

# HOMEWARD BOUND

Policy and Resource Guide For  
Housing Homeless Floridians



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**The Florida Housing Coalition Inc.** is a nonprofit, statewide membership organization, whose mission is to bring together housing advocates and resources so that everyone has a quality affordable home and suitable living environment. The Coalition has seven offices throughout Florida and has been providing training and technical assistance since 1982, both in Florida and nationally.

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## HOW TO USE THIS GUIDE

**T**his guide addresses policies and resources for homeless assistance at both the federal and state levels. The introduction gives a broad historical overview of the national response to homelessness, followed by a discussion of Florida's



evolving homeless assistance framework. The next section presents national and state data on homelessness trends over time, followed by a brief discussion of federal and state definitions of homelessness. The main body of the guide consists of an encyclopedia of terms referring to federal and state policies, programs, and best practices for addressing homelessness. Each entry has its own list of resources for further reading. The Appendix lists additional resources for homeless service providers, housing providers, and advocates.

The primary focus of this resource guide is on policies and programs related to housing people experiencing homelessness, particularly those administered by HUD. While we discuss the role of supportive services in many policies and programs for the homeless, such as the Projects for Assistance in Transition to Housing (PATH) grant from the U.S. Department of Health and Human Services, the guide does not go into detail about such programs. The Appendix includes links to resources for the supportive services component of homeless assistance.

Please note that federal and state laws and regulations change frequently. We will do our best to keep this document up to date, but the reader should consult the most recent rules and guidance for federal and state programs of interest. Stakeholders should also become active with their local homeless coalitions and continuums of care to learn more about needs and opportunities in their local communities.

# preface

Of all the hardships that low-income Americans face, homelessness is among the most extreme, and has an unparalleled power to shock the public conscience. This is especially true in Florida, where palatial residences and tourist attractions stand in sharp contrast with a homeless population of 47,862 people—the 3rd highest of any state. Contrary to popular belief, Florida’s homeless problem is not driven by economically unstable individuals and families migrating to Florida to take advantage of the nice weather—year after year of state data shows that most homeless Floridians have lived in their communities for a year or more. At the national level, the homeless population declined by 9% between 2007 and 2013, as Congress, federal agencies, and homeless service providers have increasingly invested in “Housing First” programs. Florida’s homeless population barely budged during the same period, and in 2013 it comprised 8% of the nation’s total homeless population. If Florida can move the needle on homelessness, it will be an achievement of national significance.

The homeless assistance system in America is undergoing a sea change, and is enjoying strong bipartisan political support and relatively stable funding. In 2009, the McKinney-Vento Act, the definitive federal legislation on homeless assistance, was substantially amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. The HEARTH Act embraced the Housing First model, which regards permanent housing as the first, rather than the last, step in a homeless person’s return to self-sufficiency. Moreover, the HEARTH Act requires a greater degree of coordination among stakeholders in community homeless assistance networks than ever before.

Homeless service providers and their partners in Florida, and throughout the nation, are grappling with the ramifications of the new policy and funding landscape at the federal level. It is no easy task—it requires individual service providers to cede some control; pushes many transitional housing providers to adapt their service models; and operates in an environment where affordable housing, living-wage jobs, and funding sources are limited. While advocates can and should push for more local, state, and federal funding to help their homeless neighbors find stable housing and support services, it is wise for communities to make a parallel effort to optimize their systems with the resources they already have. Communities that succeed in this effort will make the strongest case for increased funding.

Such ambitious goals are never accomplished as smoothly, quickly, or completely on the ground as high-level federal and state officials might expect. But by pursuing those goals, a community can create substantial and innovative improvements over the status quo. Any policy framework that can significantly reduce the experience of homelessness among vulnerable individuals and families is worth a shot.





## INTRODUCTION

# ADDRESSING HOMELESSNESS

THE PAST FEW YEARS HAVE SEEN A RENEWED FERVOR FOR ADDRESSING HOMELESSNESS—AND A NEW SENSE OF CONFIDENCE THAT WE AS A SOCIETY CAN SUCCESSFULLY PREVENT AND END IT.

New terms have entered the dialogue about homelessness, including Housing First, Rapid Re-Housing, and Permanent Supportive Housing. These new approaches to homeless assistance are described as “evidence-based” and “data-driven” . . . but what does that mean? What is the evidence exactly? And what roles do transitional housing and supportive services play? This section of the guide describes the history of homeless assistance policy in the U.S. and the emergence of the best practices that now dominate federal policy, followed by a discussion of Florida’s policies and programs.

### FEDERAL HOMELESS ASSISTANCE: A BRIEF HISTORY

Homelessness emerged as a national social problem in the early 1980s, driven by the perfect storm of deinstitutionalization, rising housing costs, and stagnating wages. In 1987, Congress passed the Stuart B. McKinney Homeless Assistance Act, a landmark bill that created funding programs for emergency and transitional shelter, job training, health care, and other services for the homeless, and required that homeless children have access to public education. In 2001, it was renamed the McKinney-Vento Act<sup>1,2</sup>.

By 1992, four major HUD programs had been established under the McKinney Act, all of which still exist in modified forms. The Emergency Shelter Grant (ESG) provided funding to state and local governments on a formula basis for renovation of structures for emergency shelters, shelter operation, essential services, and limited prevention activities<sup>3</sup>. In addition, HUD offered three competitive grant programs. The Supportive Housing Program (SHP) was the most diverse, supporting development, operation, and service provision for Transitional Housing (TH), Permanent Supportive Housing (PSH) for people with disabilities, and safe havens<sup>4</sup>. Shelter Plus Care provided rental assistance for homeless persons with chronic disabilities; and the Section 8 Moderate Rehabilitation Single-Room Occupancy (SRO) Program helped finance rehabilitation and rental assistance for SRO units for formerly homeless persons<sup>5</sup>.

### HOMELESS ASSISTANCE AS WE KNEW IT: THE CONTINUUM OF CARE MODEL

Initially, homeless housing and service providers applied individually for HUD's competitive McKinney funds. In 1994, however, HUD introduced a process that is used to this day. Homeless service providers were required to organize themselves into geographically delineated "Continuums of Care" or systems for planning, coordinating, and delivering services to people in all stages of homelessness. Within the CoC, individual project applications for all three competitive programs were pooled into a joint application submitted by a designated "lead agency". By collaborating on funding applications and year-round planning efforts, providers ideally avoid duplication of efforts, identify gaps, coordinate with mainstream services, and are able to seamlessly make client referrals.

The term "Continuum of Care" also refers to the linear model of homeless service provision that dominated through the 1990s and early 2000s. The archetypal client would enter emergency shelter for initial stabilization, be accepted into a Transitional Housing (TH) program after an initial period of sobriety, and "graduate" to permanent housing after completing the TH program and saving up enough money for relocation costs. McKinney-Vento-funded TH programs serve clients for up to 24 months, and many (though by no means all) are congregate facilities that require residents to accept mental health/substance abuse treatment, participate in life skills training classes, and abide by various house rules .

### THE ASCENDANCY OF "HOUSING FIRST"

Although the CoC model dominated homeless assistance policy and practice until recently, it did not hold a monopoly. In the

late 1980s, Permanent Supportive Housing (PSH) models were developed for homeless persons with disabling conditions, such as physical impairments, mental illness, and/or substance abuse. These individuals are often chronically homeless, a subgroup that comprises a minority of all those who experience homelessness in a given year, yet consumes a majority of homeless assistance resources. PSH providers offered these individuals full tenancy rights in "regular" units, and participation in supportive services was encouraged but not required as a condition of tenancy. Between the mid-1990s and early 2000s, several studies of PSH programs showed that large majorities of participants maintained housing stability for at least a year<sup>7,8</sup>.

The term "Housing First" was probably coined in 1988 by Beyond Shelter, a nonprofit in Los Angeles, CA, that offered "rapid rehousing" services to homeless families<sup>9</sup>. The premise was that stable housing is a basic right and serves as a platform for other interventions to succeed. In practice, many programs that explicitly use a Housing First (HF) model are PSH programs targeted to single adults experiencing homelessness who have severe mental illness and other impairments. While HF programs vary in the details, they usually entail placing homeless clients into housing as quickly as possible after referral, subsidizing the rent to an affordable level, and helping clients connect to intensive support services. The unifying factor in true HF programs is that clients are not required to participate in treatment or services (aside from case management) as a condition of remaining in their housing. The principles of Housing First and homelessness prevention were central to the National Alliance to End Homelessness's landmark document, *A Plan, Not A Dream: How to End Homelessness in Ten Years*, which inspired scores of communities across the nation to create their own "Ten Year Plans"<sup>10</sup>.

In 2002, the Bush administration set a national goal of ending chronic homelessness in ten years. It drew on a growing body of research showing that PSH programs using a Housing First model are highly successful at restoring chronically homeless people to housing stability, at a cost that is comparable to or even less than allowing these individuals to cycle through hospitals, jails, shelters, and other institutions. Subsequent research has strengthened this conclusion, although the evidence is mixed on whether HF reduces mental illness and substance abuse<sup>11,12,13</sup>.

Compared to homeless individuals, household heads in families experiencing homelessness have fewer problems with severe mental illness or chronic substance abuse on average, and are

## INTRODUCTION

less likely to need intensive and ongoing supportive services<sup>14</sup>. As a result, many advocates have promoted a “Rapid Re-Housing” (RRH) model for families (as well as individuals) with low to moderate barriers to housing stability. RRH programs provide just enough assistance to quickly stabilize these families in permanent housing—outreach to landlords, security and utility deposits, moving costs, temporary rental subsidies, and temporary case management addressing behaviors that directly affect a client’s housing stability<sup>15</sup>. In early 2009, HUD created a Homelessness Prevention and Rapid Re-Housing Program (HPRP), a 3-year demonstration. HUD’s most recent analysis shows that HPRP was highly successful<sup>16</sup>. Several communities also report that RRH programs have lower costs, higher rates of exits to permanent housing, and lower rates of return to homelessness after 12 months than TH programs. As the RRH model spreads, some homeless assistance providers are expanding it beyond its original focus to serve high-barrier households until they can obtain permanent supportive housing, or find another affordable living situation with adequate community supports<sup>17</sup>.

## THE FEDERAL GOVERNMENT CATCHES UP: THE HEARTH ACT, OPENING DOORS, AND BEYOND

The growing emphasis on Housing First and prevention culminated in the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, which reauthorized and updated the McKinney-Vento Act for the first time since 1992. The Emergency Shelter Grant was renamed the “Emergency Solutions Grant,” and its funding priorities shifted from emergency shelter toward prevention and Rapid Re-Housing (RRH). The competitive grant programs, meanwhile, were consolidated into a single, more flexible “Continuum of Care” program, and RRH was added as an eligible activity. The application and scoring process was revised to emphasize outcomes, including reductions in total homeless populations and returns to homelessness. The HEARTH Act also created a new Rural Housing Stability Program (RHSP), in which rural communities can compete more effectively for funding<sup>18,19</sup>.

The Obama administration followed up in 2010 with *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*, the first comprehensive planning document for federal homeless assistance policy. Chronic homelessness had declined by one-third in the preceding five years, and *Opening Doors* built on the momentum by pledging to end chronic and veteran homelessness by 2015, and family and youth homelessness by 2020. Similar to the HEARTH Act, *Opening Doors* embraced Housing First, and provided guidance for homeless assistance providers to coordinate

more effectively with mainstream social services<sup>20</sup>. It drew on emerging federal programs, including HPRP and HUD-Veterans Affairs Supportive Housing (HUD-VASH). In the latter program, the VA provides social services to qualified veterans while HUD provides a Section 8 voucher<sup>21</sup>. Around the same time *Opening Doors* was released, Congress authorized the VA to create the Supportive Services for Veteran Families (SSVF) program, which provides homelessness prevention and rapid re-housing assistance to veteran families who might not qualify for other VA benefits<sup>22</sup>.

The HEARTH Act, *Opening Doors*, and recently released HUD rules all promise to change the process of homeless assistance as well as the substance. In particular, HUD’s interim Continuum of Care rule requires CoC’s to implement “Coordinated Assessment” programs for intake and referral of homeless clients. In many communities, the homeless assistance network is fragmented, and people experiencing homelessness must approach multiple providers before finding one who will accept them. Coordinated assessment is intended to make the homeless assistance system easier to access, and to connect people experiencing homelessness with the most appropriate intervention. Ideally, coordinated assessment should result in more efficient use of homeless assistance funding by reserving intensive resources (i.e. PSH) for those with the greatest needs<sup>23,24</sup>.

## REMAINING CHALLENGES

With Housing First approaches and a strong emphasis on system coordination, this generation’s push to end homelessness might actually be successful. As one example, the 100,000 Homes Campaign was launched in 2010, and met its goal of housing 100,000 of the most vulnerable people experiencing homelessness by June 2014<sup>25</sup>. However, challenges remain at all levels, from federal policy to local implementation. As always, federal funding is stretched and uncertain. Although Congress has been relatively generous with McKinney-Vento funding in the past few years, the current funding is not enough to cover renewals for projects that have already been developed<sup>26,27</sup>. Some of the “mainstream” resources we need to create paths out of homelessness, such as public housing, the Community Development Block Grant (CDBG), and community health centers, have seen significant cuts<sup>28</sup>. Others, such as Temporary Assistance for Needy Families (TANF) and Medicaid, receive non-discretionary federal funds and can grow with demand. However, recent cuts to the Supplemental Nutrition Assistance Program (SNAP, or “food stamps”), show that even these programs are vulnerable.



Homelessness emerged as a national social problem in the early 1980s, driven by the perfect storm of deinstitutionalization, rising housing costs, and stagnating wages.

The new federal approach to homelessness is also pushing communities to diminish the role of Transitional Housing (TH). The downsides of TH have been somewhat exaggerated—the limited scholarly research finds that most TH clients who complete their programs are satisfied with their experience and find permanent housing, and programs do not generally “cream” the easiest-to-serve clients. However, “screening out” and attrition of the hardest-to-serve clients are common, especially for single adults<sup>29,30</sup>. And, as noted above, a number of communities have had better results with Rapid Re-Housing. TH providers can stay competitive and protect their investments by “retooling” their programs—tailoring them to populations that need them most, eliminating requirements for sobriety and treatment participation, and even changing their service models and repurposing their buildings<sup>31,32</sup>.

Advocates for the homeless have also struggled with the role of supportive services and how to pay for them. In Permanent Supportive Housing programs, McKinney-Vento grants are a

critical funding source for support services. However, beginning in 1999, HUD established requirements and incentives for CoCs to shift spending from supportive services toward housing. The HEARTH Act shifts funding priorities even further toward housing. Medicaid is another vital funding source, but not all services are eligible for reimbursement, and not all people exiting homelessness would necessarily qualify for it. While other federal funds exist, particularly from the Department of Health and Human Services (HHS), none has been sufficient to fill the gap left by shifting McKinney funds<sup>33</sup>. This is particularly concerning to advocates for homeless families, who fear that RRH and mainstream services will be insufficient to replace the services that families with intermediate needs—who do not qualify for PSH—have traditionally received from Transitional Housing programs<sup>34,35,36</sup>. There is not yet enough data to firmly put these fears to rest, but evidence from communities that have embraced RRH for moderate- and even high-barrier families suggests that RRH does not set these families up to fail<sup>37</sup>.

## HOMELESS ASSISTANCE POLICY IN FLORIDA

Similar to the federal government, Florida's homeless assistance policy has evolved in recent years. State-level planning, coordination, data collection, and policy development is conducted by the Office on Homelessness, a division created within the Department of Children and Families (DCF) by state legislation in 2001. Before then, Florida had some statutory language on the state definition of homelessness, the functions of local homeless coalitions recognized by DCF, and assistance programs for people who were experiencing or at risk of homelessness. However, the state's homeless assistance network was underdeveloped and fragmentary—state agencies did not coordinate on homeless policy, many Continuums of Care were not applying for or winning federal CoC grants, and existing shelter beds served less than 1/3 of the homeless population<sup>38,39</sup>.

The 2001 legislation sought to fill this vacuum. The new Office on Homelessness would be led by a Council on Homelessness, a 15-member board (later increased to 17) including representatives from relevant state departments and affiliated agencies, statewide nonprofits with an interest in homelessness, and governor's appointees. The Council's role is to develop policy recommendations and report to the governor on homelessness trends. The new law defined local Continuums of Care and vested them with responsibilities similar to those dictated by HUD. DCF-recognized CoC's would be eligible for funding from two major new state programs—the Challenge Grant and the Homeless Housing Assistance Grant. The Challenge Grant funds a wide array of services in a CoC's plan, including prevention, outreach, emergency and transitional shelter, permanent housing, and supportive services, while Homeless Housing Assistance Grants fund construction and rehabilitation of permanent and transitional housing. A \$5 million annual transfer from the Local Housing Trust Fund (which funds local State Housing Initiatives Partnership, or SHIP, programs) to DCF was authorized to help fund these new programs. Other changes in the 2001 legislation included discharge planning requirements to help medical, mental health, and substance abuse facilities avoid discharging patients into homelessness; identification of homeless persons as a high-priority population for housing funded by the State Apartment Incentive Loan (SAIL) program; and a requirement that local State Housing Initiatives Partnership (SHIP) programs include partnerships with advocates for the homeless, elderly, and migrant farmworkers<sup>40</sup>.

Florida has made considerable progress on homeless service delivery since 2001. The number of Continuums of Care increased from 21 to 28 by 2009<sup>41</sup>, and today the only counties not

included in a Continuum of Care are Baker, Union, and Dixie. Every CoC has successfully applied for HUD funding, and the aggregate level of funding has increased 38% (from \$48.7 million to \$67.2 million). The number of beds for people experiencing homelessness increased by 74% between 2001 and 2012, with permanent housing beds comprising the majority of the increase<sup>42</sup>. The Council on Homelessness has disseminated best practices on institutional discharge planning, developed a framework to prevent youth aging out of foster care from becoming homeless, and provided guidance on alternatives to criminalizing problematic behaviors of people experiencing homelessness<sup>43,44</sup>. The Florida Housing Finance Corporation (FHFC), in awarding SAIL funds, HOME Investment Partnerships Program (HOME) funds from HUD, and federal Low Income Housing Tax Credits (LIHTC or Housing Credits), has increasingly prioritized developments that serve people experiencing homelessness<sup>45</sup>.

In the past few years, Florida's homeless assistance system has experienced both losses and gains. In 2010, the State Legislature discontinued the practice of transferring funds from the Local Housing Trust Fund to DCF for homeless assistance, corresponding to sweeps of the State and Local Housing Trust Funds to fill budget deficits related to the recession<sup>46</sup>. This change contributed to the Legislature's defunding of the Homeless Housing Assistance Grant and Challenge Grants in 2012. However, in 2013, the Legislature approved two statutory changes that the Council on Homelessness had advocated for years: the state's Emergency Financial Assistance for Housing Program (EFAHP) was replaced with a more flexible Homelessness Prevention program, and Continuum of Care lead were permitted to use up to 8% of their Challenge Grant awards (when available) for administrative costs<sup>47,48,49</sup>.

The 2014 legislative session saw a revival of state support for homeless assistance. Senator Jack Latvala and Representative Kathleen Peters introduced companion bills to revive Challenge Grant funding and provide a basis for DCF to determine awards to CoCs. The bills also extended the Department of Economic Opportunity (DEO)'s training and technical assistance program for affordable housing development to CoCs, and required that Challenge Grant recipients include a coordinated assessment system in their CoC plans. Latvala and Peters originally included provisions in their respective bills to dedicate 4% of Local Housing Trust Fund revenues annually for homeless assistance<sup>50,51</sup>. These provisions were stripped from the version of the House bill that was sent to the governor, but were included as non-recurring funding in the appropriations bill signed by the Governor<sup>52,53,54</sup>.

# CASE STUDY

## BIG BEND HOMELESS COALITION

**BIG BEND HOMELESS COALITION (BBHC) IS THE LEAD AGENCY FOR A CONTINUUM OF CARE THAT ENCOMPASSES TALLAHASSEE, LEON COUNTY, AND SEVEN NEIGHBORING RURAL COUNTIES.**

Since 2006, BBHC has become the owner of three permanent supportive housing projects, including Home Front. This 53-unit apartment complex serves formerly homeless Veterans, and rents are subsidized by project-based HUD-VA Supportive Housing (HUD-VASH) vouchers. The building was rehabilitated using Neighborhood Stabilization Program (NSP) funds, and BBHC won the City of Tallahassee's bid to own and manage the project in 2010. BBHC coordinates with the Department of Veterans Affairs and other agencies to provide supportive services.

Big Bend Homeless Coalition operates other successful programs, including a Rapid Re-Housing program funded by the City of Tallahassee's Emergency Solutions Grant (ESG), a Supportive Services for Veteran Families (SSVF) program, and a 140-bed transitional housing campus. The Coalition is also the administrator of the Continuum of Care's HMIS, which boasts high bed coverage rates and data quality. These metrics have improved since the Coalition's HMIS administrators instituted a data grading system for participating agencies.

