[20] Given limited organizational capacity and funding, programs are not able to expand to help all of the families who need the help leaving or avoiding homelessness. Because demand exceeds the availability of assistance, many linkage programs prioritize families with greater need of assistance for admission into the program.

Slow program turnover. An implementation challenge faced by several linkage programs is lack of client turnover, which in turn limits the number of clients that can be served by the program over time. Families exit the linkage programs when they are able to secure their own affordable or subsidized housing. However, communities across the country continue to face affordable housing shortages and long waiting lists for subsidized housing, including public housing and the HCV program. This lack of affordable housing means that families in many of the linkage programs are not able to exit the programs successfully within the designated time frame. This causes another complication, as some of the housing supports used in linkage programs are time-limited to two years (e.g. HOME TBRA funding and transitional housing). Some communities, including HARP in Salt Lake County, have had to secure alternative funding for their housing supports to allow participants to remain in the program for more than two years as they continue to look for affordable housing or secure a housing voucher.

Indeed, some linkage programs, especially those that offer supportive housing to the hardest to serve families, have not planned for how or when to exit families from the program. Many of these families may not reach self-sufficiency in the anticipated timeframe and, in some case, may need ongoing

---

[20]   We were unable to document the demand for services in Dekalb KidsHome Collaborative.

supportive services for an extended period of time. It appears that some programs did not anticipate this continued level of assistance in their initial program design, and are now grappling with how to continue to support these clients while assisting new families.

Expiration of program funding. Maintaining funding has been a challenge for several of the linkage programs. Some of the funding streams are temporary, either one-time allocations of funding to the program or temporary federal stimulus programs such as HPRP. For example, the FHSP in Maine is no longer operational, as the stimulus-funded TANF-Emergency Funds expired in September 2010. The Bridges to Housing Program in the Portland region was initially funded through $20 million in private philanthropic grants from the Bill and Melina Gates Foundation, the Paul G. Allen Foundation, and the Meyer Memorial Trust. This funding expired at the end of 2011, requiring program staff to look for replacement funding to continue the facilitation and case management portion of the program. The longer-term sustainability of these programs will likely depend on the ability of local staff to supplement lost funding with new resources.

3. Promising Practices

This chapter identifies and describes 10 promising practices the emerged from the site visits to the 14 programs selected for the study.   These practices appear to have facilitated the development, implementation and sustainability of the programs, and program staff often said they believed the practices led to improved outcomes for families. However, this study was not designed to measure the impact of these practices on client outcomes, and thus the study is unable to draw any conclusions about the effect of these practices on the goal of preventing and ending family homelessness.

Among the 14 programs, seven had explicit partnerships with the local PHA. These programs were selected to demonstrate how communities partner with PHAs to provide mainstream housing assistance such as HCV and public housing to prevent and end homelessness among families.

The next two sections describe each of the 10 promising practices in turn, beginning with the seven practices that apply to all 14 programs, followed by the three practices that are specific to PHA programs. For each promising practice, the sections provide: an overview that describes how the practice facilitated the development, implementation and sustainability of the programs and two specific examples from the communities that participated in the study.

3.1   Promising Practices

1. *Programs closely tied their overall objectives to their target population, service interventions, and partnership arrangements, resulting in more focused programs.*

Programs in the study had missions that reflected conscious and logical decisions about whom to serve, what services to provide, who would provide them, and what outcomes to target. As a result, these programs were well-defined, and collaborating organizations had a clear sense of purpose and clearly defined roles. They are structured such that:

- The objective is appropriate and within reach of the target population.

The objective of some programs was to rapidly re-house homeless families and transition them into market-rate housing that they paid for themselves within a short period of time. Recognizing that this objective would not be reasonable for chronically homeless families with multiple barriers to housing, these programs fittingly focused on families who suffered from a short-term economic crisis and had some income (or potential for income) to support their housing expenses. Several programs opted to focus on a few key objectives rather than a long list of goals, and this resulted in a more focused program with greater follow-through in linking program participants to services.

- The service interventions are tailored to the target population to make it more likely to achieve the objectives of the program.

Programs that targeted the "hardest to serve"—for example, chronically homeless families that may be socially isolated and have fallen out of the broader social service network—tended to use a Housing First approach. This approach placed families into permanent housing before resolving the underlying issues that may have led to their homelessness. For example, the Housing First approach does not require clients to be "clean and sober" or seek treatment in exchange for housing, recognizing that the hardest-

to-serve population may be service-resistant and willing to remain homeless if compelled into treatment. The service intervention made it more likely to achieve the immediate goal of ending episodes of homelessness among families and allowed program partners to focus on the long-term goal of keeping families in their housing.

- The program partners agree with the objectives of the program and can provide the appropriate service interventions.

Programs in the study selected partners that shared a common vision for the program, and the program's objectives aligned with the missions of each individual organization. Program partners were selected to provide the appropriate constellation of service interventions, as dictated by the target population and program objectives. For example, rapid re-housing programs that targeted families who suffered from a short-term economic crisis typically partnered with local emergency shelters as the primary referral source, with job readiness and employment training organizations to reconnect families to a source of stable incomes, and with landlords to offer affordable housing options.

Family Assertive Community Treatment (FACT) Program in Chicago, IL: The objective of the FACT program is to assist young mothers and their children in stabilizing and improving their housing, employment, family well-being, and health status. The FACT program targets homeless and at-risk families with severe mental health issues and uses a modified Assertive Community Treatment (ACT) model and medium- or long-term housing subsidies. ACT models were first developed in the late 1960s and use a team treatment approach to provide comprehensive, community-based treatment, rehabilitation, and support to persons with serious mental illness. The FACT program has a systems integration manager, who periodically attends FACT team meetings and convenes a planning coalition comprised of organizations that can affect systems and community change. The FACT planning coalition members include consumers, members of the foundation community, and representatives from child development, housing, education, mental health, substance use, and vocational systems. The systems integration manager also coordinates the cross-training of staff in various social service fields. FACT team members believe that the systems integration work helps partners and service providers see the linkages between the objectives of the program and the different types of services and supports used by young homeless families, which in turn improves the provision of individual services.

Adopt-A-Family (AAF) Rapid Re-Housing Program in Palm Beach, FL. The AAF program is designed to meet a very specific goal: to limit the use of expensive hotel/motel vouchers at a time when emergency shelters are over capacity by re-housing families within 30 days of becoming homeless and helping them remain stably housed and out of the shelter system. To accomplish this objective, the program assembled a small number of partners who provide services directly related to this objective: emergency shelters to provide referrals to the program; service providers to provide credit counseling, legal services, and job readiness and employment services; a childcare voucher provider to enable the adults in families to focus on their self-sufficiency goals; and housing providers to provide and manage the rental assistance. The program uses common client intake and assessment tools to develop tailored family action plans that identify barriers to, and strategies for, attaining independent housing. As such, the tools codify and advance the program's overall mission.

2. ***Programs produced lasting partnerships through common missions, purposeful coordination, and by capitalizing on established relationships.***

Programs that laid a solid foundation for future collaborations were built on three pillars: 1) program missions that advance the goals of each partner; 2) deliberate coordination processes that fostered accountability, and 3) capitalizing on established collaborative environments.

In several communities, partner organizations were able to advance their own organizational missions, those of their partners, and the overall objective of the program simultaneously. While the varied goals of individual partners may have exceeded those of the program—for example, individual partners may work with other vulnerable populations and have a different set of objectives for these populations— the goals of the program advanced the overall mission of each partner agency, so that each had a stake in the program's success. For example, several programs in the study were designed to rapidly place homeless families into housing and help them become self-sufficient through temporary rental assistance, case management, and the provision of supportive services. Emergency shelters that served as referral sources for these programs were able to achieve their organizational missions by moving clients into housing, freeing up resources for other needy clients. Providers of employment and job training services promoted families' long-term capacity to become self-sufficient and sustain their housing by improving their job search skills and placing them in jobs, thus achieving their organizational mission. In short, lasting partnerships were based on "win-win" arrangements.

Partnerships were also built on deliberate efforts to coordinate across partners, which fostered a strong sense of accountability among partners and responsibility to clients. These efforts appeared in many forms: 1) regularly scheduled meetings between partner agencies to discuss specific client concerns and program operational issues; 2) memoranda of understanding that formalized the roles and responsibilities of each partner agency; 3) steering committees, oversight boards, and planning coalitions to oversee and monitor the program's progress and integrate systems; and 4) regional housing groups composed of elected officials and representatives from housing departments, public housing agencies, planning commissions, and community groups. These deliberate coordination efforts resulted in distinct roles and clear lines of responsibility among program partners and introduced transparency to the planning process, which in turn created a greater sense of trust among partner organizations.

Lastly, while some programs created new partnerships, others capitalized on established relationships and used the program collaboration to further cement these relationships. Prior relationships often existed between public housing agencies and landlords; social service agencies and local departments of human services; and homelessness service providers and the local Continuum of Care (CoC). Several programs built on partnership arrangements that were first created by the HPRP.

Pathways to Housing Program in Brattleboro, VT. The goal of the Pathways to Housing program is to help homeless households and households at risk of homelessness find and maintain stable housing by linking temporary housing assistance (up to two years) with case management services. The program is based on formal agreements that foster mutual accountability: between service providers and the local PHA, between the housing authority and landlords, and between families and case managers. An Oversight Committee was created specifically for the Pathways to Housing program, comprised of individuals from the Agency of Human Services, the Department of Economic Security (TANF), the Brattleboro Housing Authority, the Department of Corrections, a large shelter, and a day shelter drop-in center. The committee reviews the applications, interviews applicants, decides who is accepted into the

program, and monitors overall program policy. The committee meets monthly, and staff from individual partners (e.g., case managers) also meet regularly.

The Linkages Program in the State of New Mexico. The Linkages Program emerged from the New Mexico Behavioral Health Purchasing Collaborative, a group of 13 partner organizations that pooled their health services resources from the state. The Collaborative contracts with a lead agency to act as the single statewide entity to provide mental and behavioral health services through local organizations. The New Mexico Mortgage Finance Agency oversees the housing component of the Linkages program. At each of its three locations in the state, the program relies on local organizations to function as supportive service agencies and housing administrator organizations. The supportive service agency is responsible for using the state's existing Medicaid platform to provide case management, while the housing administrator assists families in locating and securing housing and transitions clients from the state-funded housing supports to the HCV program. A letter of agreement between the New Mexico Mortgage Finance Agency, the supportive service providers, and housing administrators delineates the responsibilities of each organization in the program.

3. ***Nontraditional organizations outside the usual social service network were valuable partners in helping to prevent and end family homelessness.***

The constellation of program partners went beyond the traditional network of social service providers and government agencies to include mortgage finance agencies, school district homeless liaisons, private housing developers, private businesses, faith-based institutions, and university personnel. Each "non-traditional" partner made important contributions. Some functioned as sources for referring clients to the program, while others were direct service providers, funders, or housing developers and managers. In a few communities—Decatur (GA), Portland (OR), and Washington (DC)—the school district liaison played an important role in monitoring the educational outcomes of children served by the program, including their attendance, behavior, and grades. The school liaisons worked on a regular basis with the case managers assigned to the families by the program. Another nontraditional partner in the provision of homeless services, a private housing developer in Lawrence, MA, played the central role in a housing program for homeless families, linking the residents of a housing development with education and employment services that help them work towards self-sufficiency. These communities demonstrated that thinking creatively when looking for partners can add value to their service interventions.

The Charitable Assistance to Community's Homeless (CATCH) Program in Boise, ID. The CATCH program is a public-private partnership that re-houses homeless families and supports them with six months of rental assistance and intensive case management, focusing on linking families to employment, income supports and other services. The program is operated by the City of Boise's Department of Community Planning and involves a group of local faith-based organizations and private businesses that provide rental assistance funding, program volunteers, and material resources. The city funds the administrative and operating costs of the program, and the United Way funds the social workers who provide case management to families. Rental assistance, volunteers to help families move into housing, donated goods and furnishings, and community awareness campaigns are provided by faith-based organizations and businesses that commit to sponsoring a family for six months.

The DeKalb KidsHome Collaborative in Decatur, GA. The DeKalb KidsHome Collaborative addresses the rising needs of families that are homeless and have children enrolled in the DeKalb County School District. The Collaborative offers education, housing, and employment services to homeless families, with the goals of helping families secure housing and income stability and helping children achieve stable school attendance and performance. The DeKalb County Schools homeless liaison provides services that help maintain student attendance such as enrollment assistance, bus tokens and transportation, as well as services that support school performance such as dental, hearing, and vision care and tutoring. The liaison also offers financial assistance for school supplies and extracurricular activities, such as uniforms, instrument rental fees, and summer enrichment camp. In addition, the homeless liaison helps connect students' families to resources that will help them find housing assistance or other services they might need to stabilize their lives.

4. ***Programs forged strong relationships between case managers, housing specialists, and landlords as a strategy for increasing housing options and promoting housing stability.***

Among the most difficult challenges confronted by programs in the study were the paucity of decent affordable housing for homeless families and the ability of service interventions to promote housing stability among high-needs clients. The most common strategy used by programs to overcome these challenges was to forge mutually beneficial relationships among case managers, housing specialists, and local landlords. Many communities already had well-established relationships between homelessness service providers and landlords prior to the development and implementation of the programs in the study. Program partners in these communities focused on maintaining and expanding the pool of landlords willing to accept homeless families by leveraging these relationships to encourage landlords to participate in new programs and to spread the word to other landlords. In other communities, the network of landlords was less established, and program partners focused on creating outreach strategies to local landlords and developing their lists of available housing options. In both cases, the local public housing agency often played an important role by supplying programs with its HCV landlord lists and offering its housing expertise.

The relationships among case managers, housing specialists, and local landlords were designed to be mutually beneficial: case managers and housing specialists representing programs were able to place homeless families into decent affordable housing; and landlords were reassured by the ongoing program support offered to tenants and by the promise of a stable source of rent (i.e., the housing subsidy). From the perspective of case managers and housing specialists, a common activity was to teach tenants how to interact positively with landlords, maintain the units, and develop their rental histories. Housing specialists also taught families about their tenant rights. These efforts were designed to promote families' housing stability, although disputes between landlords and tenants were not uncommon. Case managers and housing specialists encouraged regular communication between tenants and landlords to resolve tenancy issues, but they also intervened as needed to mediate disputes. Indeed, in some communities, landlords preferred to contact case managers who had an established rapport with tenants, understood their housing barriers, and could intervene more effectively than the landlord. The responsiveness of case managers and housing specialists to the concerns of both tenants and landlords appeared to be a critical component of communities' housing placement and stability strategy.

Adopt-A-Family (AAF) Rapid Re-Housing Program in Palm Beach, FL. The AAF program is designed to address the burgeoning use of hotel/motel vouchers as overflow units for emergency shelters, and the program set the ambitious goal of rehousing families within 30 days of becoming homeless. To meet this goal, case managers, housing specialists, and landlords work collaboratively to quickly screen, enroll, assess, and place families into housing. After program participants complete an application packet with the support of program staff, case managers use the information to help families identify where they want to live, what kind of housing is appropriate, and how much they can be expected to pay for rent once they leave the program. A housing specialist coordinates with the case manager and helps families identify housing that meets their needs and lifestyle. The specialist provides a list of landlords who are willing to accept program participants (including those with poor credit, eviction, and/or criminal histories) and to sign a rental agreement with AAF. The specialist also conducts an inspection to verify the habitability of the apartment, looking specifically for problems with fire safety, security, electricity, sanitation and whether the space is adequate for the family. While clients sign their own leases with landlords, AAF pays the security deposit and first month's rent. Landlords also sign an agreement with AAF that outlines the landlord's responsibilities as well as the amount and duration of rental assistance.

The Saunders School Apartments in Lawrence, MA. The goal of this program is to provide stable, affordable housing for families through the adaptive re-use and historic restoration of the Saunders School (a public elementary school), while assisting them in achieving self-sufficiency through education and employment services. Peabody Properties Inc., a private housing developer, is the developer and property manager for the project. As the key partner and housing developer, Peabody Properties has taken a lead role in developing partnerships with case managers from COMPASS for Kids, a social service and education collaborative that provides educational and employment training and assistance for homeless parents and children. COMPASS helps parents in Saunders School Apartments access affordable child care, work readiness, employment training, job-search support, educational program, ESOL training, and other services designed to support families in this program. The program integrates the roles of case managers and landlords within a single setting.

5. *Case managers played a central role in linking human services with housing supports, and the strongest linkages were based on deliberate planning, thorough client assessments, and intensive case management.*

Programs were intentionally designed to link human services with housing supports, and this link was often established by case managers who served as the focal point for assessing client needs, developing appropriate individual service plans, providing referrals and accompanying clients to service providers, facilitating the placement of clients into housing, conducting routine follow-ups and home visits, and gauging progress on individual service plans. The strongest linkages appeared to be forged when: 1) case managers were intentional about creating them; 2) the linkages were informed by a thorough assessment of client needs; and 3) the involvement of case managers was intensive, meeting purposefully and frequently.

While some case managers viewed their role as passive conduits to services, providing service referrals as needed, others saw themselves as active facilitators who "do what it takes" to ensure that clients are applying for and receiving eligible services and housing supports. Some case managers physically accompanied clients to service providers and followed up afterward to ensure that clients were receiving the services. Other case managers helped clients identify appropriate housing and drove

clients to view the units. In every case, the efforts of case managers to link services and housing were informed by a detailed assessment of the household's needs, typically focusing on their housing, employment and income, independent living skills, legal and criminal background, physical and mental health histories, substance abuse issues, and anticipated barriers to housing. The results of the assessment were often formalized in individual service plans that described a client's goals related to these services, how to achieve them, and by when. For some case managers, identifying and tracking the receipt of services was an intensive process, reinforced by regular meetings to review the service plans, home visits, ongoing communication with service providers, mediation with landlords, and in some cases, monitoring the attendance, behavior, and performance of children through the school district liaison.

The Permanent Supportive Housing Program (PSHP) in Washington, DC. The PSHP uses a Housing First model to help high-needs clients become self-sufficient and maintain stable housing through the provision of a housing subsidy, moving assistance, and intensive case management. The program links housing subsidies with supportive services through a partnership between the city's department of human services, the city's housing authority, the CoC lead agency, and case managers at several social service agencies. Although all partners play important roles in establishing the service-housing linkages, case managers are at the center of the program. Case managers are responsible for: 1) gauging client needs and developing service plans through intensive assessments; 2) enrolling clients in appropriate services, which may occur through either a referral or case managers physically escorting families to appointments; 3) assisting families with finding and moving into their housing by helping them complete a voucher application and taking them to view the available units; 4) completing monthly housing visits with each family to monitor their housing condition; and 5) acting as an intermediary between the families and landlords. By playing these roles, case managers are best positioned to integrate services and housing supports that are appropriate for each family.

Family Assertive Community Treatment (FACT) Program in Chicago, IL. The FACT program emphasizes housing as the primary goal, believing that mothers need to be in stable housing situations to stabilize their children and to address their own needs. A critical component of the FACT program is the team approach to coordinating services and housing supports. The FACT team is comprised of six members: a project director, a senior case manager/employment specialist, two youth therapists, a chemical dependency specialist, and a housing resource developer. Each FACT team member (except for the housing resource developer) also serves as a caseworker, serving as the main team contact for families enrolled in the program. The FACT team is supported by a therapeutic psychiatrist. As an integrated unit, the FACT team is involved in all critical stages of the program: 1) reviewing the applications and admitting families into the program; 2) discussing how to properly assist families, including the appropriate level of support and interaction with families; 3) creating treatment plans, including the needs of children in families; 4) compiling the needed documentation to access benefits and housing supports; and 5) providing mental health therapy. The team's housing resource developer coordinates with the team and is responsible for conducting a housing assessment that documents what type of housing families can afford, where they want live, and the general cost of living.

6. *The long-term stability of program funds was often uncertain, and programs pursued many different funding models that tapped into a breadth of funding streams.*

Securing long-term funding was a critical issue among all communities that participated in the study. The uncertainty was particularly acute among homelessness prevention programs that were funded mostly through HUD's HPRP and among programs that relied heavily on foundation support. Funding uncertainty was reflected in the diverse patchwork of funding streams that communities cobbled together to support their programs. Communities tapped multiple federal programs, including CDBG, Emergency Shelter Grants, Federal Emergency Management Agency Food and Shelter Grants, Historic Tax Credits, HOME Investment Partnerships Program, HPRP, HCV, HUD-VASH, Low Income Housing Tax Credits, Medicaid, Neighborhood Stabilization Program, S+C, SHP, TANF, and TANF Emergency Contingency Fund. Communities supplemented the federal support with many other funding streams, including: city funds, county property taxes, faith-based organizations, foundations (Bill and Melinda Gates Foundation, Hilton Foundation, Meyer Memorial Trust, McCormick Foundation, Paul G. Allen Family Foundation, and Polk Brothers Foundation), individual donations, private businesses, state general and housing trust funds, United Way, Washington Families Fund, and the YMCA.

Most communities had a decentralized funding model in which each organization used its own funding resources to support its participation in the program. Some communities—Chicago (IL), Portland (OR) and Yakima (WA)—obtained funding from foundations that supported activities across the participating partners. In Minneapolis/St. Paul, a centralized funding apparatus was developed to streamline the funding process and relieve participating organizations from the responsibility of renewing funding. Regardless of the approach, communities were concerned about the long-term sustainability of their funding sources, and several expected to lose their primary source of funding by 2011. In these communities, the most pressing question is: what will happen when the primary funding ends—will the program have demonstrated its value to other potential funders?

Hearth Connection in Minnesota. The Hearth Connection program provides permanent supportive housing paired with intensive case management. The program combines funding from federal, state and county sources to provide housing, health services, and case management. The majority of the program's funds come from the state, which established the Long-Term Supportive Services Fund (LTSSF) and sets aside about $10 million every two years to support the LTSSF. The program also uses Medicaid funding to provide case management, made possible by Minnesota's Medicaid waiver that allows for reimbursement of targeted, medically necessary case management. Hearth Connection meets the Medicaid match requirement with funds from the state LTSSF allocation. The program also uses funding from HHS' Substance Abuse and Mental Health Services Administration for case management. To pay for rental assistance, the program uses funds from the state housing trust fund and from HUD's S+C program and SHP. An innovative feature of the funding model is the centralization of responsibilities within a single entity. Hearth Connection alleviates the burden on partner agencies by assembling and managing these multiple funding streams and then issuing each partner a single allotment of funds to support all program activities.

Family Housing Stabilization Program (FHSP) in the State of Maine. The FHSP is a joint effort between Maine's Department of Health and Human Services and the Maine State Housing Authority to stabilize TANF-eligible families at imminent risk of homelessness. The FHSP combines two funding sources made available through the American Recovery and Reinvestment Act of 2009: TANF Emergency Contingency

Fund and HUD's HPRP. With the addition of TANF funds, FHSP is able to augment the services eligible under HPRP (rental assistance, other housing-related services, case management, and prevention services) with other services that are not allowed under HPRP but deemed critical to homeowners at imminent risk of losing their homes (mortgage assistance, assistance in paying back taxes and liens, and home improvements necessary to make the housing habitable). Each of the 13 community-based agencies that receive HPRP funds in Maine receives an additional allotment of TANF Emergency Contingency Fund to support the FHSP.

7. ***The development of standardized intake and assessment tools and data-sharing systems across partners streamlined program operations, eliminated duplicative assessments, improved service delivery, and provided common metrics for gauging progress.***

Many programs used standardized client intake and assessment tools to determine program eligibility and assess the needs of homeless families. Several programs mandated their use in an effort to reduce the duplicative work conducted by referring agencies and case managers. The use of these intake forms resulted in several operational efficiencies. The forms ensured that families referred to the program from multiple agencies met all of the program's eligibility criteria before the family was contacted for possible enrollment. This "pre-screening" allowed program staff to more easily serve their target population and maximize available resources to assist eligible families. Once contacted, families were enrolled more quickly into the program, because the standardized forms required referral agencies to append all necessary documentation. In some programs, the standardized intake process included many of the eligibility criteria used by other mainstream assistance programs—such as the HCV program, TANF, and SNAP. The incorporation of these eligibility criteria into the standardized intake forms allowed program staff to link clients to these resources as appropriate.

Many programs also implemented standardized client assessment tools. Typically, the assessment tools were first administered shortly after the intake process and then were re-administered by case managers at regular intervals during a family's time in the program. Information from these tools was used to gauge families' needs, identify issues that might prevent families from obtaining housing, inform the development of service plans, and properly match services to those needs. When administered throughout a family's stay in the program, the assessment tools provided case managers with information on the family's progress in achieving self-sufficiency. The most commonly used tool was the Arizona Self-Sufficiency Matrix, which measures a family's level of distress along 18 domains based on a five-point scale.

Some programs also developed data-sharing systems across agency partners. Data-sharing systems exposed staff across program partners to information that was previously unavailable, giving program staff a more comprehensive picture of a family's issues, needs, and housing options, which in turn resulted in better program decisions. Data-sharing systems, when combined with common assessment tools, allowed program partners to develop common metrics for gauging a family's progress and measuring program outcomes. Several programs entered information on families into their local Homeless Management Information System (HMIS), while others designed "homegrown" databases that were tailored to the program. For example, the Department of Human Services in Washington, DC developed a homegrown system that contains detailed information about each client and about available housing units in the District. The database allows partners to quickly identify qualified

participants, assess their needs, help them search for available housing units, and match families to appropriate units.

The Homeless Assistance Rental Program (HARP) in Salt Lake County, UT. The HARP program provides scattered-site affordable housing and case management to individuals and families who are homeless or at risk of homelessness in Salt Lake County. To assess families in the program, case managers are required to complete and update two standardized matrices: 1) a matrix that assesses the family's level of self-sufficiency along 20 domains (income, employment, housing, food, childcare, children's issues, adult education, legal, health care, life skills, mental health, substance abuse, family relations, mobility, community involvement, safety, parenting skills, contact with children, physical health and support network); and 2) a matrix that focuses more narrowly on housing-related domains such as rent and utility expenses, income, housekeeping issues, landlord and housing authority issues. These instruments must be completed before participants move into housing, weekly for the first month and monthly thereafter. The tools provide a consistent approach to assessing clients and gauging their progress toward self-sufficiency.

The Community Wellness Project in Alleghany County, PA. The Community Wellness Project links homeless and formerly homeless families and individuals residing in HUD-funded transitional housing or permanent supportive housing programs with employment, training and social service benefits. The program uses a professional occupational therapist from Duquesne University's Occupational Therapy Department, who helps administer the "O*NET Interest Profiler," a self-assessment tool developed by the U.S. Department of Labor Employment and Training Administration that helps clients match their interests and skills with particular types of work activities and occupations. The program also has a comprehensive data-capture tool that improves the client application process and allows for data analysis. The data are stored in a secure data warehouse that links client and program-level data from homeless assistance programs, HUD McKinney-Vento housing programs, the state's TANF program (EARN), a local Workforce Investment Act One-Stop program, and participating behavioral healthcare programs. The integrated data warehouse has resulted in several important benefits to the program: streamlined application processes for homeless families and individuals, and improved capacity of stakeholders to analyze client-, program-, and system-level outcomes.

3.2   Promising Practices Among Programs with PHA Involvement

8. *Programs developed a "continuum of housing" by using locally-funded housing supports as a gateway to federal supports provided through the PHA.*

Several programs in the study partnered with their local public housing agency to develop a "continuum of housing" that provides temporary or transitional housing assistance to homeless families with integrated case management services until the families transitioned to a permanent housing opportunity—e.g., HUD's HCV program or public housing developments. The objective of these programs was to stabilize families, link them to supportive services, and address both their short- and long-term housing needs. The programs targeted homeless families or families at high risk of homelessness.

Families participating in these programs were referred primarily by non-housing supportive service agencies, although some families also came from local emergency shelter programs. The families were

receiving services for issues that may have contributed to their homelessness (or precarious housing situation), including mental health care, addiction services, domestic violence prevention, poor credit, and lack of rental histories. After completing intake and assessment forms, case managers within these agencies identified eligible program participants and connected them with a temporary housing subsidy. The temporary housing assistance was often for two years and structured similar to HUD's HCV program, using the same eligibility criteria, payment agreement, housing quality, rent reasonableness, and fair market rent standards. The temporary housing was funded through state and local sources, often involving the state's department of human services. Upon enrollment into the program, families were simultaneously added to the HCV waiting list in their areas. The goal was to channel families into permanent, deeply subsidized housing.

These programs appeared to have well-defined processes for accessing housing assistance and supportive services. The procedures for each step in the "housing continuum" were clearly defined and the roles of partner organizations were transparent. In most cases, it appeared that programs that provide these "bridge" housing supports that were locally funded had a history of collaborative relationships with the local housing agency and other homeless service providers in the area. Housing authorities were often administering the rental assistance or providing their landlord lists and expertise to the program.

The Linkages Program in the State of New Mexico. New Mexico's Linkages Program assists homeless individuals and families with severe mental illness in transitioning into permanent housing by providing individualized case management coupled with a temporary housing subsidy. The housing subsidy functions as a "bridge" until a permanent subsidy through the HCV program is available and secured. The Linkages Program was able to secure $350,000 in state funding to support the program, with $300,000 designated for rental subsidies and $50,000 for move-in assistance and furnishings. The rental subsidies are passed through a statewide mental health services organization to provide the funding necessary for housing subsidies through three regional housing administrators. The Linkages program is based on a Housing First approach seeking to stabilize program participants in housing quickly, thus allowing them to focus on behavioral health issues that may have contributed to their homelessness. The regional housing administrators and supportive service agencies work with clients to help transition them from state-funded housing supports to the HCV program. All clients in the program are immediately placed on the HCV waiting list, which does not offer special preferences for homeless families. The bridge subsidy is structured like the HCV program and, when the HCV subsidy finally becomes available, the family maintains their same unit while the subsidy source transitions. Having met all the HCV program eligibility and housing standards, this transition is seamless for families.