The Big Bend area, like many other regions of the state, faces plenty of challenges, including reduced funding for housing and supportive service programs, and building consensus around CoC governance and a coordinated assessment system. However, the Big Bend Homeless Coalition is working to steer the region's dedicated providers and advocates toward implementing a system that quickly and effectively moves individuals and families out of homelessness and into housing.



# CASE STUDY

## THE LORD'S PLACE

THE LORD'S PLACE HAS PROVIDED SHELTER, SERVICES, AND HOUSING TO HOMELESS INDIVIDUALS AND FAMILIES IN PALM BEACH COUNTY, FL FOR OVER 30 YEARS. THE ORGANIZATION HAS A STAFF OF 93, AND WAS THE ONLY NONPROFIT INCLUDED IN FLORIDA'S TOP 100 COMPANIES TO WORK FOR IN 2014. IN THAT YEAR, 57 PERCENT OF NEW HIRES WERE FORMERLY HOMELESS CLIENTS.

The transitional housing programs operated by The Lord's Place include facilities for single women who are not domestic violence victims and men who are ex-offenders, two underserved populations in Palm Beach County. The men's campus includes an urban garden, which provides residents with a therapeutic activity and supplies the Café Joshua Catering Company, another social enterprise operated by The Lord's Place. The organization also operates two permanent supportive housing programs—one for exemplary “graduates” of the men's campus transitional program, and one for disabled adults who were chronically homeless.

As HUD's funding priorities shift away from transitional housing programs, many Continuums of Care are facing difficult decisions. However, congregate transitional housing still has a role to play for high-need populations. Although current best practices call for a “low-demand” approach in congregate transitional housing facilities whenever possible, higher-demand approaches may be appropriate for specific populations that want or need it. These populations may include youths and persons who desire a drug-free environment to recover from addiction.

## MOVING FORWARD

In short, the federal policy landscape for homelessness has shifted dramatically under the feet of state and local governments, which must now transform their systems within federally prescribed timelines, while dealing with resource constraints and an inevitable trial-and-error process. Many communities across the nation have embraced these mandates, enabling them to significantly reduce their homeless populations. In Florida, state officials and many local leaders have sought to align their priorities and resources with the federal homeless assistance model. However, our state has struggled to channel enough resources for homeless assistance programs, and many communities are divided on how to address high homeless populations in public areas. The revival of the Challenge Grant and availability of training and technical assistance is intended to break down these barriers and help local communities scale up their homeless assistance efforts. This guide will serve as a reference for homeless assistance providers and advocates, affordable housing providers, local governments, and other stakeholders who want to better understand the philosophies, trends, and resources of federal and state homeless assistance policy.



◀ For more information:

The Lord's Place  
<http://www.thelordsplace.org/home>

WPTV: The Lord's Place Offers a Garden of Hope  
<http://www.wptv.com/news/region-c-palm-beach-county/west-palm-beach/the-lords-place-offers-a-garden-of-hope>

HUD: What About Transitional Housing?  
<https://www.hudexchange.info/news/snaps-weekly-focus-what-about-transitional-housing/>



TRENDS

# NATIONAL & STATE HOMELESSNESS

TO UNDERSTAND THE EXTENT AND NATURE OF HOMELESSNESS, AND TO PLAN EFFECTIVELY TO SERVE PEOPLE EXPERIENCING HOMELESSNESS, IT IS NECESSARY TO HAVE ACCURATE DATA AT ALL GEOGRAPHIC LEVELS.

Communities across the nation have been attempting to count their homeless populations for many years, and a definitive 1996 study conservatively estimated the national homeless population to be 444,000<sup>55</sup>. Since the early 2000s, federal officials have sought to standardize the process of counting people experiencing homelessness. In 2004, HUD first released data collection standards for computer-based Homeless Management Information Systems (HMIS) at the Continuum of Care level<sup>56</sup>. That same year, HUD refined the standards for

“Point-in-Time” (PIT) counts of homeless populations to allow only scientific, statistically reliable counting methods. PIT comparisons across years and communities must still be done with care, since different numbers may reflect differences or changes in count methodologies, severe weather in a CoC on the night of the count, an increase in homelessness due to natural disasters, or other unforeseen factors. Nonetheless, PIT counts are an illuminating and commonly used benchmark for examining trends in homelessness<sup>57</sup>.

## NATIONAL AND STATE HOMELESSNESS TRENDS

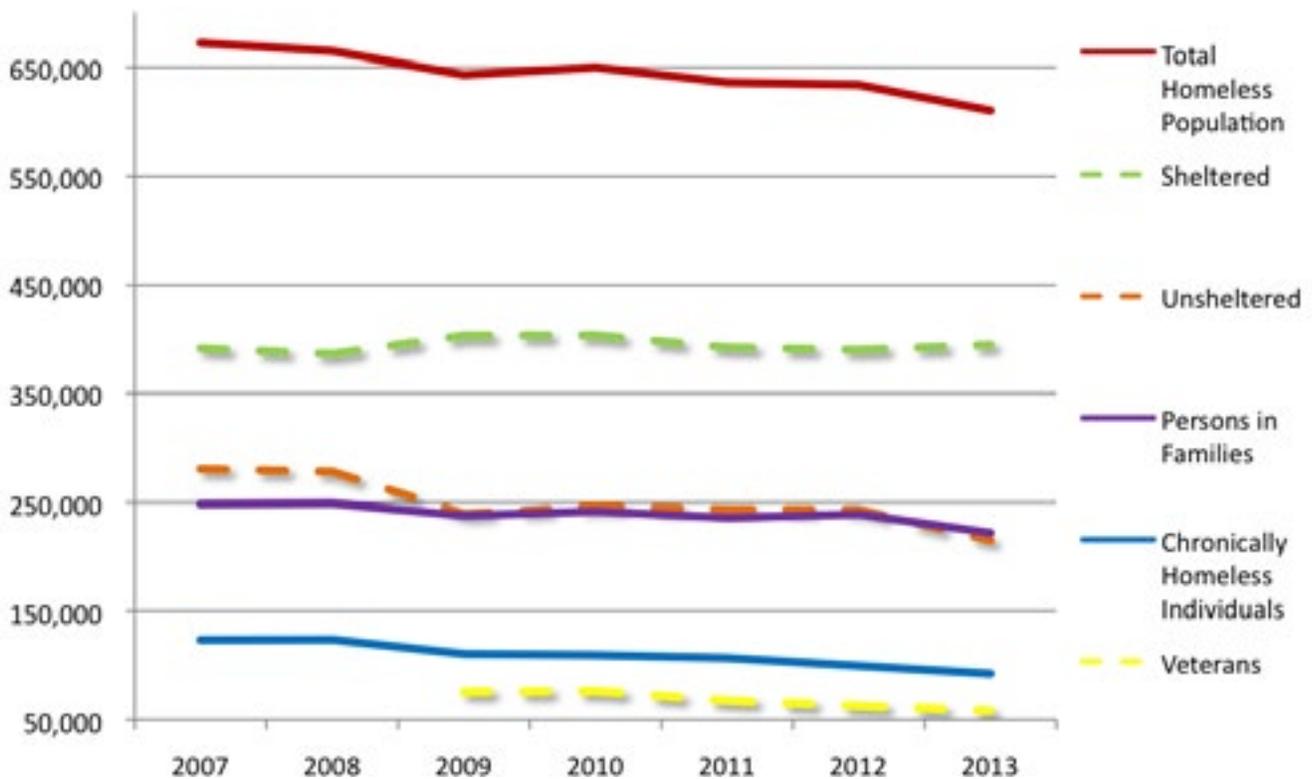
In their PIT counts, CoCs count people who meet HUD’s definition of “literally homeless”. This includes the “unsheltered” homeless population—those living outdoors or in cars, abandoned buildings, or other places not meant for human habitation—and people living in emergency shelters, transitional housing, safe havens, and motels paid for by government or charitable organizations. It does not include people who are doubled up with family and friends, or living in a motel paid for on their own. States or local continuums of care, for their own planning and awareness-raising purposes, may choose to count people who are precariously housed but not literally homeless. However, these individuals will not be considered by HUD when determining a CoC’s level of need for homeless assistance funds<sup>58,59</sup>. The next section contains a more detailed description of various definitions of homelessness.

Figures 1 and 2 show trends in the total homeless population and selected subpopulations in the United States and Florida, respectively, according to PIT counts. Table 1 shows the percent change

es in homelessness in the U.S. and Florida<sup>60,61,62</sup>. At the national level, the total homeless population dropped from 671,888 to 610,042 people between 2007 and 2013. This 9% decrease was driven by an even sharper (23%) decline in the number of unsheltered homeless people. Veteran homelessness decreased by 24% between 2010 (the first year for which an estimate of the total homeless veteran population was available for the U.S. and all states) and 2013, while chronic homelessness declined by one-quarter between 2007 and 2013. Family homelessness decreased at a slower but still substantial rate (11%).

In Florida, by contrast, the total homeless population in 2013 (47,862) was very close to the 2007 population (48,069). As Figure 2 shows, homelessness during the period shown peaked in 2010 and declined thereafter, corresponding with the peak of the economic recession and the slow recovery thereafter. In contrast to the nation overall, the unsheltered homeless population increased slightly (2%) while the sheltered population decreased

Figure 1. Homeless Population And Selected Subpopulations In The United States.

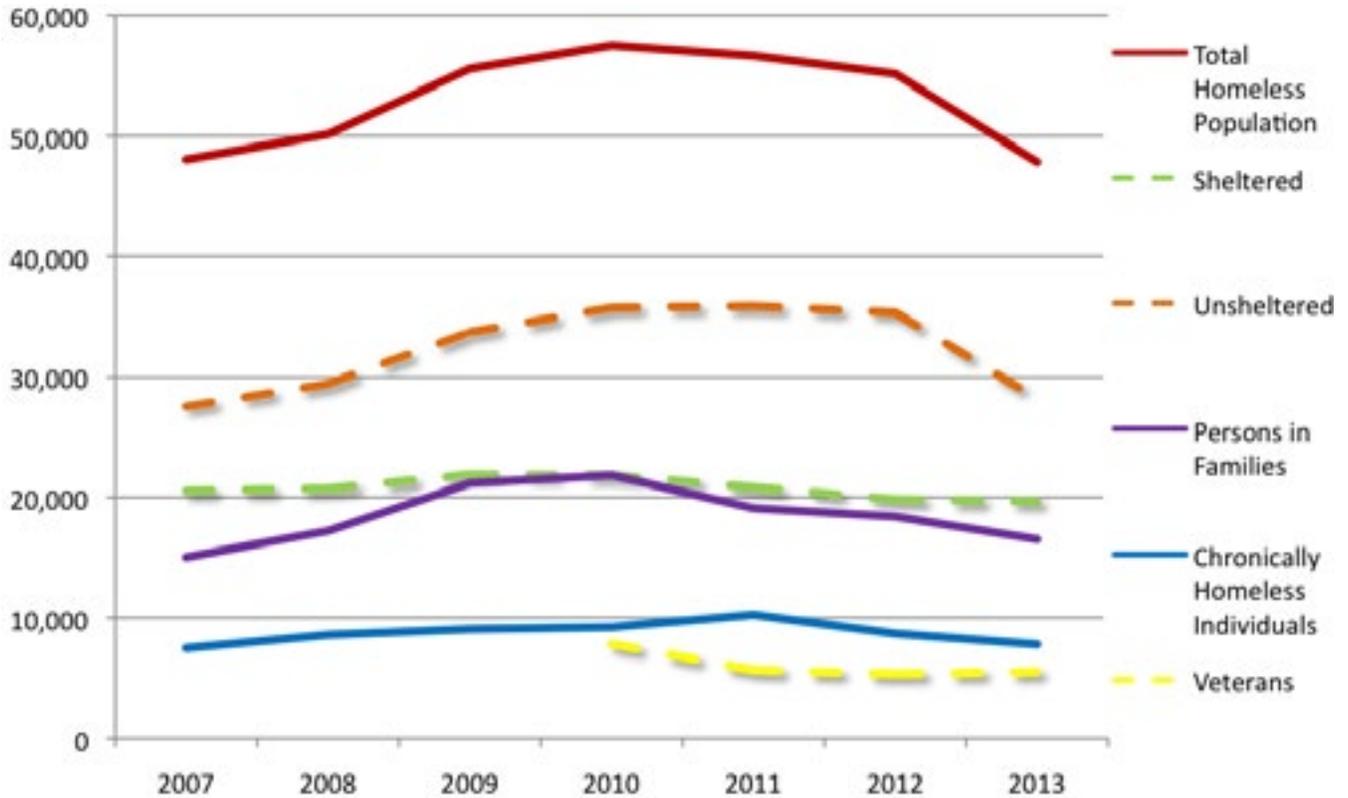


Source: HUD PIT Data

(4%). Florida’s subpopulations of homeless people in families and the chronic homeless have actually increased since 2007, by 10% and 4%, respectively. Evidently, Florida’s economic and housing market recovery has not completely pulled the most severely impacted families out of homelessness. One bright spot is Florida’s 29% decrease in homeless veterans between 2010

and 2013, a proportionately larger reduction than in the nation’s overall homeless veteran population. However, this population has not declined substantially since 2011. The renewed state funding for homeless assistance, it appears, could not come at a better time.

Figure 2. Homeless Population and Selected Subpopulations in Florida.



Source: HUD PIT Data

Table 1. Changes in Homeless Populations and Selected Subpopulations in the United States and Florida.

Homeless Population Category	United States	Florida
Total Homeless Population (2007-2013)	-9%	-0.4%
Sheltered Homeless (2007-2013)	1%	-4%
Unsheltered Homeless (2007-2013)	-23%	2%
Persons in Families (2007-2013)	-11%	10%
Chronically Homeless Individuals (2007-2013)	-25%	4%
Veterans (2010-2013)	-24%	-29%

Source: HUD PIT Data 2007 to 2013

<https://www.hudexchange.info/resource/3300/2013-ahar-part-1-pit-estimates-of-homelessness/>



## DEFINING

# HOMELESSNESS

### DEFINITION OF HOMELESSNESS

**H**UD uses the following definition of “homeless” (abridged for clarity):

1. An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
  - a. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, [etc.];
  - b. An individual or family living in a supervised ... shelter

designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or ... government programs ...); or

- c. An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;
2. An individual or family who will imminently lose their primary nighttime residence, provided that:

- a. The primary nighttime residence will be lost within 14 days of the date of the application for homeless assistance;
  - b. No subsequent residence has been identified; and
  - c. The individual or family lacks the resources or support networks ... needed to obtain other permanent housing;
3. Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
- a. Are defined as homeless under [other federal statutes];
  - b. Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;
  - c. Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and
  - d. Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment ...
4. Any individual or family who:
- a. Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life threatening conditions ...
  - b. Has no other residence; and
  - c. Lacks the resources or support networks ... to obtain other permanent housing.

Individuals and families who meet Category 1 of HUD's homeless definition are considered "literally homeless", and Continuums of Care (CoCs) count them in annual Point-in-Time (PIT) counts. The federal HEARTH Act of 2009 increased the time to imminent loss of housing in Category 2 from 7 to 14 days, and added the Category 3 definition of homelessness (families and youth who are defined as homeless under other federal statutes and are living unstably). After the HEARTH Act passed, HUD published its final rule defining homelessness on 12/5/11. Numerous commentators on the proposed homelessness definition rule had urged HUD to expand the definition of homelessness to include those who are doubled up or staying in motels not paid for by homeless service providers. However, HUD maintained that its definition abides by the HEARTH statute and directs the agency's homeless assistance resources to those who need them most. Moreover, HUD pointed out that the expanded definition of "at risk of homelessness" in the Emergency Solutions Grant

(ESG) interim rule would encompass many precariously housed individuals and families.

An important homeless subpopulation with its own HUD definition is the chronically homeless:

1. An individual who:
  - a. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
  - b. Has been homeless ... continuously for at least one year or on at least four separate occasions in the last 3 years, where the cumulative total of the four occasions is at least one year. ...
  - c. Can be diagnosed with one or more of the following conditions: substance abuse disorder, serious mental illness, developmental disability ... post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;
2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
3. A family with an adult [or minor] head of household ... who meets all of the criteria in paragraph (1) of this definition ...

Before the HEARTH Act was passed, HUD's definition of chronic homelessness only applied to unaccompanied individuals, not to families. HUD published its proposed rule for the revised definition of chronic homelessness in its ESG interim rule, released 12/5/11, and again in the Rural Housing Stability Program (RHSP) proposed rule, released 3/27/13.

Several other federal statutes have definitions of homelessness for the purposes of administering their programs:

1. Runaway and Homeless Youth Act
2. Head Start Act
3. Violence Against Women Act
4. Public Health Service Act
5. Food and Nutrition Act
6. Child Nutrition Act
7. Education for Homeless Children and Youths (Subtitle B of Title VII of the McKinney-Vento Act)

The Runaway and Homeless Youth Act defines a homeless youth as one who cannot live safely with a relative and has no safe alternative living arrangement. The other six statutory definitions include language similar to HUD's "literally homeless" category, and expand upon it to varying degrees to include those who

## DEFINITION OF HOMELESSNESS

are precariously housed. The homelessness definition in the Education for Homeless Children and Youths (ECHY) Act, administered by the U.S. Department of Education, is particularly important. It includes “children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; [or] are living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations”. Every state must have a coordinator to ensure ECHY implementation, and each school district must have a liaison to help identify homeless students and help them overcome barriers to enrolling and staying in school, including lack of transportation, immunizations and identification documents.

Before 2009, Florida’s homeless definition was similar to the relatively limited definition used by HUD. In 2009, the state’s definition of homelessness (F.S. 420.621(5)) was revised to more closely resemble the ECHY definition:

“Homeless,” applied to an individual, or “individual experiencing homelessness,” means an individual who lacks a fixed, regular, and adequate nighttime residence and includes an individual who:

- a. Is sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;
- b. Is living in a motel, hotel, travel trailer park, or camping ground due to a lack of alternative adequate accommodations;
- c. Is living in an emergency or transitional shelter;
- d. Has a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings;
- e. Is living in a car, park, public space, abandoned building, bus or train station, or similar setting; or
- f. Is a migratory individual who qualifies as homeless because he or she is living in circumstances described in paragraphs (a)-(e).

**“...Each school district must have a liaison to help identify homeless students and help them overcome barriers to enrolling and staying in school, including lack of transportation, immunizations and identification documents.”**

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  - o Head Start Act: <http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section9832&num=0&edition=prelim>
  - o Violence Against Women Act: <http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section14043e-2&num=0&edition=prelim>
  - o Public Health Service Act: <http://uscode.house.gov/view.xhtml?path=/prelim@title42/chapter6A/subchapter2/partD&edition=prelim>
  - o Food and Nutrition Act: <http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title7-section2012&num=0&edition=prelim>
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GLOSSARY OF TERMS

FOR HOMELESS  
ASSISTANCE  
POLICY

# FEDERAL POLICIES AND PROGRAMS



## McKinney-Vento Homeless Assistance Act

The McKinney-Vento Act is the definitive piece of federal legislation for federal assistance to homeless persons. In 2009, the Act was reauthorized and substantially amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. Originally passed as the Stewart B. McKinney Homeless Assistance Act in 1987, this statute responded to the substantial increase in homelessness throughout the 1980s, and included elements of legislation passed in the mid-1980s. The original bill provided for 20 programs to be administered by 9 federal agencies, including funding programs for emergency and transitional shelter, job training, health care, and adult education for

the homeless. It built on earlier legislation that made “mainstream” public benefit programs, such as Food Stamps and Medicaid, more accessible to homeless individuals, and created requirements and provisions for homeless children to receive public education. Over the years, some programs have been scaled back or eliminated, and new programs have been added. In 2000, the statute was renamed the McKinney-Vento Homeless Assistance Act.

Before 2009, the last major Congressional reauthorization of the McKinney-Vento act was included in the Housing and Community Development Act of 1992. By this time, the four

major programs overseen by HUD were in place:

- 1) **Emergency Shelter Grant (ESG):** Provided funding to state and local governments on a formula basis for renovation of structures for emergency shelters, shelter operation, services, and limited prevention activities.
- 2) **Supportive Housing Program (SHP):** Provided funding on a competitive basis for development, operation, and service provision for four main program types:
  - a) **Permanent Supportive Housing (PSH)** for disabled homeless persons,
  - b) **Transitional Housing (TH),**
  - c) **“Safe Havens”** (shelters for homeless persons who are unwilling or unable to accept housing and supportive services), and
  - d) **Supportive services alone.**
- 3) **Shelter Plus Care Program (S+C):** Provided funding on a competitive basis for rental assistance for homeless persons

with chronic disabilities, generally including those with severe mental illness, HIV/AIDS, or chronic chemical dependency. Applicants were required to provide supportive services for these residents, with their own funds or those of a third party.

- 4) **Section 8 Moderate Rehabilitation Single-Room Occupancy Program (SRO):** Provided funding on a competitive basis for rental assistance for occupants of moderately rehabilitated SRO facilities, with priority for formerly homeless tenants.

Between 1992 and 2009, changes to the McKinney-Vento Act were primarily made through Congressional appropriations and HUD’s rulemaking process. The most notable change was HUD’s introduction of the Continuum of Care (CoC) framework in 1994. The HEARTH Act of 2009 made substantial changes to the McKinney-Vento Act, including an increased emphasis on prevention and rapid rehousing, an expanded definition of homelessness, and consolidation of HUD’s three competitive grant programs into one Continuum of Care program.



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# Homeless Emergency Assistance And Rapid Transition To Housing (Hearth) Act

The HEARTH Act was passed by Congress on May 20, 2009, as part of the “Helping Families Save Their Homes” Act. The HEARTH Act reauthorized the McKinney-Vento Homeless Assistance Act for the first time since 1992, and made several substantial changes and additions:

- 1) The definition of “homelessness” was expanded. At the time of the HEARTH Act’s passage, the “homeless” definition already included persons at “imminent risk” of homelessness, defined as facing a loss of housing in 7 days with no alternative housing arrangements or support networks. The HEARTH Act increases the threshold for “imminent risk” from 7 to 14 days. The Act also expands the homelessness definition to include unaccompanied youth and families with children and youth who are defined as “homeless” under other federal statutes, have not lived independently in permanent housing for a “long term period” with “frequent moves” over that period, and will continue to live unstably for an extended period because of disability, a history of domestic violence or childhood abuse, or multiple barriers to employment.
- 2) The definition of “chronic homelessness” was expanded to include families as well as individuals.
- 3) The Emergency Shelter Grant was renamed the Emergency Solutions Grant, its share of homeless assistance funding increased, and its eligible activity requirements amended to emphasize prevention and Rapid Re-Housing.
  - a. HUD must allocate 20% of its homeless assistance funding to the Emergency Solutions Grant program, whereas the Emergency Shelter Grant received only 10% of the annual allocation.
  - b. The Emergency Shelter Grant program allowed grantees (i.e. state and local governments) to spend a maximum of 30% of their funds on prevention, and only for people with a sudden loss of income. By contrast, the Emergency Solutions Grant program imposes a 60% spending cap on grantees for street outreach and emergency shelter activities. Additionally, persons defined as “at risk of homelessness” need not have a sudden loss of income, but must have incomes below 30% AMI and unstable living arrangements (including doubling up with others or living in a motel). A “hold-harmless” provision ensures that grantees will not lose funding for emergency shelter, outreach, and related services.
- 4) HUD’s three competitive funding programs are consolidated into one competitive “Continuum of Care” (CoC) Program, which expands eligible activities and emphasizes performance. This element of the HEARTH Act codifies into law the CoC framework that HUD had already been using to award its competitive homeless assistance grants.
  - a. The CoC Program combines the eligible activities of the Supportive Housing Program (SHP), Shelter Plus Care Program (S+C), and the Section 8 Moderate Rehabilitation Single-Room Occupancy Program (SRO). Eligible activities are expanded to include limited-term rental assistance and supportive services for Rapid Re-Housing.
  - b. The CoC subtitle stipulates that an amount  $\geq 30\%$  of the combined funds appropriated to HUD for ESG and CoC must be used for permanent housing for disabled individuals or households with an adult (or minor head-of-household) who is disabled. Additionally, an amount  $\geq 10\%$  of HUD’s combined ESG and CoC funds must be used for permanent housing for families with children. These set-asides apply to the aggregate national use of funds, not to individual CoCs. Housing for homeless families with a disabled adult member contributes to both set-asides simultaneously, so the total HUD funding committed to these set-asides may be less than 40%. Although the combined amount of ESG and CoC funds are used to calculate the set-asides, the actual funds for these activities come from the CoC pool.

- c. Up to 10% of CoC funds may be used for unaccompanied youth and families with children who are defined as homeless under other federal statutes, but only if the community can demonstrate to HUD that these activities are of equal or greater priority than activities for other homeless subpopulations. An exception to this 10% cap is made for communities with a homelessness rate of  $\geq 0.1\%$ .
  - d. In evaluating funding applications, the emphasis is shifted more toward performance measures, such as the degree of coordination among CoC partners and reductions in homelessness rates, length of homeless spells, and recidivism. Prior to the HEARTH Act, scoring for CoC funds heavily emphasized community needs, CoC capacity, and the feasibility of individual projects.
  - e. The lead agency in a CoC, called a Collaborative Applicant in this act, may also apply to or be designated by HUD as a “Unified Funding Agency”. Under the traditional CoC application process, HUD awards funding directly to each project included in a CoC application. A UFA receives the community’s entire CoC allocation from HUD and subgrants it to project sponsors. The UFA is responsible for financial oversight of its subgrantees.
  - f. Project sponsors may use up to 10% of their funding for administrative costs, an increase from 5% for SHP and 8% for SPC.
  - g. In aggregate, all CoC projects (except those that provide funds for leasing a housing or support service facility) must have a 25% match. For individual projects, the matches may be greater or less than 25%, and may be cash or in kind. Prior to the HEARTH Act, each activity in the competitive grant programs (e.g. construction/rehab, operating expenses) had its own match requirements.
- 5) HUD offers incentives to “high-performing communities” and those that implement “proven strategies”. Previously, HUD had offered bonus funds to CoC applicants that made PSH a top priority, and gave higher scores to CoC applications that requested a higher percentage of funds for PSH.
- a. To be designated as high-performing, a community must have an average duration of homelessness episodes and a recidivism rate below a certain level, and have effective outreach and data management programs. A high-performing community may allocate its CoC funds however it wishes among CoC activities, and may also fund the prevention



## HUD OFFERS INCENTIVES TO “HIGH-PERFORMING COMMUNITIES” AND THOSE THAT IMPLEMENT “PROVEN STRATEGIES”.

### WHAT IS A “HIGH PERFORMING” COMMUNITY?

To be designated as high-performing, a community must have an average duration of homelessness episodes and a recidivism rate below a certain level, and have effective outreach and data management programs.



and rapid re-housing activities included in the ESG program.

b. Proven strategies include Permanent Supportive Housing (PSH) for chronically homeless individuals and families, Rapid Re-Housing for homeless families, and any other strategies that HUD designates on the basis of strong evidence. A community that fully implements a proven strategy will receive a bonus, which may be used for any CoC activity and for the ESG program’s prevention and re-housing activities.

6) HUD is required to set aside at least 5% of its CoC funding for a Rural Housing Stability Assistance Program (RHSP). Rural communities who apply for this funding compete only with other rural communities, and the permitted uses of the funding reflect the unique nature of homelessness and housing instability in rural areas. These uses include providing rental assistance and housing relocation/stabilization services to persons at risk of homelessness, and home repairs to make premises habitable. Rural communities may also use up to 20% of funds from this program for capacity building. Previously, there was no

dedicated funding stream for rural CoCs, and rural applicants competed against all other CoC applicants.

7) Project sponsors that provide emergency shelter, transitional housing, or permanent housing to families cannot discriminate based on the age of the children. An exception is made for transitional housing facilities with a targeted mission that requires them to turn away children of a certain age, provided that alternate living arrangements are available for the families they turn away.

8) Collaborative Applicants are required to ensure that project sponsors in their jurisdiction participate in a Homeless Management Information System (HMIS).

The provisions of the HEARTH Act generally took effect in 2011. On December 5, 2011, HUD issued a Final Rule on the definition of homelessness. Among other elements of the Act, HUD defines “long term period” and “frequent moves” or families and unaccompanied youth living unstably as a 60-day period and at least two moves, respectively. HUD also issued an interim rule for ESG on 12/5/2011, and a CoC interim rule on 7/31/12, and an RHSA proposed rule on 3/27/13.

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## United States Interagency Council on Homelessness (USICH)

The United States Interagency Council on Homelessness, an independent agency in the Executive Branch of the Federal Government, coordinates the efforts of 19 federal agencies to prevent and end homelessness, as well as forming partnerships with state and local governments and private organizations, conducting research, and offering technical assistance to stakeholders. Originally called the Interagency Council on the Homeless, the agency was created by the Stewart B. McKinney Homeless

Assistance Act passed in 1987. Some of the USICH's most prominent member agencies include the Department of Housing and Urban Development (HUD), the Department of Health and Human Services (HHS), and the Department of Veterans Affairs (VA). The Council became dormant in the mid-1990s, but was revived in 2002 as part of the Bush administration's commitment to end chronic homelessness. In 2010, USICH released *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*.

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“The United States Interagency Council on Homelessness...coordinates the efforts of 19 federal agencies to prevent and end homelessness...”

## Opening Doors

The HEARTH Act of 2009 required the United States Inter-agency Council on Homelessness (USICH) to develop a national strategic plan to prevent homelessness. In 2010, USICH released *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*. The *Opening Doors* plan commits to finishing the effort launched by the second Bush administration to end chronic homelessness by 2015, and sets goals of ending veteran homelessness by 2015 and homelessness among families, youth, and children by 2020. It provides a generalized roadmap for USICH’s member agencies—and their state and local partners in the public and private sectors—to follow when developing and coordinating homeless services.

With an emphasis on homelessness prevention, Housing First strategies, and the unique needs of different homeless subpopulations, *Opening Doors* addresses five major themes: 1) Increasing collaboration and capacity among all levels of government, homeless service providers, foundations, and other organizations; 2) Expanding the supply of and access to affordable housing; 3) Increasing economic security, including earning power and access to mainstream support services; 4) Increasing health and stability, including access to medical and behavioral health services; and 5) Retooling the crisis response system to prevent homelessness and emphasize Housing First. To support these goals, the Obama Administration’s FY 2011 budget included an 11.5 percent funding increase for targeted homeless programs. However, *Opening Doors* mainly advocates for more efficient use of existing resources to meet the demands of those who are homeless or at-risk of homelessness. Social service providers and funding agencies are urged to target mainstream

services toward homeless and at-risk persons, eliminate barriers to access, and coordinate their services for increased impact.

USICH issued an amendment in 2012, and has provided annual updates each year since *Opening Doors* was released. The 2012 amendment revised some of the original plan’s objectives to more clearly promote positive educational outcomes among homeless children, and to better serve unaccompanied youth experiencing homelessness. The 2013 update credited *Opening Doors* with facilitating a 6% decrease in the overall homeless population since 2010, including a 24% decrease in Veteran homelessness and a 15% decrease in the chronically homeless population. The update detailed its efforts to help homeless service providers form partnerships with Public Housing Authorities (PHAs) and Temporary Assistance for Needy Families (TANF) to target their resources toward people experiencing or at risk of homelessness, as well as a variety of demonstration programs.



The 2012 amendment revised some of the original plan’s objectives to more clearly promote positive educational outcomes among homeless children, and to better serve unaccompanied youth experiencing homelessness.

**Source:**

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## Emergency Solutions Grant (ESG)

A grant authorized by the McKinney-Vento Act and awarded by HUD on a formula basis to states, metropolitan cities, urban counties, and territories to provide emergency shelter, street outreach, and prevention services to homeless persons. HUD requires recipients of formula grants for housing and community development to submit Consolidated Plans describing how the funding will be used; thus, grantees plan and apply for ESG in tandem with Community Development Block Grant (CDBG), HOME Investment Partnerships Program (HOME), and Housing Opportunities for Persons with Aids (HOPWA) funds. ESG was titled the “Emergency Shelter Grant” until 2009, when the McKinney-Vento Act was reauthorized and amended by the HEARTH Act. Drawing on experience with the Homelessness Prevention and Rapid Re-Housing Program (HPRP), the HEARTH Act increased ESG’s emphasis on homelessness prevention, and added rapid re-housing as an eligible activity. In December 2011, HUD published an Interim Rule for the new Emergency Solutions Grant program.

ESG has five main eligible activities:

- 1) **Street Outreach:** Primarily includes engagement activities, such as identifying and assessing homeless persons on the street, and providing food and clothing; case management; and emergency outpatient medical and mental health care.
- 2) **Emergency Shelter:** Primarily includes renovation of existing buildings to serve as shelters; providing essential services such as case management, employment assistance, and substance abuse treatment; and shelter operation, including rent, utilities, and maintenance.
- 3) **Homelessness Prevention:** Includes two main types of eligible costs: housing relocation and stabilization services, and rental assistance. Eligible costs for the former include rental application fees, security and utility deposits, last month’s rent, utility payments up to 24 months, moving costs, housing search and placement, mediation with landlords and/or roommates, legal services, and credit repair. Rental assistance may be tenant-based or project-based, and may be short-term (up to 3 months) or medium-term (up to 24 months). Beneficiaries may also receive assistance for up to 6 months of rental arrears.
- 4) **Rapid Re-Housing:** Includes the same eligible costs as Homelessness Prevention.
- 5) **Homeless Management Information System (HMIS):** The HEARTH Act requires all ESG projects to participate in an HMIS, or data management system used by a local Continuum of Care (CoC) to comply with HUD’s data collection requirements.

The ESG Interim Rule contains several new requirements for grantees, such as consultation with the local CoC on how to allocate funds and operate programs. In the housing needs assessments for their Consolidated Plans, grantees must address the needs of formerly homeless households whose rental assistance will soon expire. Additionally, the Interim Rule proposes a requirement for grantees and subgrantees (or “recipients” and “subrecipients”) to use a Coordinated Assessment model for screening and referring applicants.

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## Continuum of Care (CoC)

Generally, a Continuum of Care is a system for planning, coordinating, and delivering services to people in all stages of homelessness. These services include outreach and intake, emergency shelter, transitional housing, and permanent housing, with supportive services at all stages to allow homeless clients to meet their immediate needs and progress toward self-sufficiency.

Currently, the term “Continuum of Care” has four distinct usages: 1) The comprehensive and coordinated system for assisting homeless persons, as described above; 2) The competitive homeless assistance grant program administered by HUD under the McKinney-Vento Act; 3) A geographic area where public agencies, nonprofit service providers, and other relevant stakeholders apply jointly for CoC funding from HUD, and have an ongoing planning process to address homelessness; and 4) A linear model of homeless assistance where a client transitions in stages toward independent living, often with conditions for moving to the next stage. These meanings are described in more detail below:

- 1) By consciously providing services as a part of a continuum, rather than in isolation, homeless assistance providers ideally become knowledgeable about the full menu of services avail-

able to their clients, and may quickly and seamlessly make referrals to meet each client’s unique needs. Operating as a continuum also helps providers to avoid duplication of efforts, identify unmet needs, and coordinate with mainstream social services.

- 2) Under the HEARTH Act, the 2009 bill that reauthorized and amended the McKinney-Vento Act, CoC is a single competitive grant program. Funds may be used for:

- a. Permanent Housing, including Permanent Supportive Housing (PSH) and Rapid Re-Housing (RRH). Eligible costs include acquisition, rehabilitation, new construction, leasing, rental assistance, operating costs, and supportive services. PSH is available to individuals with disabilities, and to families in which an adult or child has a disability. RRH is available to individuals or families with or without disabilities, and provides short-term (up to 3 months) or medium-term (3 to 24 months) tenant-based rental assistance and supportive services. RRH clients may receive supportive services for up to 6 months after rental assistance stops.



b. Transitional Housing (TH) for homeless individuals and families for up to 24 months. Eligible costs include acquisition, rehabilitation, new construction, leasing, rental assistance, operating costs, and supportive services. Note that CoC funds may be used to provide rental assistance to tenants of TH programs that charge rent.

c. Supportive Services Only (SSO). In addition to the supportive services themselves, eligible costs include acquisition, rehabilitation, and leasing of structures for providing supportive services for homeless persons, as well as operating costs for the structure and relocation costs for those displaced by the project.

d. Homelessness Prevention. Eligible costs include rental assistance and housing relocation/stabilization services, using the same guidelines as the Emergency Solutions Grant (ESG) program. Only CoC's designated as "High-Performing Communities" may use CoC funds for homelessness prevention (see HEARTH Act).

e. Homeless Management Information Systems (HMISs).

CoC funds can be used to preserve existing permanent housing and support service facilities for which other funding sources are no longer available. Additionally, for former TH residents and current PSH residents who were homeless in the prior 6 months, supportive services may be provided for up to 6 months after leaving TH or homelessness.

- 3) Between 1987, when the McKinney-Vento Act was passed, and 1993, agencies that wished to provide homeless assistance applied individually to HUD for competitive grant funding. Starting in 1994, HUD began requiring agencies to organize themselves into geographically delineated Continuums of Care and submit joint applications, in an effort to encourage planning and coordination of services. To form a Continuum of Care, agencies in a geographic area come together and choose the geographic boundary of the

area they serve, the lead agency (known as a Collaborative Applicant in the HEARTH Act) to administer the planning and grant application process, and the stakeholders who should be included in the CoC. A CoC may be a city, county, or region, or the "balance of state" not included in local or regional CoCs. Six states with small populations have single, statewide CoCs. In addition to service providers and government administrative agencies that specifically address homeless populations, stakeholders commonly include general providers of assisted housing; providers of medical care, mental health services, substance abuse treatment, and other supportive services; administrators of mainstream benefit programs, public schools, and workforce development programs; religious groups; and representatives from law enforcement, correctional institutions, and the business community. These CoC coalitions should not restrict their efforts to preparing grant applications, but rather should serve as ongoing strategic planning bodies. CoC service areas are not allowed to overlap.

- 4) Until recently, the Continuum of Care framework for homeless assistance was meant not only to be comprehensive and integrated, but also to be linear. The prevailing philosophy among homeless service providers was that clients had to progress through a set of steps to develop the skills needed to live independently. Sobriety has often been required for admission to an emergency shelter; while Transitional Housing (TH), which often includes requirements for sobriety and mental health / substance abuse treatment compliance, was seen as a necessary intermediate step before permanent housing. Starting in the early 2000s, the "Housing First" model has replaced the Continuum of Care model as a preferred strategy for homeless assistance. The Housing First model directs homeless persons to permanent housing as quickly as possible, without preconditions for sobriety or compliance with treatment or life skills training regimens.

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# Runaway and Homeless Youth Act (RHYA)

RHYA is a federal statute that authorizes funding for outreach, shelter, temporary housing, and supportive services for runaway and homeless youth. Originally passed as the “Runaway Youth Act” in 1974, the statute became the “Runaway and Homeless Youth Act” in 1977. RHYA funds are administered by the U.S. Department of Health and Human Services (HHS) and awarded as competitive grants to qualified public and nonprofit agencies.

The Runaway and Homeless Youth program administered by HHS includes three main grants:

- 1) Basic Center Program—Funds acquisition and renovation (limited to 15% of a grantee’s award in most cases) of structures to serve as emergency shelters. Youth up to 18 years of age (or older, if allowed by state licensing laws for such facilities) may stay in a basic shelter for up to 21 days. Basic center grants are also used for outreach, food and clothing, medical care, counseling, recreation programs, aftercare services, and other activities. Basic Center programs work with youth to reunite them with relatives or guardians, if it is in their best interest. Services are also available to youth who are at risk of becoming separated from their families.
- 2) Transitional Living Program—Supports temporary housing (up to 21 months) for youth who are between ages 16 and 22



upon entry. Temporary housing arrangements include group homes, maternity homes for pregnant and parenting youth, host family homes, and supervised apartments owned by the program or rented in the community. Transitional living programs also include outreach, medical care, mental health counseling, guidance on education, employment, and life skills, and other activities.

- 3) Street Outreach Program—Targets youth who have experienced or are at risk for sexual exploitation. Activities include, but are not limited to, outreach and education, referrals for shelter and services, crisis intervention, and follow-up support.

On 4/14/14, HHS issued a proposed rule for its RHY programs to reflect the provisions of the Reconnecting Homeless Youth Act of 2008, which requires the use of performance standards for evaluating program success. Some examples of performance standards in the proposed rule include timeliness requirements for notifying parents or guardians (if appropriate) that a youth has entered a Basic Center, ensuring that 90% or more of youth exit from Basic Shelters and Transitional Living programs to “safe and appropriate” settings, and ensuring that pregnant youth in Transitional Living programs have consistent pre-natal care. The proposed rule also makes some technical changes, including clarifying definitions.

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# Rural Housing Stability Assistance Program (RHSP)

A competitive grant program authorized by the HEARTH Act to serve rural areas whose needs have not been adequately met by the Continuum of Care (CoC) program. The Rural Housing Stability Assistance Program (RHSP) replaced the Rural Homelessness Grant Program, which was authorized but never implemented. At least 5 percent of annual funds for the CoC program must be made available for RHSP. At least 50 percent of RHSP funds must be awarded to communities with less than 10,000 people, and priority within this set-aside is given to communities with populations of less than 5,000.

For the purposes of this program, a rural community is a county:

- Of which no part is included in a Metropolitan Statistical Area; or
- In which at least 75% of the population is non-urban; or
- In a state with a population density less than 30 people per square mile, and where at least 1.25% of the land area is under federal jurisdiction. (For a county to qualify as a rural area under this category, RHSP funds cannot be awarded solely to a metropolitan city in this state.)