Pathways to Housing Program in Brattleboro, VT. The goal of the Pathways to Housing program is to help homeless households and households at risk of homelessness find and maintain housing by linking up to two years of temporary housing assistance with case management services. Program participants must be "sponsored" by a social service agency provider that provides intensive case management for the duration of the temporary rental assistance. The Pathways to Housing program is designed to be a program of "last resort" for specific population groups that have had problems accessing the private housing market due to poor credit, poor or no rental histories, and unstable sources of income. The rental assistance, administered by the Brattleboro Housing Authority, is funded by the Vermont Agency of Human Services General Fund. This temporary housing assistance is structured similar to HUD's HCV

Program. Families enrolled in the program are required to participate in case management as a condition of their rental assistance. Funding for the case management assistance is provided by individual service providers participating in the program. Although the duration of the Pathways to Housing program is two years, the average length of stay is 18 months. To increase the chances of a successful transition to permanent housing, participants in the Pathways to Housing program are required to immediately begin searching and applying for subsidized permanent housing programs as soon as they enter the program. Currently, the housing agency does not offer preferences to homeless families, although the HCV waiting list is shorter than those in other communities. Some families exit the program to public housing, others to housing supported by HCV subsidies.

9. *Streamlining the PHA's process for leasing private-market housing occurred through the re-tooling of PHA administrative procedures and the use of program partners to conduct activities on behalf of PHAs.*

Streamlining the PHA lease-up process was a challenging issue confronted by programs that partnered with PHAs. It was also a particularly important step among rapid re-housing and Housing First models that prioritized the quick placement of homeless families into housing. Staff from these programs feared "losing their clients"—in terms of developing a rapport and sometimes physically—from a protracted lease-up process that may discourage or disaffect families.

Programs approached the challenge of shortening the time between program enrollment and lease-up by using two strategies: 1) reviewing and re-tooling the PHAs' administrative procedures; and 2) utilizing program partners to conduct activities that encumber the lease-up process. Among the seven communities in the study with PHA involvement, only one—the PSHP in Washington, DC—altered HCV program requirements to accelerate the lease-up timeframe. Staff from the city's housing authority reviewed the lease-up process and identified specific steps that could occur simultaneously, rather than sequentially. The streamlined process reduced the number of PHA visits required by applicants. (The program is described in more detail below.)

A more common strategy was to utilize program partners to conduct activities on behalf of PHAs and thus ease the administrative burden on PHAs. Partner staff, most often case managers, assisted with program application, housing search, and unit inspection activities. Case managers frequently assisted clients through the program application process by helping them complete HCV or public housing applications ahead of the application appointment with the PHA. One program allowed case managers to provide documentation that applicants had been rehabilitated following criminal convictions instead of requiring this information to originate from a third party (e.g., employer, parole officer). Program staff also helped clients search for and select appropriate housing units that would likely pass inspection quickly. Another program had case managers complete housing inspections at regular intervals after lease up. The ongoing housing inspections by case managers provided assurances to the housing agency that units were being maintained by clients, especially those with intensive needs. Using program partners throughout the lease-up process appeared to create efficiencies that significantly shorten the process.

The Permanent Supportive Housing Program (PSHP) in Washington, DC. With the support of The Community Partnership (TCP, the CoC lead agency) and the case managers, the city's housing authority modified the typical, linear lease-up process. In a typical lease-up process, clients flow sequentially

through various steps—completing the housing application and eligibility determination, conducting the housing search and identifying a suitable unit, conducting the housing inspection and determining rent reasonableness, and signing the lease—with several scheduled meetings with the PHA throughout the process. The program in Washington, DC sequences the voucher application process at the same time as the housing inspection. Program participants work with their case manager to select a unit from the list of available units (provided by TCP through a shared database); visit the unit (with the case manager); complete an application while the inspection is conducted; and schedule an appointment with the housing authority. As a result, clients complete the lease-up on the first visit to the PHA rather than during multiple, time-consuming visits. In addition, the housing authority provides greater flexibility in meeting the voucher eligibility requirements, waiving repayment of arrears or fines incurred by applicants who are former public housing or HCV residents (more than five years prior). The housing authority also accepts documentation from case managers that a client with a criminal history has rehabilitated him- or herself, a task typically required of an employer or a probation/parole officer. Altogether, program staff indicate that the revised process reduced lease-up timeframes from several months to several weeks.

Bridges to Housing Program in the Metropolitan Portland, Oregon Region. Bridges to Housing is a regional initiative facilitated by Neighborhood Partnerships, a regional nonprofit based in Portland that addresses the housing and economic development needs of low-income people. Bridges to Housing serves high-need homeless families in Multnomah (includes the city of Portland), Washington, and Clackamas Counties in Oregon, and Clark County (includes the city of Vancouver) in Washington. The program's goal is to provide permanent housing and intensive case management services to stabilize families, move them towards greater safety, and improve the well-being of children. Program partners play various roles in coordinating with the local housing authority and in providing housing. In Multnomah County, families are enrolled through four non-profit agencies that are responsible for administering a total of 140 housing units for homeless families: 110 project-based vouchers, 25 public housing units and five tax credit housing units. The vouchers and the housing units are from the Housing Authority of Portland (HAP). The 110 project-based units administered by the agencies are located throughout Multnomah County. Twenty public housing units and five tax-credit housing units are located in one of HAP's HOPE VI mixed-income communities in the city of Portland. The other five public housing units are located in scattered site housing in Portland. Case managers from the non-profit agencies help clients with the housing authority applications and prepare appeals if necessary.

10. *Programs created "PSH-like" environments by integrating intensive case management and services with the Housing Choice Voucher program, allowing mainstream permanent housing subsidies to be used by families with high barriers to housing.*

A few programs in the study integrated intensive case management services with the HCV program or other form of housing subsidy in a way that simulated HUD-assisted Permanent Supportive Housing (PSH).[21] These "PSH-like" programs allowed communities to target scarce housing resources to families with the greatest needs. These approaches demonstrated that communities can coordinate housing

---

[21]   HUD-assisted PSH programs are designed to provide housing and supportive services on a long-term basis for homeless persons with disabilities.

and social services resources to target deeply without tapping into traditional sources of permanent supportive housing such as HUD's Shelter Plus Care program.

The programs frequently originated from a community or regional plan to end homelessness, bringing together nonprofit, government, housing agency, and private resources to provide the housing subsidy and services. The housing subsidy was typically a tenant- or project-based voucher, public housing, or tax credit unit. The supportive services component often had two common characteristics: 1) detailed assessments to target the neediest families; and 2) intensive, structured case management. Most programs used standard assessments among all service partners to systematically screen high-needs families for eligibility. The screening tools typically examined indicators such as length and number of times a family has been homeless, employment history, household income, interactions with state mental health systems, domestic violence history, and interactions with child welfare agencies. These details allowed service providers to quantify family need consistently and thereby identify the highest-needs families.

The cornerstone of these "PSH-like" programs was intensive case management that was characterized by a low case manager-to-family ratio and frequent contacts with families. The case manager-to-family ratio was typically very low—for example, one case manager to every 10 or 15 families—to allow case managers to build relationships with participating families and comprehensively assess their needs. Case managers contacted families at least weekly, and typically more often during a family's first few weeks in the program. Most programs required families to participate in case management and provide it for at least two years, with some extending to three years. The case management typically included several components: 1) a family assessment following intake that addressed the needs of all family members, especially children; 2) a family action plan with specific goals and deadlines; 3) frequent and deliberately scheduled contact with a case manager; 4) determining and maintaining eligibility for additional housing assistance programs; 5) service referrals and linkages to community providers such as mental health services, job training programs, employment opportunities, substance abuse counseling, domestic violence counseling, primary health care, child care assistance, and financial literacy; 6) support and advocacy in working with the judicial system, including child protection services, family courts, drug courts, juvenile detention, and gang courts; and 7) tracking a family's progress through standardized assessment tools.

Serving Families and Individuals to End Serious Trouble through Agencies' Support (FIESTAS) Program in Yakima County, Washington. The FIESTAS program places high-needs homeless families into two-year, temporary, project-based housing units managed by the Yakima Housing Authority (YHA). After this time, income-eligible families may receive a permanent project-based voucher from YHA that is not time-limited. YHA maintains a separate waiting list for homeless families and has 75 project-based vouchers set aside for these families. The housing assistance is paired with intensive case management provided by three specialized nonprofit, community-based organizations: Yakima Neighborhood Health Services focuses on health care and is a Federally Qualified Health Center; Triumph Treatment Services focuses on alcohol and drug addiction; and the YWCA focuses on domestic violence. Staff use common intake and assessment forms, based on the Arizona Self-Sufficiency Matrix, to help families identify barriers to self-sufficiency and develop action plans. Then, throughout the course of the two years, case managers use the action plans to help families identify strategies to overcome the barriers. Building Changes, the agency that provides funding for case management services, works with the case

managers to implement an approach to assisting families based on specific strategies, interventions, and supports that have been tested in other communities. Initially, families are visited as frequently as three times a week. As families become more stable, the frequency of contact declines to once per month. All housing units are inspected weekly by case managers, who are certified to conduct housing inspections. This approach ensures participants are taking care of the unit.

Bridges to Housing Program in the Metropolitan Portland, Oregon Region. The program offers permanent housing and intensive case management to families that are chronically homeless. The housing resources vary by county but include project-based and tenant-based vouchers, as well as public housing. Case management is funded through philanthropic organizations. Services are provided to each family for three years to help establish and maintain stability, with a case manager to family ratio of 1:15. A common screening tool, the "Bridges to Housing Family Needs Assessment," is used by all case managers to identify whether families are "high resource users" and eligible for the program. The maximum score on the assessment tool is 25 points, and Bridges to Housing requires at least a total of 10 points for families to be eligible to participate in the program. Bridges to Housing believes that its combination of housing supports and support services provides a less expensive and more effective long-term solution to address chronic homelessness compared to other alternatives such as shelters, motel vouchers, and other temporary, very short-term housing assistance.

Overall, the practices described above shaped how these programs were designed, structured, implemented and sustained. They highlight the need to forge intentional, well-defined partnerships with entities (e.g., social service agencies, government departments, public housing agencies, and landlords) that can offer appropriate services to target populations and expand housing opportunities for homeless families, while also looking outside of the traditional social service network for valuable partners (e.g., school district homeless liaisons, housing developers, and private businesses). Indeed, these practices suggest that linking homeless families to services and housing supports requires the active participation of many different community resources, as well as the involvement of a committed group of well-trained case managers. They also reinforce the advantages of standardized processes across participating partners to screen, enroll, and assess clients, which seemed to produce program efficiencies and may have helped to transition clients to permanent sources of housing supports. Lastly, although many communities used one-time funding streams created by ARRA that will soon expire—such as HPRP and TANF Emergency Contingency Fund—these programs also show considerable diversity in funding sources that can be tapped to sustain them, including the use of mainstream housing programs administered by local public housing agencies

Appendix A: Methodology

This report is based on on-site interviews with representatives from 14 communities with innovative programs that link human services with housing supports for the purposes of addressing family homelessness. The research approach occurred in four stages:

1. Identifying potential case study sites
2. Screening the case study sites
3. Expanding the focus of the research
4. Conducting the site visits

Each stage is discussed in turn below.

Identifying Potential Case Study Sites

Researchers used a multi-step approach to identify potential sites for the study. First, researchers attended HUD's HEARTH/HMIS conferences held in Denver and Atlanta in September 2010. During the conferences, HUD officials announced that researchers were seeking nominations for programs that linked human services with housing assistance for families in an intentional way. Attendees with knowledge of promising practices were encouraged to contact the researchers to discuss their program. Researchers identified 14 local programs that merited further follow-up.

Second, a solicitation for nominations was developed and sent out through multiple listservs in September 2010. The solicitation—or Call for Nominations—was sent to homeless service providers, social service agencies, advocates, and other stakeholders working toward ending homelessness in their community. The announcement asked participants to describe the program they were nominating and how the program met the criteria of a promising practice. In general, a promising practice had several features:

- Collaborative: The model brings a true integration of human services and housing supports to offer a coordinated package of services to homeless families.
- Implementable: The model is relatively easy to implement and can be sustained over time.
- Replicable: The model can be applied in communities of different sizes and geographies such as large urban cities, mid-sized cities or suburbs, and small towns in rural settings.
- Measurable: The model is evidence-based and measures the outcomes associated with participating family members.
- Cost effective: The model results in the efficient use of resources.

The call for nominations was distributed to HUD's CoC list, the Administration for Children and Families (ACF) list of contacts, and the U.S. Interagency Council on Homelessness' (USICH) list of individuals and organizations involved in ending homelessness.

Approximately 80 nominations were received from around the country. All nominations (through the conferences or the solicitation) were reviewed and systematically entered into a tracking spreadsheet and assessed based on program components. Programs were given a higher ranking if they relied on inter-agency or inter-organizational partnerships and/or linked housing and services through innovative program design. While programs that did not focus exclusively on families were considered, researchers focused more heavily on programs that served just families. Programs that did not serve households

with both housing and services were eliminated, as were those that were clearly not yet or no longer operational. Researchers met to discuss the 80 nominations and narrowed the field to 48 candidates.

Third, the 48 candidates were presented to six experts in the field of family homelessness to identify those sites with an established reputation. The experts were: Ellen Bassuk (National Center on Family Homelessness), Martha Burt (Urban Institute), Dennis Culhane (University of Pennsylvania), Jennifer Ho (USICH), Sharon McDonald (National Alliance to End Homelessness), and Carol Wilkins (former director of the Corporation for Supportive Housing). Each expert reviewed and commented on the list of nominations and made additional suggestions as needed. Expert input resulted in the addition of potential sites and the elimination of some sites. The entire study team examined the list of candidates following the input from the experts and selected 30 programs for further screening.

Screening Process

The 30 sites were distributed across three research teams consisting of one senior researcher and another project staff member. Each site was contacted for a one-hour phone discussion, focusing on a variety of topics, such as:

- Program features (overall mission and goals, geographic area served, targeted population),
- Housing related services (type of housing assistance offered, how assistance is determined, primary source of funding),
- Human services (type of human services offered, how services were determined, primary source of services funding), and
- Indicators of a promising model (level of collaboration, challenges to implementation, sustainability of the program, scalability, data collection around client outcomes, and whether or not the program is cost-effective).

After completing the phone discussions with 28 sites[22], the project team reviewed the results of the screening calls, focusing on the level of collaboration between agencies and organizations at each site, the types of housing and services provided to households, the sustainability and replicability of the programs, and the geographic type (rural, urban, suburban) and region to ensure diversity. Based on these discussions, project staff selected a preliminary list of 11 promising sites—7 as our "first choice" and 4 as alternate sites.   The list of sites was presented to HHS for approval with input from a Technical Working Group (TWG).   The TWG was composed of the following individuals:

- David Harris, Deputy Assistant Secretary for Human Services Policy, HHS/ASPE
- Mark Greenberg, Deputy Assistant Secretary for Policy, HHS/ACF
- Carl Harris, Deputy Assistant Secretary for Policy and State Technical Assistance, ED
- Mark Johnston, Deputy Assistant Secretary for Special Needs Program, HUD/CPD
- Danielle Bastarache, Director, Office of Housing Voucher Program, PIH/HUD
- Jennifer Ho, Deputy Director, US Interagency Council on Homelessness
- Erika Poethig, Deputy Assistant Secretary for Policy Development, HUD/PD&R
- Earl Johnson, Director, Office of Family Assistance, HHS/ACF

---

[22]   Two sites (Miami, FL and South Bend, Indiana) were non-responsive or declined to participate.

HHS approved the list of sites with input from the TWG.

Adding Case Study Sites

In reporting the selected case study sites and alternates to HHS, an interesting distinction emerged among the promising programs. Six of the 11 sites partnered in some way with the local Public Housing Agency (PHA), and 5 did not. HHS expressed interest in how these two groups may differ in providing housing and support services to homeless families. HHS amended the scope of the work to support the investigation of 14 promising practices, including 7 PHA-involved sites and 7 sites that did not involve the local PHA.

As the initial round of reconnaissance produced 11 sites (6 PHA sites and 5 non-PHA sites) to achieve the 14 total sites, additional reconnaissance was required. The identification of three additional sites for inclusion involved a two primary steps.

First, staff re-examined the original tracking spreadsheet of nominations to determine if there were programs that fit into either the PHA or non-PHA group and that met the criteria of a promising practice. Of the existing sites that were not already screened, 14 were determined to merit further follow-up. Each of the 14 sites was contacted for a one-hour screening discussion by a two-person research team. In addition to the topics identified above, potential PHA-involved sites were asked about the role of the PHA and how active or passive a player it was in the implementation of the program.

After the telephone discussions with the sites, experts in the field of PHA programs were contacted to provide a different perspective on promising programs. The initial call for nominations through the HUD, ACF, and ICH listservs resulted in a diverse set of local stakeholders in the field of homelessness. However, those with knowledge of public and assisted housing may not have received the original solicitation. Therefore, researchers spoke with three experts with in-depth knowledge of PHA programs – Ms. Leah Staub (Council of Large Public Housing Authorities), Danilo Pelletiere (at that time Research Director at the National Low Income Housing Coalition), and M. William Sermons (at that time Research Director of the National Alliance to End Homelessness).   These experts recommended a number of sites already on our list of candidates and a few sites that held less fidelity to promising model criteria than those on our list. The interviews produced two additional sites for a screening discussion.

Based on the screening interviews of the 14 sites from the existing list and the two additional sites provided by experts, project staff identified:

- Portland, OR was chosen to round out the list of 7 PHA-involved sites based on its level of inter-governmental collaboration. Bridgeport, CT, selected and approved during the initial site selection, was replaced as it was in its first stages of implementation. Washington, DC, another program considered strong during the first stage of screening, was chosen to replace Bridgeport, CT as a PHA site.
- Two additional non-PHA sites were identified (Decatur, GA and Lawrence, MA) and two alternates (Tucson/Pima, AZ and Fairfield, CT). These sites were chosen because of their high level of collaboration and innovative, but seemingly replicable, program designs.

Site Visits

Site visits to the 14 promising model sites were conducted by two-person teams consisting of one senior researcher and one other member of the research staff over two days. Because of the two-phase site selection process, visits were conducted over an extended period, from the first week in April 2011 to the second week in August. Research staff worked with the lead program or agency to identify the individuals involved at the program or community level that would be best to interview regarding the particular program. Three types of program staff were identified: representatives from the lead program agency; representatives from key partners involved in the program; and other partners involved (including case managers, housing specialists, landlords, or funders).   This third group was typically interviewed as a focus group.

Research staff developed different open-ended protocols for the three groups listed above. Lead agencies were asked about the overall vision of the program and how it fits into the community context, to describe all funding streams, housing assistance and human services available and provided to households served by the model, and questions about how organizations or agencies collaborate, how easily the program could be scaled up or down as needed, and whether the program was measurable through collected client data.   Additionally, the lead agency was asked to describe how a client would navigate the program, as well as the partners involved and their role in implementation.

Key partners were asked many of the same questions regarding client access and movement through the program and features of a promising model. However, they were asked more in-depth questions about their own organization or agency and the population it served outside of the particular program, their agency's mission, and how decisions were made around qualifying clients for their program (intake, screening, and assessments).

Other partners were interviewed as a focus group and asked questions regarding program objectives, overall community buy-in and relationships, and how well the model reflected the promising practice criteria guiding the study. All three groups were asked to discuss implementation challenges and successes.

All of the information captured was typed directly into the open-ended protocols by a member of the research team. Research staff then developed case studies for each of the site visits, which are appended to this report.

Appendix B:
Design Options for Evaluating Homeless Assistance Programs

This appendix reviews several design options for evaluating programs[23] that serve homeless families by intentionally integrating services with housing supports.[24] The appendix is based on information from the on-site interviews. Most of the programs combined human services with housing supports to end family homelessness, but some were prevention programs targeted to at-risk families. The design options address both types of programs. In addition, the appendix reviews both experimental and non-experimental approaches, describing the strengths and weaknesses of each evaluation approach.

The appendix begins by briefly summarizing the most central features of the programs in the study that influence the design options. It then describes high-level considerations for possible design options, and then presents, in turn, experimental and non-experimental design options, along with their strengths and weaknesses. Included in this discussion are estimates of scale and cost. The final section provides design recommendations for rigorously evaluating these types of programs.

Central Features of the Observed Models

The models in the study were intended to be "promising" and exemplify programs that had the potential to improve family outcomes. Thus, by design the criteria for selecting sites resulted in producing a set of study sites that had some strong common features. First, active and purposeful collaboration among agency partners was a central feature of all the study sites. A second key feature, again resulting from site selection criteria, was to use the program-level collaboration to integrate housing supports with human and health services at the front-line level. Of course, how sites implemented these two features varied greatly, depending on such factors as the population the program served and a breadth of local circumstances, and it can be fairly said that each initiative was truly unique in multiple respects.

Although program collaboration and integration of housing supports and services was by design, more surprising was a third feature that all the initiatives embodied at some level—universal use of case managers at the front-line to facilitate and integrate the provision of human services and housing supports. For example, a case manager might assist a family head with her housing needs by facilitating access to a housing subsidy and working with a landlord to avoid conflicts with clients that could lead to evictions. Similarly, case managers also ensured that clients received multiple necessary human services including financial help, mental health and employment services. The objective was to integrate suitable housing options with appropriate human services.

---

[23]   The appendix is not intended to be a fully developed design report that describes the key components of an evaluation, but rather it provides a conceptual framework for assessing the feasibility of various evaluation approaches. As such, the appendix can be a useful and accessible resource that HHS may use to inform future research projects.

[24]   The U.S. Department of Housing and Urban Development is currently conducting a study of various types of interventions to address family homelessness. The study will compare four combinations of housing and service interventions for homeless families in a rigorous, multi-site experiment, in order to determine what interventions work best to promote family stability and well-being and, within the limits of statistical power, what sorts of families benefit most from each intervention. The four interventions are a housing subsidy without services (Subsidy Only), a housing subsidy with ongoing services (Subsidy + Services), transitional housing with services but no guarantee of a permanent subsidy (Transitional Housing), and shelter, with whatever services the shelter ordinarily provides to its residents (Shelter Only).

"Case management" is a notoriously ambiguous term. At one end of the spectrum, it can describe individuals who do little more than refer people to services and supports; at the other end, it can include case managers performing comprehensive assessments, providing access to necessary services, ensuring that clients actually receive them, and carefully monitoring families' progress. The programs in the study provided much of this spectrum, including some relatively light touch approaches for people who were identified as needing only modest support in overcoming an immediate crisis. But for the most part, case managers in the study sites had much more comprehensive roles, to the extent that the case management itself was a service and not simply a way to identify needs for services that others would provide.

Finally, a very notable feature of the study sites was that the case management at the front line was very purposefully supported by the higher-level collaboration among governmental and private agencies. In fact, comprehensive case management appeared to transcend a simple referral system, because higher-level planning and collaboration made available the combination of services and supports that staff believed were necessary for improving client outcomes.

These features are important dimensions that shape the range of design options for consideration. At the family level, case managers played a central role in facilitating and integrating the provision of housing supports and health and human services, and by design this role was supported by a higher-level collaboration among agencies. Thus, in considering design options, an evaluation approach should attend to the higher, agency level of the initiatives, as well as the lower, front-line level at which case managers coordinate supports and services.

High Level Design Considerations

Specifying the kind of information that would be gained from an evaluation, the research questions that would be addressed, and the units of analysis are critical next steps to developing potential design options. Each of these topics is discussed in turn.

Information to Gain from an Evaluation

This appendix assumes that the design options would address the question of the effects of the models on improving outcomes for families—that is, it would be an impact evaluation. Thus, the appendix addresses only options for conducting an impact evaluation and does not discuss approaches to conducting an implementation, participation, or benefit-cost analysis.[25]

Although most of the programs in the study collected some outcome information and program staff often attested to their success, by itself and lacking a well-specified counterfactual, this information cannot be used to draw conclusions about the effectiveness of these programs. In lieu of evidence from the programs themselves, several independent studies were identified that focused on three programs in the study and which estimated program effects on participant outcomes. In one instance, the study had a very weak comparison group that, even on observable characteristics, very badly matched the population for which it was intended to provide a counterfactual. In the other two, the evaluations simply tracked individuals over time and inferred positive impacts where there were improvements in outcomes. Since one would expect some proportion of families to improve their circumstances even in

---

[25]   We do consider these other evaluation components in our cost estimates.

the absence of the program, this is a very weak design likely to overstate the role of the program in these improved outcomes.

The Overarching Research Question

Underlying the programs in the study was the implicit hypothesis that integrating housing supports and other services, including the use of a case manager, will reduce homelessness, increase housing stability and improve other family outcomes. Also implicit was that front-line integration would require collaboration at an agency level to ensure that necessary resources and strong operational priorities were in place to achieve this integration. Consistent with these implicit suppositions is the following overarching research question for an impact analysis of these programs:

> *Does collaboration of agencies which results in the integration and prioritization of housing supports and services, with a case manager playing a central role in this integration, accomplish the following results: reducing homelessness, increasing housing and family stability, improving employment and other economic outcomes, and improving family well-being in other dimensions?*[26] [27]

Given the agency and front-line level dimensions to the interventions, it is important to consider the appropriate unit of analysis for the impact evaluation: the individual families assisted or the communities served by the agencies studied. This question is addressed in the next subsection.

Unit/level of Analysis

Abstractly, units of analysis are entities for which data are available and which therefore can be analyzed statistically to provide evidence that addresses the research question(s). More concretely, in the case of an impact analysis of comprehensive housing assistance and homeless service models, there are two possible units of analysis. At one level, there are families about whom researchers either have or can collect data, such as whether they are homeless at a particular time, how many children are in the family, or whether they receive public assistance. At another level, there are communities, or other geographical entities, or "sites" about which researchers either have or can collect data, such as the total number of families who become homeless in a given year and the unemployment rate. In the case of the programs in the study, clearly the intervention models operate at a minimum of at least two levels: the higher, site-level collaboration among organizations and funders and the family level at which families receive the housing supports and services. Considerations for determining the best unit of analysis for an evaluation include:

1. the level at which the intervention operates;
2. the availability of data or the ability to collect it at a given level;

---

[26]   In a full-fledged research design, other sub-questions would be specified, but in this appendix we limit our discussion to this primary one.

[27]   In framing the question to include multiple outcome domains, we are not implying that the standard for success should be achieving improved outcomes in all of them compared to the counterfactual. The main outcomes would presumably be in the housing domain, and only if there were positive effects in that domain would one expect positive impacts on economic and family well-being outcomes.

3. the statistical power of the design—i.e., its ability to identify true effects of an important magnitude as statistically significant when they occur; and

4. related to considerations #2 and #3, the cost of the evaluation.

Given that, as is almost always the case in evaluations, there are many more families than communities/sites, other things being equal, consideration #3 implies that family is preferable to site as the unit of sampling for the analysis—more random draws from a population of families or communities leaves less scope for chance uncertainties in the research findings. However, other things are not always equal, so other considerations may weigh more strongly than power, and, therefore, both levels are considered as possible units of analysis in the discussion below.

Experimental Design Options

This section focuses on experimental design options, i.e., studies based on randomly sampling and assigning either families or sites to the intervention or non-intervention groups to be compared to measure impacts. Since random assignment produces equivalent intervention (i.e., treatment) and non-intervention (i.e., control) groups and thus unbiased estimates of effects, it is the preferred design, where feasible. This section begins with family-level, random assignment designs, then reviews site-level randomized experiments. As described more fully below, the unit of sampling or random assignment may be different from the unit of analysis. In particular, assuming data are available, or could be collected, at the family level, it is preferable for reasons of power for the unit of analysis to be the lower, family level even when the higher level units, sites, are randomized.

Given that there are two levels at which the models operate, one might assume that adequately addressing the primary research question would require the higher level, or "site," to be the unit of random assignment. If data were available or could be collected only at the site level, one might measure impacts by comparing aggregate outcomes for these geographic units, or perhaps trends in these outcomes, to other comparable units, or to themselves prior to implementation of a collaboration, or a combination of these two comparisons. More likely, one would collect family-level data, and the evaluation would conduct analyses at this lower level to measure impacts using multi-level modeling to account for clustering of families within sites.[28]

Although selecting a higher level unit of analysis seems natural in this case, in some circumstances it is not necessary, and there are good reasons for not immediately excluding from consideration a family-level unit of analysis. Because sites are the units of random assignment, experimental designs at the higher level almost universally require many more sites to obtain equal power, and this typically results in substantially higher costs. In a site-level random assignment design, it is easy for the result to be a combination of many more sites and still less power than a family-level random assignment design. Thus, the experimental design options begin with the possibility for family-level random assignment.[29]

---

[28]   Multi-level modeling is necessary to avoid understatement of standard errors and, thus, overstatement of statistical significance.

[29]   We refer to the lower-level unit of analysis as the "family," but, since families can be unstable, in practice one would identify a focal adult to define the family unit for longitudinal tracking and analysis. Most likely, in the case of a single-parent family, it would be that parent, and in the case of a two-parent family, it would be the

There are two key issues related to determining the possibility of family-level random assignment in any site or community. First, can a control group be created? That is, are there families in the community who are eligible for the intervention (i.e., integrated housing supports and services, coordinated by intensive case management), but who in the absence of the study would not receive them due to funding or capacity constraints? Second, if there are such families, has the higher level of agency collaboration served to make their treatment more integrated even in the absence of a direct intervention on their behalf? For example, the higher level collaboration might establish relationships among providers that result in families more generally receiving more integrated services, even where they don't receive the full set of supports and services that the intervention model provides.