Eligible applicants include nonprofits and local governments, but only one application per county may be funded. Furthermore, a

rural county or its representing agency cannot simultaneously apply for RHSP and CoC funds. In order to be eligible to apply for RHSP funds, the county must withdraw from any CoC of which it is a part, and transfer CoC grants for any existing projects to an agency outside the county. However, the advantage of RHSP is that rural counties compete only against each other, rather than against other CoCs (or communities within their own CoCs) that have larger populations and service capacity.

RHSP provides funding for a wide range of activities that reflect the unique needs of rural areas, listed below. Several of these activities may be used to serve very low-income households living in severely substandard housing, as well as individuals and families who are experiencing or at risk of homelessness. For all activities except leasing, data collection, and administration, a 25% match in cash or in kind is required.

1. Rent, mortgage, and/or utility assistance for households that are at least 2 months behind on such payments, to help them avoid eviction, foreclosure, or loss of utility service. A household may receive assistance under this activity for up to 12 months, including months for which arrears are paid.
2. Relocation assistance for clients who are moving out of the county for work, education, or reunification with family.

“...THE ADVANTAGE OF RHSP IS THAT RURAL COUNTIES COMPETE ONLY AGAINST EACH OTHER, RATHER THAN AGAINST OTHER COCS (OR COMMUNITIES WITHIN THEIR OWN COCS) THAT HAVE LARGER POPULATIONS AND SERVICE CAPACITY.”

## Small Communities Given Priority

At least 50 percent of RHSP funds must be awarded to communities with less than 10,000 people, and priority within this set-aside is given to communities with populations of less than 5,000.



## FEDERAL POLICIES AND PROGRAMS

Eligible costs include security and utility deposit, first month's rent, moving expenses, and providing housing information.

3. Short-term emergency lodging in a hotel, motel, or existing emergency shelter. The initial time limit on assistance is 3 months, but assistance may be extended month-by-month if needed. RHSP funding under this activity cannot be used to supplant existing funding for an emergency shelter—it must be used to temporarily increase the shelter's capacity. RHSP communities should use this activity only as a last resort.
4. New construction to develop permanent housing or transitional housing (TH) for people who are experiencing or at risk of homelessness. The applicant must demonstrate that the county lacks adequate units that could be rehabilitated to provide housing at lower cost than new construction.
5. Acquisition of structures to provide supportive services, TH, or permanent rental housing for people who are experiencing or at risk of homelessness.
6. Rehabilitation of structures to provide supportive services, TH, or permanent rental housing for people who are experiencing or at risk of homelessness.
7. Leasing of structures to provide supportive services, TH, or permanent rental housing for people who are experiencing or at risk of homelessness.
8. Rental assistance for program participants living in permanent housing or TH, provided they are not already receiving rental assistance from another program. Assistance may be tenant-based or project-based, and may be short-term (up to 3 months), medium-term (3 to 24 months), or long-term



(more than 24 months). It may also be used to pay a security deposit and first and last month's rent.

9. Operating costs for permanent housing and TH, provided the project is not already receiving RHSP funds for rental assistance or leasing.
10. Rehabilitation and repairs of severely substandard housing owned by an individual or family at or below 50% of area median income. This activity is available for homeowners in the "worst housing situations", meaning that the home has serious health and safety defects, and at least one major system (e.g. roofing, plumbing) is failing. If the homeowner moves away from the house less than 3 years after the repairs or rehabilitation are complete, he or she must repay the assistance.
11. Supportive services, such as case management, child care, and transportation.
12. Costs associated with acquiring and using federal surplus property, including preparing applications and bringing properties up to code.
13. Capacity building, including staff salaries, training, and travel. A county may use up to 20 percent of its RHSP award for capacity building activities.
14. Data collection costs, including the costs of developing and operating a Homeless Management Information System (HMIS).
15. Administration, up to 7.5% of the county's total RHSP grant.

HUD released a proposed rule for the Rural Housing Stability Assistance Program on 3/27/13. The rule also contains a proposed definition of chronic homelessness that is compliant with the HEARTH Act.

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## Challenge Grant

A flexible grant provided by the Florida Department of Children and Families (DCF) to continuum of care lead agencies for a variety of homeless assistance and prevention activities. The Challenge Grant, along with the Homeless Housing Assistance Grant, was created by 2001 legislation that instituted a comprehensive framework for homeless assistance planning and coordination. Currently, the maximum annual award per CoC is \$500,000.

Challenge grants may be used to fund housing and service activities in a CoC's plan. The criteria for awarding grants include both the quality of services and amount of federal funding leveraged by

a CoC, and the CoC's level of need for homeless housing and services. Activities commonly funded by Challenge Grants include, but are not limited to:

- Emergency financial assistance to prevent eviction
- Meal programs
- Outreach
- Assistance in obtaining identification documents
- Emergency and transitional shelter
- Permanent housing
- Referral hotlines
- Supportive services, including case management, physical and mental health care, and transportation
- Job skills training

## FLORIDA POLICIES AND PROGRAMS

Additionally, a CoC lead agency may use up to 8% of its challenge grant award for administration.

Between 2001 and 2009, the Challenge Grants were funded in part by transfers of \$5 million or more from the Local Housing Trust Fund (LHTF; funded by documentary stamp tax revenues and provides a dedicated revenue source to local governments for the State Housing Initiatives Partnership [SHIP] program). However, for every year between 2008 and 2013, the State Legislature swept most of the Local Housing Trust Fund revenues. As a result, funding for the Challenge Grants was eliminated in 2012. A bill

passed in 2014 revived the Challenge Grants, amended the criteria for awarding grants to reflect a CoCs population and prevalence of homelessness, and allowed DCF to specify grant award levels in its solicitations for applications. The bill originally included provisions to transfer 4% of the Local Housing Trust Fund appropriation annually for homeless assistance; of this 4%, 95% was directed to DCF to support homeless service delivery in CoCs, and 5% would be used by DEO to hire a statewide technical assistance provider to work with the CoCs. However, in the 2014 General Appropriation Act signed by the Governor, the transfer of funds from the Local Housing Trust Fund was nonrecurring.



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## Homeless Housing Assistance Grant

A competitive grant provided by the Florida Department of Children and Families (DCF) to continuum of care lead agencies to fund acquisition, construction, or rehabilitation of permanent or transitional housing for people experiencing homelessness. The Homeless Housing Assistance Grant, along with the Challenge Grant, was created by 2001 legislation that instituted a comprehensive framework for homeless assistance planning and coordination. To receive Homeless Housing Assistance Grant (HHAG) funding, a project must be incorporated into the local Continuum of Care plan. Preference is given to projects that have the most units, leverage additional funds, and are located in CoCs with the highest needs for homeless housing and services. Currently, the maximum annual award per project is \$750,000, of which up to

5% may be spent on administration. No more than two projects per CoC may receive funding, and the units must be reserved for people experiencing homelessness for at least the first 10 years of the project's operation.

Between 2001 and 2009, HHAG was funded in part by transfers of \$5 million or more from the Local Housing Trust Fund (LHTF) to DCF. However, for every year between 2008 and 2013, the State Legislature swept most of the Local Housing Trust Fund revenues. As a result, funding for HHAG was reduced in 2010 and eliminated entirely in 2012. To date, funding has not been restored.

“...Funding for HHAG was reduced in 2010 and eliminated entirely in 2012. To date, funding has not been restored.”

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## Homelessness Prevention Grant

A competitive grant provided by the Florida Department of Children and Families (DCF) to continuum of care lead agencies to help families avoid homelessness and remain permanently housed. The Homelessness Prevention (HP) grant was created by state legislation in 2013, replacing the Emergency Financial Assistance for Housing Program (EFAHP). Currently, Florida's HP program is funded entirely by Temporary Assistance for Needy Families (TANF) funding from the federal government. HP grant funds are available to CoC lead agencies with a local continuum of care plan that includes a homelessness prevention element. In the 2014 HP grant cycle, the maximum award amount for a lead agency ranged from \$50,000 to \$70,000, depending on the size of the continuum of care. Preference is given to lead agencies that are able to leverage additional funds for the HP program, have effectively implemented HP programs in past years, and are able to demonstrate that services addressing clients' health, employment, and education needs are available.

Homelessness Prevention funds may be awarded to families with minor children—including 18-year-olds who are in school or a

career training program, and have never been married—that are below 200% of the federal poverty level and at risk of homelessness due to a documented financial or other crisis. Families are required to participate in case management, which includes a written plan identifying which costs will be paid by HP assistance and setting a timeline for payments. Eligible uses of funds include up to 4 months of past-due rent, mortgage, and utility payments per family, staff and operating costs for case management, and up to 3% of the lead agency's grant for administration. The lead agency may determine many of the details of participant selection and grant administration, including priorities for selecting families and the maximum award that a family may receive.

The Homelessness Prevention program reflects several years' worth of advocacy by DCF's Office on Homelessness. EFAHP, the program it replaced, was much more limited. Families had to apply directly to DCF's main office in Tallahassee, rather than to their CoC lead agency or the agency's subgrantee. The maximum award per family was \$400, and utility payments and case management were not eligible expenses.

**HOMELESSNESS PREVENTION FUNDS MAY BE AWARDED TO FAMILIES WITH MINOR CHILDREN—INCLUDING 18-YEAR-OLDS WHO ARE IN SCHOOL OR A CAREER TRAINING PROGRAM, AND HAVE NEVER BEEN MARRIED—THAT ARE BELOW 200% OF THE FEDERAL POVERTY LEVEL AND AT RISK OF HOMELESSNESS DUE TO A DOCUMENTED FINANCIAL OR OTHER CRISIS.**



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## Continuum of Care Staffing Grants

Funds appropriated by the Florida Legislature to help pay salaries for staff members of Continuum of Care lead agencies. The staffing grants were introduced in 2001, as part of the comprehensive legislation that established a homeless assistance planning framework and created the Challenge Grant and Homeless Housing Assistance Grant. The 2001 statute provided funds for CoC staff through a pre-existing “Grant-in-Aid” program, which was administered by DCF district offices and funded services similar to the

Challenge Grant. (The statute for the Grant-in-Aid program still exists, but the program has not been funded since 2008.) The staffing grants were defunded for several years during the economic recession, except for a non-recurring appropriation in 2012. The 2013 General Appropriations Act restored recurring staffing grant funds in the amount of \$2 million, and the 2014 General Appropriations Act provided an additional \$1 million in non-recurring staffing grant funds.



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## Housing First (HF)

**A** homeless assistance model centered around placing homeless individuals and families in permanent housing, quickly and without preconditions, and connecting them to the services they need to maintain housing stability and live as independently as possible. The underlying principle is that homelessness is physically and psychologically stressful, and homeless persons can more effectively address issues such as mental illness, addiction, and employment barriers once they are stably housed. Housing is seen as a basic human right, one that should not be conditioned on sobriety or participation in treatment and supportive services.

Since the early 2000s, Housing First has gained popularity as an alternative to the “Continuum of Care” (CoC) model, which assumes that homeless persons must become “ready” for housing by overcoming addictions, mental illness, and other personal impediments to maintaining stable housing. Under the CoC model, many homeless persons move from emergency shelters to Transitional Housing (TH) programs, which often require residents to participate in treatment and other services. Housing First proponents argue that many TH programs fail to retain high-need clients, and

may exhibit “creaming”, or selective admission of families with relatively few barriers. Although most households who complete TH programs (which last up to two years) find stable housing, HF proponents argue that rapid placement in permanent housing would achieve the same results more cheaply and humanely.

The term “Housing First” was likely coined by Beyond Shelter, a nonprofit organization in Los Angeles, CA, that provides services to poor and homeless families with children. Beyond Shelter’s “Housing First” program, started in 1988, provides Rapid Re-Housing (RRH) services to homeless families. Current RRH programs also use a Housing First model. However, the term “Housing First”, and studies that explicitly examine it, usually focus on individual adults with mental illness, substance abuse, or other chronic impairments in Permanent Supportive Housing (PSH).

The first program to use HF for adults with chronic impairments was Pathways to Housing in New York City. Pathways was founded by Sam Tsemberis, a clinical psychologist and outreach worker who was frustrated with the frequent failure of the homeless assistance system to help people with mental illness. Eligible people

experiencing homelessness are referred to Pathways by outreach teams, shelters, drop-in centers, jails, and hospitals, and Pathways maintains relationships with a network of private landlords willing to lease to its clients. To place a client in housing, Pathways signs a lease and subleases the unit to the client. Each participant is linked with a staff team of professionals in fields such as medicine, psychiatry, and vocational rehabilitation. Program participants are required only to pay 30% of their income for rent and meet regularly with a case worker, although their staff teams strongly encourage them to use available services. A number of Housing First programs around the country use the same basic model that Pathways pioneered, with some variations. For example, some programs own or master-lease the housing in which they place clients, and others may partner with public (i.e. Housing Authority) or nonprofit housing providers.

The spread in popularity of HF was driven by several lines of evidence. First, research on Pathways and other housing programs for the homeless suggest that housing subsidies play a central role in helping homeless persons achieve stable housing. Second, analyses of administrative records have revealed that most people who enter emergency shelters exit homelessness without formal assistance, and do not become homeless again within the study horizons. As a result, a disproportionate share of homeless assistance resources are consumed by the minority of people who are chronically or episodically homeless. Third, the costs of emergen-

cy and transitional shelters and crisis services may be largely offset by providing permanent housing and case management, and may even provide substantial savings. Fourth, HUD statistics show that 155,000 people were chronically homeless in 2006—a relatively manageable number, and one that was already dropping due to increased investment in PSH. Fifth, an early Pathways study showed that HF did not increase clients' substance use, as some analysts had feared. HF did not reduce clients' substance use, but neither did TH, casting doubt on the latter model's effectiveness at promoting "housing readiness". Finally, formal surveys and anecdotal evidence showed that homeless people themselves prefer permanent housing to transitional housing.

Despite the growing popularity of Housing First, most of the academic studies conducted by the mid-2000s focused on the Pathways program and included Tsemberis as an author. The number of studies has increased considerably since then, although many have methodological problems. Several studies lack control groups for HF participants, and other problems include small sample size, selection bias, and lack of assessor blinding. However, the more rigorous studies do find that HF provides more housing stability than the CoC model, at a cost that is comparable to or less than that of crisis services used by the chronically homeless. Another topic in need of new research is the effectiveness of Housing First programs (including PSH and RRH) for families.

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# CASE STUDY

## SEATTLE'S DOWNTOWN EMERGENCY SERVICES CENTER PROVIDES PERMANENT SUPPORTIVE HOUSING TO CHRONIC HOMELESS WITH ALCOHOL ADDICTION

### DOWNTOWN EMERGENCY SERVICES CENTER (DESC) WAS AN EARLY ADOPTER HOUSING FIRST.

The agency's most famous development is 1811 Eastlake, which was developed in partnership with the Low Income Housing Institute and serves chronically homeless persons with severe alcoholism. The tenants, on average, have had 16 failed attempts at conventional substance abuse treatment. Residents are not required to participate in services, but they receive plenty of support from a tightly coordinated team of residential counselors, clinical support specialists, and community-based providers. Residents are allowed to drink in their rooms, but peer-reviewed studies of 1811 Eastlake have found that their average alcohol consumption decreases over time. Three-fourths of residents stay in their units for at least a year, saving taxpayers about \$2,500 per person per year in crisis services like jails and hospitals.

DESC differs from many successful Housing First providers in that it places clients primarily in large developments that it owns

and manages. This approach has some drawbacks, such as limiting clients' housing choices. However, on-site staff quickly addresses problems as they arise, and tenants appreciate the quality, privacy, and independence of their apartments.



For more information:

- Downtown Emergency Service Center, <http://www.desc.org/1811.html>
- USICH Model Program: 1811 Eastlake, [http://usich.gov/usich\\_resources/solutions/explore/1811\\_eastlake](http://usich.gov/usich_resources/solutions/explore/1811_eastlake)

## Permanent Supportive Housing (PSH)

Housing (usually rental) with “wrap-around” support services for individuals and families with barriers to living independently, such as mental illness, substance abuse, and physical disability. Synonyms for Permanent Supportive housing include “supported housing”, “service-enriched housing”, and “independent housing”. Although PSH programs vary, the model has several core elements: 1) the client holds a lease, and has the same rights as a renter in the private market; 2) to the extent possible, the housing consists of “normal” units that are integrated into the community, rather than clustered in an institutional setting; 3) ongoing community-based support services such as case management, medical and mental health care, substance abuse treatment, and life skills training, are available; and 4) participation in services is not required to maintain tenancy. PSH is based on the principle that clients should have a choice in the type of housing and services they receive, and that service provision should be “based on mutual trust and respect, rather than on paternalism and coercion”<sup>1</sup>. Additionally, the PSH model draws from empirical evidence that clients are more likely to maintain housing stability if they believe they have a choice in their living arrangements. Thus, although the PSH model developed before the Housing First model, it pioneered many of the same principles and is vital to the success of Housing First programs.

Permanent Supportive Housing arose in the 1980s as an alternative to institutional or residential treatment facilities for individuals



with mental illness and other impairments. Since the late 1990s, numerous academic studies around the nation have demonstrated that PSH improves housing stability and reduces hospitalizations for homeless individuals with mental illness. The positive effect of PSH is more apparent in studies in which control group clients receive no specific housing intervention. Studies that compared PSH clients to clients of other housing models (e.g. group homes or subsidized housing with non-intensive case management) had mixed results: some showed PSH to promote housing stability more than other models, while other studies showed no difference. The success rate of PSH also varies among client subpopulations, and may attenuate over time. Those who are young, have psychotic disorders (as opposed to mood disorders), or have co-occurring mental illness and substance abuse, are less likely to attain housing stability. On a related note, substantial minorities of PSH tenants leave within two years, often for less favorable living arrangements. Moreover, the research has yielded mixed results on the ability of PSH to improve other outcomes, such as mental health and substance abuse treatment and employment.

Most PSH programs and scholarly research focus on individuals, but the model is expanding to serve homeless families with high barriers to housing stability. One study from 2006<sup>2</sup> shows that family PSH programs have high rates of housing stability, but may be less effective at promoting economic self-sufficiency

outcomes, such as mental health and substance abuse treatment and employment.

Most PSH programs and scholarly research focus on individuals, but the model is expanding to serve homeless families with high barriers to housing stability. One study from 2006<sup>2</sup> shows that family PSH programs have high rates of housing stability, but may be less effective at promoting economic self-sufficiency

Since the late 1990s, numerous academic studies around the nation have demonstrated that **PSH improves housing stability and reduces hospitalizations for homeless individuals with mental illness.**

and reunification with children who had been placed outside the household (e.g. with relatives or in foster care). A study released in 2013<sup>3</sup> found that families in PSH at the beginning of the study were more likely to maintain housing stability over a 30-month follow-up period than those in emergency shelter or Transitional Housing (TH), although 36% of PSH families remained unstable. The PSH programs cost more than the TH programs, but the researchers argued that the greater cost was necessary to achieve better outcomes. They suggested that PSH and other homeless assistance programs can improve outcomes and reduce costs by introducing “Trauma-Informed Care” (TIC), a service delivery model that identifies the role of past trauma in a client’s current struggles, and emphasizes engaging clients in ways that avoid triggering post-traumatic responses.

Since 1987, McKinney (-Vento) funds have been a major source of support for PSH operating expenses, contributing to 61% of the roughly 237,000 PSH beds reported in 2010. In 2008, the federal government revived another PSH funding source that had been previously underutilized: HUD’s Section 811 Supportive Housing for Persons with Disabilities program. Section 811

has traditionally provided capital advances for the development of multifamily rental housing for very low-income people with disabilities, and was recently amended to provide Project Rental Assistance (PRA) funds through state agencies. The PRA may provide subsidies to extremely low-income disabled persons in new or existing rental housing.

McKinney-Vento funding is also a critical source for support services, especially in communities with few other resources. However, beginning in 1999, HUD established requirements and incentives for Continuums of Care (CoC’s) to shift spending from supportive services toward housing. Medicaid is another critical source of support, but not all services are eligible for reimbursement, and not all people exiting homelessness would necessarily qualify for it. While other federal funds exist, mainly from the Department of Health and Human Services (HHS), none has been sufficient to fill the gap. Homeless assistance providers, advocates, and policy makers hope that the Affordable Care Act, and the *Opening Doors* plan’s emphasis on coordinating with “mainstream” human service programs, will increase funding for PSH services.

<sup>1</sup> Wong et al. 2007

<sup>2</sup> Corporation for Supportive Housing 2006.

<sup>3</sup> Hayes et al. 2013.

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## Rapid Re-Housing (RRH)

RRH is a strategy to help homeless households regain housing stability by helping them to secure permanent housing as quickly as possible. Unlike Permanent Supportive Housing (PSH), RRH assistance is temporary (usually lasting several months), is offered at the minimum level necessary to help a client achieve stable housing, and is targeted toward the issues that directly affect a client's ability to maintain stable housing. RRH is a form of the Housing First (HF) model, although the classic RRH model targets homeless people who have lived independently in the past, are capable of doing so in the future, and lack a severe and chronic impairment. In particular, RRH programs are seen as an alternative to long shelter and transitional housing stays for homeless families who are capable of maintaining stable housing with few or no supportive services. These programs can also be used for single adults, though, and some communities have used RRH successfully to re-house people with moderate or high barriers to obtaining and maintaining stable housing. For those with the most significant barriers, RRH can provide temporary assistance while the client and his or her case managers develop a permanent support network (based on PSH or otherwise). In many communities, RRH was pioneered with funding from the Homelessness Prevention and Rapid Re-Housing Program (HPRP), a one-time HUD program created in 2009 by the American Recovery and Reinvestment Act.

Well-designed Rapid Re-Housing programs make a distinction between a client's barriers to *obtaining* housing and *maintaining* it, and help clients overcome the first barrier before addressing the

“...A PERMANENT HOME SERVES AS THE PLATFORM UPON WHICH CLIENTS CAN SUCCESSFULLY TACKLE THE ISSUES THAT MIGHT THREATEN THEIR HOUSING STABILITY.”

### Overcoming Barriers

RRH programs help clients cover housing start-up costs, including moving expenses, security and utility deposits, and a limited amount of rental and utility costs. In addition, program staff helps clients find landlords who are willing to rent to tenants with low or no income, poor credit, past evictions, and criminal records.

second. In other words, a permanent home serves as the platform upon which clients can successfully tackle the issues that might threaten their housing stability. The two main barriers to obtaining housing are financial barriers and tenant screening barriers. RRH programs help clients cover housing start-up costs, including moving expenses, security and utility deposits, and a limited amount of rental and utility costs. In addition, program staff helps clients find landlords who are willing to rent to tenants with low or no income, poor credit, past evictions, and criminal records. In fact, many RRH programs are proactive, with staff members conducting outreach to landlords and identifying appropriate rental units in advance.

To help clients maintain housing stability once they have moved in, RRH program staff makes routine follow-up visits to the tenant for a limited period of time, and are available to mediate disputes with the landlord. RRH providers may encourage the tenant to obtain services that would indirectly improve his or her housing stability, such as mental health services or child enrichment activities, but the RRH assistance is not contingent on the client participating in these programs.

Rapid Re-Housing is an alternative to the Transitional Housing (TH) model that has dominated homeless assistance since the 1980s, which often assumes that clients need to learn skills for housing retention in a structured environment before living independently. RRH proponents note that most poor families do not become homeless, those who do become homeless usually exit



## HOMELESS ASSISTANCE ACTIVITIES AND MODELS

shelters quickly without formal assistance, and those who spend the most time in shelters (including emergency and transitional shelters) are not necessarily the heaviest users of crisis-related social services. Moreover, several studies from the 1990s suggested that housing subsidies are a stronger determinant of housing stability than social services for families leaving shelters. Since annual shelter costs are higher than annual rental subsidies would be, and communities nationwide face a shortage of affordable housing, proponents argue that RRH is a more efficient use of homeless assistance funds than TH.

There is some debate about the effectiveness and efficiency of RRH, especially as it relates to family homelessness. For example, the Institute for Children, Poverty, and Homelessness (ICPH) in New York City has blamed an RRH program introduced by Mayor Michael Bloomberg for increasing shelter populations, costs, and returns to homelessness. However, ICPH's analysis has deep methodological flaws, including a failure to control for other variables and a misleading time horizon for analysis. Supporters of RRH do recognize the possibility of creating a financial “cliff effect” for RRH families once their subsidies run out, which should be weighed against other considerations when structuring the housing subsidy. (For example, a rental subsidy that declines over time

would reduce the cliff effect, but may pose difficulties for clients that need more time to achieve stability.) Other researchers are open to the idea that low-risk families may need little more than a housing subsidy, but worry that families with greater need—many of which have household heads with histories of trauma—will not receive adequate support from overburdened mainstream services (e.g. behavioral health clinics, child care subsidies).

There is little academic research on RRH or Housing First programs for homeless families. Some earlier studies suggest that receipt of a housing subsidy is the most important predictor of a family's successful exit from homelessness, with supportive services showing no significant effect on a family's housing outcome. Other studies suggest that supportive services improve housing outcomes, especially for high-risk families. However, emerging evaluations of RRH programs around the country show dramatically lower costs and lower rates of return to the homeless assistance system than emergency shelter and TH. In other words, RRH may not end a family's poverty and housing instability, but it reduces homelessness (as measured by entry into the homeless assistance system), which has substantial negative physical and mental health effects in its own right.

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# CASE STUDY

## VIRGINIA MAKES A COMMITMENT TO RAPID RE-HOUSING FOR FAMILIES EXPERIENCING HOMELESSNESS

HOW DOES AN ENTIRE STATE EMBRACE RAPID RE-HOUSING (RRH) AND REDUCE FAMILY HOMELESSNESS BY 16% IN THREE YEARS? WITH A BACKBONE OF LEADERSHIP THAT EXTENDS FROM THE GOVERNOR, THROUGH STATE AGENCY HEADS, AND DOWN TO LOCAL COCS, AND WITH BUY-IN FROM HOMELESS SERVICE PROVIDERS AROUND THE STATE.

Drawing on lessons learned from HPRP, the state has shifted from spending 100% of its ESG allocation on emergency shelter to spending nearly half on RRH. A statewide “Learning Collaborative”, conducted by the National Alliance to End Homelessness and funded by the Fannie Mae foundation, gave technical assistance to providers to help them make the shift.

The capstone of the Learning Collaborative was a 100-day challenge to providers to house as many families as possible. Par-

ticipating agencies housed a total of 545 families, a 52% increase in their average housing placement rate. And the competition brought out true innovation, like the “Home for the Holidays” Christmas campaign in Fredericksburg. Instead of their usual “Adopt-a-Family” campaign to give presents to children in emergency shelters, local nonprofits collected donations to help families pay the first month’s rent, security and utility deposits needed to get back into housing.



Image from St. Joseph’s Villa website ([www.neverstopbelieving.org](http://www.neverstopbelieving.org)). Then-Governor Rob McDonnell visits the Harrison family, one of the first to receive RRH from St. Joseph’s Villa.

For more information:

- National Alliance to End Homelessness Webinar: Resetting State Priorities to End Homelessness  
<http://www.youtube.com/watch?v=ovHaOtN4zsg>
- National Alliance to End Homelessness: 545 Families in Virginia Now Have Homes  
<http://www.endhomelessness.org/blog/entry/545-families-in-virginia-now-have-homes#.VBMz6WMXPk8>

## Homelessness Prevention and Rapid Re-Housing Program (HPRP)

Included in the American Recovery and Reinvestment Act (ARRA) of 2009, HPRP provided \$1.5 billion for a three-year program to help persons who were homeless or at risk of homelessness quickly obtain permanent housing. The program was largely intended to help households that had lost their homes or were unstably housed due to the recession. In a broader sense, though, it was designed to shift the approach of homeless assistance providers from a crisis response and “Continuum of Care” model to one that emphasizes prevention and Rapid Re-Housing, while minimizing the duration of homeless spells.

HPRP funds were awarded to 535 state and local governments, using the same formula by which Emergency Shelter Grant (ESG) funds are allocated. (In 2009, the HEARTH Act renamed ESG as the “Emergency Solutions Grant”.) Most grantees conducted both homelessness prevention and rapid re-housing programs, but the majority of funds were spent on homelessness prevention. For both programs, the two main activity categories were “financial assistance” and “housing relocation and stabilization services”. Financial assistance could be short-term (up to 3 months)

or medium-term (up to 18 months), and included rental and utility assistance, security and utility deposits, moving costs, and hotel or motel vouchers. Housing relocation/stabilization services included case management, outreach, housing search and placement, legal services, and credit repair, and could last up to 18 months. The most common forms of assistance were rental assistance and case management.

HPRP was quite successful, serving about 1.15 million people and exceeding its goal of moving 70% of participants to permanent housing by the end of Year 2 (the most recent grant year for which summary data is available). In both years, nearly 88% of participants exited to permanent housing. In Year 2, 65% of clients who were literally homeless upon entry moved to a housing situation that was classified as “stable”, and 67% of participants who were at-risk of homelessness achieved stable housing. Grantees were required to expend their funds by the Fall of 2012. To help them continue to serve HPRP clients and maintain the practices instituted by HPRP, HUD provided training for grantees to use Emergency Solutions Grant (ESG) funds to provide similar services.

**“HPRP WAS QUITE SUCCESSFUL, SERVING ABOUT 1.15 MILLION PEOPLE AND EXCEEDING ITS GOAL OF MOVING 70% OF PARTICIPANTS TO PERMANENT HOUSING BY THE END OF YEAR 2...”**

### Achieving Success

“In both years, nearly 88% of participants exited to permanent housing. In Year 2, 65% of clients who were literally homeless upon entry moved to a housing situation that was classified as “stable”, and 67% of participants who were at-risk of homelessness achieved stable housing.”



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- HUD. 2011. Homelessness Prevention and Rapid Re-Housing Program (HPRP): Year 2 Summary. [https://www.onecpd.info/resources/documents/HPRP\\_Year2Summary.pdf](https://www.onecpd.info/resources/documents/HPRP_Year2Summary.pdf). Last accessed 9/25/13.
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# CASE STUDY

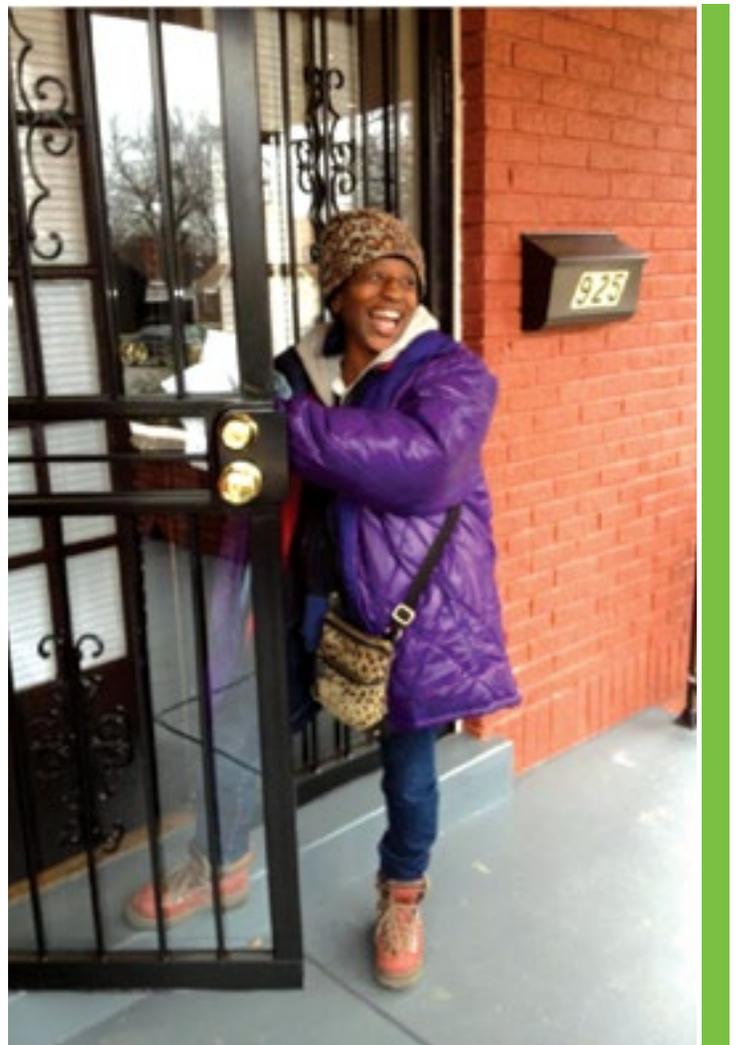
## MEMPHIS, TN USES HPRP TO TRANSFORM ITS SYSTEM FOR HOMELESS FAMILIES

WHEN THE CITY OF MEMPHIS RECEIVED HPRP FUNDS, A PARTNERSHIP OF PUBLIC AGENCIES, SOCIAL SERVICE PROVIDERS, AND OTHER STAKEHOLDERS TOOK THE OPPORTUNITY TO INSTITUTE COORDINATED INTAKE AND ASSESSMENT.

The intake system consists of a 24-hour hotline for basic screening, and a central intake site to assess families for shelter diversion, prevention assistance, or admission to emergency shelter or transitional housing. The site also houses a benefits coordinator who helps families apply for food assistance, Medicaid, and other mainstream benefits.

Families admitted to HPRP were evaluated using a standardized assessment tool, Structured Decision Making (SDM), which can predict future child abuse and neglect. Families with moderate to high scores received a “Family Housing Advocate,” a culturally competent worker trained not in case management, but in helping families identify their strengths and develop support networks of relatives and friends. These advocates also provided referrals for case management and other support services.

From 2009 to 2011, over 90% of HPRP recipients remained stably housed for at least a year. HPRP alone could not prevent an 11% increase in family homelessness in the Memphis/Shelby County from 2009 to 2011, brought on by record levels of poverty and unemployment. However, family homelessness has declined by 25 percent since 2007.



For more information:

- USICH Model Program: Memphis Emergency Housing Partnership  
<http://www.msnbc.com/melissa-harris-perry/mayor-declares-end-vet-homelessness>
- National Alliance to End Homelessness: Community Snapshot of Memphis-Shelby County  
<http://www.endhomelessness.org/library/entry/community-snapshot-of-memphis-shelby-county>

## Transitional Housing (TH)

A homeless assistance model that provides interim housing to homeless persons leaving emergency shelter, coupled with services to help them develop the stability and skills needed to maintain permanent housing. Although TH programs vary considerably in housing type, populations served, services offered, and requirements for service participation, they generally offer “smaller facilities, more privacy, and more intensive services with greater expectations for participation”<sup>4</sup> than emergency shelters. As part of the traditional “Continuum of Care” (CoC) model of homeless assistance, participation in a TH program is often the only way for homeless persons to obtain housing relocation assistance and associated services, and often includes sobriety and service participation requirements. In the early 2000s, the Housing First (HF) model emerged as a challenge to the TH model. Housing First proponents argue that providers can help homeless persons achieve housing stability more effectively and cheaply by helping them move quickly into permanent housing and providing “wraparound” support services, without requiring sobriety or service participation.

The Transitional Housing model developed in the late 1980s, as it became apparent to service providers and policy makers that the needs of many homeless people—especially those exiting jails, mental health institutions, and detox centers—went beyond emergency shelter. When the McKinney Homeless Assistance Act was passed in 1987 (renamed the McKinney-Vento Act in 2000), it included a Supportive Housing Program to provide funding for both Transitional Housing and Permanent Supportive Housing (PSH) projects. The growth of TH was also fueled by HUD’s introduction of the CoC process for awarding McKinney funds, which allowed suburban and rural communities to compete successfully for funding. Compared to major urban areas, homelessness in these smaller communities was characterized less by single adults than by families, who were less likely to need or be eligible for PSH (which required that the head of household be disabled). Additionally, many homeless assistance providers favored TH

because they lacked housing development capacity and found that nonprofit housing providers and public housing authorities were often reluctant to target homeless persons. In 1999, to shift the emphasis of its competitive homeless assistance grants back toward providing permanent housing, Congress began requiring HUD to spend at least 30% of its McKinney funding on permanent housing. Even with this set-aside, the number of TH programs continued to grow through the 2000s. By 2004, the U.S. had over 220,000 TH beds, of which about half are designated for single adults and half for members of homeless families. For each TH participant, McKinney funding is available for a maximum of two years.

Individual TH programs have a variety of target populations, types of housing and supportive services, and requirements for service participation. Some programs target individuals with mental illness, substance abuse, and/or physical disabilities, and others target families, including those fleeing domestic violence or with a pregnant head of household. Programs may offer housing in stand-alone facilities, apartments clustered in larger complexes (which may also include emergency shelters and/or permanent housing for program “graduates”), or “regular” housing units scattered throughout the community. Some units allow participants to “transition in place” by taking over the lease after completing the program, as the TH support services are gradually withdrawn. Supportive services may include mental health and substance abuse treatment, medical care, child care, budgeting and parenting classes, life skills training, job skills training, and relocation assistance. In terms of requirements that clients participate in services, TH programs range from “low-demand” with few requirements, to “high-demand” with strictly enforced rules. High-demand programs often require residents to submit to medication management, random drug tests, and curfews; participate in group activities; and conduct routine chores. Residents may gain privileges (such as increased off-site travel) as they progress through the program, and may lose privileges when they break rules. An individual or head of household who severely or repeatedly violates the rules may be asked to leave the program.

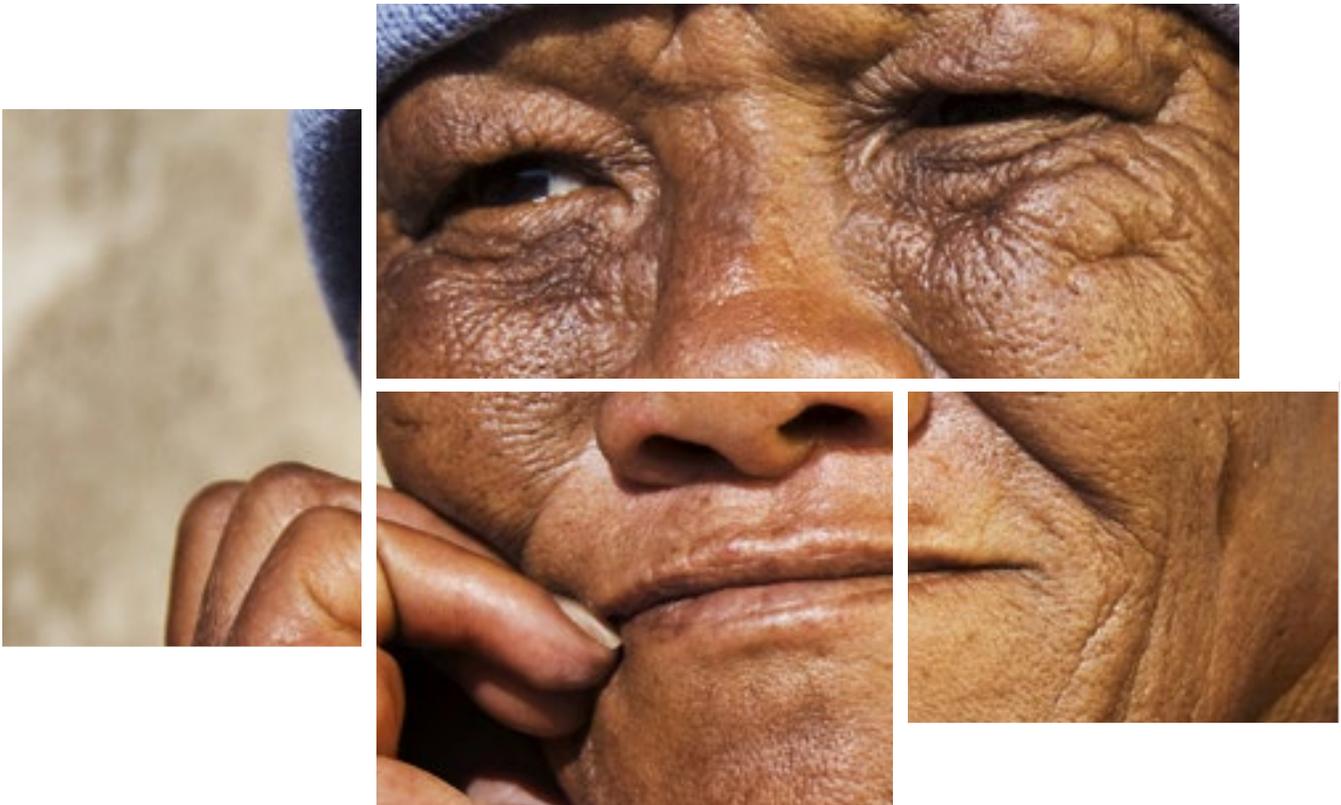
“...Virtually all analysts agree that a greater supply of affordable housing would expand the success of both Transitional Housing and Housing First.”

Although HUD, state and local governments, and service providers have amassed considerable experience with TH programs, there are few formal studies on TH. The studies that do exist report program retention rates ranging from 13% in a program targeting individuals with co-occurring mental health and substance abuse issues<sup>5</sup>, to 77% in a study of 53 family TH programs<sup>6</sup>. Attrition (participants withdrawing voluntarily or being asked to leave) is especially prevalent in programs targeting mentally ill individuals. Among individuals and families that successfully complete TH programs, 70%<sup>7</sup> to 88%<sup>8</sup> attain stable housing. Additionally, many participants express satisfaction with the programs and experience improved income and employment levels. For example, a study comparing demonstration TH housing for AFDC-eligible families to the alternatives (i.e. in emergency shelters and hotels) found higher rates of housing stability, program satisfaction, and other outcomes among the TH participants<sup>9</sup>.

However, several findings from these studies cast doubt on the TH model's underlying assumptions. For mentally ill individuals, although program completion has been linked to improvements in housing stability, psychiatric symptoms, and employment, participants do not necessarily improve in all these areas simultaneously.