With respect to the first question, in the sites included in the study, twelve were able to provide a clear answer to whether there were eligible families who were unserved by what would be the treatment in an evaluation. All twelve reported that there were such families. Of course, the adequacy of their numbers to provide a control group sample sufficient to support a reliable treatment/control group comparison to estimate program impacts is a separate question.

On the second issue, the focus of the site visits was the programs themselves, and thus the issue of whether the agency-level collaboration required to support the model had affected those served outside of it was not explored. However, even if it had affected their treatment, it was clear that a large support and service gap existed between those served by the model and those who were not. Nonetheless, as in any random assignment evaluation, it would be necessary to explore the nature of likely control group services and supports when excluded from the focal intervention, and the evaluator would want to select sites only where these supports and services were substantially different in quantity and key features from the model to be tested. In addition, the evaluation itself should examine the actual differences in detail in order to understand the treatment/control differential.

Family-Level Random Assignment

***Study Sites*:** The programs in the study were carefully vetted to identify the most promising models, and thus these sites are an ideal starting point for assessing their suitability for random assignment evaluations.   However, three major reasons make almost all the study sites unlikely candidates:

1. Small numbers of eligible families served
2. Long-term housing supports resulting in low turnover
3. Program dependent on ARRA funding

The first two reasons, either alone or in combination, account for most of the sites being unsuitable. The small number of families served primarily stems from a combination of small numbers of housing supports combined with relatively lengthy stays. Since families already in the program cannot be randomly assigned, the combination of few slots and even fewer becoming available for new families would result in very small samples even over a relatively extended time. For example, the Hearth Connection in Minnesota has relatively large numbers currently served but very low turnover—staff reported one or two openings per month across the state.

---

mother, as that is the parent most likely to remain with the children in the event of a break-up. If there were no parent, one would select the adult playing the parental role.

With respect to the third reason, of two programs heavily dependent on ARRA funds, one plans to close at the end of the year and the other has ended enrollment.[30] It is possible that with further investigation, one or two of the sites with larger numbers and greater turnover might be a viable family-level random assignment candidate.

Given that none of the individual sites appear to have sufficient sample size potential for a family-level experiment, an alternative approach would be to pool the sites together in an effort to overcome the paucity of new client enrollments. Although it can be trite to describe particular programs as unique, in this case there is considerable heterogeneity among them in many critical dimensions: target populations, kinds of housing supports provided, kinds of services provided, length of both supports and services, intensity of case management, agencies involved, funding streams, PHA involvement or not, and others. The common thread of higher-level collaboration among diverse agencies has resulted in a hodge-podge of front-line service delivery models, each of which seems to fit well within its setting, but which resemble each other only in very broad outline.

There may be other existing sites that embody the characteristics of the sites in the study and include the larger numbers or higher turnover that could generate an adequate sample or models and populations that could be pooled. However, given the breadth and depth of the process used to identify sites to visit, this seems unlikely.

New Sites in a Demonstration: Given the very limited possibilities for using the study sites to evaluate the kinds of programs in the study, it appears that using random assignment of families requires sponsoring a demonstration that goes substantially beyond evaluation of programs as they currently exist. Acknowledging that, in the short term, funding for a project such as the housing with services voucher demonstration included in the President's Fiscal Year 2011 and 2012 budget proposals is not very likely, it nonetheless seems to be the only path to achieving a highly rigorous evaluation of programs that integrate housing supports and services. A demonstration involving far fewer than 10,000 vouchers requested in the Administration's demonstration proposal, may be a possibility—and statistically adequate as discussed below. Providing vouchers to sites would address both the number of families that programs could serve and, since they would create "new" openings into which previously unserved families could be randomly assigned, the low turnover problem of families occupying slots for lengthy periods would be eased as more slots enter the "inventory" of slots that can be filled. This might even allow for program models that include permanent supported housing with very low turnover to be included in an evaluation if enough *new* slots are allocated into that category. Finally, some of the study sites potentially could be included, if they were sufficiently like other sites programmatically to be pooled with them, and if the main scale barrier to their participation was limited housing supports and not, for example, insufficient eligible families to create adequate treatment and control groups.[31]

A significant advantage of a demonstration approach is the ability to develop and implement one or more models uniformly across sites (and for a uniformly identified population), based on the knowledge that was acquired during the site visits. For example, although there is case management in all the

---

[30]   Adopt-A-Family of the Palm Beaches, Inc. in Lake Worth, Florida and Family Housing Stabilization Program in Maine.

[31]   We do not have information about numbers of unserved, eligible families in the sites we visited, only the statement of site contacts that there were such families.

programs, it varies greatly across the sites in terms of what supports and services are covered, intensity, and the extent to which the delivery of identified services is assured. A demonstration approach could specify a set of criteria sufficient to define the models to be tested, while providing some flexibility on how the they are implemented. For example, some models might provide indefinite-term vouchers and some might provide time-limited housing support. The criteria defining the models would rely on the most promising features observed in the case studies to specify strong and relatively uniform models across sites. Implementation of each model in multiple sites would allow both potentially estimating individual site effects and pooling across sites to provide more precise estimates for the model overall, while modestly improving external validity (i.e., the generalizability of the findings).

A disadvantage of a demonstration strategy is that, since new sites would be involved, they may not implement approaches as well as sites that initiated collaborations earlier—and spontaneously, without the incentive of vouchers. In addition, even if equally motivated and capable operationally, they will have less experience designing and implementing their chosen models when the evaluation starts. This speaks to the need to monitor implementation carefully prior to, and in the early stages of, random assignment to ensure a test of a high quality intervention.

Two Potential Family-Level Random Assignment Designs Which Vary in Their Control Group Conditions: The services and supports the treatment group receives do not in themselves determine the question an experiment answers; what the control group receives plays an equally important role. There are two possibilities that would be very informative:

- The control group receives "usual care"

- The control group receives the same kind of housing voucher the treatment group receives but otherwise receives "usual care"

"Usual care" refers to the housing supports and services that families would receive in the absence of the model. Thus, the first design would answer the question: What are the effects of the model in its entirety compared to this usual care benchmark? Usual care would be expected to vary substantially by control community, but that heterogeneity of the counterfactual is a typical feature of many evaluations.[32] Here usual care likely would vary according to the typical service package of each community, given the population served. For example, if the program was a prevention model, control group families might receive no services, or they might receive services to avoid eviction or some help locating a new place to live. In a program for families already homeless, it might be that control group families could access shelter and receive assistance locating new housing but not a housing subsidy.[33]

The second design would answer the question: What do well-integrated services add to housing supports? The kinds of vouchers provided could vary across models or within models, for example, based on target populations, as long as they were equally available to target population members in the

---

32   For example, in an experimental impact study of Head Start, one would expect that the proportions of children in the control group primarily cared for by a parent or relative, in center-based care, in family care and in pre-school would vary substantially across communities. This is in fact the case in the National Head Start Impact Study (Puma et al., 2010).

33   In a fuller design, one would specify more completely what "not a housing subsidy" would encompass to ensure a sufficient distinction between treatment and control conditions.

control group and to those assigned to the treatment group. For example, a site that targeted families with severe and multiple problems might provide vouchers to both treatment and control group families for as long as families were income eligible, whereas a site that targeted families experiencing a short-term crisis might provide more transitional, time-limited housing support to both treatment and control group families. The critical matter would be to provide control group members the same kind of voucher that they would receive were they in the treatment group in order for the evaluation to isolate the added value of the services provided only to treatment group members. This value-added question is a very fundamental issue in how best to allocate resources to prevent and ameliorate homelessness and one that would be particularly important to HHS given its funding of services but not housing supports *per se*.

A significant downside to the second design is the increased cost of providing more vouchers, which would double if sample sizes are held constant and families divided equally between the treatment and control group in both designs. In fact, voucher costs would almost surely more than double since the true effects, if any, in the second design are likely to be smaller (the treatment/control differential for the second design is a portion of that difference for the first), and thus require a larger sample to detect them as statistically significant. A third, even more policy-valuable and more expensive design, would be a multi-arm design that included all three conditions: usual care, voucher only, and voucher integrated with services. Of course, this design would compound the scale and attendant cost downsides just described, and thus is not pursued further in this appendix.

Either of the two main designs would produce very valuable information for policy and practice. Like all design choices, they pose important trade-offs. In the first design, the evaluation would estimate the effects of the package of housing supports and services, but estimates for the two separate parts of this combination would not be subject to experimental analysis. To what extent each component contributed to improved outcomes would remain unknown. The second design would cleanly estimate the added value of services, but the effects of either housing supports alone or the entire package would not be estimated. While one could assume that housing supports would have some effect on some outcomes, e.g., homelessness, how large these effects would be, as well as their effects on other outcomes, such as family stability, earnings and family well-being would not be informed by this study. The question of how well the current study would augment the evidence gained from other studies, e.g., the Homeless Families study described in the next paragraph, becomes relevant.

Scale: In a more elaborated design document, a power analysis would be conducted to determine sample sizes sufficient to reliably detect policy-significant effects in these two designs should they exist. However, given limited resources and no readily available data on variances of outcome variables needed to do power calculations, attempting to develop a specific power analysis for these designs is difficult. Instead, one can suggest sample sizes based on a similar HUD-sponsored evaluation: The Impact of Housing and Services Interventions on Homeless Families, also known as the Family Options Study. The Family Options Study is a multi-arm test of interventions to reduce family homelessness. Depending on the circumstances, families can be randomly assigned to one of three groups (sometimes not all three are available to a given family) or a control group. The three groups are 1) a rent subsidy of indefinite duration and considerable depth (rent minus 30 percent of family income, usually in the form of a Housing Choice Voucher), with no services except for housing search assistance; 2) a rent subsidy of limited duration, sometimes also less depth, and modest, temporary services; and 3) property-based

transitional housing, which means that the family must move into a property that provides intensive services along with supervision of the family for up to two years. As a result, each of the three treatment groups can be compared to each other or to the control group. The largest two groups are projected to have 637 families randomly assigned with a 25 percent attrition rate, resulting in 478 who will complete a survey and thus be available for analysis. For a binary outcome variable, this results in a minimum detectable effect (MDE) of 4.6 percentage points for a 10/90% characteristic of the population, 7.0 percentage points for a 30/70% characteristic and 7.6 percentage points for a 50% characteristic.[34] These seem to be acceptable MDEs for an outcome such as whether a family becomes homeless. Before moving ahead with samples of this size in the current project, it would be important to determine the importance of detecting smaller effects, especially in the second design where controls would receive housing vouchers, or if a higher MDE was satisfactory, and to explore interval variables such as days homeless and continuous variables such as earnings.

Enrolling only sites that could serve over 600 families in the treatment group at a particular site in a year or two would significantly limit the number of communities that might participate in the demonstration, even with vouchers added. Although it would negatively affect the precision of estimates at the site level, a design with 200 families randomly assigned to treatment over two years in each of three sites operating the same model seems preferable to a design with 600 families assigned to treatment at one site. Even this design, with 400 families per site, likely would limit communities potentially available for an evaluation to the largest US cities if the intervention targeted families *already homeless*. For example, of the 432 Continuums of Care (CoCs) in 2011, 33 had 200 or more homeless families (sheltered and unsheltered) on the night of the January PIT count. Many of these CoCs cover the largest U.S. cities. Of course, many, many more families become homeless over an 18- to 24-month period, so many more localities than 33 would meet this standard. Unfortunately, data needed to estimate this larger number are currently unavailable.[35]

Outcomes: Relying on administrative records wherever possible, such as through Homeless Management Information Systems (HMIS) or Unemployment Insurance earnings records, is efficient and has the potential to include more universal coverage than surveys that are subject to non-response.[36] Nevertheless, there are important outcomes that administrative records do not cover or do not cover reliably, such as housing stability and family well-being. Thus, a preferred approach both maximizes the use of administrative data and also collects survey data to capture the key outcome domains: homelessness, housing stability, economic self-sufficiency, and adult and child well-being.

Cost: Given the great number of unknowns at this point, providing a dollar figure for funding a family-level random assignment demonstration of either design is difficult and can be estimated only to the nearest $5 million dollars. The estimate includes just the costs of an evaluation, not program costs for vouchers or for services. In addition, any impact evaluation based on an experimental design also

---

[34]   Of course, these are independent of the subject matter, i.e., the MDE is a function only of the specific proportion and not what it is a proportion of, and only intended to indicate the research context by describing a similar study.

[35]   In developing a full design, one could also consider lower numbers per site per model with more sites.

[36]   The HMIS might be more complete than a survey for the area and population covered, but it would be less universal if it omitted certain populations or failed to coincide with the catchment area of the program.

should include process, implementation and cost benefit analyses, which are accounted for in the estimate.

For purposes of estimating costs for the two designs, one can assume that:

- Three models tested, each in three sites with 200 treatment group members and 200 control group members, resulting in a total research sample of 3,600 in nine sites, half of whom have access to treatment (1,800 treatment group members, 1,800 control group members).
- A baseline and two follow-up surveys, one each at 12 and 36 months, are conducted. (Of course, costs would be lower with fewer surveys)
- Interviews are attempted with all 3,600 sample members in each wave.

The estimated cost of this type of evaluation is $10 to $20 million.

With respect to vouchers, the necessary number for the design in which the control group gets only usual care is 1,800. In addition, for some models, the vouchers could be time-limited, which would result in lower program costs than were all the vouchers open-ended.

Site-Level Random Assignment

New Sites in a Demonstration: Since current sites in the study already operate the model the evaluation would test, they could not be included in a study that randomly assigns sites to the treatment or control conditions, except in the unlikely event that they would discontinue their integrated programs if they were assigned to be a control site.[37] Moreover, although one might find some communities willing to implement the models under consideration without a voucher inducement, finding the necessary numbers of sites seems very unlikely.   Thus, only new sites could be included.

Significant advantages accrue to site-level designs. There is greater potential for crossovers with in-site, individual random assignment. Although evaluators have reliable methods for deterring crossovers, with such vulnerable families front-line staff may be tempted to try to circumvent procedures to help particular families in deep need. In control group sites, this kind of crossover assistance would not be possible. Furthermore, related to this vulnerability of families, program operators often will have to encounter families assigned to the control group in a family-level design (but not in a site-level design), and this may lead them to have greater ethical concerns about it and make them less likely to agree to participate.

However, site-level random assignment also has disadvantages. In particular, whereas a site conducting family-level random assignment has a strong interest in preserving a clear treatment/control differential so as not to downwardly bias estimates of what it believes are the positive effects of its program, a control site in a site-level design has no such incentive and thus might initiate a more integrated approach to serving families. Another related problem about control sites is the expectations that the site recruitment entity would need to place on prospective sites. All of the sites considered for selection would need not to be currently operating the models of integration the project would evaluate, but be willing to do so if picked for the treatment group and to *not* do so if picked for the control group. This

---

[37]   There would also be the question of whether they could entirely undo previous collaborations given that relationships had been established.

carries a problematic feature. What would the sites need to do to show that they could collaborate sufficiently to implement the models with fidelity, if they are not currently collaborating? If they needed to show only very minimal levels of (i) collaboration, (ii) willingness to commit necessary funding resources, and (iii) ability to implement the front-line integration before being randomly assigned, then it is likely that a significant proportion assigned to the treatment group would not implement the model with fidelity, and this would lead to lower true positive effects than a model fully implemented in all treatment sites. On the other hand, were potential sites required to meet higher standards, it is quite possible that those assigned to control groups would begin to operate in a more coordinated fashion. However, as stated before, in site-level random assignment, the control site has no incentive to prevent this from happening.

Scale: An even more significant disadvantage of site-level random assignment is the much larger number of sites that it would be necessary to enroll to attain adequate statistical precision for the impact analysis. Lacking data on within-site and cross-site variances on primary outcomes, it is difficult to conduct a power analysis that would relate numbers of sites and numbers of individuals to minimum detectable effects (MDEs), the smallest true impacts with a high probability of being detected as statistically significant). The power of a site-level design depends on the proportion of total variance in family-level outcomes which is cross-site as opposed to within-site—the intra-class correlation—and the ability of site-level co-variates to account for it. In the absence of this necessary information, one can only guess the numbers of sites required, and the number of families within them.

That being said, it seems very likely that at least 30 treatment and 30 control sites would be necessary. If the same number of families were included as in the family-level design, this would imply 60 families per site on average.[38] Thus, it would be necessary to recruit roughly seven times as many sites as in nine-site family-level design (although it might be easier to recruit them), and it would require the evaluation operating in over seven times as many sites. Since it would not involve monitoring random assignment of families, on average, this would be less burdensome and costly per site, but certainly not in total given the much larger number of sites. Again, it is probable that this design would very likely have less power than the family-level design. Because of statistical inefficiency, and the added cost it implies, where it is possible to conduct random assignment at either the family or site level, it is almost certainly preferable to do it at the family level.

Outcomes: Same as for family-level random assignment. Perhaps there would also be some interesting higher-level outcomes related to collaboration for which impacts could be computed with site-level random assignment, but they would be secondary.

Cost: Higher than for family-level random assignment.

Non-Experimental Design Options

Family-Level Non-Experimental Designs

In discussing both family- and site-level random assignment, one must assume that such studies would rely, at least in part, on new data for measuring outcomes. However, it is difficult to justify the same

---

[38]   Sixty families per site might be too small, but determining its adequacy would require specifying further details and having appropriate data.

investment in collecting new data for a weaker study design in which random assignment is not used to eliminate the threat of selection bias. Therefore, this section discusses the weaker "non-experimental" designs in the context of existing data.[39]

Current Sites: A non-experimental design with current sites would face the same problems as a family-level random assignment design—small numbers of individuals receiving the test intervention, limited capacity to add new research subjects, and very substantial heterogeneity in programs. However, one advantage of a non-experimental design is that in theory the evaluation could use families already in the program to the extent they could be identified in existing data sets, since their status need not be determined randomly, and in some cases this might result in much larger analysis samples—at least in the intervention condition—than an experimental design. The only existing data sets that we have identified that contain family-level data related to homelessness are the local Homeless Management Information Systems (HMIS) for which HUD has established standards for a common set of core data elements.

One strategy for utilizing HMIS would be to identify for each current site, i.e., a site which we observed in the study, one or more comparison sites that had similar demographic characteristics, economic and housing conditions, and homeless populations. Other surveys, e.g., the American Community Survey, could provide community level background data that could be linked to the HMIS, and homeless population characteristics could come from the core data elements from the HMIS. In addition to creating comparison groups at the site level in this fashion, for each family identified in the intervention site one could also identify one or more contemporaneous matching families in the HMIS for the comparison site, matching on available family background and current status variables.[40] This comparison could be the basis for an impact estimate for each program, and an evaluation could then derive an overall impact estimate, or estimates for clusters of similar programs. In addition, to the extent that there are other communities that were not part of the study sites and that have integrated housing supports and services, these sites, along with their matched comparison site(s), could be included in the analysis.

One very significant problem with this design is that, since the treatment was not randomly assigned to sites or families, one could not be confident that any estimated impacts were not the result of unobserved heterogeneity across the sites-- for example, that the sites that integrated housing supports and services did not provide better (or worse) programs independent of their collaborations. A standard way to try to account for this kind of problem would be to identify not only cohorts that became homeless after introduction of the integrated model programs, but also cohorts in both intervention and comparison sites that transitioned through homelessness prior to implementation of the model. This difference-in-differences approach would account for unobserved site characteristics affecting outcomes that were either time-invariant or that changed in the same way in the intervention and comparison sites. Although it is a substantial assumption that *all* unobserved site characteristics that affect outcomes are of this nature, this design would be much stronger than a simpler comparison site model.

---

[39]   We briefly describe one non-experimental alternative with new data collection below.

[40]   The universal data elements are very limited, primarily consisting of demographic characteristics and current housing status.

Implementing either of these approaches is dependent on two conditions:

1. Currently, only aggregate data on the universal data elements are reported nationally to HUD. This design would require that local CoCs permit researchers to use family-level HMIS data, possibly stripped of individual identifiers.   (With identifiers, it would be possible to match to other data sets, such as UI earnings records and Medicaid utilization records. So stripping of identifiers would mean losing the opportunity to estimate effects on a broader range of outcomes.)
2. It is necessary to define clear standards for what constitutes "integrating housing supports and services" in order to identify intervention sites that do so and comparison sites that do not.

However, even if it were possible to meet these conditions, these designs would have very significant limitations:

1. Most of the integrated programs visited in the study are organized by units other than CoC, e.g., by county, city, or, even, state, so using HMIS data would not fully capture who has participated in the program.
2. HMIS data capture only the sheltered homeless, thus precluding evaluation of programs with target populations of those at-risk for homelessness and the non-sheltered homeless. Theoretically, one could use other data sets to capture families at-risk of homelessness. However, given the great difficulty of predicting from among a very broad population those who will become homeless, realistically a non-experimental evaluation of prevention programs is not likely to produce credible findings.
3. HMIS core data are significantly limited, and (without actually undertaking analyses that attempt to do so) potentially incapable of predicting outcomes such as future homelessness or days of homelessness. Certainly, before proceeding, it would be important to develop predictive models of key outcomes and use out-of-sample tests to validate them. For example, one might identify two comparison sites for each model site, and see if a model based on one comparison site predicted impacts in the other, in which case one would disbelieve the model.
4. One would be limited to outcomes that exist in current data; attempting to identify families and survey them would involve costs that arguably cannot be justified in a non-experimental setting and likely yield a very low response rate.

Thus, although one can describe abstractly a family-level non-experimental design using existing data, in reality the availability of data or ability to reasonably gather data to support a credible evaluation is highly suspect.

Scale: Since in this design the evaluation would analyze existing data, scale itself is not an issue.

Cost: In this design, it is important to include a limited implementation study sufficient to describe the programs and, only if cost data were readily available, a limited benefit cost study. Consistent with the belief that spending substantial resources on new data collection in the context of a non-experimental design is not a good investment, these component studies would be less comprehensive than in the case of the experimental designs. As with the experimental designs, precise estimates are not possible without further development of design details, but could be in the range of $500 thousand to $2 million.

Costs are lower than for the experimental options discussed earlier because no resources are needed to set up and execute random assignment or to collect new primary data for the impact study.

*New Sites***:** As mounting a demonstration would require the cost of new data collection as well as other costs, and could not include families who passed through homelessness *earlier* than when the study began, when in a demonstration mode there is no advantage to using non-experimental methods and obtaining weaker findings rather than using random assignment. In addition, where relatively high quality non-experimental designs could be used, costs are likely to be substantially higher than for most non-experimental approaches and problems of feasibility greater. For example, many of the programs use an assessment scale with a cutoff to determine family eligibility, and this could be part of a demonstration. Potentially, this could be the basis for a regression discontinuity analysis.[41] However, to achieve the same power as an experimental design, such a design would need three to four times as many research subjects.

Site Level Non-Experimental Designs

Current Sites: One could conduct a non-experimental evaluation of existing sites similar to the family-level analysis described above, but using aggregate data at the community level rather than picking individual families in each set of sites to improve the match quality. That is, one would match one or more comparison communities that had not implemented integrated housing supports and services to those that have done so. This would have several potential advantages over family-level non-experimental designs. First, it could look at outcomes that are available in the aggregate for communities but not for individual families; this could allow a richer set of outcomes to be explored. Second, a community-level difference-in-differences analysis in which changes over time in key outcomes before and after implementation of the integrated model compared to analogous changes over time in comparison sites is probably more feasible at the higher level, as identifying pre-cohorts of families in the HMIS data could prove infeasible. At the community level, the outcome of homelessness, both sheltered and unsheltered, could be measured using PIT counts.

However, the difficulties in developing credible impact estimates using site-level data are at least as great as at the family level:

1. As there are many fewer sites than families, there would be significant problems of limited degrees of freedom and power to analyze impacts when compared to a family-level design.
2. Many of the integrated programs are relatively small in comparison to the homeless problem in the communities in which they operate. Thus, even successful programs may have difficulty affecting aggregate outcomes at the community level to a degree that could be detected. Taken together with the first problem, these two difficulties would very likely result in a study in which any true effects, even if policy significant for those treated, would be too small to be found statistically significant.
3. The low likelihood of affecting aggregate measures would be even lower for more distal outcomes such as employment, family stability and housing stability.

---

[41]   We say "potentially" because one would need to be sure that, given that the threshold for eligibility would be, or become, known in advance, front-line staff would not fudge the assessment and move families across the boundary capriciously and break the link between the eligibility variable and family outcomes from which regression discontinuity designs get their ability to non-experimentally identify program impacts.

Scale: Since in this design the evaluation would analyze existing data, scale itself is not an issue.

Cost: Hard to determine without further investigation, but could be in the range of $500 thousand to $2 million.   Costs are lower than for the experimental options discussed earlier because no resources are needed to set up and execute random assignment or to collect new primary data.

New Sites: As with a family-level non-experimental design, there are no advantages favoring developing a demonstration project with a site-level non-experimental design over one with a random assignment design.

Conclusion

The strongest design to evaluate the impact of programs that integrate housing supports and human services to reduce homelessness and improve housing stability and other family outcomes is a demonstration that relies on family-level random assignment. Given the nature of the programs observed in the study, a family-level random assignment design is both methodologically appropriate and feasible were the federal government to provide some number of housing vouchers.

While it is also theoretically appropriate and feasible, a community-level random assignment design would be much less statistically efficient and much more costly to achieve the same level of statistical certainty, and we do not recommend it, given the opportunity to implement a strong, family-level design. We also do not recommend that HHS pursue a non-experimental design, because we are unable to identify such a design that could be based exclusively on existing data that could produce reliable evidence on which policy or program decisions could be confidently based. Developing the *new* data needed to support a minimally acceptable non-experimental design would be inordinately costly. Were HHS to undertake the expense and respondent burden of such additional data collection, we believe this could only be warranted if a much stronger family-level random assignment design were used.

As regards the policy comparison the study would make, we have described what could be learned from two different random assignment tests depending on the counterfactual condition, i.e., usual care or usual care plus a housing voucher, to which integrated housing supports and services would be compared. We are not making a suggestion regarding which is of most policy and program importance. Both designs could be more fully elaborated and should be before any choice between them, or other family-level random assignment designs, is made

Appendix C:
Boise, ID (Charitable Assistance to Community's Homeless)

CATCH Program
Boise, ID

Overview

The Charitable Assistance to Community's Homeless (CATCH) program is a public-private partnership, started in 2006, operated by the City of Boise's Department of Community Planning.   Partnerships exist between the City of Boise (who administers the program) and a group of local faith-based organizations and private businesses (who provide rental assistance funding, program volunteers and material resources). The program rehouses homeless families and supports them with six months of rental assistance and intensive case management that focuses on linking families to employment, income supports and other services. The overall objectives of the program are to help families achieve economic self-sufficiency and maintain their housing stability after the six-month period.

Linked Program Design

The CATCH program provides families with rental assistance in scattered-site, market-rate units for six months (including deposit and, in some cases, payment of past utility debt), which is coupled with intensive case management. The City funds the administrative and operating costs of the program, and the United Way funds the social workers providing case management to families. Rental assistance is paid by faith-based organizations, businesses, and congregations that commit to sponsoring a family for six months. Faith-based organizations include First Presbyterian Church, Southminster Presbyterian Church, Ahaveth Beth Israel, and Emmanuel Lutheran Church. Businesses include: Idaho Power, Building Constructors Foundation, Tomlinson and Associates, Idacorp Investment Group, and Wells Fargo. After six months in the CATCH program, the family "graduates" and, in virtually all cases, remains in the unit paying their own rent. Local staff attribute the high success rate to a combination of factors. First, program participants are required to focus on gaining employment throughout their enrollment in the program, and participants are continuously looking for employment opportunities during this time. Second, participants receive intensive case management to help find employment, and each participant has a goal plan that describes their progress in obtaining employment and is reviewed weekly with case managers. Third, affordable housing is within the reach of program participants. Rents are affordable (typically between $500 and $600 monthly) and many families are living in Low Income Housing Tax Credit (LIHTC) properties and Section 42 housing (a state law that requires developers to set-aside a certain percentage of units per development as affordable). To date, only two of the 136 families served in the program have been unable to pay their own rent after graduation. In these two instances, because the family has been looking for work but not been successful, CATCH has extend the program by a month or so until the family has been able to find employment.

According to program staff and the project participants interviewed during the site visit, case managers continue to work with families after the rent assistance has ended for as long as necessary, and site visitors found evidence of ongoing counseling and resource linkage for families as much as a year after graduation.

Target Population

The program can serve 22 families during a six-month period or roughly 40 families over the course of a year—depending on turnover rates. There are currently 19 families on the waiting list.

The program targets homeless families with children currently residing in specific local homeless shelters (discussed below). There are several eligibility criteria for the program—clients must:

- be a U.S. citizen,

- not be a registered sex offender,

- not have any warrants in any state,

- not have convictions or arrests for crimes of violence against persons or property within the last five years,

- not have current use of illegal substances,

- not have convictions or arrests for drugs or DUI's within the last six months,

- be willing to submit to random drug testing,

- be an Ada County resident for the past year, and

- demonstrate a willingness to work toward self-sufficiency by obtaining sustainable income and permanent housing.

The referral sources include a men's emergency shelter (River of Life); a women's emergency shelter (City Lights); an emergency shelter that accepts men, women and families (Interfaith Sanctuary); a shelter for women and children escaping domestic violence (Women and Children's Alliance) ; and the Salvation Army, which has a small number of emergency shelter and transitional housing units (TH). The Salvation Army refers clients mostly from its emergency shelter units, but on rare occasions will refer clients from the TH program.