For this population, evidence has mounted in the past decade that Housing First is more effective at achieving housing stability. For families, meanwhile, a follow-up to the study of 53 TH programs found that program restrictiveness had virtually no effect on graduates' outcomes (including housing stability, employment and education, and the emotional health of mothers and children); and mothers' personal characteristics (including employment and tenure history, mental illness, substance abuse, and encounters with domestic violence or the justice system) seldom had consistent effects on all the outcomes measured.

Research on TH has also raised the issue of "creaming", or selecting households with relatively few barriers for participation in TH programs. Since TH programs for individuals have a long history of targeting those with substantial barriers, the charge is usually leveled at family programs. The 2006 study of 53 family TH programs suggests that creaming occurs, but not to the extent that HF's top advocates imply. All programs in the study required that participants have poor rental histories and multiple evictions, and about one-third targeted mothers with mental health or substance abuse issues, while another third screened out mothers with these issues. 15% of programs had no sobriety requirement for entry, and another



## HOMELESS ASSISTANCE ACTIVITIES AND MODELS

15% required only a day or two of sobriety. Other studies suggest that programs “screen in” families where the head of household is motivated and willing to comply with program rules.

Housing First proponents cite these findings, combined with several studies suggesting that receipt of a housing subsidy is the strongest predictor of a family achieving housing stability, to argue that most families would have equal or greater success in HF programs, compared to TH. They suggest that TH programs be targeted toward subset of high-need individuals and families, such as domestic violence survivors, homeless youth, and recovering addicts, as a voluntary alternative to Housing First rather than a sole pathway for receiving housing relocation assistance.

Other researchers embrace many aspects of the HF model, including the lack of requirements for sobriety and service participation, but warn against transferring too many resources away from Transitional Housing. They point to data on the substantial minority of family heads with multiple barriers, and note that there may not be enough affordable housing and funding for mainstream supports for all the families that would be eligible for HF programs. Housing First proponents counter that Transitional Housing graduates face the same challenges once they “graduate”, and that Transitional Housing has poorer outcomes at higher cost. However, virtually all analysts agree that a greater supply of affordable housing would expand the success of both Transitional Housing and Housing First.

<sup>4</sup> Barrow and Zimmer 1999.

<sup>5</sup> Rahav et al. 1997, in Barrow and Zimmer 1999.

<sup>6</sup> Burt 2006.

<sup>7</sup> Matulef et al. 1995, in Barrow and Zimmer 1999.

<sup>8</sup> Rog et al. 1995, in Barrow and Zimmer 1999.

<sup>9</sup> Roman and Zhu 1996 and Nathan et al. 1995, in Barrow and Zimmer. “AFDC” is “Aid to Families with Dependent Children”, which became “Temporary Assistance for Needy Families” (TANF) in 1996.

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# CASE STUDY

## COMMUNITY CONNECTIONS JACKSONVILLE REPURPOSES TRANSITIONAL HOUSING

COMMUNITY CONNECTIONS JACKSONVILLE (CCJ) HAS PROVIDED TRANSITIONAL HOUSING TO WOMEN AND FAMILIES FOR OVER 25 YEARS, IN ADDITION TO YOUTH AND FAMILY SUPPORT, LITERACY AND WORKFORCE DEVELOPMENT SERVICES. HOWEVER, CCJ HAD A CHANCE TO TRY RAPID RE-HOUSING (RRH) WHEN IT RECEIVED HPRP FUNDS FROM CLAY COUNTY, FL.

RRH had higher success rates at lower cost per person than the agency's existing transitional housing programs, and CCJ staff used this data to persuade board members to make a wholesale shift from transitional housing to RRH.

In 2013 and 2014, CCJ began phasing out two of their three transitional housing programs. New clients with relatively low barriers were admitted and clearly informed that the programs would be closing soon. Clients with greater needs were referred to programs that could serve them better. CCJ expects to receive Rapid Re-Housing funds in late autumn 2014. As Housing and Support-

ive Service Director Will Evans says, "We got tired of managing homelessness and decided to end it. As I tell my staff, 'Our business is to put ourselves out of business.'"

Community Connections Jacksonville's shift from TH was relatively simple, since the two programs that are closing had been converted from congregate to scattered-site several years earlier. For guidance on repurposing a congregate TH building, visit the National Alliance to End Homelessness's "Retooling Transitional Housing" webpage.



For more information:

- Presentation from the National Alliance to End Homelessness 2014 National Family and Youth Conference  
[http://b.3cdn.net/naeh/f3b6b54fd5822f1ae9\\_40m6bcg71.pdf](http://b.3cdn.net/naeh/f3b6b54fd5822f1ae9_40m6bcg71.pdf)

## Coordinated Intake and Assessment (CI&A)

An intake and assessment model for clients seeking homeless assistance that uses a defined point of entry and standardized assessment procedures. CI&A is an alternative to the model found in many communities, in which clients must navigate the homeless assistance system by themselves to find a provider. Fragmented intake and assessment systems are described as “provider-centered”: the services a client receives depend on which provider chooses to accept him or her, rather than the client’s actual needs. Moreover, each provider may use a different assessment process. CI&A, by contrast, is “client-centered”: the intake worker refers the client to the most appropriate program for his or her immediate needs after only one assessment. As the client progresses to different stages of the homeless assistance system, the standardized assessments become increasingly detailed, an approach known as “progressive engagement”. Based on favorable experience with CI&A in the HPRP program, HUD has begun requiring that Continuums of Care (CoCs) implement the practice, and that all homeless assistance providers receiving Continuum of Care or Emergency Solutions Grant (ESG) funds participate.

The entry point to the homeless assistance system may be centralized or decentralized, and may use physical or virtual intake centers. In one central intake model, a client enters the system at one physical location, although there may be different intake facilities



for different subpopulations (e.g. individuals and families). This model is most likely to succeed in small communities or those with efficient public transportation. Alternatively, a central intake system may use a telephone hotline, such as 2-1-1. Decentralized models include multiple intake centers throughout the community, and a “no wrong door” approach in which every provider is able to conduct intake and assessment.

HUD advises that the assessment questions at the entry point should be relatively simple, rather than “a full psychosocial evaluation”<sup>10</sup>. The intake worker will generally refer the lowest-need clients to homelessness prevention or shelter diversion programs. If emergency shelter is necessary, the shelter will help the clients minimize their stay by assessing them for Rapid Re-Housing (RRH) eligibility. Clients who do not qualify for RRH are further assessed for more intensive alternatives, such as Permanent Supportive Housing (PSH), substance abuse treatment, or Transitional Housing (TH). This pattern of assessments

that become increasingly detailed depending on the client’s level of need, known as “progressive engagement”, spares lower-need clients the burden of lengthy assessments. Additionally, because clients referred to providers have already been assessed using standards agreed upon by all providers in the community, individual programs can accept clients quickly without spending excessive staff time and money on their own assessments.

“Fragmented intake and assessment systems are described as “provider-centered”... CI&A, by contrast, is “client-centered”...”

<sup>10</sup> HUD 2013. CoC’s Coordinated Assessment System Prezi.

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# CASE STUDY

## MONTGOMERY COUNTY, OH, USES “FRONT DOOR ASSESSMENT” TO MATCH THE RIGHT PEOPLE TO THE RIGHT PROGRAMS

WHEN THE DAYTON-MONTGOMERY COUNTY, OH, CONTINUUM OF CARE RELEASED ITS 10-YEAR-PLAN TO END CHRONIC HOMELESSNESS IN 2007, USE OF HOMELESS ASSISTANCE RESOURCES WAS INEFFICIENT AND PROGRAM-CENTERED.

Some high-need individuals and families were shut out of programs that could help them by strict eligibility criteria. Other homeless persons were admitted to whichever program agreed to take them, resulting in many clients receiving more or fewer services than they needed.

Starting in 2007, a “Front Door Committee” worked with a consultant and local stakeholders to develop a coordinated intake and assessment process. By 2009, all Requests for Proposals and contracts for local and HUD homeless assistance funding required recipients to participate in developing the Front Door Assessment (FDA). The FDA, which was launched in 2010, consists of two parts: 1) a brief intake assessment, administered within three days after a person or family enters an emergency shelter, and 2) a comprehensive assessment, administered during a household’s second week in shelter. The first step allows shelter providers to divert households with alternatives to longer shelter stays. In the second step, households are ranked as low-, medium-, or high-barrier, and referred to appropriate interventions.

In a review conducted six months after the FDA was launched, over 95 percent of participants said that the program was an improvement, although the community continues to fine-tune the process. The FDA system is credited with contributing to a nearly 50 percent drop in chronic homelessness from 2007 to 2013.



For more information:

- USICH Model Program: Front Door Assessment  
[http://usich.gov/usich\\_resources/solutions/explore/front\\_door\\_assessment](http://usich.gov/usich_resources/solutions/explore/front_door_assessment)
- Montgomery County, OH Homeless Solutions Plan  
[http://www.mcoho.org/services/fcfc/homeless\\_solutions.html](http://www.mcoho.org/services/fcfc/homeless_solutions.html)

## Homeless Management Information System (HMIS)

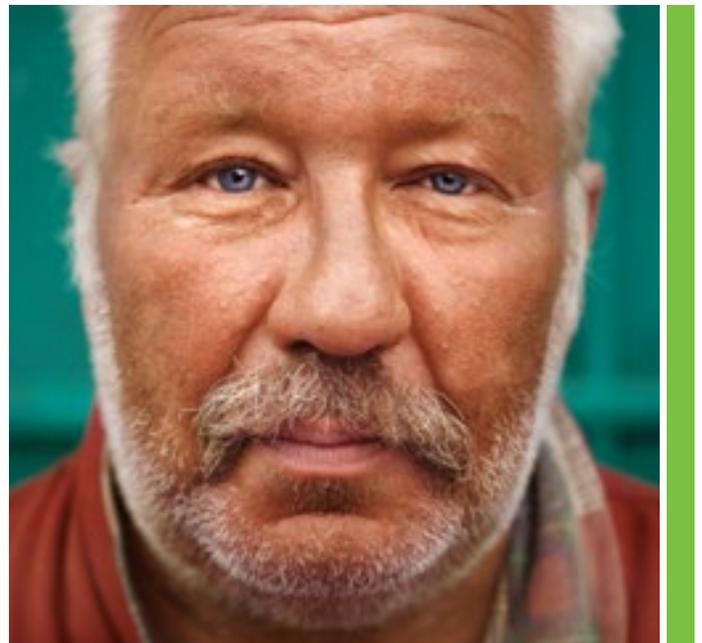
A local or regional electronic database that tracks the use of homeless assistance services by individuals and households. Congress, recognizing a need for nationally uniform and detailed data on homeless persons and their use of services, directed HUD in 2001 to develop data collection standards. The standards, first released in 2004, require each Continuum of Care (CoC) to use an HMIS. In December 2011, HUD issued an HMIS Proposed Rule to comply with new requirements from the HEARTH Act of 2009. The proposed rule codifies several practices that HUD had previously offered as guidance, such as the requirement for all clients and all projects assisted by McKinney-Vento funds to be entered into the HMIS, and the responsibility of the CoC for ensuring that agencies under its jurisdiction participate.

The purpose of HMIS data is to determine the size and characteristics of homeless populations that use assistance programs; facilitate assessment and referral for clients; identify service gaps; measure program performance; and develop funding priorities. HUD specifies minimum data collection requirements for all homeless assistance clients, including but not limited to: name, date of birth, age, race and ethnicity, disability status, veteran status, program entry and exit date, and where the client stayed before entering the program. Administrators of McKinney-Vento projects for which an Annual Progress Report (APR) are required must collect additional information, such as: income, non-cash benefits, detailed disability data, employment, education, and reason for leaving the program. Service providers for domestic violence victims are prohibited from entering client-level data into HMIS, but must use separate comparable database. HUD's HMIS standards also include privacy and security requirements.

HMIS data is a major component of the Annual Homeless Assessment Report (AHAR), which HUD has submitted to Congress

annually since 2007. HMIS data is used to determine the number and demographics of people at various geographic levels who enter emergency shelters and Transitional Housing over the course of a year. It also serves as the basis for a "Housing Inventory Count" (HIC), in which the number of different types of beds—emergency shelter, transitional and permanent housing, and safe havens—are counted on a single night in January. (The HIC coincides with the annual Point-in-Time (PIT) count.) These two HMIS-based data sources can be used to calculate the average occupancy rate and turnover rate of beds for homeless persons.

Note that some types of beds are counted in the HIC, even though their users are not included in annual homeless counts or PIT counts. For example, Permanent Supportive Housing beds are counted in the HIC, but their residents are no longer homeless.



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## Point-in-Time (PIT) Count

HUD requires every Continuum of Care to conduct regular Point-in-Time (PIT) counts of people in its geographic area who are “literally homeless”. This includes individuals and families who live outdoors, in a place not meant for human habitation (such as a car, transit station, or abandoned building), or in an emergency shelter, a safe haven, transitional housing, or a hotel or motel paid for with a voucher from a government agency or charitable organization. The main purpose of a Point-in-Time count is to collect data that allows CoCs and HUD to understand the size, characteristics, and needs of homeless populations, and plan resources accordingly. Each CoC conducts its Point-in-Time count and Housing Inventory Count on the same night, and both are major components of the Annual Homeless Assessment Report (see HMIS) that HUD submits to Congress. Currently, HUD requires CoCs to conduct an annual PIT count of the sheltered homeless population, and a biennial count of the unsheltered population (which includes those living in places not meant for human habitation). However, HUD strongly encourages CoCs to conduct unsheltered PIT counts annually.

In most cases, CoCs are required to conduct their Point-in-Time count on a single night between January 22nd and 31st. HUD

chose this timeframe because homeless people are more likely to use shelters in the winter, and thus are easier to count. Public concern about the homeless also tends to be greatest in the winter, and PIT counts can raise awareness and increase political will to help the homeless. By requiring that most CoCs conduct their PIT counts at roughly the same time, HUD allows PIT data from different communities to be compared more easily, and minimizes the chance that multiple CoCs will count people who are migrating from one community to another. However, a community with a longstanding tradition of conducting PIT counts at another time of year may receive a waiver from HUD. Additionally, a CoC with a particularly large or rural geographic area or limited staff may receive permission from HUD to conduct its count over a much longer period than a single night.

HUD began requiring CoCs to conduct Point-in-Time counts in 2003. Before then, some CoCs conducted their own local homeless counts using a variety of methods, while others estimated their homeless populations by extrapolating data from other communities. In 2004, HUD refined its Point-in-Time requirements, stipulating that communities only report unsheltered homeless people



## HOMELESS ASSISTANCE ACTIVITIES AND MODELS

that they had actually counted, or extrapolated using statistically reliable methods. This requirement replaced the unscientific methods that many communities were using to estimate their unsheltered homeless populations. For example, some communities estimated their unsheltered populations by multiplying an “adjustment factor” to their sheltered populations, or by augmenting their unsheltered count to include people who were believed to be present but were not actually seen by count volunteers.

For both its sheltered and unsheltered homeless populations, a CoC is required to collect both “population” and “subpopulation” data. As of the 2014 PIT count, CoCs must count both the number of individuals and the number of households in each of three population categories<sup>11</sup>:

- Households with adults only
- Households with at least one adult and one child
- Households with children only

Starting with the 2014 PIT count, for each of these homeless populations, CoCs must also count the number of people in different age group, gender, ethnicity, and race categories specified by HUD. The 2014 PIT count also introduces a requirement for CoCs to collect separate population data for veteran households.

CoCs are also required to count the number of homeless persons in each of five subpopulations:

- Chronically homeless individuals
- Chronically homeless families
- Adults with a serious mental illness
- Adults with a substance abuse disorder
- Adults with HIV/AIDS

For chronically homeless families, CoCs must count both the number of families and the number of people in these families.

For a few years before the 2014 PIT count, veterans were another required subpopulation; the new requirement for veteran population data has eliminated the need for a veteran subpopulation. Victims of domestic violence comprise an optional subpopulation category that CoCs may count.

HUD issues two separate guidance documents for the sheltered and unsheltered components of the PIT count, each of which describes a slate of approved methodologies. For each PIT count component, a CoC may use a combination of methods that best reflects its unique local circumstances. The methods for unsheltered counts are more complex, due to the inherent difficulties in locating, characterizing, and avoiding double-counting of people who are not staying in shelters. By contrast, sheltered counts can be greatly simplified by a community’s Homeless Management Information System (HMIS), if the providers of a majority of shelter beds participate in HMIS (i.e. the “bed coverage” rate is high) and the data quality is good. Both the sheltered and unsheltered count have two main elements: a “basic count” of all homeless individuals encountered on the night of the count; and collection of population and subpopulation data for all, or a statistically representative sample, of those counted<sup>12</sup>. Population and subpopulation data may come from interviews of sheltered and unsheltered homeless persons using a standard survey instrument or, for sheltered homeless persons, HMIS data or individual client surveys filled out by shelter providers.

Point-in-Time counts require considerable planning and coordination. Depending on the experience and capacity of the CoC, planning a PIT count can take between three months and a year. Moreover, HUD’s guidance documents for sheltered and unsheltered PIT counts are updated periodically, and the notices HUD issues for each year’s Point-in-Time count may contain changes to the guidelines from the previous year’s count. Thus, when planning a PIT count, a CoC should use HUD’s most recent guidance materials.

<sup>11</sup> An unaccompanied homeless person counts as a household.

<sup>12</sup> One exception is a HUD-approved method for conducting interviews at a separate time from the count. This method is particularly useful if the CoC conducts its count in a “blitz” during late-night and early-morning hours, when most people counted would be asleep. The sample of people interviewed must still be statistically valid, so that the CoC can extrapolate the data to the entire unsheltered population; but it is not a sample “of those counted”.

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# HOMELESS SUBPOPULATIONS

## Chronic Homelessness

The McKinney-Vento Act defines a chronically homeless individual or family as one that:

- 1) Is literally homeless (i.e. living in a place not meant for human habitation, an emergency shelter, or a safe haven);
- 2) Has been homeless for at least 1 year, or on at least 4 separate occasions (≥15 days each) in the past 3 years; and
- 3) Has a head of household with a disability, which may include mental illness, a substance abuse disorder, a physical disability, etc.

The definition of chronic homelessness includes persons who have resided in an institutional setting, such as a jail, hospital, or

substance abuse treatment facility for less than 90 days, if they met the other criteria for chronic homelessness prior to entry. Historically, only unaccompanied individuals were counted as chronically homeless, but the HEARTH Act of 2009 expanded the definition to include persons in families. The working definition of chronic homelessness above has not been finalized; the proposed revisions to the old definition were included first in the Emergency Solutions Grant interim rule (released 12/5/11), and later in the Rural Housing Stability Program interim rule (released 3/27/13; see HEARTH Act).

In 2013, 109,132 people, or about 18% of the total homeless population, were chronically homeless. The average chronically

## HOMELESS SUBPOPULATIONS

homeless person resembles the “Skid Row” image that comes to mind when many people think of homelessness—he is male, between the ages of 35 and 54, unsheltered, and likely to suffer from multiple disabilities, such as co-occurring mental illness and substance abuse. Many chronically homeless persons are distrustful of authority figures, reluctant to seek shelter or services, and unable or unwilling to comply with the sobriety and treatment requirements of many Transitional Housing (TH) programs. Outreach workers engage these individuals by making persistent contact and gradually building a rapport. A growing body of research suggests that a Housing First (HF) model is best for promoting housing stability and reducing use of crisis services among the chronically homeless.

“IN 2013, 109,132 PEOPLE, OR ABOUT 18% OF THE TOTAL HOMELESS POPULATION, WERE CHRONICALLY HOMELESS. THE AVERAGE CHRONICALLY HOMELESS PERSON RESEMBLES THE “SKID ROW” IMAGE THAT COMES TO MIND WHEN MANY PEOPLE THINK OF HOMELESSNESS—HE IS MALE, BETWEEN THE AGES OF 35 AND 54, UNSHELTERED, AND LIKELY TO SUFFER FROM MULTIPLE DISABILITIES, SUCH AS CO-OCCURRING MENTAL ILLNESS AND SUBSTANCE ABUSE.”

### Why Aren't They Seeking Services?

“Many chronically homeless persons are distrustful of authority figures, reluctant to seek shelter or services, and unable or unwilling to comply with the sobriety and treatment requirements of many Transitional Housing (TH) programs.”

Research in the late 1990s and early 2000s showed that the chronically homeless account for a disproportionate number of days spent by clients in homeless shelters, and cycle through costly public crisis systems, such as jails, emergency rooms, and mental health treatment facilities. In response, the Bush administration set a national goal of ending chronic homelessness and building 150,000 units of Permanent Supportive Housing (PSH). The combination of federal incentives and local efforts (including “10-Year Plans” to end homelessness) has contributed to a 25% decline in the population of chronically homeless individuals between 2007 and 2013.