Human Services Offered

CATCH staff and volunteers directly provide case management, counseling, budgeting, goal-setting, job-seeking and resume assistance. Other services such as vocational training and financial counseling (provided by the Department of Labor and Mountain West Bank, respectively), are provided to families at the CATCH program offices by other organizations. CATCH staff link clients to other organizations or agencies that provide services to low income families in Boise, and guide families in how to access these services. Follow-through is the responsibility of the family. Some examples include: the Department of Health and Welfare (DHW), which provides families benefits such as TANF, food stamps, child care assistance, and health care for families who do not qualify for Medicaid.   The Terry Riley Center provides physical and mental health services. St. Vincent de Paul (with which there is an MOU) provides material start-up needs such as food, clothing, and furniture. L-Ada (a non-profit community action agency) provides energy assistance. Affinity (a nonprofit) provides mental health services. The Department of Labor provides job training and vocational training workshops.

Mountain West Bank provides financial services to all interested clients, including free savings and checking accounts. Mountain West and Wells Fargo support the CATCH Match program that promotes savings through matching the amount a family saves dollar for dollar, up to $1,000. CATCH Match is offered during program participation and for one year past graduation; many families end up with a $2,000 savings account.

Housing Supports Offered

The key housing support is six months of full rental assistance in scattered site, market-rate units identified, applied for, and secured by the families in the CATCH program. While clients sign their own leases with landlords, CATCH pays the deposit and first month's rent and agrees (in writing) to pay the monthly rent for as long as the family is in the CATCH program, usually six months. CATCH has developed relationships with a number of private landlords, the most significant of which is Tomlinson and Associates, an affordable housing developer that provides a number of affordable units (e.g., LIHTC) to the program. Additionally, Tomlinson and Associates regularly sponsors (or donates the rent for) families in the program.

CATCH case managers teach families to budget realistically (one strategy is to have families save all of their receipts so they can identify where they spend their money), pay off debt when possible, and prioritize rent payments. While they are in the program, families are encouraged to build savings through the CATCH Match program.

Key Partners

The Key partners are listed in the table below.

Key Partners	
Name of Partner	**Role**
City of Boise Community Planning Department (CPD)	• The CATCH program manager and founder is on the CPD staff; • CPD provides office space, program administration (including payroll, bookkeeping and accounting), and publicity.
Boise Mayor's Office	• Program leadership and public relations; • The Mayor was instrumental in getting the program off the ground by hosting meetings with the faith and business communities, helping to gain their support and sponsorships and creating partnerships.
Faith-based Sponsoring Organizations and Businesses (examples include: Emmanuel Lutheran Church, Wells Fargo, Boise Legacy Constructors Foundation, First Presbyterian Church, Ahaveth Beth Israel synagogue, Idacorp Investment, and a local Catholic church)	• Donate funds for rental assistance for families; • Provide volunteers to move families into housing; • Donate goods and furnishings; • Raise community awareness.
United Way	• The United Way funds the case management through the salaries of social workers on staff.

Key Partners	
Name of Partner	**Role**
Tomlinson and Associates	• Provides access to many of the affordable units used by families in the program; • They have one of the few MOUs with the City associated with this program.
Emergency Shelters	• Identify potential families and provide CATCH referrals.

Funding Streams

The City of Boise provides general funds to support the operation of the program and the salary of its manager. The United Way provides annual grant funding for the case management (salary of social workers). The rest of the funding for the CATCH program comes from private donors. All donations, including the United Way Grant, are sent to the City but earmarked for CATCH.

Human services outside of those offered directly by CATCH are funded by the organizations that provide them.

Promising Features

Collaborative: This program relies on the collaboration of the Boise CPD, local emergency shelters who identify and refer potential families, the Mayor's office that creates sustained support, and faith organizations and private businesses that provide the rental assistance and the affordable housing units. It receives no support from traditional U.S. Department of Housing and Urban Development and U.S. Department of Health and Human Services programs and resources for homeless families.

Replicable: The CATCH program has already been replicated in nearby Canyon County. In this instance, the Department of Health and Welfare (DHW) took the lead in establishing local support for the program (similar to the role of the Mayor in Boise). However, the program design is the same: families are identified in local shelters and housed through local (Canyon County) CATCH sponsors and provided intensive case management. The DHW plays a more significant role in the Canyon County program, having staff regularly communicate directly with CATCH staff regarding families' needs.

Sustainable: In the meeting with funders it was clear that, because the administrative and operating costs remained separate from the actual rental assistance, it was easier to engage funders and raise the money to sponsor families. Boise believes this is a sustainable way to serve homeless families in the area.

**Appendix D:
Brattleboro, VT
(Pathways to Housing)**

Pathways to Housing
Brattleboro, VT

Overview

The goal of the Pathways to Housing program is to help homeless households and households at risk of homelessness find and maintain stable housing by linking temporary housing assistance (up to two years) with case management services. The program was designed in 2004 (implemented in 2006) and provides families and individuals with a two-year rental housing subsidy in the private market. Program participants must be "sponsored" by a social service organization that provides intensive case management for the duration of the rental assistance. In 2010, the program served 27 households, including 25 families and two individuals.

The program is operated by the Brattleboro Housing Authority (BHA) and funded by the Vermont State Agency of Human Services (AHS). The BHA administers the rental assistance, which is structured like the Housing Choice Voucher program: program participants pay 30 percent of their adjusted gross income on rent, and the Pathways to Housing program funds the remainder through the grant from AHS. The BHA established formal partnership agreements with social service organizations to provide the mandatory case management.

The program targets households that have (or will have) a stable source of income and are likely candidates to pay for their housing once their immediate barriers are addressed. For most program participants, the main barriers to stable housing are credit issues, establishing a positive rental history, and maintaining consistent employment or sources of income. Some participants may also have other types of issues such as mental health problems that also need to be addressed through links to community services. Most participants are referred to the Pathways to Housing program from other service providers in the community, such as emergency shelters. The principal aim of the program is to help families address these barriers and, as a result, find and maintain housing on their own. To increase the chances of a successful transition to permanent housing, participants are required to apply for permanent housing opportunities as soon as they enter the Pathways to Housing program.

Linked Program Design

Pathways to Housing links housing assistance, in the form of a two-year rental subsidy, with intensive case management provided in clients' homes by the referring agency. Service providers (referral agencies) identify clients enrolled in their respective programs that may benefit from the program. Most frequently, households have received services through foster care or TANF to address any barriers that would prevent them from living on their own. These might include substance abuse or mental health issues. Before the client fills out an application for the program, the service provider must have an executed MOU with the BHA that outlines the specific roles and responsibilities of the BHA and the referral agency. Once the agencies have established an MOU, the case manager completes a pre-application with the family that provides basic information (e.g., address history, head of household social security number, criminal history) for BHA to conduct a background check on their credit, rental, and criminal history. The background check is not used to qualify or disqualify families from the program, but to help the family identify barriers to housing and prepare a plan to address those barriers.

The prospective client then completes an extensive application with their case manager that includes an Individual Service Plan (ISP). The full application includes a complete employment history and a detailed physical and mental health history. The Individual Service Plan must include detailed goals and action steps to address each barrier that may derail the family from maintaining stable housing. The agencies are not required to use the Pathways ISP format if one has been completed in the referring agency format.

An Oversight Committee, comprised of individuals from the Agency of Human Services, the Department of Economic Security (TANF), the Brattleboro Housing Authority, the Department of Corrections, Morningside Shelter (the largest referral agency), and the Day Shelter Drop-In Center, reviews the applications, interviews applicants, decides who is accepted into the program, and monitors overall program policy. During the interview with the Oversight Committee, prospective families are asked about their finances, history, goals, and personal issues such as mental health and substance use that could affect housing stability and success. Immediately following the interview, the committee decides whether or not to admit the family into the program. Often, the committee will accept a family with a contingency placed on the applicant. For example, if a head of household has struggled with substance use or mental health issues, he or she may be asked to participate in regular counseling as a prerequisite for program entry.

Once admitted to the program, the applicant and case manager will meet with staff from the BHA to determine household income and calculate the household's 30 percent portion. BHA also provides the family with information about any known vacancies in the area. Brattleboro has a strong network of landlords that work regularly with the BHA to provide housing for this program. BHA has a network of landlords that are used by the housing authority's Section 8 voucher program. BHA uses this network for the Pathways program as well. The head of household signs a lease that includes an addendum referencing requirements of the Pathways to Housing program. These requirements include that the household participate in case management for the duration of the lease and that the household is required to accept any permanent source of housing offered during the term of the lease.

BHA executes a separate Housing Assistance Payment contract with the landlord that specifies the amount of rent paid by the tenant and by the BHA. Program participants execute a lease directly with the landlord.

Families enrolled in the program are required to participate in case management. The intensity of case management varies depending on the needs and goals of the family. At the start of the program, case managers typically meet with participants once a week or more. As the family settles into the program and makes progress towards the goals set out in the Individual Service Plan, the intensity of case management may decrease. At a minimum, case managers must maintain monthly contact with the participant. BHA and case managers respond to any issues or problems between the household and landlord. Landlords are directed to contact BHA's program coordinator about issues, and the coordinator then strategizes with the case manager about how to address the issue.

All case managers work with the family on a monthly budget, which is submitted to the BHA program coordinator. The program coordinator also facilitates a monthly case manager meeting to discuss

difficult cases and share resources. In August 2011, the partners decided monthly meetings were not needed, and the case managers will meet quarterly moving forward.

Target Population

The Pathways to Housing program targets three specific subpopulations that have problems accessing the private housing market due to poor credit, poor or no rental histories, and unstable sources of income:

- Families who receive TANF,

- Youth aging out of foster care, and

- Women being discharged from prison, and their children.

Program leadership designed the program to be a "last resort" for families (and individuals). Based on the assessment of case managers, if prospective participants have other housing opportunities or options, those families or individuals must use those services first before accessing the Pathways program.

There are numerous organizations that provide referrals to the Pathways to Housing program. All organizations that refer clients to the program must agree to provide those clients with intensive case management throughout their enrollment in the program (discussed in more detail below). The referral sources and case management providers are: Morningside Shelter (the only emergency shelter in Brattleboro), Youth Services of Windham County, Department of Corrections, Agency of Human Services, the AIDS Project of Southern Vermont, and the Drop-In Center, a day shelter for homeless individuals. Formal agreements are established with referral organizations before a client can apply for the program.

The program serves between 13 and 20 households at a time and can serve up to 27 households over the course of a year. During the most recent fiscal year, 24 of the 27 households served were families receiving TANF, two were youth who aged out of foster care, and one was a woman recently discharged from prison who was accompanied by her family. To date, 124 households have participated in the Pathways to Housing program.

Human Services Offered

The primary service provided to families in the Pathways to Housing program is intensive case management. The case managers working with the families in the program identify their unique service needs and provide linkages to those services in the community. Frequent service referrals and linkages include mental health services, substance abuse counseling, TANF, employment preparation services, vocational rehabilitation, child care services, education, and WIC. Case managers also work with the family on financial management and budgeting on a monthly basis.

Housing Supports Offered

All families and individuals in the Pathways to Housing program are provided with a two-year housing subsidy. The housing assistance is contingent on the family receiving and actively participating in case

management. If the family stops participating in case management, the BHA, case manager, and the Oversight Committee(OC) intervene to work with the family on complying with the requirement. If the family does not participate in case management, housing assistance will be terminated. Prior to providing rental assistance each month, the BHA receives a monthly update on each household in the program. These monthly reports include progress toward the household's goals, services received, and any changes in household finances. Case managers are required to submit monthly budgets to BHA for each Pathways participant. The BHA uses this information to adjust the participant's portion of the rent payment, if necessary.

Although the duration of the program is two years, the average length of stay in the program is 18 months. When participants enroll in the program, they are required to begin searching and applying for subsidized permanent housing programs immediately. Often a household will be accepted into a (subsidized) permanent housing program while participating in the Pathways to Housing program; they are required to accept offers of affordable permanent housing. Many families are accepted into public housing from the Pathways to Housing program.

Key Partners

The Pathways to Housing program is a collaborative arrangement between several key partners: the Vermont Agency of Human Services (AHS, the grantor), the Brattleboro Housing Authority, local homeless service providers and local landlords. Formal agreements exist between all parties that establish the responsibilities of each organization. AHS and BHA have a grant agreement that allows BHA to access state funds annually to pay for the rental assistance. In summary, the partners and their roles are described in the exhibit below:

Partner	Role
Vermont Agency of Human Services	Grantor for housing subsidy; Referral source for a small number of families
Brattleboro Housing Authority	Grantee; administers rental payments to landlords; helps identify vacant units and negotiate rents with landlords for families; monitors family progress
Morningside Shelter (primary referral source) Department of Corrections Youth Services of Windham County AIDS Project of Southern VT	Referral source; provides in-kind case management to families or individuals referred to the program. Develop Individual Service Plan with family and monitor progress. Links families with community services.
Department of Economic Security Day Shelter Drop-In Center	Oversight Committee member
Landlord Network	Provides housing to participating families; Works with the BHA to meet Fair Market Rent standards; informs BHA of vacancies and anticipated vacancies.

Funding Streams

Rental assistance is funded entirely through the State of Vermont's Agency of Human Services General Fund. The State of Vermont's AHS initially granted the BHA annual funding in the amount of $149,000 to support the program. In the most recent fiscal year, however, that grant amount was reduced to $80,000. Funding for case management is provided by each service provider from their own

organization's funding streams. A majority of referrals come from the Morningside Shelter, and the majority of case management is provided through shelter social workers. The shelter funds case management through a contract with the state to provide services to TANF recipients (locally called Reach-Up), private dollars, and other Morningside funding sources. The BHA and the AHS field director hope to include case management funding in future grant amounts to relieve the burden on organizations.

Promising Features

Collaborative: The program relies on the collaboration of the state's Agency of Human Services and the Brattleboro Housing Authority to fund and operate this program. The director of programs for the housing authority works closely with the AHS field director. The AHS field director sits on the oversight committee, and attends monthly Pathways case managers meeting.   This model also relies on a daily working partnership between the BHA and local service providers.

The BHA believes the model has worked because of the collaborative decision-making process undertaken with AHS and the local service partners. This is grounded in a philosophy that all partners are working towards a common goal – preventing and ending homelessness – both for the communities' homeless population as a whole and for individual program participants. All decisions about admitting participants into the program or addressing participant problems are made collectively by the (OC) – regardless of the resources each agency contributes to the program. The commitment of OC members appears to extend beyond gaining resources for their agency's clients. For example, the Executive Director of the Drop-In Center sits on the OC even though Pathways to Housing does not typically serve her chronically homeless clientele.

Replicable: BHA believes this program can be easily replicated on smaller or larger scale between housing and services agencies. It has already been replicated on a larger scale in Burlington, VT.

Innovative:

- Intake process: The program has clearly defined the target population and is rigorous about assisting these households. Once the application is completed, the applicant is interviewed by the OC. OC members believe this personal interaction where the applicant can present his or her case is critical. It creates a sense of accountability for participants and OC members.

- BHA/Case Managers address participant problems immediately: Beyond financial guarantees from BHA, landlords elect to participate in the program because BHA and the case managers address any tenant issues in a timely manner. If a participant is disturbing neighbors or the participant's portion of the rent is late, the program coordinator and case manager immediately visit the participant to address the issue.

- *Exit Strategy*: Program participants are required to apply for any available permanent housing resource as soon as they are accepted into the program. If the participant is offered a resource during the 2-year Pathways to Housing program, he or she is required to accept the unit. The lease addendum codifies the requirement so that the participant, the landlord, and the service agency all understand that the participant may live in the unit for less than two years.

Appendix E:
Chicago, IL (Family Assertive Community Treatment Program)

Family Assertive Community Treatment (FACT) Program
Chicago, IL

Overview

The objective of the Family Assertive Community Treatment (FACT) is to assist young mothers and their children in reaching stability in all aspects of their lives, including housing, employment, family stability, and self-sufficiency. The FACT model aims to assist homeless families with severe mental health issues and related needs, who may encounter barriers when attempting to access other types of homeless services.   The FACT model seeks to influence and impact young mothers and their children by linking them with housing and social services supports, as well as strengthening system integration in the Chicago area.

The FACT program uses a modified Assertive Community Treatment (ACT) model and a harm reduction approach to provide clinical and social services to young homeless families who may encounter barriers when attempting to access other types of homeless services. Housing is provided through a transitional housing program (Families Building Communities), dedicated tenant-based rental subsidy vouchers provided through Chicago's Low Income Housing Trust Fund (LIHTF), and other sources (e.g., HUD-VASH).

Linked Program Design

The FACT program was developed in 2008 in response to the Conrad N. Hilton Foundation initiative "Strengthening At-Risk and Homeless Young Mothers and Children." Staff at Beacon Therapeutic, a Chicago nonprofit, were interested in developing a program to expand on their current work with at-risk children and to help stabilize homeless families, as they saw there was a need to develop strategic services for homeless families. Specifically, there was a growing need to ensure that children in homeless families were receiving developmental assessments and linked with programs that help them stay on target with their social, emotional, and educational development. Simultaneously, Heartland was looking for an opportunity to modify the ACT model and apply it to families, but had not been able to secure the funding necessary to implement this type of resource-intensive program. There also was anecdotal evidence that young homeless families were in need of services and could benefit from high intensity services like those provided through the ACT model.

When researchers from the National Center for Family Homelessness notified Beacon and Heartland leadership about the Conrad N. Hilton Foundation's initiative, both organizations saw it as an opportunity to expand the services for homeless families in Chicago. They decided to combine their expertise and advance and expand the work already underway with homeless children and adults at both organizations. With the assistance of local advocates such as the McCormick Foundation, the Polk Brothers Foundation, Prince Charitable Foundation, and the Chicago Department of Family Support Services, the Conrad N. Hilton Foundation selected Chicago and the FACT model as a fourth and final project study site.

The FACT model emphasizes housing as the primary goal, believing that mothers need to be in a stable housing situation to help stabilize their children as well as begin to address their own needs. A critical

component of the FACT model is the ACT team approach to coordinating and providing assistance to enrolled families. The FACT team is comprised of six members: a project director, a senior case manager/employment specialist, two youth therapists, a chemical dependency specialist, and a housing resource developer. Each FACT team member also serves as a caseworker, serving as the main team contact for a family enrolled in the program. The housing resource developer does not have her own caseload, as she spends a great deal of time identifying and building relationships with tenants. In addition to tracking families active in the program, the housing resource developer also maintains contact with families that have graduated from the program.

The FACT team is also supported by a Beacon Therapeutic psychiatrist, as well as the case manager for the Families Building Communities (FBC) case manager. To facilitate increased communication and cooperation between the FACT team, all members of the team are co-located in one Beacon Therapeutic facility. In addition, the FACT model has a systems integration manager who attends FACT team meetings, convenes a planning coalition that meets quarterly, and has established a ''FACT Systems Integration Plan" to guide specific system integration goals and objectives.

Families are referred to the FACT program by multiple sources, including DCFS, emergency shelter staff and other homeless and social service programs. The FACT program also receives some self-referrals. A paper referral form is completed for each referred family. Initially, each referral was discussed by the FACT team. However, one FACT team member now reviews the referrals and decides which families seem to be appropriate for the program, and what families need to be reviewed by the entire team. If the FACT team decides the family would be a good fit for the program, a member of the FACT team will complete more comprehensive four-page intake screening with the family over the phone or in-person. The assessment examines housing, education and employment history of the mother, as well as information about her minor child(ren). In addition to the intake screening, the mother also completes a "What I Want from FACT" worksheet. The completed intake screening and worksheet is then reviewed and discussed by the entire FACT team who decide whether to admit the family to the program. If the program cannot accommodate the family at the time of their referral, the FACT team will place the family on a waiting list for the program.

Once the intake process is complete and the FACT team decides to admit the family to the program, the team provides the family with referrals to meet their most immediate needs identified through the intake process. The team then discusses approaches to best assist the family, as well as what level of support and interaction the family may need. The next step in the process is for the family to undergo a comprehensive assessment with the FACT team member who will be handling their case. At this point, the mother is required to sign a form agreeing to participate in the program. While the family begins to address their immediate needs, the FACT team works with them to get benefits and necessary paperwork in place so that the family can move into housing as soon as possible. The FACT staff works to keep up-to-date contact information for participating families, in case they cease to be engaged in the program.

The FACT team also works with the family during this time to create a treatment plan based on the priorities identified by the family during the intake and assessment process. One unique aspect of the FACT model is that it offers services specifically for the child(ren) enrolled in the program. The Ages and Stages Questionnaire (ASQ) is administered to children within 21 days of enrolling in the FACT program

if the child is in their parent's custody. If the child has a higher need for clinical or case management services, they will have their own case opened, be administered the Trauma Symptom Checklist Young Child (TSCYC) and the Child Behavior Checklist (CBCL), and have their own treatment plan independent from their mother's.

Once a treatment plan for a family is in place, the FACT team begins to meet with the family in their home or where they are currently residing. Typically, the FACT team works to house families first. FACT team members indicated that "housing is the core focus of the program from day 1." Staff explained that with a harm reduction model, it is easiest to get families to focus on obtaining housing upon entry into the program, even if they are not willing to address their other issues. The FACT team will also work with the family to get them enrolled in mainstream benefits programs, such as Medicaid and food assistance.

The housing resource specialist conducts a Housing Choice Assessment with each client, where they discuss what type of housing they can afford, where they want live, as well as general cost of living. This assessment also helps build landlord relationships, as it helps to ensure that families are placed in units that best fit their needs and abilities. The FACT team staff then assists families in securing a unit by helping them complete application paperwork, conducting follow-up regarding admission to the unit, and assistance in negotiating unit repairs. Also, the FACT team helps the family gather the necessary documentation to accompany their housing application.

While the family is working to obtain housing, the mother and child(ren) also begin to receive mental health services from the FACT therapists, as well as clinical staff at Beacon Therapeutic. If the family is maintaining their housing successfully, program staff begin to work on daily living activities, as well as working on addressing past traumatic events in the parents' or children's' lives. Once a family is housed, typically the frequency of meetings with the FACT team declines. In an effort to incentivize meetings with the FACT team, the program now offers gift cards to families as a reward for their attendance. In addition to gift cards, the FACT team also distributes bus passes and Metro passes to families. The FACT team continues to provide case management until a family is stably housed, and the child(ren) are on track for growth and development. Staff acknowledged that this is a highly individualized and variable graduation framework, but underscored that the path to self-sufficiency is different for every family.

The FACT team approach to providing services to homeless families naturally links and integrates services and supports. Families receive support and case management from all members the FACT team, in addition to maintaining a regular point of contact on the team as long as they are enrolled in the program. However, the program still faces barriers to successfully linking services and supports.

The FACT team explained that transitioning families to financial self-sufficiency remains a challenge. Without a reliable income, it is difficult for families to find or maintain housing opportunities. The recent economic climate has exacerbated the families' ability to find permanent employment opportunities. Staff shared that some families give up on finding employment, feeling a sense of hopelessness that they will never be able to find viable employment options. This rejection contributes to the mothers' negative feelings of self-worth. FACT team members commented that adding a benefits coordinator to the FACT team may assist families in successfully applying for the Social Security benefits for which they most likely qualify. FACT team members cited families where the mother was

emancipated from Chicago's DCFS as the most difficult to assist in becoming self-sufficient. Many of these young mothers struggle to navigate life tasks such as obtaining housing and employment. In addition, staff mentioned that these clients can often be very argumentative and confrontational, making it even more difficult to assist.

Target Population

The target population for the FACT model is young mothers with a mental health diagnosis who have small children and are residing in shelters or are exiting the child welfare system who are in need of housing and support services. Generally, the FACT program targets the hardest to serve families, who need intensive, wrap-around assistance. The FACT model also has several eligibility requirements. The program only serves young women ages 18-25 that have a minor child under the age of five. The mother must have a severe mental health or substance abuse diagnosis (Axis 1), and may also have a history of domestic violence. Families served by FACT must be homeless or at-risk of homelessness and be from the City of Chicago.

As of March 31, 2011, the FACT program enrolled 69 families. The FACT program director stated that the program receives on average between 10-20 referrals a month. In the first quarter of 2011, the FACT program received eight referrals, and enrolled three new families, in addition to re-enrolling three families who had left the program at an earlier date. Families who are not eligible for the FACT program are referred to other relevant homeless services in Chicago.

Human Services Offered

The FACT model provides a wide range of human services to the families it serves, both through the FACT team as well as through referrals to other services and programs. These services are identified and coordinated through the integrated case management component of the program. The case manager assists the mothers in applying for services and mainstream benefits (e.g. TANF,SNAP), and often accompanies the mothers to appointments or meetings, providing an additional layer of support for the family. Families receive therapy and mental health counseling from FACT team therapists, as well as Beacon Therapeutic psychiatrists. Substance abuse counseling is also provided to mothers directly through the FACT team. Medical and dental care are provided to families through Heartland's Healthcare for the Homeless program, as well as referrals to other providers in the city.

Mothers work with the FACT employment specialist to identify training programs and employment opportunities. In addition, they work with the FACT team to improve their interview skills and develop their resumes. In some instances, mothers are referred to adult education programs or employment training programs. Case managers also work with mothers on life skill training, including budgeting classes, household management, and financial literacy. For many mothers, this is their first time living on their own and running a household, so FACT staff work to model appropriate behaviors for them.

The FACT model also provides extensive services to children in the program. Children are enrolled in other Beacon programs, such as their Early Head Start program and their therapeutic daycare center. The program also provides counseling and early intervention assistance for children with social or behavioral concerns or cognitive delays.

Housing Supports Offered

Families enrolled in the FACT program receive either medium- or long-term housing subsidies. There are two main sources of housing support for the program.

- *Chicago's Low Income Housing Trust Fund (LIHTF)*. The LIHTF is funded through a fee on marriage licenses in Illinois. The state then distributes this money to counties to support the preservation and creation of affordable housing opportunities through subsidies to eligible families. All families pay 30 percent of the average median income, with the lowest rent being $140 per month. One challenge of the Housing Trust Fund funding stream is that participating landlords must go through a lengthy paperwork and inspection process, a process that often deters landlords from participating. Housing Trust funds units are available as long as the family meets certain income requirements. If a family needs a long-term subsidy but none is available, FACT staff may place them in a FBC unit temporarily until a Housing Trust fund unit opens up.

- *Families Building Communities (FBC) program*. This Heartland transitional housing program offers families 24 months of tenant-based rental assistance in private market rental housing. FBC vouchers are funded by Heartland through HUD's Supportive Housing Program. For FBC units, the lease is in the name of the eligible family, not the FACT program. The staff of the FBC program work closely with the FACT team to place families and continue with supervision. FBC program staff attend weekly FACT staff meetings and FACT families living in FBC units share one case manager to encourage increased cooperation and coordination. One drawback of FBC housing is that families must be able to assume the full rental cost when program rental subsidy assistance expires at the end of the 24 month program.

In addition, the FACT team has utilized one HUD-VASH voucher, several Family Unification Program (FUP) vouchers, and was exploring the use of HPRP funding, but has not yet been successful in utilizing this funding source for their families.

The FACT program has succeeded in building strong relationships with landlords. Staff shared that landlords have accepted multiple program participants and realized that issues that arise are typically specific to one family and not the program as a whole. Through the FBC program, Heartland works with a network of over 200 landlords, which they are able to leverage for the purposes of the FACT model.

FACT staff acknowledged that moving forward, they may encounter problems finding housing units for participating families, and thus need to work on diversifying the program's housing options. The Chicago Housing Authority has not yet been receptive to learning about the FACT program or providing targeted housing assistance to FACT families. Placements in LIHTF housing units have permanent subsidies as long as the family meets income requirements, so there is a low turnover rate in these units. There are a limited number of vouchers for the FBC program as well. It is difficult to find housing units that will assist young mothers with little to no income. The program's work building strong relationships with landlords is a critical component of the program to ensure that adequate housing assistance is present moving forward.

Linking Human Services and Housing Assistance for
Homeless Families and Families at Risk of Homelessness
Task Order #: HHSP23337006T

Key Partners

- Beacon Therapeutic

- Heartland Alliance

- University of Illinois at Chicago

Beacon Therapeutic and Heartland Alliance are the two principal partner organizations in the FACT model. Beacon Therapeutic has extensive experience working with children dealing with a multitude of social, behavioral, and emotional challenges and risks, including homelessness. Beacon runs a therapeutic day school for students' ages 3 to 21 years of age, as well as several programs targeted to assisting homeless children and youth. For the FACT model, Beacon is the lead organization, also serving as the fiscal agent for the program. All funding for FACT program services comes through Beacon Therapeutic.

Beacon has a formal memorandum of agreement with Heartland to provide housing and case management services to FACT families. Heartland has over a hundred year history of assisting vulnerable populations in the Chicago area, including persons who are homeless. Prior to the FACT program, Heartland had extensive experience with both the harm reduction and ACT models. Heartland staff also has significant experience in housing, tenant advocacy, assisting families in choosing the best housing opportunities. Heartland contributes their extensive housing experience to the FACT model, supplying the Housing Resource Specialist and a case manager to the FACT team. Heartland also contributes housing subsidies through its Families Building Communities (FBC) program, a transitional housing program for homeless families.

In addition to Beacon Therapeutic and Heartland, several smaller organizations collaborate on the FACT model. Voices for Illinois Children, a local advocacy organization, has assisted with systems integrations work undertaken by the FACT team. Although initially slated to take on a larger role in the model, Inner Voices provides advocacy and oversight support through participation in the FACT model's Steering Committee and Planning Coalition.

The FACT model is being evaluated by two organizations. The National Center on Family Homelessness (NCFH) is conducting an evaluation of the Strengthening At-Risk Young Mothers and Children initiative for the Hilton Foundation. Beacon and Heartland also engaged the University of Illinois at Chicago as a local research partner, which is conducting an evaluation of the FACT program to supplement the NCFH evaluation.

Funding Streams

Currently, the FACT model is primarily funded by foundations. The Hilton Foundation provided the initial investment in the model through their Strengthening At-Risk and Homeless Mothers and Children initiative. This investment was backed by a one for one match from local Chicago foundations including the McCormick Foundation and the Polk Brothers. Foundation. This funding is used to pay for the staffing and operations of the FACT team, as well as the planning work related to systems integration and the program evaluation. In addition to foundation support, Beacon Therapeutic obtains reimbursement through Medicaid for eligible clinical services.

Funding for the FACT program moving forward is uncertain. The Hilton initiative funding is set to end in June 2011. The CEO of Beacon Therapeutic is leading an effort to secure funding for the program moving forward. DCFS and the Department of Family and Support Services are considering providing support for FACT, but at this time it is not clear whether this will be enough funding to sustain the program for any length of time. The team is also applying for federal grants in an effort to continue the program. In addition, the FACT team continues to explore ways to increase Medicaid support for program services.

Promising Features

Collaborative: The FACT model is a collaboration of two agencies – Beacon Therapeutic and Heartland Alliance. The FACT team is comprised of Beacon and Heartland staff members who bring their respective expertise – child development, mental health services, and housing – to the families they serve.

In an effort to increase the collaboration between the FACT team and other service organizations in Chicago, the FACT program model also includes a systems integration component. Heartland has been engaged in systems integration work for over fifteen years, with some of the information they gained informing the FACT model. One FACT staff member is dedicated to doing systems integration work full-time. Initially, this staff member attended FACT team meetings to understand what issues were being faced by the families and the team trying to assist them. The systems integration staff member then convened a Planning Coalition to guide this work and provide strategic oversight in further developing relationships between service providers and the model to better assist homeless families in Chicago. The Planning Coalition developed a "Solutions in Systems Integration Plan" that identified five priorities for assisting homeless families – each priority topic then had its own working group. Another focus of the systems integration work is the cross-training of staff in various social service fields in other disciplines. Staff believes that the systems integration work helps Coalition members and service providers see the linkages between the different types of services and supports being used by young homeless families.

The FACT program also has a steering committee that provides guidance and direct oversight to the program. At quarterly meetings, members of Beacon and Heartland staff, as well as members of the research team focus on keeping the project on-task and provide guidance on specific challenges and issues faced by the FACT team.

Outcomes: The FACT team considers a family as being successful in the program if the family has stabilized and has achieved what they identified they wanted from the program at entry on the "What I Want From FACT" tool. Successful families have no DCFS involvement, are in independent housing and are more self-sufficient, either accessing resources on their own, or successfully maintaining employment. Anecdotally, several families have successfully graduated the program and are living independently.

Since its inception, the FACT team has been preparing to measure outcomes of the program. The University of Illinois at Chicago has worked closely with the FACT team to introduce the study component to participating families, who are being tracked as part of their evaluation. Primarily, the study is concerned with measuring the differences in several health and quality of life measures before

and after FACT program participation. The study will also consider what services are being used by mothers and if they are helping them gain housing and employment.

Cost Effective: Due to the team approach and the intensive case management component of the FACT model, it is an expensive model to implement. Although Heartland considered beginning a program for homeless families for years, it wasn't able to implement one until the Hilton Foundation money became available. The FACT team believes they are able to provide a better array of services and supports through the use of the ACT model, especially by using the consistent family assessment.

Appendix F:
Decatur, GA (DeKalb KidsHome Collaborative)

DeKalb KidsHome Collaborative
Decatur, GA

Overview

The DeKalb KidsHome Collaborative (the "Collaborative") was formed in 2010 to address the rising needs of families that are homeless and have children enrolled in the DeKalb County School District. The Collaborative offers education, housing, and employment services to homeless families, with the goals of assisting families in securing housing and income stability and stable school attendance and performance. In addition, the Collaborative seeks to eliminate the duplication of services across agencies.

The Collaborative was sparked by one family. In an improvised manner, the four organizations came together to serve a family that needed shelter, employment, educational support services, and housing search and rental assistance. The successful experience of working together inspired the group of local organizations to formalize their partnership and establish a standardized referral system to continue their work. The resulting partnership provides an avenue for the DeKalb County School District Homelessness Liaison to refer families who are identified as homeless to emergency shelter, transitional housing, or rapid re-housing services. While receiving housing services, family members also can receive job placement assistance through an agency partner. To date the collaborative has served about 90 families.

The Collaborative targets homeless households in an economic crisis and in need of temporary housing assistance. The program is intended for families that have the capability to maintain housing once they are stabilized; it is not intended for households with multiple, intensive needs. An estimated 90 percent of households are referred directly for rapid rehousing assistance, and the remaining 10 percent require stays in emergency or transitional shelter. Clients can enter the Collaborative through any of the partner agencies, but most originate from the school district.

Linked Program Design

By forming the Collaborative, partners are able to link a variety of human services with housing supports. Together, Collaborative members have developed their own continuum of services that includes a spectrum of housing assistance—emergency shelter, transitional housing, and rapid re-housing—supported by educational support, job placement assistance, case management, financial education, and transportation assistance. Most referrals originate from the school district, but any agency can refer a family that has children in the DeKalb County school system. Typically, the Homeless Liaison assesses and refers the family to the appropriate Collaborative partner based on needs. For example, a family that is already homeless would be referred to the Decatur Cooperative Ministry's (DCM) emergency shelter or Project Community Connect, Inc.'s (PCCI) Rapid Re-housing program depending on the household service needs and whether the household has an income source or possibility of income.

The Homeless Liaison conducts a phone assessment with the parent or guardian of each student that is referred for the school district's homeless services. Student referrals come from school administrators

and teachers, or from other service agencies. Families can also call the liaisons directly for services. All families that have been referred for school district homeless services must be assessed or reassessed every year so the school district can determine homeless status for that school year and complete an assessment of student needs. The assessment gathers information about the services a student needs to attend school (e.g., transportation, supplies) and also gathers information about where the family is living and the services adults may need. During this process, the Homeless Liaison can identify a family that may be a candidate for the Collaborative program. The main qualifications are having a source of household income, being homeless according to Department of Education definitions, and experiencing a short-term economic crisis (e.g., job loss). The Liaison then completes the Collaborative referral form to the most appropriate agency.

Upon formation, the Collaborative defined the roles of each partner and developed formal MOU's that each partner signed. The program allows each partner to individually provide its own services, but depends on partners to make appropriate referrals. In turn, each partner has agreed to "prioritize" the referrals it receives from Collaborative partners—that is to, serve clients within 72 hours of referral. To ensure that partners make informed referrals, the Collaborative developed a uniform referral form that collects information on income, family composition, school of enrollment, and current housing situation. Partners have also agreed on a referral procedure. The referring partner follows-up with the partner within a day or two to check on the progress in serving the client. Agency staff believe the commitment to a common goal – families securing stable, long-term housing – and a referral system that requires accountability to partners fosters a strong sense of responsibility to clients. Case managers from each agency also meet monthly to address issues with the referral process or discuss difficult cases.

Target Population

The KidsHome Collaborative targets families that are homeless (using the Department of Education McKinney-Vento definition, which includes families that are doubled-up) and have children attending school in DeKalb County School District. The household must either have a source of income (e.g., disability benefits, employment) to help them maintain independent housing or have adult members who are able to maintain employment (e.g., have a history of working, but have lost a job). The intent is to help families who are homeless because of a short-term economic crisis and in need of temporary assistance (e.g., emergency shelter, security deposit, rent or utility arrears, first and last month's rent) to return to stable housing. Families in need of long-term supports for severe mental health or ongoing substance abuse issues would not be appropriate for the program. Intensive case management is limited to households that enter the program via an emergency shelter or transitional housing program.

The Collaborative seeks to prevent families who only need short-term assistance from being "over-served" by the system – e.g., homeless families referred to transitional housing because a slot is available when short-term rental assistance may be more appropriate. The continuum of housing services offered by the Collaborative– emergency housing, transitional housing, and rapid rehousing – provides housing options that can be targeted to families depending on their circumstance.

Human Services Offered

Each partner in the KidsHome Collaborative provides some level of human services as part of their everyday routine, and these services are available to all clients regardless of their involvement in the program.

The DeKalb County Schools Homelessness Liaison provides a variety of services intended to help maintain student attendance (e.g., enrollment assistance, bus tokens, bus transportation), to support school performance (e.g., dental, hearing, and vision care; tutoring), and to provide financial assistance for school supplies and extracurricular activities (e.g., uniforms, instrument rental fee, summer enrichment camp). In addition, the Homelessness Liaison helps connect a student's family to resources that will help them find housing assistance or other services they might need to stabilize their lives.

First Step Staffing provides employment placement and staffing services, similar to any for-profit temporary staffing agency. These services may include resume assistance, job search assistance, job coaching, and referrals to training programs, to accompany the organization's main function of temporary or temporary-to-permanent job placement services. First Step also provides public transportation subsidies (i.e., Metropolitan Atlanta Rapid Transit Authority [MARTA] cards) and helps clients purchase tools and/or uniforms that may be required for a job. In addition to helping clients prepare for and find employment, First Step Staffing helps adults with long-term disabilities apply for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits. However, few Kids Collaborative families receive these services because most clients do not have a long-term disability.

DCM provides case management for clients staying in its emergency shelter and transitional housing programs, both Collaborative clients and other participants. Each DCM program has a case manager that helps connect families to the resources they need through onsite case management at the housing program. The case manager assesses client needs, including screening for any public benefits for which the household may be eligible. The program directly provides transportation assistance (e.g., MARTA cards, gas cards) and makes referrals to partner organizations based on client needs (either within or outside of its KidsHome Collaborative partners). DCM uses a household assessment tool that identifies client barriers and then develops a household service plan to address each barrier. DCM also runs a financial management class that is mandatory for its residential clients but open to other families as well.

PCCI assists the household with the housing search process and negotiating with landlords, in addition to providing financial assistance (e.g., security deposit, first and last month's rent, utility arrears) to secure housing. By the time a family is referred to PCCI for rehousing services, they should have addressed their major barriers to maintaining permanent housing such as a steady source of income. Thus, PCCI does not provide intensive case management.

Housing Supports Offered

Among the Collaborative members, PCCI and DCM serve as the housing assistance providers for KidsHome clients. PCCI provides a range of services intended to quickly place homeless clients into permanent housing. PCCI first matches each client with a housing counselor who helps clients establish

a budget and locate affordable housing through PCCI's network of landlords. PCCI also conducts its own housing quality inspections. Once a client finds housing, PCCI provides financial assistance commensurate with each household's level of need. This could include up to three months of rental and/or utility assistance, a security deposit, and payment of utility arrears. Upon move-in, PCCI continues to follow up with clients for up to six months to make sure the family is still stably housed. PCCI usually places clients into market-rate housing with landlords who have rents that they will be able to afford without assistance once they are stabilized. The landlords are willing to accept families who may have poor credit history.

DCM operates an emergency shelter that houses clients for 30 to 90 days, as well as a transitional housing program that allows client to stay for up to 24 months. At one time, DCM provided homelessness prevention services for families who are at imminent risk of eviction, but HPRP funding for this program has been expended.

Key Partners

The KidsHome Collaborative consists of five primary partners who work together on housing, employment, and schooling issues to stabilize families and help them regain their independence.

1. *Project Community Connections, Inc. (PCCI)* – PCCI serves as the lead agency for the Collaborative and has two functions: (1) to provide rapid re-housing services to clients and (2) to act as the administrative and fundraising lead for the program. For rapid re-housing services, PCCI assists clients with housing search and negotiating with landlords, conducts housing inspections, and provides funds for security deposit, first month's rent, and utility arrears that would prevent a household from establishing utilities in a new unit. As the administrative lead, PCCI has taken a lead role in developing and distributing marketing materials, submitting grant or other applications to secure funding, and developing agreements, forms, and systems among partners. The Collaborative recognized that existing funding sources were temporary and thus made deliberate efforts to develop marketing materials that could educate the community about the program and be used as fundraising tools.

2. *Decatur Cooperative Ministry (DCM)* – DCM offers emergency and transitional shelter to clients who are not immediately ready for independent housing. It provides case management to all of its residential clients, as well as a financial management course that can be attended by other Collaborative clients.

3. *First Step Staffing* – First Step is a non-profit, employment placement agency and provides job placement assistance for clients transitioning from homelessness into independent housing.

4. *DeKalb County School System Department of Student Support Services Homeless Program* – The department provides educational support services for students who are homeless or at risk of homelessness and provides referrals to KidsHome Collaborative housing partners.

5. *DeKalb Public Education Foundation* acts as the Collaborative's fiscal agent and provided private funds for the development and printing of the program marketing materials.

The Collaborative has also worked with several other organizations to develop the program. The Collaborative works with a legal services organization to provide pro-bono assistance in designing and implementing MOUs between partners. It also works with a strategic consultant to help the Collaborative develop a logic model and establish target program outcomes. In addition, the Collaborative works closely with the DeKalb County Continuum of Care, which awarded HPRP funds to DCM and PCCI to provide rapid re-housing and homelessness prevention in DeKalb County. (DCM's homelessness prevention funds have been expended). Finally, the United Way is a new funder for the KidsHome Collaborative, recently awarding a 2-year, $125,000 grant for Collaborative activities.

Funding Streams

At present, each partner in the DeKalb KidsHome Collaborative utilizes its own resources to support its role in the program, rather than the partners sharing a pool of funds dedicated to program activities. The resources that each partner currently uses are:

- PCCI uses funding from several HUD programs, including HPRP funds to deliver Rapid Re-Housing services and McKinney-Vento Supportive Housing Program funding. In addition, PCCI receives funding from the Fulton County Department of Human Services, FEMA Emergency Food and Shelter Grant funds, as well as several small private donations. PCCI also generates some program income from a rental property it operates.

- DCM uses local Community Development Block Grant (CDBG) funding, a state Emergency Shelter Grant (ESG) grant, FEMA Emergency Food and Shelter Grant funds and a grant from the United Way. The remainder of DCM funding comes from private grants and donations, which originate from foundations, congregations, individuals, and the private business sector.

- DeKalb County Schools receives Department of Education McKinney-Vento and Title I funds. DeKalb County Schools also provides funding for transportation services for homeless students.

- First Step Staffing generates program income through a fee it charges employers who hire its clients, similar to any for-profit staffing agency. It also receives funding from local foundations and DeKalb County, as well as CDBG and ESG.

Promising Features

Collaborative: The KidsHome Collaborative emerged out of recognition that agencies serving homeless people need each other to provide a holistic, yet targeted set of services to their clients. Rather than relying on a long list of local community service organizations, Collaborative members decided to formalize their relationships with each other, creating a sense of trust among partners and comfort knowing that clients will be served appropriately and in a timely manner. Partners have signed formal MOUs, communicate often, and utilize standardized forms and procedures to ensure consistency across agencies.

Implementable: The key to implementing the KidsHome Collaborative was identifying the services that are vital to stabilizing homeless families and then building partnerships among organizations that

provide those services.   Because most communities have organizations that provide each service component that is included in the Collaborative model (i.e., schools, employment services, shelter, rapid re-housing), forming this kind of collaborative should be possible anywhere.

Measurable: During program design, Collaborative members worked with a consultant to help them develop a logic model, including the outcomes the collaborative wanted to achieve. Though partner organizations are still working on developing a shared data management system, they are focused on the key outcomes each partner needs to track and the data each needs to collect to report on those outcomes, which include housing stability, income stability, and stable school attendance and performance.

Appendix G:
Lawrence, MA (Saunders School Apartments)

Saunders School Apartments
Lawrence, MA

Overview

The goal of the Saunders School Apartments model is to provide stable, affordable housing for families through the adaptive re-use and historic restoration of the Saunders School (a public elementary school), while assisting them in achieving self-sufficiency through education and employment. The project was spurred by a Request for Proposals from the City of Lawrence, Massachusetts to redevelop this school building in the center of town. Following redevelopment, the Saunders School Apartments now provides 16 two-bedroom units of affordable housing and supportive services for homeless families.

Peabody Properties Inc., a private housing developer, is the developer and property manager for the Saunders School Apartments project. Their long-term goal is to institutionalize the supportive housing model they developed for this site at other locations. Peabody Properties noted that in September 2010, more than 600 homeless families in Massachusetts were temporarily staying in motels with little or no support systems and believes that the cost of developing and operating the Saunders School Apartments was considerably less than providing temporary housing for a family through motel vouchers.

Linked Program Design

The Saunders School Apartments is staffed by an on-site resident service coordinator (RSC), as well as a part-time property manager (shared with another Peabody-managed building in Lawrence). The RSC is responsible for providing case management services to families. Beginning in August, the RSC will also assume the role as a "coach" for the key service provider, COMPASS for Kids. COMPASS uses the term "coach" rather than "case manager" to focus on supporting families to become more self-reliant and accountable and to move beyond a traditional role of reporting to a case manager on their progress. The RSC will assist families in fulfilling their employment and education goals, help parents identify and connect with appropriate employment and education resources, as well as support their progress in achieving their education and employment goals. The RSC's salary and time will be split 50-50 between Peabody and COMPASS. The property manager ensures that families are fulfilling the requirements of their lease and deals with any tenant issues that may arise with the families. The on-site staff is also supported by a Peabody grants and projects manager.

Applicants referred to the program complete an initial application administered by Community Teamwork (CTI) during a one-week period and are then interviewed by CTI for eligibility for Housing Choice Voucher program.   Those families determined to be eligible families are housed on a first-come, first-served basis, taking into consideration the Lawrence residency requirement.   Once a family is accepted into the Saunders School Apartments, the RSC completes an intake assessment with each family and inputs the information into the local Homeless Management Information System (HMIS). The assessment includes the basic identifiers, demographic information, and program utilization information collected from all individuals entering homeless programs. The RSC meets with each family to develop a service plan. Families must continue meeting with the RSC at least once a month, though most families

are interacting with the RSC at least weekly to monitor their progress with goals outlined in the service plan. Indeed, individual service plans will be updated as long as the family continues living at the Saunders School Apartments. The staffing level and costs for case management services may increase or decrease as goals are established and work begins on implementing family action plans.

Target Population

To be eligible for the Saunders School Apartments, a family must have been previously certified as homeless by their referral agency, generally a homeless shelter. Program applicants are screened by Community Teamwork (CTI), a regional non-profit housing agency/community action program that administers the Housing Choice Voucher Program (HCVP) under contract to the Commonwealth of Massachusetts's Department of Housing and Community Development (DHCD). Applicants for units at Saunders must pass the voucher program's eligibility requirements and a Peabody Properties' background check for recent criminal activity.   The program also requires that half of the families (at least eight households) residing in the apartments must have recently resided in Lawrence.

The first cohort of 16 families moved into the Saunders building on March 1, 2011. Currently, all of these families have a female head of household, and most are young mothers ages 20-25 with young children. Peabody advertised the program through the local Continuum of Care and the Merrimack County Homeless Coalition, as well as notices in the local newspaper.

Human Services Offered

Beginning in August 2011, COMPASS will help parents at Saunders School Apartments access affordable child care, work readiness, employment training, job-search support, educational programs, English for Speakers of Other Language (ESOL) training, and other services designed to support families in this program. COMPASS is partnering with the local community college, Northern Essex Community College, to provide college classes. Parents will have access to subsidized employment opportunities through two local employers, Little Sprouts, a local early childhood development program that has received accreditation by the National Association for the Education of Young Children (NAEYC), and Salvatore's, a conglomerate of Italian restaurants. Both Little Sprouts and Salvatore's committed to the project early on. Through their work at Roxbury Community College, COMPASS had an existing relationship with Little Sprouts. Salvatore's approached Peabody during the planning phase of Saunders School Apartments to see how they could help families enrolled in the program. COMPASS is also working with the Notre Dame Education Center in Lawrence to provide GED and ESOL classes for program participants and intends to offer soft skills and computer literacy training to program participants. Parents will be expected to complete 30 hours of employment training or education each week.

The Little Sprouts early childhood development program for children from infants through kindergarten accepts Commonwealth Childcare Vouchers for Homeless Families (child care vouchers funded with state TANF dollars) and also offers scholarship spots at its local sites, including in Lawrence.   Some families at Saunders School Apartments already have homeless child care vouchers which they will be able to retain as long as they are income-eligible, and other eligible families will receive assistance from the RSC to apply for these vouchers or scholarships.

Housing Supports Offered

The rent subsidies for the 16 units are funded by project-based Housing Choice Vouchers administered by CTI on behalf of the state DHCD. Rents paid by the residents are no more than 30 percent of the household income or a minimum rate of $25 a month.

Key Partners

- Peabody Properties, Inc.

- COMPASS for Kids

- Little Sprouts

- Salvatore's restaurants

- Notre Dame Education Center

- Northern Essex Community College

Peabody Supportive Housing LLC, a subsidiary of Peabody Properties, Inc., developed the Saunders School Apartments and serves as its management entity. Peabody Properties was founded in 1976 and manages 10,000 units of residential housing throughout New England. Peabody's portfolio includes: state and federally assisted multi-family housing complexes, elderly/disabled housing, assisted living, historical restorations, luxury developments, and condominium management.   Peabody Resident Services, Inc. is the resident services subsidiary of Peabody Properties that is responsible for developing partnerships with community agencies and resident organizations to develop resident-driven programs that assist with successful tenancies and management.

Other key partners in the model include: COMPASS for Kids, a Lexington-based social service and education collaborative that provides educational and employment training and assistance for homeless parents and children; Little Sprouts, a local early childhood development program that has received accreditation by the National Association for the Education of Young Children (NAEYC); and Salvatore's, a conglomerate of Italian restaurants.

Funding Streams

Saunders School Apartments used a large number of funding streams that were utilized to develop and manage the project. To finance the project, Peabody Properties secured:

- Low Income Housing Tax Credits (LIHTC) allocated by the Commonwealth of Massachusetts;

- HUD Neighborhood Stabilization Funds (NSP) from the Commonwealth and the City of Lawrence;

- HUD Home Investment Partnerships Program (HOME) funds from the City of Lawrence;

- Federal and Commonwealth historic tax credits (related to historic preservation of the Saunders School); and,

- State affordable housing trust funds.

Peabody was able to leverage many of these resources based on its reputation and understanding of housing financing. By obtaining local support, they were able to more easily leverage state funding for the project.   Peabody was also able to link up with local service providers and employers based on its existing work in the community. Presenting a partnership that included housing, case management services, child care support, and employment opportunities also strengthened Peabody's proposal by demonstrating that it would be able to start the project as soon as funding was secured.

As a private developer, Peabody was able to fund the front-end planning and inspection costs for this project by using its own funds until project funding was secured. The Peabody staff noted that a non-profit developer might not have access to enough capital to fund the planning and inspection costs until project funding is secured.

The rent subsidies for the 16 units are funded by project-based Housing Choice Vouchers administered by CTI on behalf of the state DHCD. The on-site case manager is partially funded by the Homelessness Prevention and Rapid Re-Housing (HPRP) program. Services provided by COMPASS are funded through multiple Commonwealth of Massachusetts funding streams, as well as foundation funding and private fundraising efforts.   Examples of State funds supporting the program include Community Service Block Grant (CSBG) funds to pay for a portion of the supportive services, and TANF funds to provide child care vouchers for families in the program.

Promising Features

At the time of the site visit (July 2011), families had only been residing at the Saunders School Apartments for four months, and assessments and action plans were just being completed for all households. Based on experiences with other programs, such as COMPASS's program in Roxbury, Massachusetts, it is anticipated that families will remain in the program for two years.   Because the program is new, at the time of the site visit, only preliminary baseline data was available. Performance data is not expected until early 2012.

Measurable: Peabody Properties, Inc. will use its own internal management systems to measure the success of this program and will included such factors as: rent payments, maintaining housing stability, no tenant disturbance calls, avoiding eviction, using earned income as source of rent, and eventual move-out to market-rate housing.   For other affordable housing developments in its portfolio, Peabody Properties indicated that its eviction rate was lower than 5 percent, and the company believes that this low rate is due to its comprehensive resident services program. Since this project is only a few months old, measurable data is not available yet to see how long families will continue to live at Saunders School Apartments, the rate of turnover, and whether families are able to transition to market-rent housing when they move out.

Cost effective: This model includes a full-time, on-site case manager, whose salary is split 50-50 between Peabody Properties and COMPASS. The cost of having an on-site case manager for 16 families is high compared to other Peabody sites, where residents do not need intensive case management services to achieve self-sufficiency. COMPASS estimates that its annual costs are about $7,500 per household, and Peabody Properties estimates that its annual costs for supportive services per family (primarily for a portion of the on-site case manager's salary and benefits) are approximately $3,000 per household per year.

Collaborative: Supportive services on-site are coordinated by the Peabody RSC in collaboration with the COMPASS social service and education collaborative, which includes employment, education, supportive services, child care partnerships, and employment opportunities.

The funding for redevelopment and operation of the Saunders School Apartments, along with the supportive service partnerships, includes a broad base of local, state, and federal housing funding sources: Low Income Housing Tax Credits, Neighborhood Stabilization Funds, state and federal historic preservation tax credits, HOME funds, and the state housing trust fund, and the Housing Choice Voucher Program.

Implementable: According to the partners involved with this model, a key to implementing this model is building the partnership with the housing agency and the service partners early in the pre-development process. This model required a considerable investment of time and resources to address early community opposition to the plan to redevelop a de-commissioned public school into an affordable housing development serving homeless families. Without designated funding (e.g., from a foundation, or other special fund), a non-profit affordable housing developer might have difficulty carrying the predevelopment costs for this model. The Peabody staff indicated that the planning process was nearly 18 months and included considerable staff time to meet with local officials, attend hearings and neighborhood meetings, secure funds for the project, and build the supportive service partnerships.

Appendix H:
Palm Beach, FL (Adopt-A-Family of the Palm Beaches, Inc.)

Adopt-A-Family of the Palm Beaches Rapid Rehousing
Palm Beach, FL

Overview

Founded in 1983, Adopt-A-Family of the Palm Beaches, Inc. (AAF) is a multi-service agency with a mission to restore self-sufficiency and stability to families in crisis by providing access to a comprehensive package of services.   Interviewees reported that from 2007 to 2009 Palm Beach County experienced a 300 percent increase in homeless families. Emergency shelter beds and permanent supportive housing programs for homeless families reached full capacity, and the county began using hotel/motel vouchers to meet overflow demands. When the Palm Beach County Department of Housing and Community Development (the County) was granted Homelessness Prevention and Rapid Rehousing Program (HPRP) funds from the U.S. Department of Housing and Urban Development (HUD) in August 2009, it subcontracted with AAF to implement a Rapid Rehousing Program (RRH) for homeless families. The goals of the program are to limit the need for expensive hotel/motel vouchers by rehousing families within 30 days of becoming homeless and to help the families become self-sufficient and remain stably housed for a year after program exit. The RRH program pairs rental assistance with case management for 3 to 18 months, depending on how quickly a family can become economically self-sufficient. The program uses a pre-existing coalition of social service agencies to share client information and expedite referrals both from those agencies to RRH housing assistance and to those agencies for other services the families may need. AAF is no longer accepting applications for enrollment, and the HPRP funding is expected to expire around the end of calendar year 2011[42]. As of the end of July 2011, the program has served 124 families (representing 371 persons in families).

Linked Program Design

AAF's RRH program is a HUD-funded HPRP program and follows HUD's guidance and regulations concerning HPRP program eligibility, process, services, etc. The RRH program operates with a housing first philosophy that stabilizes households with the immediate provision of housing, along with supportive services to address the issues that may have led to their homelessness. Although the support can last for up to 18 months, the average length of time in the program is about seven months. The amount of assistance is based on the families' incomes and ability to sustain housing on their own. Families graduate from the program when they have enough income to sustain their own housing, when they reach an income level above 50 percent of AMI, or when they obtain an alternative housing program (i.e. VA Supportive Housing vouchers (VASH), HUD Housing Choice Vouchers (HCV), or CoC permanent supportive housing). RRH case management continues for three months after the family exits the program—that is, after the family's RRH subsidy has ended.

Homeless families are referred to RRH from one of eight "entry points": local emergency shelters or programs that administer emergency hotel/motel vouchers. Staff at these entry points have been trained to understand the program, the eligibility requirements, and the referral process. This makes the assessment and intake process run smoothly and quickly. Staff from the entry points complete an

---

[42]   AAF has predicted how much funding the current families will require to graduate from the program, and is working to help all current families become self-sustaining by the time the funding expires.

application packet that is uniform across the entry points and contains: a verification of homelessness, releases of information, authorization of informed consent, and a signed (by the family) agreement/ understanding of the rules and regulations of the RRH Program. They also complete an RRH Assessment tool with the family; it includes information about the family members; housing barriers and housing history; financial information and employment history; identification paperwork; and substance abuse, mental health and legal histories.

Within 24 hours of referral, the RRH Program Manager contacts the family and schedules an interview that takes place within a week. The program manager will verify the information on the application and confirm each family's eligibility. If the family is found eligible, the program manager accepts it into the program and assigns an RRH case manager. Families are typically served on a first-come-first-served basis; however the program is currently not accepting new families and is not maintaining a waiting list.