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## 100,000 Homes Campaign

The 100,000 Homes Campaign is a national movement, launched in 2010, to house 100,000 chronically homeless individuals and families by July 2014. The 100,000 Homes campaign has over 200 participating communities, which had collectively housed over 105,000 people by September 2014. The campaign was started by Community Solutions, a nonprofit based in New York City that researches homelessness, fosters partnerships among homeless assistance stakeholders, offers training and technical assistance for case management and service delivery, and develops affordable housing. 100,000 Homes is based on the premise that housing the chronically homeless is an urgent moral imperative, since street homelessness reduces a person's lifespan by 25 years on average. The campaign embraces a Housing First approach, and provides communities with a three-pronged model for housing their chronically homeless members:

1) **Registry Week:** Communities develop a registry of all their members who are chronically homeless and living on the street. This homeless subpopulation is targeted because its members are most likely to avoid shelters and service providers, and thus may never obtain housing without outreach efforts. For each homeless person who is identified and willing to participate, a volunteer records a name, takes a photograph, and administers a survey with questions about health conditions, institutional history, and other risk factors. This survey, known as a "Vulnerability Index", identifies those

homeless persons who are most likely to die on the street without housing. Those with the highest Vulnerability Index scores are prioritized for housing, and their survey feedback is used to identify federal, state, and local funding sources for which they might be eligible. This matching exercise significantly expedites the process of housing these individuals.

2) **Tracking Progress:** Communities participating in 100,000 Homes aim to house 2.5% of their chronic and vulnerable homeless populations monthly, and are expected to report on their progress. The national 100,000 Homes team uses the data to make comparisons among similar communities. As an incentive to submit reports regularly, the national team publicizes a list of "Fully Committed Communities", or those that have submitted at least three consecutive monthly reports.

3) **Improving Local Systems:** 100,000 Homes argues that the main impediment to housing the chronically homeless is not lack of funding, but fragmentation of service delivery. The national program offers guidance for participating communities to streamline their housing placement systems and improve service targeting. Many communities started this process with a "Rapid Results Housing Placement Boot Camp", in which stakeholders mapped their community's current homeless assistance system and devised ways to improve it.



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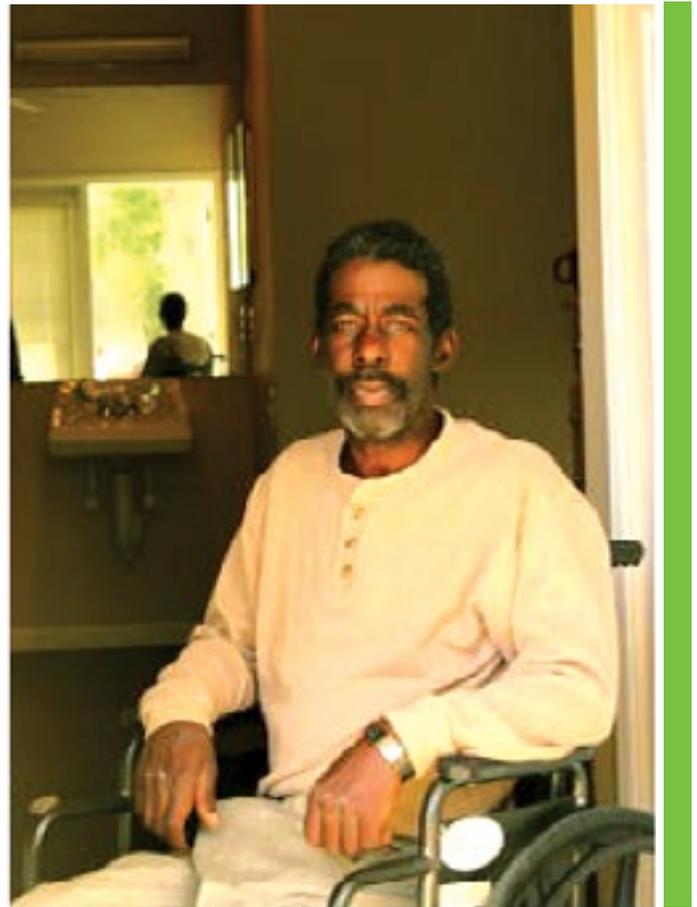
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# CASE STUDY

## 100 HOMES JACKSONVILLE MAKES NATIONAL NEWS

JACKSONVILLE, FL JOINED THE 100,000 HOMES CAMPAIGN IN NOVEMBER 2011. AT THAT TIME, THE CITY HAD A CHRONIC HOMELESS POPULATION OF 1,104 PEOPLE. BY LATE MAY 2014, THE NEW YORK TIMES REPORTED THAT THE POPULATION HAD DROPPED TO 399. HOW DID THEY DO IT?

100 Homes Jacksonville is collaboration of more than 20 public and private entities, including Ability Housing of Northeast Florida, a permanent supportive housing provider, and the Emergency Services and Homeless Coalition of Northeast Florida, the Continuum of Care lead agency. By July 2014, the campaign had housed 761 people, of whom 351 are Veterans. Campaign partners achieved this impressive result by contacting other communities to find out what worked, and holding biweekly conference calls to share data and identify roadblocks. Rather than taking the existing rules as a given, the partners took steps to speed up the process and make it more flexible wherever possible. For example, the Jacksonville Housing Authority agreed to allow units to be rented to chronically homeless people with certain misdemeanor arrest records. Shannon Nazworth, President of Ability Housing, reflects, “The successes made people in the community think, Wow, we can actually move the bar on this. We can end long-term homelessness.”



David, housed 2-9-2012. Photo from 100 Homes Jacksonville website ([www.100homesjax.org](http://www.100homesjax.org))

For more information:

- 100 Homes Jacksonville

<http://www.100homesjax.org/>

- Florida Times-Union: ‘Remarkable’: 100 Homes Jacksonville Far Exceeds Goal, Houses 761 Homeless

<http://jacksonville.com/news/health-and-fitness/2014-07-09/story/remarkable-100-homes-jacksonville-far-exceeds-goal-houses>

- New York Times: The Push To End Chronic Homelessness is Working

<http://opinionator.blogs.nytimes.com/2014/05/28/the-push-to-end-chronic-homelessness-is-working/>

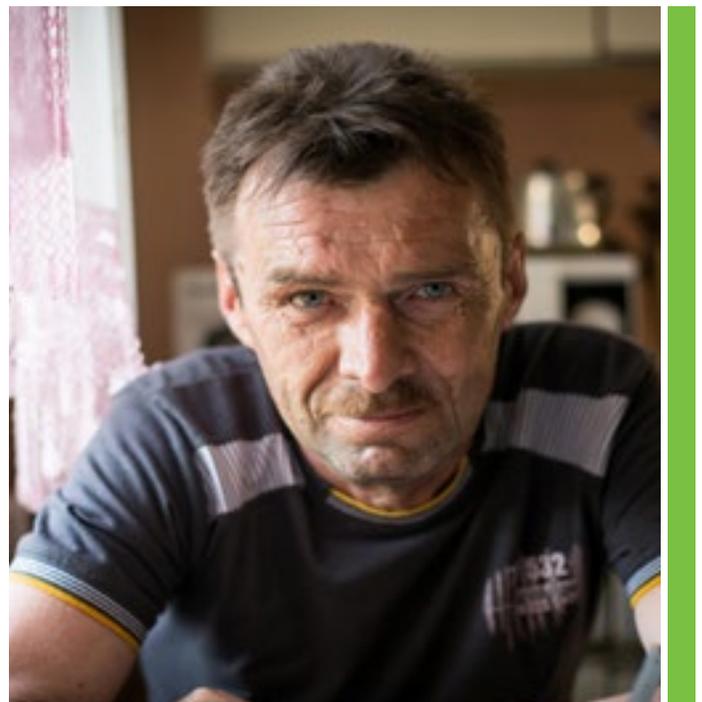
## Rapid Results Housing Placement Boot Camp

The Rapid Results Housing Placement Boot Camp was a training and organizing module used by the 100,000 Homes Campaign to help communities improve their housing placement systems for homeless veterans. 100,000 Homes collaborated with the Rapid Results Institute to develop the Boot Camp in late 2011, and the initiative was also sponsored by HUD, the US Interagency Council on Homelessness (USICH), and the US Department of Veterans Affairs.

The “Rapid Results” model was developed by the Rapid Results Institute (RRI), a Connecticut-based nonprofit that primarily facilitates human service projects in the developing world. RRI’s core philosophy is that the key factor for success in development projects is “human motivation and confidence”<sup>13</sup>, rather than more funding or training. RRI helps communities launch 100-day initiatives to achieve “seemingly impossible”<sup>14</sup> goals for a specific issue. Ideally, the practices and mindsets that participants use to pursue these goals become normalized and scalable.

Each Rapid Results Housing Placement Boot Camp lasted one day, and included representatives from essential stakeholder groups: current and former homeless veterans, the local government agency with primary responsibility for homeless assistance, the local Continuum of Care and public housing authority, HUD, the VA, and the U.S. Interagency Council on Homelessness, and private landlords. Participants started by creating a schematic map of their community’s current housing placement system, and then developed a map of an ideal system. Gaps, redundancies, and roadblocks in the current system were identified, and participants revised the first map to show improvements that could realistically be made in the near term. At the end of the Boot Camp, participants set an “unreasonable but achievable”<sup>15</sup> goal for housing homeless veterans in the next 100 days—often 100 veterans—and developed a follow-up plan.

By September 2012, about fourteen cities had conducted Boot Camps, and preliminary reports suggest that the model improves housing placement speed. Many boot camps were conducted on a regional basis, with stakeholders from multiple communities attending. The Rapid Results Institute’s successor to the Boot Camps is the 25 Cities Initiative, conducted in 25 cities across the U.S. with the highest populations of homeless veterans. Local homeless assistance stakeholders in these cities are working with representatives from the Rapid Results Institute, Community Solutions (the nonprofit that started the 100,000 Homes Campaign), HUD, USICH, and the VA on a longer-term version of the Boot Camp efforts to streamline systems and speed up housing placement.



<sup>13</sup> Rapid Results Institute 2013.

<sup>14</sup> Ibid.

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# CASE STUDY

## HOW DID SALT LAKE CITY, UTAH, END CHRONIC VETERAN HOMELESSNESS?

“AFTER ONE PIVOTAL (AND TENSE!) CONVERSATION [AT A BOOT CAMP], THE VA AGREED TO UTILIZE 100% OF HUD-VASH RESOURCES FOR CHRONICALLY HOMELESS VETERANS AND TO FOLLOW THE HOUSING FIRST PHILOSOPHY. THEY ALSO AGREED TO RELOCATE THEIR HOMELESS OUTREACH TEAM TO THE ROAD HOME, THE CITY’S LARGEST HOMELESS SHELTER.

Housing Authorities reduced voucher process time from 90 days to 1 day by agreeing to come to the new Veterans Housing Outreach office at The Road Home and by working with HUD to get permission to collect alternative identification such as a DD-214 instead of a state issued ID and Birth Certificate. ... [We stopped] identifying ways we couldn’t do things, and ... encouraged ourselves to rise above our current structures and figure out how to make things happen. ...

“We [still] have work to do. The lines of communication we have developed ... have changed how we serve. ... We have developed multi-agency collaborations in a number of areas including housing for individuals who are chronically homeless, families and individuals with high shelter nights.”

-Melanie Zamora,  
Director of Housing Programs at The Road Home,  
Salt Lake City



For more information:

- MSNBC: Salt Lake City Joins Phoenix in Ending Veteran Homelessness  
<http://www.msnbc.com/melissa-harris-perry/mayor-declares-end-vet-homelessness>

## HUD-VASH

The Department of Housing and Urban Development and Veterans Affairs Supportive Housing (HUD-VASH) program is a collaboration between HUD and the VA to provide housing vouchers with “wraparound” support services for the most vulnerable homeless veterans. HUD-VASH was created in 1992, and provided vouchers and case management for about 1,700 veterans with severe mental health or substance abuse problems. Although veterans were required to agree to a treatment plan prior to program admission, treatment participation was not required for voucher retention. In 2008, the federal government revived HUD-VASH, and has provided new funding for the program every year since then. Since 2008, over 68,000 vouchers have been awarded. HUD-VASH plays an important role in meeting the national goal of ending veteran homelessness by 2015, set forth in the 2010 *Opening Doors* plan.

When HUD-VASH was revived in 2008, the VA selected 132 Veterans Affairs Medical Centers (VAMCs) to provide case management for participating veterans. HUD-VASH vouchers may be either Housing Choice Vouchers (HCVs) or Project-Based Vouchers (PBVs). To allocate the HCVs, HUD annually selects PHAs based on their performance and local need, and sends them invitations to apply for vouchers. To qualify for a voucher, an applicant must meet the McKinney-Vento definition of homelessness, be eligible for VA health care, require case management to achieve housing stability and independent living, and agree to participate in case management. VAMCs conduct outreach, screen applicants using the above-mentioned criteria, refer eligible applicants to local PHAs, and provide case management for voucher recipients. PHAs, in turn, screen applicants for income eligibility and sex offender status; registered lifetime sex offenders are barred from the program.

Once a VAMC has approved a veteran for HUD-VASH, the veteran and his or her case manager develop a Housing Recovery Plan, which may include physical and mental health treatment, counseling for maintaining housing stability, and legal services. Although the recipient is required to participate in case management, sobriety and treatment compliance are not conditions for remaining in the program. When a voucher holder becomes sufficiently independent that case management is no longer needed, the PHA is encouraged to replace his or her HUD-VASH voucher with a regular voucher. When a HUD-VASH voucher is freed up, the PHA is required to issue it to another qualifying veteran. However, if a regular voucher is unavailable for a HUD-VASH recipient who no longer needs case management, the recipient may stay in the program with minimal or no case management.

Although HUD-VASH has always been a low-demand program, HUD and the VA have explicitly adopted a Housing First approach for the program. To ensure that the neediest veterans are helped and maximum public savings achieved, priority is given to the chronically homeless, as well as women, families with dependents, the disabled, and veterans of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF). HUD-VASH likely plays a role in the 24% decline in veteran homelessness between 2010 and 2013, but room for improvement remains. A recent VA-sponsored study found that HUD-VASH participants who receive Rapid Re-Housing (RRH) assistance, using an inventory of pre-inspected apartments, are more likely to find permanent housing and maintain it for 12 months than those who search for housing on the open market after receiving a voucher. Additionally, HUD and the VA have found that local partners must strike a balance between maximizing voucher utilization and targeting the chronically homeless, who are often hardest to serve.

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## Supportive Services for Veteran Families (SSVF)

A program offered by the U.S. Department of Veterans Affairs (VA) to “promote housing stability among very low-income veteran families who reside in or are transitioning to permanent housing.” SSVF was created in 2010, and was modeled in part on the Homelessness Prevention and Rapid Re-Housing Program (HPRP). Funds are awarded to private nonprofit organizations and consumer cooperatives to provide housing stabilization services to veterans and their families. To qualify for SSVF, a veteran must have served in an active military branch, and may have any discharge status other than “dishonorable”. As a result, SSVF fills some of the coverage gaps in HUD-VASH and the VA’s Grant and Per Diem program. In early 2014, the VA changed its SSVF guidance documents to restrict eligibility to veterans who are eligible for VA medical benefits, which generally requires that they served at least 24 continuous months of active duty. The change reflected legal uncertainty about whether SSVF could serve veterans who are ineligible for VA medical benefits. However, in late March 2014, the VA lifted the moratorium on serving these veterans, a change reflected in the most recent SSVF program guide.

SSVF is available to very low-income ( $\leq 50\%$  of area median income) veteran families that are “occupying permanent housing”, a partly counterintuitive term that includes three separate categories. Category 1 includes families who are currently residing in permanent housing, but will imminently become homeless if they do not receive homelessness prevention assistance. Category 2 includes families who are homeless and are scheduled to enter permanent housing in the next 90 days, but will lose this housing and become homeless without Rapid Re-Housing (RRH) assistance. Category 3 families have exited permanent housing to search for housing that is more responsive to the family’s needs and preferences, and are likely to remain homeless without RRH assistance. Although the official wording of Category 2 implies that it can only be used for homeless veterans who arranged to enter permanent housing before applying for SSVF, in practice this is not the case. Category 2 applies to veterans who exited permanent housing more than 90 days ago, and who would not have access to permanent housing but for this program.



SSVF grantees may use funds for outreach, case management, and assisting clients in obtaining benefits from the VA and other mainstream agencies. If necessary, grantees may provide clients with time-limited financial assistance for housing stabilization expenses, including current rent and arrears, security and utility deposits, moving expenses, transportation, and child care. Each SSVF Notice of Funding Availability (NOFA) issued thus far has required that grantees limit their funding to families who would become or remain homeless “but for” SSVF, a policy that is codified in the proposed rule from May 2014. Additionally, the NOFAs have prioritized specific populations, such as households that are extremely low-income ( $\leq 30\%$  area median income), have at least one dependent, have a veteran who served in Iraq or Afghanistan and/or is female, or live in rural or tribal areas.

In Fiscal Years 2012 and 2013, the first two years of the program, nearly 100,000 veterans and their family members received assis-

tance. Of those participants who have exited the program, 86% and 84% exited to permanent housing in the first and second years, respectively. Permanent housing exit rates were higher for families with children, which were more likely to receive homelessness prevention assistance.

SSVF has grown considerably since it was first implemented. In FY 2012, about \$60 million was awarded to 85 grantees. By FY 2014, this amount had increased to nearly \$300 million awarded to 301 grantees. An additional “surge” of \$300 million in non-recurring funds was made available in early 2014 to 76 high-priority Continuums of Care. Furthermore, on 5/9/14, the VA issued a proposed rule to replace the current SSVF rule. The new rule would extend the time limits for certain benefits, including rental assistance and child care, and would allow grantees to provide additional benefits to extremely low-income families.

In Fiscal Years 2012 and 2013, the first two years of the program, nearly 100,000 veterans and their family members received assistance. Of those participants who have exited the program, 86% and 84% exited to permanent housing in the first and second years, respectively.

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## Grant and Per Diem (GPD) Program

The Grant and Per Diem Program is a Department of Veterans Affairs (VA) program that funds Transitional Housing (TH) and associated services for homeless Veterans. Funding is available to nonprofits and state and local governments, for programs in which at least 75% of clients are Veterans. The “Grant” portion of the program funds up to 65% of the costs for construction, acquisition, or renovation of a structure that provides transitional housing and/or services. Grant recipients are given priority for “Per Diem” funds, which provide a maximum of \$43.32 per day per Veteran for the costs of operating supportive housing and/or services (including salaries). For programs that provide supportive services only, Per Diem funding is limited to 1/8 the hourly cost of care, for a maximum of 8 hours per day. Grantees that receive

Per Diem funds only may use a “transition-in-place” model (see “Transitional Housing”).

The Grant and Per Diem program has declined in importance as Housing First models have become increasingly popular for serving homeless Veterans. The total pool of homeless Veterans has decreased in recent years, and those that remain are increasingly choosing Housing First programs such as Supportive Services for Veteran Families (SSVF) and HUD-VASH. As a result, some GPD-funded programs have empty beds, which are not reimbursable by Per Diem funds. The VA is considering changes to the GPD program, such as allowing grantees to convert their programs to Permanent Housing or Rapid Re-Housing, and targeting hard-to-serve veterans.



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## Youth Homelessness

Unaccompanied adolescents and young adults become homeless for a variety of reasons. Many homeless youth have fled abusive homes, been kicked out, or aged out of the foster care or juvenile justice systems. Lesbian, gay, bisexual, and transgender (LGBT) youth are disproportionately represented—LGBT individuals comprise 20 to 40 percent of the unaccompanied homeless youth population, and only 3 to 5 percent of the general population. Youth homelessness presents unique challenges and risks, since adolescence and young adulthood is one of the most critical stages in a person’s intellectual, social, and emotional development. It is particularly important for developing “executive functioning” skills, including planning, problem solving, and delaying gratification. The trauma that youth experience both before and after becoming homeless—including sexual assault and exploitation—poses a threat to developing these skills, and best practices in serving youth include trauma-informed care and helping youth reintegrate into their communities and prepare for independence.



Over the course of a year, an estimated 500,000 to 1.7 million youth become homeless for at least one night. The 2013 Point-in-Time (PIT) counts identified 46,924 homeless youth, but this is believed to be an undercount for a variety of reasons. For example, homeless youth tend to frequent different locations than the older homeless individuals captured in PIT counts, and are less likely to admit that they are homeless. In 2012, the United States Interagency Council on Homelessness (USICH) launched the Youth Count! initiative, in partnership with other federal agencies, to develop and test new Point-in-Time count methodologies for youth in nine participating communities.

The two main statutes governing federal policy on unaccompanied homeless youth are the McKinney-Vento Act and the

Runaway and Homeless Youth Act. The McKinney-Vento Act requires that homeless children and youth, including school-aged unaccompanied youth, have access to “free and appropriate” public education (FAPE). The Act’s provisions mitigate the instability and barriers to enrollment associated with child and youth homelessness. For example, homeless children and youth may stay enrolled in the schools they attended before becoming homeless, even if their nighttime location is outside the school district. The Act also enables homeless students to enroll immediately, even if they cannot produce documents such as birth certificates, proof of guardianship, and immunization records.