Additionally, case managers use a self-sufficiency assessment matrix modeled after the Arizona self-sufficiency matrix to assess clients. (The Arizona self-sufficiency matrix was among the first standardized tools develop by localities to assess the needs of homeless individuals.) The AAF matrix was implemented in June 2009 (just before HPRP funding was announced) by all homeless programs in the CoC. It is designed to help case managers and families develop Family Action Plans that identify barriers to, and strategies for, attaining independent housing and exiting the program. To date, about 30 percent of families have been able to obtain HUD-VASH, state subsidized housing or HCV at exit. Some families—notably large families with single parents—have had difficulty finding gainful employment that will pay for housing that is appropriate for large families. The matrix and the plan are updated every three months; they measure clients' level of self-sufficiency on a spectrum, ranging from "in crisis" to "empowered". Nineteen areas of self-sufficiency are measured: housing, employment, income, food, childcare, children's education, adult education, access to health care, life skills, family/ social network, transportation, community involvement, parenting support, legal, mental health, substance abuse, safety of home environment, credit and disabilities.

Target Population

Adopt-A-Family serves homeless families with children in Palm Beach County, targeting families coming from area emergency shelters or hotels/motels used as overflow shelters. In addition to meeting HUD's definition of homelessness, all eligible families must have incomes below 50 percent of area median income (AMI) and must sign an agreement with AAF. The agreement stipulates that families will comply with the program's rules and regulations, including the requirement to meet at least monthly with a case manager and look for employment.

Human Services Offered

- Common referrals for program participants include the following:

- Legal services

- Credit counseling

- Education and employment services

- Benefits, including SNAP, Medicaid or the Children's Health Insurance Program (CHIP)

- Mental and physical health care

- Education and afterschool programs for children zero to five and in elementary school

- Links to alternative housing subsidies (e.g. VASH, HCV, state-subsidized housing, CoC permanent supportive housing)

The majority of families who enter the RRH program are already linked to SNAP and to Medicaid or the CHIP program for children's healthcare; AAF estimates that about 10 percent of RRH families are linked to those benefits after they enter the program.

Housing Supports Offered

Case managers use the information from the assessment tool to help families identify where they want to live, what kind of housing is appropriate (i.e. size, single-family, apartment, etc.), and how much they can be expected to pay for rent once they leave the program. An RRH Housing Specialist helps families identify housing which suits their needs and lifestyle. The specialist provides a list of landlords who are willing to accept RRH tenants (including those with credit, eviction and/or criminal histories) and sign a rental agreement with AAF. Per HUD HPRP rules, the housing units also have to be "rent reasonable" and pass HUD habitability standards. When possible, families are referred to "affordable" tax credit apartments identified by the Florida Housing Coalition. Families have the option of using the Housing Specialist list or finding housing on their own; many families already know, for instance, which school district and neighborhood they prefer. This process can take 30 days or more, especially for single mothers with several children.

Once the family selects a unit, the Housing Specialist conducts an inspection to verify the habitability of the apartment, looking specifically for problems with fire safety, security, electricity, sanitation and whether the space is adequate for the family. While clients sign their own leases with landlords, AAF pays the security deposit and first month's rent, with the intent that the family will continue to pay its own rent when it becomes self-sufficient. Landlords also sign an agreement with AAF that outlines the landlord's responsibilities as well as the amount and duration of rental assistance.

Key Partners

Partner	Role
Adopt-A-Family	• Lead agency and direct service provider • HPRP subgrantee
P.B. County Dept of Housing & Community Development	• HPRP grantee and contractor • Monitor program • Planning, coordination and resource development • CoC lead entity
Center for Family Services	• Shelter provider (largest referral source) • Direct service provider (mental health services)
CredAbility	• Direct service provider (credit counseling and classes)
Legal Aid Society	• Direct service provider (legal services)
Lord's Place	• Shelter provider (referral source) • Job readiness and employment services

Partner	Role
United Way of Palm Beach County	• Funder • Convener
Veterans Administration	• Housing voucher provider • Referral source (homeless veterans and their families who are waiting on VASH vouchers)
YWCA of Palm Beach County	• Childcare vouchers • Children's programs

Funding Streams

The bulk of funding for RRH comes from a 3-year federal stimulus program: HUD's HPRP funds. This funding went to the Palm Beach County Department of Housing and Community Development, which contracts with AAF to provide the RRH program for homeless families. HPRP pays for rental and utility assistance, 2 full-time equivalent RRH case managers, and the RRH Program Manager. Local community foundations pay for the Housing Resource Specialist, and the United Way pays for program administrative costs such as AAF's Deputy Director, who provides oversight and the financial officer who tracks program costs. The program costs about $1 million per annually.

The United Way also funds many of the participating service providers (including the Legal Aid Society, CredAbility, YWCA, and the Center for Family Services) and the staff person at the Family Empowerment Coalition.

Palm Beach County ad valorem property taxes, funded through a referendum to create special taxing districts for general funding of nonprofits are distributed by a citizen advisory group and pay for many of the supportive services accessed by RRH participants.

Promising Features

Measurable: This program enters quarterly performance data into a shared HMIS database that is currently unable to produce electronic reports about program performance and client outcomes. In lieu of that, the County has developed a performance data excel spreadsheet that AAF completes by hand; the County uses the spreadsheet to complete HUD-required Quarterly Performance Reports. These reports track family outcomes related to housing stability and income growth, the reduction in the use of hotel/motel vouchers and emergency shelter beds, and the average length of time families live in those temporary settings.

Collaborative: This program is a product of a collaborative planning and resource development approach led by the Palm Beach County Department of Housing and Community Development and the United Way of Palm Beach County. They utilize agreements and common intake and assessment tools from referral and service providers active in the 11-agency Family Empowerment Coalition and they have formed a working partnership with the Veterans Administration that includes cross-referral and sharing of data.

Replicable: The program uses tools, agreements, policies and procedures, and other materials that are very well documented and easily replicated. The use of a program manager, case managers and a

housing specialist is fairly standard for an HPRP RRH program and has been replicated in many communities. While the service partnerships may involve a different constellation of organizations within other communities, the use of collaborative partnership and referral agreements are also replicable.

Sustainable: The program was developed with the theory that rapid rehousing would be a better and less expensive fit for homeless families than the use of hotel/motel vouchers, but AAF has not yet done a cost analysis. Palm Beach County and AAF are hopeful that they can sustain the program with the following funding sources: HUD Emergency Solutions Grant; County ad valorem taxes; United Way; private foundations; and organizational fundraising.

Appendix I:
Pittsburgh, PA (Community Wellness Project)

Allegheny County Community Wellness Project
Pittsburgh, PA

Overview

The Community Wellness Project of Allegheny County, Pennsylvania (the "Project"), which includes the City of Pittsburgh, is run by the Allegheny County Department of Human Services (ACDHS). ACDHS also leads the local CoC. The Project links homeless and formerly homeless families and individuals with a disability who are residing in HUD-funded transitional housing (TH) or permanent supportive housing (PSH) programs with employment, training and social service benefits.

Linked Program Design

The Project was born out of an earlier collaboration Duquesne University's Occupational Therapy (OT) Department and the ACDHS. In the earlier program, ACDHS hired an intern from Duquesne to apply Occupational Therapy approaches to homeless clients, with the goal of increasing their self-sufficiency. An occupational therapist is now the full time Project Specialist who continues this work and has expanded the linkages to an array of housing and supportive services, such as employment, training, and social service benefits (e.g. child care subsidies, "dress for success" clothing, transportation assistance and budgeting help). The Department's philosophy of working to improve the occupational functionality and productivity of people "most in need" permeates the work of the Project.

The Project Specialist trains direct service staff (usually case managers) located in housing programs to include income and employment goals in participants' individual housing plans and then offers practical suggestions (including mainstream benefits for which a client may be eligible), worksheets, assessment tools, and resource information. In some cases, OT interns are placed with the program to provide supplemental OT case management focusing on employment and training goals. Housing staff are also trained in using the SOAR model, a method of streamlining the application process to SSI/SSDI benefits.

The Project also has a comprehensive data-capture tool that improves the client application process and allows for data analysis. An ACDHS-run Data Warehouse links client and program-level data from homeless assistance programs, HUD McKinney-Vento housing programs, PA-EARN (TANF), CareerLink (a Workforce Investment Act One-Stop program) and participating behavioral healthcare programs. The integrated data warehouse is a unique approach to sharing data and has resulted in several important benefits: streamlining the application processes for homeless families and individuals, and improving the capacity of stakeholders to analyze client, program and system level outcomes. It is a good example of how data can inform program interventions.

Target Population

This program targets homeless families and individuals who are already living in housing provided by an Allegheny County SHP Network[43] housing program: either Transitional Housing (TH) or Permanent Supportive Housing (PSH).

Within the resident population of Allegheny County TH programs, the Community Wellness Project targets homeless families with the following characteristics:

- A history of employment and a demonstrated willingness to obtain employment or seek additional training; and

- A likelihood of a successful move to independent housing within 6-12 months.

Among residents of the Allegheny County PSH programs, the Community Wellness Project targets homeless families with a different set of characteristics:

- Families in which one of the adult members has a permanent disability that prevents the person from being able to support himself or herself and their family in independent living;

- Families unable to work consistently at a sustainable wage level; and

- Families that require long-term support and structure (at least 7 months) from program staff.

Human Services Offered

Housing case managers located in TH and PSH programs are trained by the Project Specialist to help clients identify employment and training goals to include in their individual housing plans. Participants are assessed for their areas of interest, using the U.S. Department of Labor Employment and Training Administration's "O*NET Interest Profiler." O*NET is a self-assessment tool that helps clients match their interests and skills with particular types of work activities and occupations. Participants are also scored on the PA Self-Sufficiency Index to determine areas for capacity building. The PA Self-Sufficiency Index helps match incomes to the cost of basic necessities such as housing and utilities. This tool is used to help clients understand what they need in terms of income and benefits to become self-sufficient. Participants are then linked to the following human services, depending on their eligibility and their individual goals, interests and levels of self-sufficiency:

- PA-EARN (TANF), SSI, SSDI, Medicaid, and Medicare;

- Employment services, such as job search skills, job coaching, resume building, training in how to utilize WIA One-Stop centers, job interviewing skills, job development; and

- Education and Training programs.

---

[43] The Allegheny County SHP Network is run by the CoC Housing Program Administrator and includes all transitional and permanent supportive housing funded by HUD through the McKinney-Vento Act. There are currently 857 units of housing; about 42 percent are occupied by homeless families, totaling 360 homeless families across all agencies.

Housing Supports Offered

The clients of the Project are existing tenants of TH and PSH. TH provides rental assistance for up to 24 months, along with case management aimed at readying families and individuals to move into independent housing. PSH provides subsidized housing (normally charging no more than 30 percent of adjusted income) and case management for as long as the client remains in the program (it is not time-limited). Case management in PSH is aimed at helping families and individuals remain in stable housing for as long as possible.

Key Partners

- Housing Providers: Members of HUD SHP Network (65 programs in 43 agencies across the county);

- Employment Service Providers: Nonprofit employment programs, Education and Training programs, PA Office of Vocational Rehabilitation, Workforce Investment Act One-Stop (CareerLink);

- Leadership: ACDHS, Duquesne University; and

- Income Resources: EARN Supervisor, SSI/SSDI Outreach, Access and Recovery (SOAR) Coordinator

Funding Streams

Housing	Services	Program Staff/Admin
• HUD McKinney-Vento programs • PA HAP[44] • Private Foundations • Local Housing Trust Fund (funded through deed transfer fees)	• ACDHS: Children & Youth Funds • ACDHS: PA-EARN • Workforce Investment Act • PA Behavioral Health funds • Medicaid	• HUD Continuum of Care Administrative Dollars

Promising Features

Collaborative: The ACDHS has a strong focus on collaboration, data-driven planning and documentation of processes. They are also the lead agency for the CoC, so the Project Specialist is able to work in tandem with the CoC Housing Program Administer (and lead CoC planner), as well as with other ACDHS staff. The support of the Duquesne University Department of Occupational Therapy, which trains and places OT student interns with the Project and serves on the Employment and Training Advisory Board. The Training Advisory Board isa collaborative working group that meets monthly to coordinate supportive services linkage and address mainstream service access and utilization issues among SHP populations. The Specialist recruits members, invites resource presenters and organizes meetings and notes.

---

[44] According to Project staff, these are "state-allocated funds used across 5 service categories (emergency shelter, bridge housing, rental assistance, case management, innovative housing). They can be used to pay for, personnel, operating, equipment costs, client-related costs, etc."

Measurable: Participation in and access to a cross-program, multiple-system Data Warehouse that provides the means to analyze client, program and system level outcomes. The Community Wellness Project has begun analyzing outcome data on a quarterly basis.

Appendix J:
Portland, OR
(Bridges to Housing)

Bridges to Housing
Portland, OR

Overview

Bridges to Housing is a regional initiative facilitated by Neighborhood Partnerships, a regional non-profit based in Portland, Oregon that addresses the housing and economic development needs of low-income people. Bridges to Housing serves high need, homeless families in Multnomah (includes the city of Portland), Washington, and Clackamas Counties in Oregon, and Clark County (includes the city of Vancouver) in Washington. The program's goal is to provide permanent housing and intensive case management services to stabilize families, move them towards greater safety, and improve the well-being of children.

Following the success of the area's regional transportation planning efforts that led to the creation of the Tri-Met public transportation system, community leaders next wanted to focus on the issue of affordable housing. The three Oregon counties invited representatives from Clark County in Washington to join in their planning efforts since research showed that people frequently moved among the four counties looking for affordable housing; and, all four counties were trying to address the increase in the number of homeless families in their communities. A regional housing group was formed, and its planning efforts were funded by a HUD Economic Development Initiative (EDI) grant. Facilitated by Neighborhood Partnerships, this regional housing group eventually formed the Bridges to Housing program. Its members now include elected officials from the four counties, their respective housing departments, public housing agencies, development commissions, and unaffiliated community leaders.

Neighborhood Partnerships received about $20 million in philanthropic funding from the Bill and Melinda Gates Foundation, the Paul G. Allen Family Foundation, and the Meyer Memorial Trust to implement the Bridges to Housing program and provide funding for program facilitation, training, technical assistance, case management, and evaluation services. The Bridges to Housing Program funneled funding to the four participating counties to help implement their programs.

Linked Program Design

The Bridges to Housing program offers permanent supportive housing and intensive case management to enrolled families. Initially case management services were offered for a two-year period; however, the time period was recently extended to three years based on requests from the four county governments. The additional time was requested to help stabilize families. Families are referred to the Bridges to Housing program through a network of providers. Often they are identified as eligible for the program after calling the 2-1-1 community information hotline or through community partners such as emergency shelters, the Washington State Department of Social and Health Services, the Oregon Department of Human Services, and school homelessness liaisons. Case managers throughout the Bridges to Housing program have a 1:15 case manager to family ratio. The ratio is low so that all families can build a relationship with their case manager, who will assist families with developing and implementing their action plan to become self-sufficient and address their children's needs.

A common screening tool, the "Bridges to Housing Family Needs Assessment" is used by all case managers to identify whether families are "high resource users" and eligible for the program. The common assessment tool includes indicators such as length and number of times a family has been homeless; employment history; household income; interactions with state mental health systems; domestic violence history; and interactions with child welfare agencies. The maximum score on the assessment tool is 25 points, and Bridges to Housing requires at least a total of 10 points for families to be eligible to participate in the program. Currently, the average score of families at intake is 14 points, although some families have scored as high as 22 points. In addition to a common screening tool, the four counties also use common intake and assessment tools that were developed by the program staff and the case managers.

In Clackamas County, Oregon, families are enrolled through the county Social Services Department. The family completes the screening tool and then the Social Services Department determines which families are eligible for the program. Families who are deemed ineligible are notified via mail. The County has established a preference on its Section 8 waiting list for families in the Bridges to Housing Program. Once eligibility has been established, the County works with families to find housing as quickly as possible. Case managers work with families to develop an action plan and identify goals to achieve self-sufficiency. They then meet with families weekly to review their progress and set new goals if necessary. The case managers also work with the children in the family and their schools.

In Multnomah County, families are enrolled through four non-profit agencies, Central City Concern, Human Solutions, Impact Northwest, and Catholic Charities. The four non-profits administer a total of 140 units for homeless families: 110 project-based vouchers, 25 public housing units and five tax credit housing units. The vouchers and the housing units are from the Housing Authority of Portland (HAP). The 110 project-based units administered by the agencies are located throughout Multnomah County. Twenty public housing units and five tax-credit housing units are located in one of HAP's HOPE VI mixed-income communities in the city of Portland. The other five public housing units are located in scattered site housing in Portland. There is a central waitlist within the county. When a family's name comes up on the waitlist, it is contacted by whichever agency has a unit available. Case managers from that non-profit agency will help clients with housing authority applications and prepare appeals if necessary. Once families are housed, case managers follow up weekly or bi-weekly with them.

In Washington County, Oregon, families are enrolled through the local Community Action Program that is part of county government. Families receive a permanent subsidy through a Section 8 voucher for scattered site housing. At the time of the site visit in July 2011, 33 families had completed the Washington County Bridges to Housing program, and 13 were currently enrolled in the program.

In Clark County, Washington, families are enrolled in the Bridges to Housing program through Share ASPIRE (Achieving Self-Sufficiency Personal Improvement and Resource Education), a program of the non-profit organization Share of Vancouver, Washington. Share ASPIRE is a coordinated system for providing case management, housing, and connections to supportive services for homeless families and individuals in Vancouver and Clark County, Washington. Families are assessed using the common assessment tool and then case managers present the family's information to a county committee which scores the family's eligibility. The family's housing eligibility must also be approved by the Vancouver Housing Authority (VHA). Participants in the program receive project-based vouchers for use in

scattered site units owned by VHA. Eligible families are typically housed within three to six weeks. After the family moves in, the case manager follows up by completing the common intake tool and working with the family to create an action plan with self-sufficiency goals. The county has the capacity to serve 30 families through the Bridges to Housing program at one time. To date, 45 families have graduated from the program.

Target Population

Bridges to Housing was developed to serve a specific segment of high-needs homeless families. The program targets families who face multiple barriers to stability and are chronically homeless. Many of the families have had multiple episodes of homelessness in the past and face a litany of issues: extreme poverty; unemployment; mental, behavioral, and physical health concerns; and other challenges. Nearly 30 percent of the families participating in the Bridges to Housing program had an open case with the public child welfare systems in Oregon or Washington at the time of their enrollment.

The Bridges to Housing program began in 2007. As of December 31, 2010, 359 families, including 729 children, have been served across the four counties. These figures include families who have graduated from the program and families that are currently enrolled in the program.

- Multnomah County, Oregon: 206 families

- Clark County, Washington: 76 families

- Washington County, Oregon: 42 families

- Clackamas County, Oregon: 35 families

At the time of the July 2011 site visit, there were 199 families currently enrolled in the program:

- Multnomah County, Oregon: 140 families (maximum number of enrollees)

- Clark County, Washington: 30 families (maximum number of enrollees)

- Clackamas County, Oregon: 16 families (no maximum number of enrollees per county)

- Washington County, Oregon: 13 families (no maximum number of enrollees per county)

Preliminary evaluation data prepared by Portland State University in May 2011 showed that 81 percent of the enrolled families at that time were female single-parent households; 14 percent were two-parent households; and four percent were father-only households. At intake, 74 percent of the families had one or two children; 23 percent had three to four children; and 3 percent had five or more children.

Human Services Offered

Bridges to Housing is designed to ensure that there is continuing interaction among case managers to share information and resources, and identify training needs. Partner agencies can use flexible funds, up to $1,700 per family per year, to help pay for rent, furniture, housekeeping and cleaning services, documentation (e.g., birth certificates), after-school programs, tutoring, health care not covered through other sources, and services that will help families achieve their goals (e.g., job training). These "flex funds" are disbursed at the discretion of case managers. Based on discussions with the individual

counties and the case managers, it did not appear that social service agencies gave a priority preference to families participating in the Bridges to Housing program. The case managers indicated that the services utilized by each family are based on their individual needs and not a standardized menu of services provided by designated agencies.

Housing Supports Offered

Financial support for housing assistance varies by county and also by a family's eligibility for different housing programs. The types of housing supports include: public housing units and Housing Choice Voucher Program (HCVP) vouchers administered by local housing authorities; tax credit units administered by a local housing authority; and rental assistance using state housing assistance and McKinney-Vento funds. Initially, the Bridges to Housing program included case management services for two years; however, based on their experiences with families, Bridges to Housing granted the counties' request that services be extended for three years. For families who receive HCVP vouchers, these vouchers are not time-limited and are active for as long as the family is income-eligible and meet other HUD eligibility requirements. There are also no time limitations for families in public housing or tax-credit units as long as they continue to meet eligibility requirements for their unit.

Key Partners

- Neighborhood Partnerships

- Washington State Department of Social and Health Services

- Oregon Department of Human Services

- Multnomah, Clackamas, and Washington Counties, OR; Clark County, WA

- City of Portland, OR and City of Vancouver, WA

- Housing Authority of Portland (HAP)

- Central City Concern, Human Solutions, Impact Northwest, and Catholic Charities

- Share ASPIRE

Funding Streams

As previously mentioned, Bridges to Housing was funded through private philanthropic grants from the Bill and Melinda Gates Foundation, the Paul G. Allen Family Foundation, and Meyer Memorial Trust, totaling about $20 million. This funding for program facilitation, supportive services, training, technical assistance, and evaluation services is coming to an end in 2011. The three foundations have notified Bridges to Housing that their funding was for start-up costs only and that the foundations will not be providing on-going funding for Bridges to Housing. For the remainder of this year, each of the participating counties is contributing funds to Neighborhood Partnerships to continue its facilitation and training activities for Bridges to Housing. At this time, no additional funds are forthcoming to continue the external evaluation by Portland State University. Neighborhood Partnerships is currently seeking additional public and private funding to continue its facilitation role with Bridges to Housing. Staff

stated that facilitation costs and maintaining funding for intensive case management services and ongoing housing supports are the main challenges confronting the program.

Promising Features

Collaboration: Bridges to Housing utilizes a 24-member Regional Steering Committee comprised of elected officials, and community leaders from the four counties, along with other "neutral" members who do not represent the needs of a specific county. This steering committee was designed to foster the vision and mission of the program, and made initial decisions about how the foundation funding was to be allocated to each of the counties. There is also a Coordinator Committee including program representatives from the four counties that meets quarterly to discuss programmatic needs. Each of the four counties also has its own Implementation Team that sets directions and monitors program performance for their specific county. Case managers from the four counties also meet monthly for trainings and to collaborate on addressing family needs. There is a Memorandum of Understanding (MOU) between each county and Bridges to Housing; and, in each county, there are MOUs among the county government, the public housing authority(ies) and their state's lead social service agency (Department of Human Services in Oregon, and the Department of Social and Health Services in Washington).

Measurable: Case managers in the four counties all use the same intake, assessment, and reporting tools so that individual and program performance can be measured for the entire Bridges to Housing Program. The case management tools were developed by the case managers from the four counties.

Neighborhood Partnerships has retained the services of Portland State University's (PSU) Regional Research for Human Services to do annual evaluations of the Bridges to Housing program. PSU uses HMIS data, interviews with heads of households, case manager reports, and key informant input to collect and analyze information about the program. "The Bridges to Housing Evaluation: 2009 Year-End Report" was published in April 2010. A report for 2011 is expected to be available in early 2012. Evaluation services were funded through the original funding from the three philanthropic funders (Gates, Allen, Meyer); this funding will all be expended by the end of 2011 and it is unknown if additional funding will be available for future evaluation efforts.

Cost effective: Bridges to Housing believes that its combination of housing supports and support services provides a less expensive and more effective long-term solution to address chronic homelessness compared to other alternatives such as shelters, motel vouchers, and other temporary, very short-time housing assistance because of the program's emphasis on also addressing self-sufficiency, family stabilization, and the needs of children. With philanthropic funding, Bridges to Housing has also been able to provide technical assistance, training, evaluation services, and facilitation services that would otherwise have to be duplicated on a county-by-county basis.

Appendix K:
(State of) Maine (Family Housing Stabilization Program)

Family Housing Stabilization Program
State of Maine

Overview

The Family Housing Stabilization Program (FHSP) was a joint effort between Maine's Department of Health and Human Services (DHHS) and the Maine State Housing Authority (MaineHousing). The goal of the FHSP was to stabilize TANF-eligible families at imminent risk of homelessness by linking TANF-funded financial assistance with Homelessness Prevention and Rapid Rehousing (HPRP) financial assistance, which includes rental assistance, other housing-related services, and case management. The FHSP provides prevention assistance to families in order to keep them in their homes, but some families may be relocated to more affordable housing if their current living situation is not sustainable. A few families who became homeless were rehoused through this program. The program is no longer operational due to funding constraints (explained below).

The FHSP served a broader band of the at-risk population than the State of Maine was able to serve using HPRP funds alone. Discussed in more detail below, FHSP funds were often used for homeowners at risk of homelessness. FHSP funds were used for mortgage assistance, for the purchase of items necessary to make a unit "habitable" (e.g., major kitchen appliances), and for the payment of back taxes or liens which also threatened many low income homeowners in the state. None of these uses were allowable under the HPRP program.

Linked Program Design

The FHSP capitalized on the infrastructure developed for the HPRP program. The TANF Emergency Funds were distributed to all agencies administering HPRP. The State of Maine has three HPRP grantees representing three separate entitlement areas: State of Maine, City of Portland, and Cumberland County. All three grantees and their subgrantees coordinated to launch the FHSP. In total, 13 community-based agencies across the state were directly involved in the implementation of the FHSP. Families who accessed services at any of the 13 agencies were screened and assessed for the FHSP by Housing Stability Specialists working for the HPRP program. If the family qualified for the FHSP, those funds were used either alone or in tandem with HPRP funds depending on a household's unique needs.

The Housing Stability Specialists helped the family through an application and assessment process and determined whether the family qualified for the program. The specialist transmitted the application to the central DHHS office where three DHHS workers, focusing specifically on this program, processed the application. Each household could access one-time FHSP financial assistance up to $2,500. These funds were used by homeowners to pay mortgage or back taxes, for major appliances, security deposits, arrears, rent, utility payments, liens, plumbing or electric service needs, home repair, and expenses necessary to sustain housing (e.g. heating system, septic system, or wells), credit counseling, or other housing stabilization services. These funds could also be supplemented with HPRP funds if the one-time need was greater than $2,500.

**Linking Human Services and Housing Assistance for
Homeless Families and Families at Risk of Homelessness**
Task Order #: HHSP23337006T

Target Population

Families in the program must be TANF-eligible, have a child under the age of 21, and be at imminent risk of homelessness. The following criteria were used to define those families who were at-risk and program eligible:

- Has either been evicted or received an eviction notice with respect to a private dwelling;

- Homeowner who has been served a foreclosure notice by the court;

- Living in a doubled up situation that is not sustainable or that is coming to an end;

- Discharge within two weeks from an institution at which the person has been a resident for at least 180 days; or

- Living in owned or rented housing that is not fit for human habitation.

In total, there were 203 households served through the FHSP between February and September of 2010.

Human Services Offered

Families received case management services from the HPRP subgrantees. Each of the 13 agencies assessing families also provided case management to families who received prevention assistance through FHSP. The case managers worked with families to develop a "Stability Plan," which is a requirement of households receiving HPRP resources. In the Stability Plan, families were required to identify barriers to housing stability, set goals, and work on household budgeting.

Housing Supports Offered

The housing supports provided by the FHSP were primarily prevention-oriented financial assistance-- one-time payments to help families at-risk of homelessness stay in their homes. In some cases, families were relocated to more affordable housing because their current housing situation was not sustainable. In these cases, program staff would work with landlords in the community to identify a more affordable unit and would help with security deposits, rent assistance, and utilities. In some cases, families living in shelters were rapidly re-housed using this funding source.

The focus of the FHSP was housing stabilization, providing other types of supportive services only when necessary to stabilize a family in their home. The TANF Emergency Funds were more flexible than the HPRP funds, allowing program staff to provide additional services. For example, these funds were used for purchase or repair major appliances, home repair, credit counseling, or legal help. If a family had needs beyond housing stabilization, they were referred or linked with other agencies in the area. These linkages, however, were not a fundamental component of the program.

Key Partners

- Maine's Department of Health and Human Services

- Maine State Housing Authority

The main collaborators in the FHSP were Maine's DHHS and MaineHousing. HPRP subgrantees provided case management services which occasionally led to outside referrals, but the main focus of the program was on linking TANF and HPRP funds.

Funding Streams

The funding used for this program is a combination of TANF-Emergency Contingency Funds and HPRP funds.

Promising Features

Collaborative: The FHSP model was a notable (albeit short-lived) collaborative effort to leverage resources and provide adequate assistance to families at imminent risk of becoming homeless. The program brought together TANF Emergency Funds with HUD HPRP funds. While TANF funds were used to support the program, HPRP staff did the "on-the-ground" work, assessing families and making an eligibility determination that was then sent to and approved by DHHS workers.

Measurable: All information was entered into communities' Homeless Management Information System (HMIS) by the 13 subgrantees that assessed and worked with families. MaineHousing is the statewide HMIS administrator, and is able to identify how many services families utilized from FHSP, from HPRP and whether they became homeless after accessing prevention assistance. Indeed, although final data analysis is still in process, MaineHousing reports that recidivism rates (rates of shelter entries following prevention assistance) were quite low compared to other HPRP families that did not receive additional TANF-funded assistance.

Implementable: Because the FHSP used a program framework already in existence, the implementation was not a challenge. The program essentially used a more flexible funding source to increase its ability to implement a program already in place. Once the funding was secured, MaineHousing was able to implement the program immediately.