Under the McKinney-Vento Act, The Department of Education administers the Education for Homeless Children and Youth (ECHY) program, which provides formula grants to states for data collection, planning, and coordination related to education of homeless youth. States, in turn, subgrant ECHY funds to local educational agencies (LEAs) on a competitive basis. Every LEA, whether or not it receives an ECHY subgrant, is required to have a local liaison to identify and coordinate services for homeless students. Local liaison responsibilities include arranging transportation for homeless students, helping them or their guardians obtain required documents, and referring them and their parents or guardians to community services targeted to homeless families. Because the ECHY definition of homelessness is relatively broad, these services are available to children whose families are living doubled-up or in motels due to economic hardship (see Definition of Homelessness).

The Education for Homeless Children and Youth program applies to all school-aged children and youth, whether or not they are staying with a parent or guardian. By contrast, the programs

## HOMELESS SUBPOPULATIONS

authorized by the Runaway and Homeless Youth Act (RHYA) largely target unaccompanied youth. The U.S. Department of Health and Human Services (HHS) administers funds that support outreach, shelter and supportive service facilities, and transitional living programs for unaccompanied homeless youth.

As part of its efforts to promote the *Opening Doors* goal of ending youth homelessness by 2020, USICH released its *Framework to End Youth Homelessness* in February 2013. The *Framework* outlines plans for improved data collection and a “preliminary intervention model” for preventing and ending youth homelessness. The model focuses on four core outcomes for youth: 1) stable housing, 2) permanent connections among family, peers, and other social networks, 3) education and employment, and 4) Social/emotional well-being.

The *Framework* provides a road map for disseminating screening and assessment tools that identify “risk factors” and “protective factors” among homeless and at-risk youth, and service providers are advised to use Trauma-Informed Care and Positive Youth Development approaches. Trauma-informed care, as discussed above and in the Permanent Supportive Housing and Rapid Re-Housing sections, sensitizes service providers to

the role that trauma plays in a youth’s thought and decision-making processes. Service providers are also trained to avoid communication styles that trigger post-traumatic responses. While Trauma-Informed Care helps youth to heal from past trauma, the Positive Youth Development approach helps youth identify personal strengths, form relationships, and find opportunities to contribute to society.

For many years, Florida’s affordable housing providers have been attuned to the high risk of homelessness among youth aging out of foster care. These youth are considered a “special needs” population in Florida Statutes addressing state housing programs, and several developments financed by state affordable housing funds provide transitional or permanent housing for this population. In 2013, the State Legislature passed a bill sponsored by Senator Nancy Detert (R-Venice) to allow youth to remain in foster care until their 21st birthday (or 22nd in the case of disabled youth.) The support of a foster home, combined with services provided by the Florida Department of Children and Families (DCF), is intended to help foster youth avoid homelessness and transition to independent living.

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# CASE STUDY

## EMMAUS PLACE IN MIAMI

EMMAUS PLACE IS A 7-UNIT HISTORIC APARTMENT BUILDING IN DOWNTOWN MIAMI FOR YOUNG MEN AGED 18 TO 22 WHO ARE TRANSITIONING OUT OF FOSTER CARE. CAMILLUS HOUSE OWNS THE BUILDING, WHICH WAS RENOVATED WITH THE HELP OF A DEMONSTRATION LOAN FROM THE FLORIDA HOUSING FINANCE CORPORATION. RESIDENTS PAY 30 PERCENT OF THEIR INCOMES FOR THE FURNISHED ONE-BEDROOM UNITS, AND SUPPORTIVE SERVICES ARE PROVIDED BY CASA VALENTINA. RESIDENTS MUST BE ENROLLED IN HIGH SCHOOL, COLLEGE, A GED PROGRAM, OR A VOCATIONAL/CERTIFICATE PROGRAM, BE DRUG-FREE, AND DEMONSTRATE A CAPACITY TO LIVE INDEPENDENTLY. ONCE THEY HAVE COMPLETED THE PROGRAM, THE YOUNG MEN MAY CONTINUE TO RECEIVE AFTERCARE SERVICES FROM CASA VALENTINA.

Programs such as Emmaus Place are best suited to relatively stable and motivated youth aging out of foster care. Youths participating in Casa Valentina programs are generally eligible for Florida's Road-to-Independence Program (F.S. 409.1451), which provides a stipend to youth who are transitioning from foster care, enrolled full-time in post-secondary education, and making adequate academic progress as defined by their educational institution. Under the *Nancy C. Detert Common Sense and Compassion Independent Living Act*, passed by the Florida Legislature in 2013, students with disabilities or other recognized challenges may be enrolled at less than full-time status.

The Act also provides a safety net for foster youth who may be unable or unwilling to enroll in school, and thus would be ineligible for programs such as Emmaus Place. In general, youths are eligible for continued foster care up to age 21 (or 22 for those with disabilities) if they are in school, em-



ployed, or enrolled in a program designed to eliminate barriers to employment. However, exceptions are made for young adults with documented physical, intellectual, emotional, or psychiatric impairments.

For more information:

- Camillus House

<http://www.camillus.org/main/emmaus-place/#.VBSfSBYXPk8>

- Casa Valentina

<http://www.casavalentina.org/portal/our-program#.VBSZNxYXPk8>

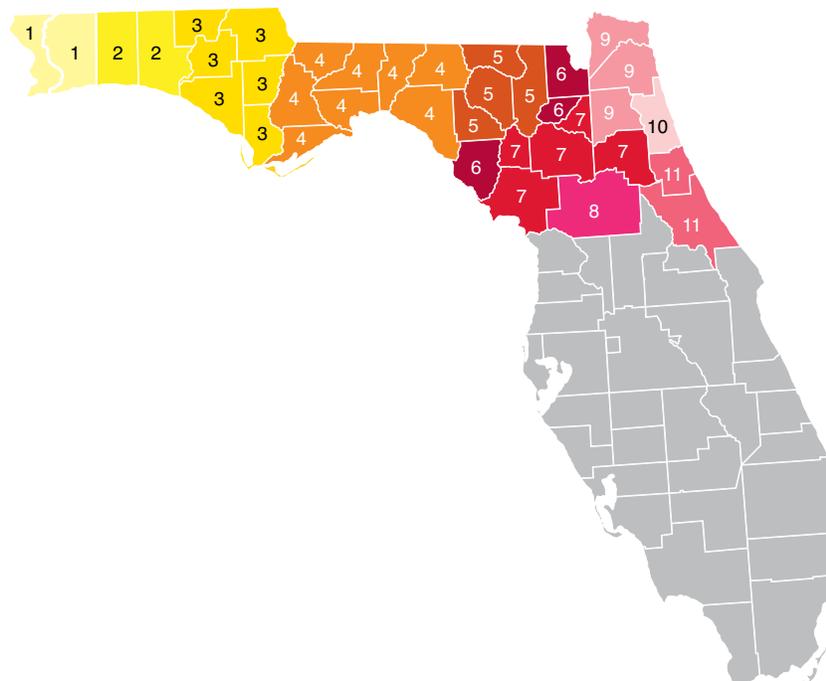
- Florida Housing Coalition: Senator Detert is Successful Champion for Youth Aging Out of Foster Care

<http://www.flhousing.org/wp-content/uploads/2013/06/Senator-Detert-is-Successful-Champion-Vol-29-No-2-June13-11.pdf>

# CONTINUUMS OF CARE IN FLORIDA

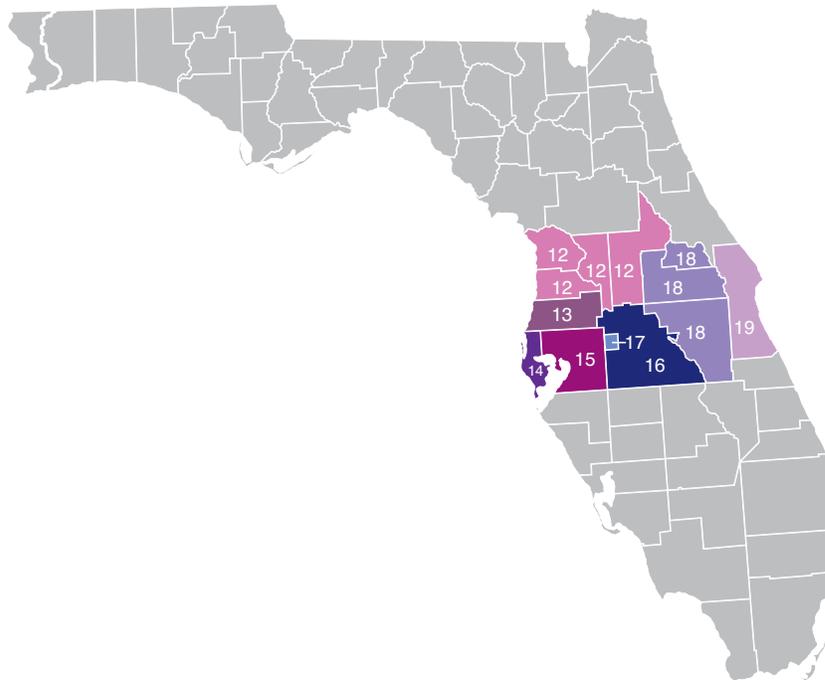
## CONTINUUMS OF CARE IN NORTH FLORIDA

	AGENCY	COUNTIES SERVED
1	EscaRosa Coalition on the Homeless <a href="http://www.ecoh.org">www.ecoh.org</a>	Escambia, Santa Rosa
2	Opportunity, Inc. <a href="http://www.okaloosawaltonhomeless.org/">http://www.okaloosawaltonhomeless.org/</a>	Okaloosa, Walton
3	Homeless and Hunger Coalition of Northwest Florida <a href="http://homelesshungercoalitionnwfl.org/">http://homelesshungercoalitionnwfl.org/</a>	Bay, Calhoun, Gulf, Holmes, Jackson, Washington
4	Big Bend Homeless Coalition <a href="http://www.bigbendhc.org/">http://www.bigbendhc.org/</a>	Leon, Franklin, Gadsden, Liberty, Madison, Taylor, Jefferson, Wakulla
5	United Way of Suwanee Valley <a href="http://www.unitedwaysuwaneevalley.org/other.html">http://www.unitedwaysuwaneevalley.org/other.html</a>	Columbia, Hamilton, Lafayette, Suwanee
6	Not included in a Continuum of Care (Florida has no "Balance of State" CoC)	Baker, Dixie, Union
7	Alachua County Coalition for the Homeless and Hungry <a href="http://www.acchh.org">www.acchh.org</a>	Alachua, Putnam, Bradford, Levy, Gilchrist
8	Marion County Homeless Council <a href="https://www.mchcfl.org/">https://www.mchcfl.org/</a>	Marion
9	Emergency Services and Homeless Coalition of Northeast Florida <a href="http://www.eshcnefl.org">www.eshcnefl.org</a>	Duval, Clay, Nassau
10	Emergency Services and Homeless Coalition of St. Johns County <a href="http://homelesscoalitionstjohns.com/">http://homelesscoalitionstjohns.com/</a>	St. Johns
11	Volusia/Flagler County Coalition for the Homeless <a href="http://vcch.org/">http://vcch.org/</a>	Volusia, Flagler



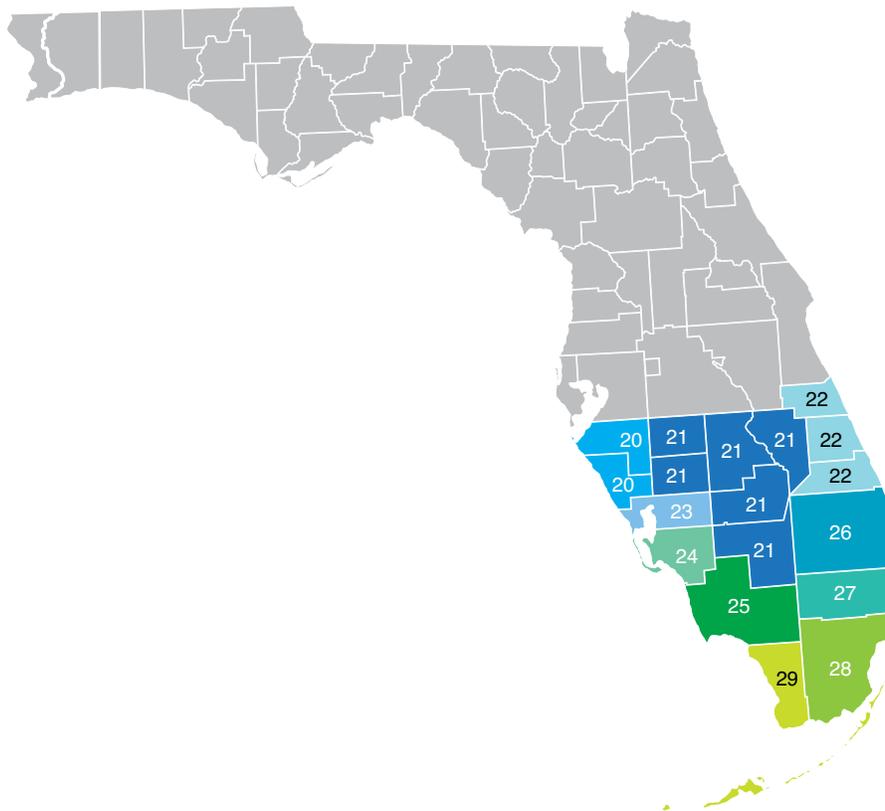
## CONTINUUMS OF CARE IN CENTRAL FLORIDA

	AGENCY	COUNTIES SERVED
12	Mid-Florida Homeless Coalition <a href="http://www.midfloridahomeless.org/">http://www.midfloridahomeless.org/</a>	Citrus, Hernando, Lake, Sumter
13	Coalition for the Homeless of Pasco County <a href="http://www.paschohomelesscoalition.org/">http://www.paschohomelesscoalition.org/</a>	Pasco
14	Pinellas County Homeless Leadership Board <a href="http://www2.pinellashomeless.org/">http://www2.pinellashomeless.org/</a>	Pinellas
15	Tampa Hillsborough Homeless Initiative <a href="http://www.homelessofhc.org/">http://www.homelessofhc.org/</a>	Hillsborough
16	Tri-County Human Services <a href="http://tchsonline.org/">http://tchsonline.org/</a>	Polk (excluding City of Lakeland)
17	Homeless Coalition of Polk County <a href="http://www.polkhomeless.org/">http://www.polkhomeless.org/</a>	Polk (City of Lakeland only)
18	Homeless Services Network of Central Florida <a href="http://www.hsncl.org/">http://www.hsncl.org/</a>	Orange, Osceola, Seminole
19	Brevard County Housing and Human Services Department <a href="http://www.brevardcounty.us/HumanServices/CommunityResources/CareCoalition">http://www.brevardcounty.us/HumanServices/CommunityResources/CareCoalition</a>	Brevard



## CONTINUUMS OF CARE IN SOUTH FLORIDA

	AGENCY	COUNTIES SERVED
20	Suncoast Partnership to End Homelessness <a href="http://suncoastpartnership.org/">http://suncoastpartnership.org/</a>	Manatee, Sarasota
21	Highlands County Coalition for the Homeless <a href="http://www.highlandshomeless.com/">http://www.highlandshomeless.com/</a>	DeSoto, Glades, Hardee, Hendry, Highlands, Okeechobee
22	Treasure Coast Homeless Services Council <a href="http://www.tchelpspot.org/wordpress/">http://www.tchelpspot.org/wordpress/</a>	Indian River, Martin, St. Lucie
23	Charlotte County Homeless Coalition <a href="http://www.cchomelesscoalition.org/">http://www.cchomelesscoalition.org/</a>	Charlotte
24	Lee County Department of Human Services <a href="http://dhs.leegov.com/Pages/default.aspx">http://dhs.leegov.com/Pages/default.aspx</a>	Lee
25	Hunger and Homeless Coalition of Collier County <a href="http://collierhomelesscoalition.org/cchhc/">http://collierhomelesscoalition.org/cchhc/</a>	Collier
26	Palm Beach County Division of Human Services <a href="http://www.pbcgov.com/communityservices/programs/humanservices/">http://www.pbcgov.com/communityservices/programs/humanservices/</a>	Palm Beach
27	Broward County Homeless Initiative Partnership <a href="http://www.broward.org/HumanServices/CommunityPartnerships/HomelessInitiativePartnership/Pages/Default.aspx">http://www.broward.org/HumanServices/CommunityPartnerships/HomelessInitiativePartnership/Pages/Default.aspx</a>	Broward
28	Miami-Dade County Homeless Trust <a href="http://www.miamidade.gov/homeless/">http://www.miamidade.gov/homeless/</a>	Miami-Dade
29	Monroe County Homeless Services Continuum-of-Care <a href="http://www.monroehomelesscoc.org/">http://www.monroehomelesscoc.org/</a>	Monroe



# appendix

## GENERAL INFORMATION AND REFERENCE FOR HOMELESS ASSISTANCE

United States Interagency Council on Homelessness (USICH)	<a href="http://usich.gov/">http://usich.gov/</a>
National Alliance to End Homelessness (NAEH)	<a href="http://www.naeh.org/">http://www.naeh.org/</a>
Corporation for Supportive Housing (CSH)	<a href="http://www.csh.org/">http://www.csh.org/</a>
National Coalition for the Homeless	<a href="http://nationalhomeless.org/">http://nationalhomeless.org/</a>
National Center on Family Homelessness	<a href="http://www.familyhomelessness.org/">http://www.familyhomelessness.org/</a>
National Association for the Education of Homeless Children and Youth	<a href="http://www.naehcy.org/">http://www.naehcy.org/</a>
National Network for Youth	<a href="http://www.nn4youth.org/">http://www.nn4youth.org/</a>
National Coalition for Homeless Veterans	<a href="http://www.nchv.org/">http://www.nchv.org/</a>

## MAJOR FEDERAL HOMELESS ASSISTANCE PROGRAMS

### U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD)

Emergency Solutions Grant (ESG)	<a href="https://www.onecpd.info/esg/">https://www.onecpd.info/esg/</a>
Continuum of Care (CoC)	<a href="https://www.onecpd.info/esg/">https://www.onecpd.info/esg/</a>
Rural Housing Stability Assistance Program (RHSP)	<a href="https://www.onecpd.info/rhsp/">https://www.onecpd.info/rhsp/</a>

### U.S. DEPARTMENT OF VETERANS AFFAIRS (VA)

HUD-VA Supportive Housing (HUD-VASH)	<a href="http://www.va.gov/homeless/hud-vash.asp">http://www.va.gov/homeless/hud-vash.asp</a>
Supportive Services for Veteran Families (SSVF)	<a href="http://www.va.gov/homeless/ssvf.asp">http://www.va.gov/homeless/ssvf.asp</a>
Grant and Per Diem Program (GPD)	<a href="http://www.va.gov/homeless/GPD.asp">http://www.va.gov/homeless/GPD.asp</a>

### U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

Projects for Assistance in Transition from Homelessness (PATH)	<a href="http://pathprogram.samhsa.gov/">http://pathprogram.samhsa.gov/</a>
Health Care for the Homeless	<a href="http://bphc.hrsa.gov/about/specialpopulations/">http://bphc.hrsa.gov/about/specialpopulations/</a>
Grants for the Benefit of Homeless Individuals—Services in Supportive Housing (GBHI-SSH)	<a href="http://beta.samhsa.gov/grants/grant-announcements/ti-14-007">http://beta.samhsa.gov/grants/grant-announcements/ti-14-007</a>

### PROGRAMS FOR RUNAWAY AND HOMELESS YOUTH

Basic Center Program	<a href="http://www.acf.hhs.gov/programs/fysb/resource/bcp-fact-sheet">http://www.acf.hhs.gov/programs/fysb/resource/bcp-fact-sheet</a>
Transitional Living Program	<a href="http://www.acf.hhs.gov/programs/fysb/resource/tlp-fact-sheet">http://www.acf.hhs.gov/programs/fysb/resource/tlp-fact-sheet</a>
Street Outreach Program	<a href="http://www.acf.hhs.gov/programs/fysb/resource/sop-fact-sheet">http://www.acf.hhs.gov/programs/fysb/resource/sop-fact-sheet</a>

## FLORIDA PROGRAMS FOR PEOPLE EXPERIENCING HOMELESSNESS

Office on Homelessness, Department of Children & Families	<a href="http://www.myflfamilies.com/service-programs/homelessness">http://www.myflfamilies.com/service-programs/homelessness</a>
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## ACCESSING MAINSTREAM BENEFITS

Plan Objective: Accessing Mainstream Benefits	<a href="http://usich.gov/plan_objective/accessing_mainstream_benefits">http://usich.gov/plan_objective/accessing_mainstream_benefits</a>
Federal Guidance for Mainstream Programs	<a href="http://usich.gov/usich_resources/federal-guidance-for-mainstream-programs/">http://usich.gov/usich_resources/federal-guidance-for-mainstream-programs/</a>
Strategies for Improving Homeless People's Access to Mainstream Benefits and Services	<a href="http://www.urban.org/uploadedpdf/412089-strategies-for-improving.pdf">http://www.urban.org/uploadedpdf/412089-strategies-for-improving.pdf</a>

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