Appendix L:
(State of) Minnesota (Hearth Connection)

Hearth Connection
State of Minnesota

Overview

The broad objective of the Hearth Connection program is to end long-term homelessness through the provision of permanent supportive housing (PSH). In pursuit of this objective, Hearth Connection serves as an intermediary between a diverse set of funding streams and direct service providers who operate PSH programs. In its role as intermediary, Hearth Connection secures, distributes, and leverages government funds for housing and services and works with an extensive network of 28 supportive housing providers. These providers help clients to access scattered site housing units from private landlords, and offer an array of supportive services focused on housing retention, family stability, improved physical and behavioral health status, and self-sufficiency.

The Hearth Connection program was developed in the early 1990s when planners and CoC stakeholders in Minnesota sought to address the high costs of providing emergency health care and service-intensive interventions to the area's long-term homeless population. Local leaders developed the MN Supportive Housing and Managed Care Pilot, operated by Hearth Connection, to implement a more cost-effective strategy for serving the long term homeless. The pilot was incorporated in 1999 and was first awarded funding in 2000. Currently, the program's maximum capacity at any one time is 1,165 people (including about 240 families served per year).

The Hearth Connection program is based on the core philosophies of harm reduction and housing first in order to help stabilize clients' lives and achieve housing stability. Harm reduction focuses on first reducing the harmful consequences associated with substance abuse or other high risk activities rather than forcing a client to immediately discontinue use or engagement. Housing first focuses on getting a homeless client into permanent and independent housing as a first step in addressing other issues that may have led to homelessness. This program is committed to long-term engagement with clients, regardless of tenancy disruptions that may result in evictions, arrest, or other loss of housing. Hearth Connection providers do not terminate a participant family involuntarily unless the family exhibits extreme behavior such as physically abusive or life threatening behavior.

Linked Program Design

The program sees itself as a "services program with a housing component." All 28 service partners provide both housing and case management services. Upon enrollment clients are matched with a case manager who immediately begins to address the client's most critical health, housing, and self-sufficiency needs. One of the first steps however is to identify a housing unit that will appropriately accommodate the client and help them move into that unit. The length of time it takes a client to find and move into housing varies by client, but usually takes between one and six months.

Once a client is housed, program staff help him/her to connect with the resources and supports necessary to maintain housing (e.g., transportation, household needs, school enrollment). In providing services to clients experiencing long-term homelessness, Hearth Connection providers try to identify the specific barriers that led to the client's history of long term homelessness and address those barriers so

that their housing instability doesn't continue in the future. It is up to the assigned case manager to determine what services they need. The program tries not to proscribe the process required for each client as much as focus on the key outcomes (e.g., housing stability).

One of the greatest challenges to linking human services and housing supports has been getting the service and housing dollars to match so that both are available at the same time for each client that enrolls. If the program has too much of one type of funding, it cannot provide supportive housing with a balanced level of case management and rental assistance.

Target Population

Hearth Connection focuses on three household types—families, singles, and unaccompanied youth— who have experienced long-term homelessness, defined as experiencing one year of continuous homelessness or four episodes of homelessness in three years. In addition, the program seeks to enroll the "hardest to serve" – or those who have failed out of all other homeless assistance, mental health, and/or substance abuse programs. As long as a potential client meets the long-term homeless definition they are eligible for the program; no issue excludes them from entering the program (e.g., legal, housing history, credit, and criminal activity). When the program has an opening, Hearth Connection administrators consider two key factors for selection of the next client: social isolation (i.e., no connection with family or community support) and the presence of multiple disabilities.

Because the Hearth Connection housing model is permanent supportive housing, units do not "turn over" frequently. Hearth Connection staff estimate that new openings are available across the state, on average, one or two times per month. The program relies on community partners (e.g., emergency shelters, drop-in centers, street outreach) to refer clients to the program. Each time the program has an opening, community stakeholders (usually a team of county workers, shelter advocates, and/or child protection advocates) get together and talk about whom among their nominations is most in need of services at that time. The referring agency must verify client eligibility and provide a signed statement that attests to the client's history of long-term homelessness.

Human Services Offered

Partner agencies provide intensive case management focused on identifying the barriers that lead to a client's long-term homelessness and addressing those barriers to help the client achieve stable housing. While the delivery of services varies at each partner organization, the case management team typically includes a family advocate, a housing specialist, an educational support specialist for children, and/or a mental health counselor. Providers often work with local organizations to help clients secure additional support and resources, such as food banks, churches, mentoring programs, and utility assistance programs

One unique feature of the Hearth Connection model is that services are expected to be ongoing as the severity of its clients' issues make them vulnerable to cycling in and out of homelessness. As a result, the Hearth Connection program focuses more on maintaining client stability than on "graduation". The program has recently focused on trying to "step down" services as some participants are getting to the point that they no longer need the same intensity or duration of services (e.g., approaching housing stability). For example, weekly case management meetings might be cut back to monthly meetings with

a case manager, or the receipt of a housing subsidy without the case management. Even so, Hearth Connection works to make sure clients know that they can participate in services as long as needed. The program's ultimate goal is for participants to improve their lives and never return to homelessness and the program is designed to provide services as long as they are needed. Given that many participants have experienced limited external support in their lives, there is a constant discussion about when the need for support services is truly gone.

Housing Supports Offered

The Hearth Connection program provides rental assistance that subsidizes housing such that a client pays no more than 30 percent of his or her income toward housing. Staff verify a client's household income every three months in order to confirm that the amount of the housing subsidy is accurate. In addition, housing providers assist clients to locate housing units and negotiate rental agreement with landlords as needed. Once a client signs a lease they are subject to all applicable MN tenant laws. The provision of additional housing support varies by providers. For example, some providers conduct landlord outreach and track their contacts in a database, while others help clients with furnishing their units or provide a stipend for purchasing household items.

Key Partners

Hearth Connection is a nonprofit organization that acts as an intermediary between government and local nonprofit service providers to end homelessness in Minnesota. Hearth Connection acts as the administrator for three multi-county collaboratives, and manages all tasks associated with integrating a variety of sources of housing and services funding so that providers can focus entirely on serving clients. Each of the three regional collaboratives that Hearth Connection manages is inclusive of independent CoC planning groups, county governments, and tribal bands. These different political and planning jurisdictions all send referrals to Hearth Connection through their various shelter, outreach and service centers and partners. The service partners that make up each collaborative are listed below:

1. Metro Regional Long-Term Homeless Project: Seven counties making up the Twin Cities metropolitan area have a collaborative agreement to operate a metro-wide long-term homeless project (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington). PSH providers in this regional collaborative include:

   - American Indian Community Development Corporation
   - Cabrini Partnership
   - Emma Norton Services
   - EMERGE Villages
   - Guild Incorporated
   - Lutheran Social Service
   - Mental Health Resources, Inc.
   - New Foundations
   - People Incorporated RS Eden
   - Simpson Housing Services
   - Spectrum Community Mental Health

- St. Stephen's Human Services
  - Wilder Foundation
  - YouthLink

2. <u>Northeastern Regional Long-Term Homeless Project:</u> Seven counties (Atkin, Carlton, Cook, Itasca, Koochiching, Lake and St Louis) and three tribal bands of the Minnesota Chippewa Tribe (Bois Forte, Fond du Lac and Grand Portage) have a collaborative agreement to operate a project focused on Native Americans experiencing long-term homelessness in Northeastern Minnesota. PSH providers in this regional collaborative include:

- American Indian Community Housing Organization
- Bois Forte Human Services
- Carlton County Human Services
- Center City Housing
- Churches United in Ministry
- Fond du Lac Human Services
- Human Development Center
- Life House
- Range Mental Health Center
- Salvation Army

3. <u>Southern Regional Long-Term Homeless Project:</u> Twelve counties collaborate to operate a long-term homeless project across South Central and Southeastern Minnesota. PSH providers in this regional collaborative include:

- Blue Earth County Human Services
- South Central Human Relations Center
- Zumbro Valley Mental Health Center

Funding Streams

Hearth Connection developed an innovative funding structure for the model that combines federal, state, and county funds to provide case management and rental assistance. One of the unique features of this model is that Hearth Connection alleviates the burden on service providers by assembling and managing multiple funding streams so that providers receive only one pool of money with which to carry out all activities. In addition, Hearth Connection has strategically aligned its funding so that one source is used as leverage for other sources. For example, federal funds leverage local county resources; county resources are used to augment the Medicaid income; and state funds are used as a bridge housing subsidy while a permanent subsidy through the local public housing authority is accessed.

A majority of the program's funds comes from the State. The primary funding source is a grant from the MN Department of Human Services, the Long-Term Supportive Services Fund (LTSSF).   The state passed legislation in 2001 to add the LTSSF to the state's budget in the amount of $10 million every two years. The funds are allocated through five multi-county collaboratives, of which Hearth Connection manages

three. LTSSF monies generally fund case management and provide flexible funds for housing-related needs (e.g., deposit, first month rent, furniture, etc.). In some cases LTSSF funds can temporarily contribute to a client's housing assistance if that client is waiting for a permanent voucher from the local housing authority. In addition to the LTSSF, the state has an established housing trust fund that pays a portion of the rental assistance provided to clients.

Hearth Connection's funding also includes a number of federal funding sources to supplement the state funding described above. The program uses Department of Housing and Urban Development (HUD) Shelter Plus Care and Supportive Housing Program funds to provide rental assistance. The program also uses Medicaid funds from the Department of Health and Human Services to pay for case management services. That funding is made possible by Minnesota's Medicaid waiver that expands the list of reimbursable services to include targeted medically necessary case management. Hearth Connection meets the match requirement for its Medicaid funding with funds from the state LTSSF allocation. The program also uses funding from the Substance Abuse and Mental Health Services Administration for case management. Finally, Hearth Connection uses Department of Health and Human Services TANF funds to pay for child care and employment assistance for participants who enrolled in the original pilot program (between 2000 and 2006), and anticipates receiving some additional TANF funding in the future.

Promising Features

Measurable: The program received a Robert Wood Johnson Foundation (RWJF) grant to conduct a comparison study of how the outcomes associated with participating clients compared to those of a matched group of clients who were not enrolled in the program. They have found that the ability to demonstrate program outcomes with reliable data has made a huge difference in their leverage with key stakeholders and funders. As part of that study, Hearth Connection developed its own management information system ("co-pilot"). All of the supportive housing providers in Hearth Connection's network have access to co-pilot and case managers enter data about once a week. Hearth Connection can produce detailed dashboard outcomes reports by provider, region, or aggregated,

Hearth Connection data shows that on average, 90 percent of clients are housed within six months, 80% are housed within three months, and the remaining 10 percent take longer to house, usually because of a severe criminal record (e.g., sexual predators). Identifying the number of people/families who have successfully "graduated" or exited from the program is tricky for this program because they don't usually speak in terms of "graduation" (as previously discussed).   However, over the last year, Hearth Connection has improved its exit reason options to get a better picture its participants' situation when they leave the program.

Cost effective: Hearth Connection does not directly measure per client costs. However, the RWJF study did include an analysis of mainstream services costs of pilot and non-pilot participants and found that while the overall costs did not decrease for pilot participants, there was a shift away from higher cost emergency systems to lower cost preventative systems. Hearth Connection estimates that they serve about 1,400 annually and get about $5 million (from LTSSF only) annually. Based on these estimates, the cost per client is about $2,860, which staff estimate may be higher than other programs because of the intensity of its service delivery.

Collaborative: The model uses Hearth Connection's leadership and influence across the state to assemble key stakeholders at multiple levels of governance focused on addressing the issue of homelessness, including counties and continuums of care. Key members of these regional collaboratives assemble quarterly to review audits, caseloads, systems change strategies, etc.

Implementable: To the extent that other states or jurisdictions can secure a similar pool of flexible funding and regional collaboration, the program is replicable in other places. Though not necessary, success may depend on the ability of a community to identify an effective organization that can serve as the intermediary between funding streams and service providers.

Appendix M:
(State of) New Mexico (Linkages Program)

Linkages Program
State of New Mexico

Overview

New Mexico's Linkages Program assists homeless individuals and families with severe mental illness in transitioning into permanent housing by providing individualized case management coupled with a temporary housing subsidy. The housing subsidy functions as a "bridge" until a permanent subsidy through the Housing Choice Voucher (HCV) program is available and secured. Since its inception in 2008, the program has operated in two urban communities, Albuquerque and Santa Fe, and one rural community, Silver City. Program participants reside in scattered-site units supported by State-funded housing subsidies while receiving support services funded by Medicaid. The Linkages program is based on a Housing First approach, seeking to stabilize program participants in housing quickly, which, in turn, allows them to focus on the behavioral health issues that may have contributed to their homelessness.

Each service region in the State has access to 13 service slots available to families and individuals, for a total of 39 vouchers at a single point in time. Vouchers are available to both individuals and families; the program does not have preferences for household type and does not operate differently for singles versus families. In Albuquerque, 10 of 13 service slots are reserved for non-reservation Native Americans.

At each of the three locations, the program is implemented jointly by a support services agency and a housing administrator organization. The supportive service agency is responsible for using the State's existing Medicaid platform to provide case management, and the housing administrator assists families in locating and securing housing and transitioning clients from the state-funded housing supports to the HCV program. Each of the support service providers is a Federally Qualified Health Center that bills Medicaid for mental health and case management services that they provide directly to Linkages families. Together, these organizations provide housing and support services to aid program participants in maintaining tenancy and becoming self-sufficient.   Exhibit 1 provides an overview of the key partnership structure. Exhibit 2 provides information about other partners and their roles, which is described in more detail below.

Linked Program Design

After the basic application is completed and program eligibility is verified by case managers and the housing administrator staff, case managers with the supportive services providers complete a formal assessment. Although each provider uses its own assessment and case planning tools, all protocols include a detailed housing history, employment and income history, assessment of independent living skills, legal history, physical and behavioral health histories, and assessment of future housing barriers. After enrollment, the case manager works with the participant to develop a service plan for her/his time in the Linkages program. The service plan includes specific housing stability goals and action steps required to achieve housing goals. Service Plans may also include client-defined goals related to family stability, educational attainment, and increasing self-reliance. Service plans are updated quarterly throughout a family's enrollment in the program. After interviewing the application and reviewing the

program requirements, the case managers from the supportive services organization contact their local housing administrator to notify them of the eligible applicant to Linkages.

Staff from the housing administrator then meets with the applicant in person. First, the housing administrator staff completes a background check of each participant in the program. Linkages will not accept any individual with a:

- Conviction for sexual assault or molestation;

- Conviction of a violent crime within the past five years;

- Conviction for assault and battery with a dangerous weapon;

- Conviction for distribution or trafficking of illegal drugs; or

- Other history that indicates the likelihood for physical violence toward staff or other participants.

Once the family passes the background check, staff from the housing administrator will work with the family to verify its income and identify potential rental units. Rental units are usually identified from an existing pool of available units owned or managed by landlords who are familiar with the HCV program and who have previously rented to other Linkages or HCV clients. Case managers will also work with other landlords who are not familiar with Linkages to explain the program approach and assure landlords of the added support that enrolled families receive through the Linkages program. Enrolled families are responsible for selecting which unit to rent, typically based on family size, access to transportation, proximity to social supports, and other factors related to the family's preferences. The process of completing the entire enrollment process—from the background check to securing a rental unit—can take from several days to several weeks, depending on the specific needs and preferences of the family.

Rental units in the program must meet basically the same standards as the HCV program: the Housing Quality Standards (HQS), the Rent Reasonableness standards, and the Fair Market Rent (FMR) guidelines for the region. Upon enrollment in the Linkages program, families are simultaneously added to the HCV waiting list for their region. Currently each region does not identify special preferences for Linkages clients or other families experiencing homelessness. Prior to occupying a unit, Linkages participants must sign a Tenant Responsibility Agreement that outlines their responsibilities as a tenant in the program. Similar to HCV, participants then pay 30 percent of their income in rent, and their housing subsidy covers the remaining rent under a Housing Assistance Payment (HAP) contract between the housing administrator and the owner. The housing administrator also pays the security deposit and the first month's rent using Linkages program resources.

Households frequently stay in the program for 18-24 months, due to the long waiting lists for HCV in these areas. Participating households in Silver City have the shortest length of stay in the program, due to the higher turnover of PHA vouchers in that region. When HCV subsidies finally become available to Linkages families, the family maintains their same unit while the subsidy source transitions. Having met all the HCV program eligibility and housing standards, this transition is seamless for families. After transitioning to the HCV subsidy families continue to be eligible to receive Medicaid-funded CCSS case management services.

The Bridge program also has waiting lists at each of the three sites. Although waiting lists are routinely purged to delete those families who have been able to make other housing arrangements, each site's list contains several dozen names. Turn-over rates are very low, and Linkages partners are only able to enroll about ten new families annually across all three sites.

A successful exit from the Linkages program occurs when a household transitions to permanent housing such as a PHA voucher or—less frequently—is able to afford market-rate rent. The goal is for program participants to develop their housing management skills that include paying rent on time and interacting successfully with landlords and neighbors. Participants are also considered successful when they are able to identify and nurture natural support systems for themselves such as family, friends, church communities, work environments, and other affinity groups. Participants are also expected to improve their ability to manage the symptoms of their behavioral health problems and seek necessary treatment when appropriate. By the end of the program, participants should no longer need intensive case management and should be better able to maintain tenancy.

Target Population

To be eligible for the Linkages program, an individual or family must be homeless or at-risk of homelessness, and have a diagnosis of severe mental illness. Many of the individuals served through Linkages have a dual diagnosis of mental illness and substance abuse.

In most instances, families that are referred to the Linkages program are currently receiving services from one of the supportive service agencies. However, potential clients are also referred from area emergency shelter programs and homeless outreach teams. When multiple clients are referred to the program and an insufficient number of service slot are available, the support service provider prioritizes families for enrollment based on the longest period of time spent homeless and the most challenging housing barriers. The case managers at the support service provider agency are responsible for helping potential participants complete an application for the program and verify their homeless status and mental health diagnosis using the program eligibility form, which is standard across the three service providers.

Human Services Offered

The Linkages program emerged from the New Mexico Behavioral Health Purchasing Collaborative (the Collaborative) 2007 Long-Range Supportive Housing Plan.   The Collaborative is a group of 13 partner organizations that collectively pool their health-services money from the State to provide services as a single statewide entity. The Collaborative contracts with OptumHealth as the single statewide entity to oversee this process and provide mental health and other behavioral health services to state residents through numerous local organizations. Each of the support service providers in the Linkages program receives Medicaid reimbursement for providing case management to Linkages families. The behavioral health and case management services are part of the State's existing Medicaid plan; no Medicaid waiver was required to reimburse Linkages support service providers for case management services. A Letter of Agreement between the New Mexico Mortgage Finance Agency, housing administrators and the support service providers outlines the following responsibilities for each of the support service providers:

- Determine client eligibility for the Linkages program based on program criteria including documenting required behavioral health diagnosis, housing need, and appropriateness of client for the program

- Assist client to complete applications for the Linkage program and for the HCV program

- Provide pre-tenancy support, move-in assistance, and post-tenancy support to the client

- Serve as tenant services liaison, reviewing clients' rights and responsibilities related to the lease

- Complete regular (at least monthly) home visits to monitor clients' progress in maintaining housing and achieving goals

- Maintain Linkages program file and check lists that include applications, related documentation, program participation agreements, tenancy responsibility documentation, client progress notes, community team staffing meeting notes, and ensure that all required forms are complete and signed

- Maintain detailed program data collection and tracking and ensure monthly documentation of program data collection elements for program evaluation

Housing Supports Offered

The MFA oversees the housing component of the program. MFA has experience overseeing HUD homeless programs, which made them an appropriate partner to manage the housing component of the Linkages program. MFA partners with the Region V Housing Authority in Silver City and the Santa Fe Housing Authority to provide general programmatic and policy guidance to each of the housing administrators in the program.   In Albuquerque, the role of the housing administrator is filled by the Supportive Housing Coalition, a local nonprofit organization. The Santa Fe County Housing Authority is the program's housing administrator for the Santa Fe area.

The relationships between MFA and each of the three housing administrators are supported by formal memorandums of understanding. These memoranda outline the following responsibilities for each of the Housing Administrators:

- Establish and maintain a waiting list for participants in the Linkages supportive housing voucher program

- Ensure all applicants meet income and program guidelines for HCV assistance

- Establish and maintain up-to-date lists of landlords and property managers who are able to meet HCV housing quality standards

- Maintain communications and coordination with the Supportive Service Provider

- Issue accurate and timely Housing Assistance Payments (HAP) to landlords

- Maintain all records and client data for the Linkages program

- Prepare monthly reports and audits for MFA review

Key Partners

Partner	Support Service Provider	Housing Administrator
Albuquerque	First Nations Community Healthsource Albuquerque Healthcare for the Homeless	Albuquerque Supportive Housing Coalition
Santa Fe	LifeLink Inc.	Santa Fe County Housing Authority
Silver City	Border Area Mental Health Services	Region V Housing Authority

Other key statewide partners include:

Partner	Role
New Mexico Mortgage Finance Authority	• Oversee the housing component of Linkages program on behalf of the State of New Mexico • Monitor progress of Linkages grantees • Prepare reports and analysis of program activity • Maintain Linkages policies and procedures documentation • Facilitate coordination and planning meetings with Linkages partners
OptumHealth New Mexico	• Act as a "Single Statewide Entity" to administer a statewide pool of behavioral health resources • Receive $350,000 annually from State of New Mexico to fund the Linkages program • Act as Medicaid agent responsible for reimbursing eligible Comprehensive Community Support Services (CCSS) provided by Linkage Support Service Providers

Funding Streams

With the support of the Collaborative, Linkages was able to secure line item funding in the state's Department of Human Services budget. The $350,000 in funding is used to support the housing component of the program. Of this funding, $300,000 goes to rental subsidies, while the remaining $50,000 is distributed to the supportive services partner organizations for other costs such as assisting participants in obtaining furnishings for their new units or other move-in expenses. This state funding is passed through the Collaborative to OptumHealth, the single entity in New Mexico for providing mental health services. OptumHealth has a Memorandum of Understanding with MFA, which then contracts with the three housing administrators to provide the funding necessary for the housing subsidies. In addition to the amount of the voucher, for each active rental subsidy, the housing administrator receives a monthly administrative fee of $50. Support services for Linkages clients are funded through OptumHealth as the statewide agent for reimbursements of community mental health services that use state and federal Medicaid dollars.

Promising Features

Cost effective: By using a Housing First model to target individuals and families with severe mental health issues, there is likely a reduction in the number of expensive crisis and emergency services utilized by these households.

Collaborative: From its inception, the Linkages program required a high amount of collaboration from both state and local partners. The Linkage model built upon existing relationships in the Collaborative and brought together the expertise of multiple state agencies and staff.   The pooling of mental health resources by all state agencies enabled the model to be funded by OptumHealth, the single funding entity in the state of New Mexico.   At the local level, support service and housing administrator agencies were also willing to work together to serve families to ensure they were receiving an adequate level of support in the program. The model also leveraged the already existing knowledge of service support providers with case management and housing administrators' existing relationships with landlords.

Implementable: The Linkages model could be implementable as it leverages existing funding streams and service functions. Medicaid funding covers the majority of the supportive service costs for the program. The housing component of the Linkage model is fairly simple, relying on the infrastructure already in place for HUD's Housing Choice Voucher, resulting in a very minimal additional burden for the housing administrator staff. This model needs a significant amount of designated funding to support the housing subsidies, which may be difficult to secure from state or local governments in the existing climate of tight state budgets. The model has also been successfully implemented in both urban (Albuquerque) and rural (Silver City) settings, as well as in a community with a very high cost of living (Santa Fe).

Appendix N:
Salt Lake County, UT (Homeless Assistance Rental Program)

Homelessness Assistance Rental Program
Salt Lake County, Utah

Overview

Salt Lake County's Homeless Assistance Rental Program (HARP) provides scattered-site affordable housing and case management to individuals and families who are homeless or at-risk of homelessness in Salt Lake County. The program is coordinated by the Community Resources and Development (CRD) Division of the Salt Lake County Department of Human Services (SLDHS). It is managed by the Housing Authority of Salt Lake County and uses time-limited (24 month maximum) HOME Tenant-Based Rental Assistance (TBRA) vouchers coupled with case management paid for by four other SLDHS Divisions (see below). The HARP model was conceived in response to the Salt Lake Council of Government's Ten Year Plan to End Homelessness, as well as the county mayor's desire to reduce the number of people in prisons and jails by providing supportive housing for individuals and families who are homeless or most at risk of homelessness (i.e. those with mental health, substance abuse, criminal justice or foster care issues) as well as interaction with the criminal justice system. HARP operates with a Housing First philosophy that aims to stabilize households with the provision of housing, along with supportive services to address the issues that may have led to their incarceration and homelessness or risk of homelessness. The HARP program has housed 116 families since its inception in February 2006.

Linked Program Design

Behavioral (mental) health, substance abuse, criminal justice and/or youth services case managers working in specific programs funded and identified as HARP referral sources from one of the four participating SLDHS Divisions identify potentially eligible clients and help them complete the HARP application packet. The packet includes:

- an authorization to release information to organizations participating in HARP, including the Public Housing Authority and Salt Lake Criminal Justice Services;

- information about household members, homelessness status, income and assets, and education and employment verification;

- a criminal background check to identify potential issues with landlords; and

- a list of client responsibilities.

In order to focus case managers and client families on housing issues as well as the treatment or criminal justice issues that brought them in contact with the program in the first place, the HARP program requires the completion and regular updating of two matrices: one that assesses the family's level of self-sufficiency in 20 domains (income, employment, housing, food, childcare, children's issues, adult education, legal, health care, life skills, mental health, substance abuse, family relations, mobility, community involvement, safety, parenting skills, contact with children, physical health and support network); and another that focuses more narrowly on housing-related domains (such as rent and utility expenses, income, housekeeping issues, landlord and Housing Authority issues). These instruments must be completed before participants move into housing; weekly for the first month; and monthly

thereafter. This ensures some consistency among case managers and provides the HARP staff with a regular means of information about the participants and their progress.

The Housing Authority's stated vision and mission includes serving the homeless population, and their focus is on accepting clients from the referral agencies, whenever possible. HARP has a limited number of reasons to reject an applicant – primarily a history of arson, sexual offense or manufacturing methamphetamine on Housing Authority property.

Once a household is accepted into HARP, it is issued a voucher to secure housing. Families work on their own or with their case managers to find a unit of their choice with a willing landlord at market rate. Housing Authority staff share a list of landlords who have been willing to accept the TBRA vouchers and are willing to accept HARP participants, but clients are not compelled to use those landlords. Most families are reportedly able to find housing within two to three weeks after the voucher is issued.

During their time in the HARP program, families continue to receive case management from their referring SLDHS Division Case managers within each Division help families to develop service plans that identify services and assistance needed to help them maintain their housing while in the HARP program and sustain it after their HARP participation ends. For the first month in housing, households meet weekly with their case managers; after that, households must have contact with their case managers at least twice a month, including a monthly home visit.

Salt Lake County recently decided to expand HARP by adding specific slots for special subpopulations. Fifty slots are master-leased for individuals in the Right In Right Out (RIO) program that have recently left prison or jail. There are also five HARP slots dedicated to young mothers that are pregnant or have small children and who are in need of housing. In addition, there are 10 HARP slots reserved for youth who are aging out of foster care and need housing assistance.

HARP is designed to offer rental assistance for up to 24 months, but the average length of time in the program is 14 months. Families exit the program when they are able to pay for their own market-rate housing or when they obtain a permanent rental subsidy, such as a Housing Choice Voucher or HUD-Veterans Affairs Supportive Housing (VASH) voucher.   As the HARP program has aged, the availability of affordable housing and/or subsidized housing (e.g. Housing Choice Vouchers and HUD-funded Permanent Supportive Housing units) has decreased. A few families with longer-term housing barriers (e.g. seriously disabling mental illness, little or no employment history, recurring substance abuse problems) have not been ready or able to sustain their own housing at the end of the 24-month HARP time limit. In those cases, the HARP program replaces the expired TBRA funding with county general funding that is not time-limited.

A staff member at the Housing Authority serves as the primary coordinator for the HARP program. Case managers, referral agency leaders, Housing Authority staff, and executives from the four SLDHS Divisions meet once a month to share information about program capacity, outcomes, and resource or program structural issues, gaps, or needs.   In addition, the Housing Authority's HARP coordinator meets with case managers weekly to share information about participants, review updated assessments and plans and try to proactively resolve any potential or recurring problems.

Target Population

To be eligible for HARP, a family must reside in Salt Lake County and be certified as homeless or at risk of homelessness per the definition used by the U.S. Department of Housing and Urban Development (HUD). Families are referred to HARP by subcontracted case managers from four different Divisions of the SLCDHS: Youth Services, Substance Abuse Services, Behavioral Health Services, and Criminal Justice Services. By design (reflected in the specified referral sources), a high proportion of families that enter the program have a member of the household who has: recently been incarcerated; has had interaction with a mental health or drug court because of a mental health or substance abuse problem; or, is aging out of the foster care system. The County mandates that 50 percent of clients served by HARP at any time are exiting incarceration or a court-ordered residential treatment facility. The rental assistance provided by HARP can be used by households whose income is at 80 percent of the area median income (AMI) or below. HARP participants pay either the larger amount of $50 or 30 percent of their monthly income for rent.

Human Services Offered

The case management component of HARP is decentralized, with a variety of organizations providing case management to HARP households. The Four County divisions (Youth Services, Substance Abuse, Mental Health, and Criminal Justice Services) that refer households to HARP are required to provide the case management component of the program, usually through contract agencies. Because the case managers are employed and trained by different organizations, the case management component of HARP differs across the program based on the knowledge and service-approach at each organization. The use of the Housing Matrix is the only common instrument in use. Generally, the case managers assist households with finding employment and educational opportunities, enrolling in Medicaid and other federal and state benefits, and helping them identify and apply for permanent housing opportunities. To supplement case management, HARP also utilizes four Americorps volunteers to serve as service coordinators for HARP families. In teams of two, Americorps volunteers visit HARP families to complete the housing matrix monthly and the self-sufficiency matrix quarterly. These Americorps volunteers build a relationship with the HARP families and act as an additional advocate on their behalf.

Housing Supports Offered

The main housing support offered is the up to 24 months of rental assistance. However, a few families with longer-term housing barriers (e.g. seriously disabling mental illness, little or no employment history, recurring substance abuse problems) have not been ready or able to sustain their own housing at the end of the 24-month HARP time limit. In those cases, the HARP program replaces the expired TBRA funding with county general funding that is not time-limited. HARP is the result of collaboration between numerous county agencies and organizations. In developing the HARP model, County staff sought to leverage the expertise of the Housing Authority of Salt Lake County. The Authority already had experience managing Housing Choice Vouchers, public housing and permanent supportive housing projects, as well as having developed an established network of landlords. Existing personal and professional relationships between key staff at the County and the Housing Authority facilitated an inter-governmental agreement between the two entities, and the agreement of the Housing Authority to coordinate and manage HARP.

Key Partners

The two main partners in HARP are, as mentioned above:

- Housing Authority of Salt Lake County

- Salt Lake County Divisions of Youth Services, Substance Abuse, Mental Health, and Criminal Justice Services

Four additional organizations are partners in HARP:

- The Department of Workforce Services provides an employment specialist that offers employment services to HARP households involved with the criminal justice system. The employment specialist assists participants in developing a resume and references, creating business cards, and identifying employment opportunities. The specialist also conducts workshops on different employment topics. Participating organizations are currently discussing the feasibility of training HARP case managers on these employment-related topics.

- The Fourth Street Clinic (Healthcare for the Homeless) offers physical and mental health care for adults and children participating in HARP. Households can visit the clinic at any time for services, and may be referred to other organizations for a wider variety of medical services.

- The Church of the Latter Day Saints Humanitarian Services offers HARP participants the opportunity to shop at their Deseret Industries thrift stores with their case managers to purchase any home furnishings they made need. Participants get vouchers from their case managers for beds and mattresses (if needed), as well as for other household items from their thrift stores. The case manager accompanies them to the store to help them pick out appropriate items to furnish their unit.

- The University of Utah is a research partner in HARP, authoring two studies (in 2007 and 2010) that looked at the effectiveness of the HARP program in decreasing jail/prison time for participants and tried to measure the program's cost effectiveness. (See the section on "Measurable" for the results of the studies.) It also looked at exits to permanent housing, but did not follow up to see whether participants were able to remain in permanent housing. There are plans to do another study in 2013.

Funding Streams

The program started in 2004 with $300,000 in HOME TBRA. SLDHS approached the Public Housing Authority to manage the program because of their experience with Housing Choice Vouchers, their knowledge of both landlords and tenants, and their quasi-governmental status which made it easier to do an inter-governmental agreement. In 2005, the county added $250,000 from the county general fund; in 2011, the HARP budget was about $1 million of combined HOME TBRA, county general fund and miscellaneous smaller resources.   Ten percent of the funding goes to the Housing Authority for administrative costs; none of the funding goes to case management or other services. Case management costs are spread throughout the four participating SLDHS Divisions, so it is difficult to pinpoint the precise cost of the whole program. The Division of Behavioral Health Services funds 75 percent of all services through Medicaid. County staff is working to identify and leverage additional

funding streams for HARP, including Social Service Block Grant (SSBG) and Temporary Assistance for Needy Family (TANF) funding.

Promising Features

Measurable: The University of Utah "Evaluation of the Homeless Assistance Rental Program" found a $2.71 return on every $1 invested in the program, and substantial reductions in interaction with the criminal justice, substance abuse treatment and mental health systems. These findings were based on a comparison to another housing assistance program's participants whose baseline characteristics were not well-matched to HARP participants. In addition, it found exits to permanent housing for more than 50 percent of participants.

Cost effective: The HARP model leverages existing in-kind case management services that are already being provided to HARP-eligible clients by DHS Service Divisions whether or not they participate in HARP housing. University of Utah research found the HARP model to be more cost-effective than serving family members in correctional facilities or residential treatment programs, but, as described above, the research design for the study was not strong.

Collaborative: The HARP model capitalized on a high level of collaboration between various County divisions, the Salt Lake County Housing Authority, as well as local nonprofit organizations that provide additional supportive services to HARP families. This collaboration is built upon longstanding personal relationships between key staff, as well as existing relationships between service providers. None of the organizations have formal agreements to provide services under HARP.

Implementable: This program can be implemented in communities with collaborative cultures and some kind of centralized planning/funding body (in Salt Lake City, it is the County government), a joint focus on reducing homelessness, and a housing provider (here, the Housing Authority) with experience and belief in a Housing First philosophy. The use of HOME TBRA funds to pay for rental assistance and the de-centralized nature of the case management also make the model more implementable.

Appendix O:
Washington, DC (Permanent Supportive Housing Program)

Permanent Supportive Housing Program
Washington, DC

Overview

Since August 2008, the Family Services Administration within the DC Department of Human Services (DHS) has managed the Permanent Supportive Housing Program (PSHP) for homeless families and individuals living in Washington, DC. The PSHP uses the Housing First model, which focuses on getting homeless clients into permanent housing as a first step in addressing other issues that may have led to their homelessness. Although most clients served by the program are individuals, it has served 250 families so far and is working to place an additional 29 families. In keeping with the purpose of the study, the rest of this summary focuses on the families served by the program.

The primary goal of the program is to help clients become self-sufficient and maintain stable housing by providing clients with a housing subsidy, moving assistance, and intensive case management. The housing subsidy—a permanent housing voucher—is provided through local funds or the local Public Housing Authority. The moving assistance includes housing search assistance, a $300 gift card to Target, and landlord mediation. Clients are assigned to case managers who help them address issues and risks that might threaten their housing stability (e.g., substance abuse, unemployment, mental health, lack of health insurance).

Linked Program Design

The program links housing subsidies with supportive services through the collaboration between DHS, the Washington, DC Housing Authority (DCHA), The Community Partnership (TCP) and the case managers. DHS is the lead agency that coordinates across the partner organizations; DCHA provides the federal housing supports; TCP finds units, coordinates with landlords, and pays rent to landlords (for the locally funded vouchers); and case managers ensure that the housing and services are matched appropriately to the needs of clients.

With the support of TCP and the case managers, DCHA was able to streamline the voucher lease-up process by conducting the inspection simultaneously with the application process, rather than the typical linear process.   A typical client will work with their case manager to select a unit from the list of available units (provided by TCP through a shared database); visit the unit (with the case manager); complete an application while the inspection is conducted; and then schedule an appointment with DCHA. As a result, the client can complete the lease-up on the first visit to the PHA rather than require multiple, time-consuming visits. According to interviewees, the lease-up time has been reduced from three months to three weeks, and getting vulnerable (and potentially transient) clients into housing quickly was described as a key to the program's success.

In addition, DCHA provided greater flexibility to meeting the voucher eligibility requirements. For example, case managers are allowed to provide DCHA with documentation that a client with a criminal history has rehabilitated him or herself, a task typically required of an employer or a probation/parole officer. DCHA also agreed to waive repayment of monies by previous voucher or public housing recipients whose debt dates back five or more years (or is very small).

Landlords who participate in the program have agreed to waive standard tenant screening procedures and are comfortable leasing to PHSP clients because they recognize the role of case managers in promoting and mediating client stability and in serving as an alternative point of contact for landlords. Landlords are also attracted by the stable source of rent (i.e., the voucher).

Two unique aspects of service delivery approach are:

1. DHS cannot mandate that clients utilize case management services. The Homeless Services Reform Act of 2008, a District law, mandated that the provision of housing to the homeless population cannot be dependent on one's participation in case management. As such, case managers are mandated to provide services, but their clients are not mandated to utilize them. Case managers expressed some frustration with this exemption, but it has not created problems with landlords because tenants are still obligated to adhere to their lease requirements and may be evicted if problems are not properly resolved.

2. DHS maintains a shared database that contains detailed information about each client and about available housing units in the District. The database also allows partners to quickly score and identify qualified participants, search for available units, and match families to appropriate units. Interviewees indicated that the shared database has been instrumental in the daily operation of the program.

Target Population

Although the program initially served homeless people with a wide range of needs, the program has evolved and currently targets the "hardest to serve". DHS identifies these clients through a vulnerability index that ranks the risk level of potential clients based on their responses to a survey (the Vulnerability Assessment for Homeless Households). DHS distributes the survey to homeless assistance providers located throughout the DC community that, in turn, administer the survey to their clients. The vulnerability assessment includes questions related to family composition, demographic information, homelessness history, health, child well-being, criminal background, income, and support network. Upon completion of an assessment, providers return the survey to DHS, which enters the responses into a shared database that calculates an index score. When a voucher becomes available, DHS selects the client with the highest vulnerability index score and assigns that client to a case manager. If multiple families have the same score, DHS staff consider other factors that make one client more appropriate than others for immediate assistance (e.g., the presence of infants) or more difficult to support through a permanent housing voucher due to eligibility considerations (e.g., the size of the household and criminal history).

Human Services Offered

Case managers are at the center of the program, connecting clients to the appropriate services and providing several housing-related services to clients (described in the next section).   Case managers are assigned to clients as soon as they are selected for PSHP, and the typical caseload for a case manager is 10 families. In terms of the human services component, case managers are responsible for:

Identifying client needs–the client assessment process reviews the specific needs of clients, and case managers view the assessment as an ongoing process that is refined as they establish a rapport with clients. Based on the needs assessment, case managers develop a service plan for each member of the family, which must be updated periodically (some update the plans every 3 months; some annually).

Enrolling clients in appropriate services—a case manager's approach to connecting clients to services depends on the client; for some, a referral to a service provider suffices, while for others the case manager may physically take the client to appointments and maintain routine contact with the service provider. Case managers are required to complete a monthly housing visit to each client, which provides an opportunity for the case manager to gather information about the condition of the client's housing unit. Also, case managers are required to monitor the educational status of school-age children in the family, including their attendance, performance, and behavior. This is typically done in collaboration with the school's homelessness liaison. The nature of the program requires a very close relationship between client and case manager.

Although DHS establishes basic reporting requirements and minimum interactions with clients, it allows case management agencies the flexibility to design their own service delivery models. To monitor performance, case managers receive training from DHS and DCHA on specific program rules and eligibility processes, hold weekly meetings with DHS PSHP staff, and are held to minimum contact and assessment requirements.

Housing Supports Offered

PSHP provides housing vouchers to all clients, either funded through local funds or through the federal Housing Choice Voucher program. The federally-funded vouchers are permanent while the locally-funded vouchers are intended to be permanent but may be susceptible to the availability of city funds. Eligible units are both scattered-site and site-based.

In addition to vouchers, TCP uses DHS funds to pay the security deposit for each unit provided to PSHP clients, distribute furniture vouchers for clients, issues a $300 gift card (Target) for household items, and maintains a database with client and unit information to facilitate the identification and selection of appropriate units. However, the program is beginning to reduce the value of these additional supports (or drop them altogether) due to the expiration of a major source of funding.

Finally, case managers provide housing-related assistance in addition to the needs assessments and service referrals described above. These include:

1. Assisting clients with finding and moving into a housing unit—this includes helping them fill out a voucher application, taking them to view the units, and helping them settle into their units.

2. Acting as an intermediary between client and landlord—case managers work to empower their clients and prefer to have clients work directly with their landlords, but they may also intervene with landlords as needed. For example, case managers indicated that some landlords take advantage of their clients, and case managers may consult with housing specialists within their agencies to train clients on their tenant rights. In other instances, clients may be violating building rules, and landlords will call the case manager to intervene. Forging mutually

supportive relationships between program staff and landlords was described as a key to the program's success.

Key Partners

- DC Department of Human Services (DHS). DHS is the lead agency in the PSHP project, and coordinates with the other key partners listed below.

- DC Housing Authority (DCHA. DCHA set aside 350 housing choice vouchers for PSHP clients. DCHA is responsible for coordinating the housing inspection, conducting rent reasonableness determinations, and the lease-up process.

- The Community Partnership (TCP. TCP is the entity that manages the local Continuum of Care, and its role in the program differs slightly depending on the source of the housing assistance. For locally funded vouchers, TCP recruits landlords, identifies units for the program, manages landlord relationships, and distributes monthly rent payments to landlords on behalf of DHS. For federally funded vouchers, TCP helps to identify units for the program, collects and forwards landlord documentation required by DCHA, and schedules the lease signing on behalf of the client. DCHA issues all rent payments for clients utilizing federally funded vouchers. In addition, TCP processes and pays security deposits for all clients and coordinates the supplemental housing assistance provided to clients (e.g., Target gift card, furniture vouchers).

- *Case management provider agencies.* Eight community-based organizations implement 5-year contracts with DHS to provide case management services for clients enrolled in PSHP. Case managers help link clients to human services and also provide landlord mediation services to prevent client evictions. Four of the eight agencies serve families, including: Metropolitan Educational Solutions, Community of Hope, Transitional Housing Corp, and Community Connections.

In addition, during the program's inception, the Mayor's Office was instrumental in garnering local funding for the program and providing the political support necessary to implement the program. Interviewees indicated that the Mayor's Office included a dedicated line item in the City's budget for the program, ensured that city agencies understood the importance of the program, and defended the decision to target clients with the greatest needs.[45]

Funding Streams

The program uses a mix of local and federal funding. The program was initially supported by a $10 million line item in the District's annual budget and a one-time federal appropriation of $17 million for fiscal years 2010 and 2011. In addition, DCHA allocated 350 federally funded vouchers to the PSH Program (for both families and individuals).

---

[45] During the program's inception there was debate about who should benefit from the program. Some wanted to target clients with the greatest needs—often chronically homeless people—because they need the assistance the most and because the provision of permanent housing was viewed as an effective way to reduce the burden on city services (e.g., police involvement and emergency room visits). Others argued that teachers, firefighters, police officers and other community-serving individuals (and their families) who may be struggling economically should be targeted for financial support.

The City funding is subject to each year's budgeting process, but has slowly increased over time and is expected to double by 2012, just as the federal allocation expires. On net, however, the increase in the local funding is expected to be offset by the loss of the federal funding, and interviewees expressed concern that local funding will soon be used to support the entire program, except for the PHA vouchers. Indeed, local dollars have been the only source of funds used thus far to provide an array of services and supports (e.g., case management, security deposits, and furniture vouchers).[46]

DHS initially also had a small amount of foundation funding and hopes to do more outreach to foundations to support the program in the future. DHS also has the flexibility to allocate TANF funds to the program, but it has not yet to tap these resources.

Promising Features

Cost Effective: While the provision of a permanent housing subsidy is expensive, program staff believe that PSHP offers a better investment compared to the costs incurred by chronically homeless families who may use several expensive services (e.g., shelter services, emergency rooms, and the criminal justice system). However, the program does not currently track program costs, although some case managers have started to think about tracking this information.

Collaborative: According to interviewees, the program has prompted a greater level of coordination and collaboration across city agencies, particularly between the DHS Family Services Administration and the DCHA Housing Choice Voucher Program. The program does not rely on MOU's between city agencies, and relationships are kept informal. Nonetheless, DHS hosts regular meetings between key partners (DCHA, TCP, and case managers) who were unaccustomed to working closely with their counterparts in the other organizations.

Replicable: The key drivers of success for PSHP are characteristics that any program could have: a strong relationship with the local housing authority, strong political support, and a flexible approach to providing housing assistance. The latter stemmed from the availability of local funds that provide supplemental assistance to recipients of federal vouchers, as well as modifications the DCHA applied to its voucher application and lease-up process. Also, the program was modeled on the Common Ground approach in New York City, suggesting that the Housing First model is portable and can be replicated elsewhere.

---

[46]   PHAs can use their administrative fee for supporting these types of services and supports if they chose, although usually there is not enough funding for these activities.

**Appendix P:
Yakima, WA (Serving Families and
Individuals to End Serious Trouble through
Agencies' Support)**

Yakima Neighborhood Health Services - FIESTAS
Yakima, Washington

Overview

The mission of the FIESTAS (Serving Families and Individuals to End Serious Trouble through Agencies' Support) program is to aid families in Yakima County, Washington in becoming self-sufficient by pairing two-year transitional housing with intensive case management services. The FIESTAS program was started in 2006 and is a partnership between the Yakima County Department of Human Services, Yakima Neighborhood Health Services (YNHS), Triumph Treatment Services and the YWCA. Funding for case management is provided by the Washington Families Fund administered by Building Changes,[47] and is paired with housing assistance using McKinney-Vento Supportive Housing Program (SHP) funds and project-based vouchers through the U.S. Department of Agriculture (USDA) Rural Development voucher program and HUD's Housing Choice Voucher Program (HCVP). The housing assistance using SHP funds is administered by YNHS and Triumph Treatment Services; and the housing assistance from both voucher programs is administered by the Yakima Housing Authority. Building Changes requires that FIESTAS' case mangers utilize the principles of the Arizona Self-Sufficiency matrix—a client assessment tool that measures the severity of client's needs across multiple dimensions—to assess and track progress on families' move towards self-sufficiency.

The FIESTAS program is modeled after the Sound Families initiative that provided service-enriched housing for homeless families in Pierce, King, and Snohomish Counties in Washington State (the greater metropolitan Seattle area). Sound Families was a multi-year, $40 million investment by the Bill and Melinda Gates Foundation that funded case management and supportive services for a total of 1,445 households (including 2,700 children) in transitional housing and permanent supportive housing units between 2000 and 2007. The majority of families were in transitional housing units with a maximum two-year stay, though the average stay was just over 12 months. The Sound Families initiative involved many collaborative relationships among non-profit and for-profit housing developers, property managers, service providers and local housing authorities. A primary strategy of the initiative was to obtain permanent housing for families exiting the program through agreements with local housing authorities to provide Section 8 vouchers or give families priority for a public housing unit. All Sound Families participants received intensive case management, which was broadly defined as in-home weekly case management, plus at least weekly phone contact. Families who needed specialized services, such as drug and alcohol treatment, education, job training, mental health services, were typically referred to off-site providers. The Bill and Melinda Gates Foundation contracted with the Northwest Institute for Children and Families (NICF) at the University Of Washington School of Social

---

[47] Building Changes is a non-profit organization based in Seattle, Washington whose mission is uniting public and private partners to create innovative solutions through expert advice, grant making, and advocacy for lasting change. Its approach to ending homelessness is multi-faceted to coordinate housing and service delivery systems in meeting the needs of homeless populations. The organization primarily serves government and nonprofit organizations in the state of Washington. Its activities support agencies that serve about 8,000 individuals annually, including individuals and families with children who are experiencing homelessness, along with the housing agencies and service providers that support them. Its website is: www.buildingchanges.org

Work to conduct on-going evaluations of the Sound Families program. According to Building Changes, the findings from six evaluation reports prepared by NICF were incorporated into the program guidelines for the Washington Family Fund. The Washington Family Fund was designed to expand the Sound Families model to other communities in Washington State capable of implementing a similar program.

Linked Program Design

The FIESTAS program places homeless families into two-year temporary housing using the housing assistance described above.   For this transition phase, all housing assistance has a two-year limit, including the project-based vouchers from YHA. During this time, families receive intensive case management with the goal of achieving greater self-sufficiency within these two years.   As families reach the two-year time limit, they will have typically taken one of the following three pathways: Some Income-eligible families have received or will receive a new project-based voucher from YHA that is not time limited. YHA maintains a separate waiting list for 75 project-based vouchers that have been set aside for homeless families in Yakima County, including graduates of the FIESTAS program. Some families transitioning out of the FIESTAS program may earn enough income to move into market-rate housing.   Other families have dropped out of the program. To date, three families have dropped out and moved out of the Yakima area.

Except for dropouts, all families can receive a third year of case management as they transition into permanent housing and out of the FIESTAS program if they request it.

Families are visited between three times a week and once a month, depending on how self-sufficient the family is and whether it is achieving the goals stated in its action plan. Additionally, all housing units are inspected weekly by case managers, who are certified to conduct housing inspections.

Case managers work with families to identify goals and services to help families achieve self-sufficiency or become more self-reliant.   Staff use common intake and assessment forms, based on the Arizona Self-Sufficiency Matrix, to help families identify barriers to self-sufficiency. Then, throughout the course of the two years, case managers use action plans to help families identify strategies to overcome these barriers. The case managers also use small achievements, for example, obeying rules and keeping an apartment clean, to help measure progress towards self-sufficiency.

Building Changes, the agency that provides funding for case management services, works with the case managers at the three FIESTAS partner agencies to use a detailed approach to assisting families. The approach is based on specific strategies, interventions, and supports that have been tested in other communities. Building Changes calls its approach "The Five Pillars," which includes:

1. early intervention and prevention;

2. coordinating access to support services;

3. rapid re-housing;

4. providing services tailored to meet each family's individual needs; and

5. increasing economic opportunity through education and workforce services.

Target Population

The FIESTAS program currently serves 47 families through project-based vouchers for units located in both urban and rural settings. The program is targeted to assist homeless families in Yakima County with moderate and high needs. The Washington Families Fund provided two rounds of grant funding for FIESTAS, each targeted to a population with a different level of need. The first round of funding for the FIESTAS program, allocated to the Yakima County Department of Human Services, was dedicated to serving clients with "moderate needs."   The second round of funding, allocated to Yakima Neighborhood Health Services, was dedicated to serving clients with "high needs."   "Moderate needs" clients are families who have had stable housing and employment, but who have recently become homeless due to a specific situation such as a job loss, loss of a rental housing unit due to increased rent or housing conditions, burdensome medical expenses, or a change in household composition. "High needs" clients are families that are chronically homeless and face two or more barriers to self-sufficiency.   The table below shows the distribution of the housing assistance for the FIESTAS program.

Families with Moderate Needs: 27 units with project-based vouchers

# of Units	Management of Units	Funding Source	Location of Units
5	YWCA	HUD Housing Choice Voucher Program (HCVP) administered by YHA	YWCA facility with housing dedicated to households impacted by domestic violence located in downtown Yakima
18	Triumph Treatment Services	McKinney-Vento Supportive Housing Program (SHP)	Duplexes throughout Yakima County
4	Yakima Neighborhood Health Services	McKinney-Vento Supportive Housing Program (SHP)	Apartment complexes throughout Yakima County

Families with High Needs: 20 units with project-based vouchers

# of Units	Management of Units	Funding Source	Location of Units
14	Yakima Housing Authority with dedicated waiting list managed by Yakima Neighborhood Health Services	USDA Rural Development Voucher Program	Apartment complexes managed by YHA throughout Yakima County
6	Yakima Neighborhood Health Services	McKinney-Vento Supportive Housing Program	Apartment complexes throughout Yakima County

Human Services Offered

Each of the three non-profit, community-based organizations comprising the FIESTAS program focuses on addressing a specialized need for families in the program: Yakima Neighborhood Health Services focuses on health care; Triumph Treatment Services focuses on alcohol and drug addiction; and the YWCA focuses on domestic violence.   Families enter the program based on their relationship with one of these three organizations. Services from all three organizations are available to all FIESTAS' participating families. With state and local funding, Triumph Treatment Services also employs a child advocate who provides support to all families in the FIESTAS program. The advocate is available to work with families in addressing issues with the State child protection services office, local schools, juvenile detention, drug and gang courts, and other child-related services in the community.

A key component of the FIESTAS program is the partnership between these three community-based organizations and other public agencies such as the Yakima County Department of Human Services, the Yakima Housing Authority, the Washington State Department of Social and Health Services, along with other community-based organizations providing services such as legal aid, job training programs, child care resources, and mental housing counseling.

An additional key component of the program is the technical assistance, training, and financial support provided by Building Changes. With funding from the Washington Families Fund, Building Changes provides three to four trainings per year and on-going technical assistance to the program partners, including to case managers and their supervisors on topics ranging from informational interviewing to program management.

Housing Supports Offered

As described in the tables above , there are 47 project-based housing vouchers available through the FIESTAS program: 27 vouchers are targeted to "moderate needs" homeless households and 20 vouchers are targeted to "high needs" homeless households.

Twenty-two of the 27 project-based vouchers for moderate needs households are funded with McKinney-Vento SHP funds and are managed by Triumph Treatment Services (18 vouchers) and YNHS (4 vouchers). Both agencies maintain their own waiting lists. If one of the agencies does not have a voucher available when a family enters the FIESTAS program, the household will be referred to the other agency if it has an available voucher. Five of the project-based vouchers are funded through HUD's Housing Choice Voucher Program, administered by the Yakima Housing Authority. These five vouchers have been allocated to the YWCA for its facility in downtown Yakima that provides up to two years of transitional housing for households in the FIESTAS program impacted by domestic violence.   The YWCA manages the dedicated waiting list for these vouchers.

Fourteen of the 20 project-based vouchers for high needs households are funded through the USDA Rural Development voucher program. These 14 vouchers are administered by the Yakima Housing Authority. The remaining six vouchers are funded through the McKinney-Vento SHP program and these vouchers are administered by YNHS.   The waiting lists for both sets of vouchers are managed by YNHS.

Following the transition phase, families may be able to receive project-based HCVP vouchers through
YHA if they are still income-eligible.

Key Partners

- Yakima Department of Human Services

- Yakima Neighborhood Health Services

- Triumph Treatment Services

- YWCA

- Yakima Housing Authority

The FIESTAS program involves partnerships with a number of organizations. These include community-
based partner organizations, several nearby emergency shelters (La Casa Hogar, The 107 House, Noah's
Ark), the Yakima County Drug Court, Yakima County Department of Human Services and Central
Washington Comprehensive Mental Health. Most referrals come from programs at the partner
agencies, primarily the community health clinic and health care for the homeless van operated by YNHS;
drug and alcohol addiction services provided by Triumph Treatment Services; and the domestic violence
shelter program at the YWCA.

Funding Streams

The majority of funding for the FIESTAS program's supportive services comes from the Washington
Families Fund (WFF), created through a combination of private funds (twenty-three private foundations)
and funds from the State of Washington. The State of Washington selected Building Changes to
distribute WFF funds to government and non-profit agencies in the state using a competitive grant
process. Currently, Building Changes distributes $17 million dollars across 19 counties in Washington
state to target chronically homeless families. The first round of funding received by the FIESTAS
partnership required the partnership to provide a two-to-one funding match. Match funds came from
Yakima County Department of Social and Health Services and from YNHS, Triumph and the YWCA.
FIESTAS is able to count Medicaid as part of the match funds they have available. The WFF funding is
provided for ten years, though recipients are required to re-apply after four years. The combination of
match funds and WFF made $3,500 available per unit per year for case management.

However, in 2007, Building Changes recognized the need for a more robust service package— some
families were not successful even with the current package of case management services. Building
Changes then altered their next funding round to meet this need. Funding was dedicated for "high
needs families," or families who are chronically homeless and have at least two barriers to self-
sufficiency. With the second round of funding, additional funds were allocated per household by WFF;
however, the local matching requirement was reduced to a one-to one funding match. The combination
of match funds and WFF made a range of $5,000 to $7,000 available per unit per year for case
management.

Promising Features

Collaboration: The FIESTAS program's strength is its collaboration among partner organizations and community service providers. Case managers from all the partner agencies meet monthly to discuss community problems, issues they are facing, and strategies for working with families. The collaboration allows clients to draw on the specialized skill-sets offered by partner agencies. Additionally, partner agencies work in concert to support each other's efforts and ensure that homeless families do not "fall through the cracks." For example, Triumph Treatment Services described how a homeless man with a large family approached the agency looking for housing. Triumph's program was full, but they were able to use their well-established relationship with YNHS to accommodate the family. Additionally, all partner organizations utilized a child advocate, who is employed by Triumph Treatment Services. Finally, the Yakima Housing Authority's commitment to the program was apparent through its allocation of vouchers and dedicated waiting lists.

Measurable: As a condition of its grant funding, Building Changes requires the FIESTAS program and its partners to use the Arizona Self-Sufficiency Matrix to track and measure individual performance using a five point scale for eighteen domains. Use of the matrix allows FIESTAS to collect data on both individuals and total program performance. All case managers receiving training on using the matrix.

Cost effective: Based on evaluated outcomes from the Sound Families initiative (NICF, University of Washington School of Social Work), Building Changes and the FIESTAS program believe that by incorporating the same principles for service-enriched housing for homeless families in Yakima County that the impact of their program will be more cost effective and beneficial to families than the use of shelters or other short-term temporary housing. They also believe the two-year transition program of housing and support services helps stabilize families so they can achieve greater self-sufficiency and self-reliance.

Implementable: This model has five key implementation factors that can be replicated elsewhere: (1) a collaborative partnership of government agencies, housing agencies, and service providers who communicate frequently and work to support each other and families to address homelessness in their community; (2) dedicated funding from Building Changes that funds case management services, training, and technical assistance, and requires a consistent approach and case management tools among case managers at the partner agencies; (3) a commitment to provide two years of transitional housing and support services for all families in the program; (4) a dedicated waiting list at the Yakima Housing Authority to provide project-based Housing Choice Vouchers to eligible families graduating from the FIESTAS program; and (5) case management services to families for up to one year after they graduate from the FIESTAS program.