Homelessness Resolution Strategy
Rochester and Monroe County
Final Report

Prepared for the City of Rochester

September 2012
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Housing Innovations

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Introduction, Methodology and Background

Summary of Request

In the summer of 2011, the City of Rochester issued a request for proposals to develop a Homelessness Resolution Strategy for the City. Specifically, the City was requesting a study to identify the program and facility elements required to establish a comprehensive system for rapid housing and re-housing solutions for the homeless and those at-risk for homelessness.

The goals of the study were to provide facilitation services and recommendations relative to the implementation of:

1. A community-wide/common intake process
2. Needs assessment and placement system
3. Recommendations regarding type, design and location of facility (ies) for short term and permanent support-based placements.

Upon completion of the study, the City requested a written report with recommendations addressing each of the elements listed below:

1. Best Practices: Results of research on best practices for rapidly re-housing households and reducing recidivism
2. SPOE: Review of and recommendations for improving upon the current comprehensive emergency placement system in Monroe County for homeless families and individuals
3. Facility Need by Type: Identification of the need for additional or replacement facilities in number of units and number of beds (as compared to the existing inventory) by type of facility (i.e., emergency placement, safe haven shelter, "housing first" permanent housing) and for various homeless populations (families, youth, single women, single men)
4. Potential Site Locations: Identification of potential site location(s) by type of facility(ies) including a description of required amenities
5. Site Location Challenges: Identification and analysis of each potential issue regarding site location that could hinder or increase the costs for successful development (such as access to amenities, transportation, potential environmental concerns, and neighbor-hood impacts)
6. Costs Estimates: Estimated itemized costs for establishing and operating said facility (ies) including staffing and amenities
7. Potential sources of funding
8. A time frame for establishing said facility/ies.

Methodology for the Evaluation

The study was conducted by a consulting team consisting of staff from DePaul and Housing Innovations and researchers from the University of Pennsylvania. A project Advisory Group was constituted to help guide the study and shape the recommendations. The Advisory Group was charged with providing input and feedback to the team throughout the process. See Appendix 1 for a listing of Advisory Group Members.

The consulting team used both quantitative and qualitative data to formulate the recommendations that follow. Additionally, the team visited homeless programs in the community and held community input forums in October of 2011, and February and September of 2012 to review findings, research and get input from a broad group of stakeholders. Best practices were also researched and summarized.

Previous plans developed by the City and Monroe County were reviewed, including:

- Housing Options for All: A Strategy to End Homelessness in Rochester/Monroe County (2007)
- The Supportive Housing Production Implementation Plan prepared by InSite Housing Solutions (2008)
- Continuum of Care Plans (2010 and 2011) prepared for the US Department of Housing and Urban Development (2010 and 2011)
- City of Rochester Draft Consolidated Community Development Plan (2011-2012)
- Annual Action Plan for Housing & Community Development in Suburban Monroe County (2011)

Additionally, the team reviewed quantitative data from a variety of sources including:

- Rochester Continuum of Care's (CoC) HMIS (Homeless Management Information System)
- The CoC Annual Homeless Assessment report for the period 10/1/10-9/30/11
- Housing/Homeless Services Annual Reports prepared by the Monroe County Department of Human Services (2009-2011)
- Program data from the YWCA

The consulting team worked with the Advisory Group to shape the recommendations that follow. The Advisory Group received information about federal policy trends and initiatives, best practices in rapidly rehousing people and coordinated access to emergency shelter. The Group also reviewed and commented on the methodology for projecting housing need as well as the suggestions for coordinated access/intake. Their input was invaluable and critical in shaping recommendations that are tailored to the needs of Rochester and Monroe County.

During the process, open community forums were held to share findings and recommendations and receive, input, suggestions and feedback.

Housing Innovations staff for this project included Suzanne Wagner and Liz Isaacs. Dennis Culhane and Thomas Byrne of the University of Pennsylvania performed the calculations of housing need and helped shaped the recommendations for best practices. Gillian Conde of DePaul provided tremendous support in convening the Advisory Group and the community forums.

Brief Overview of Homelessness and the Homeless System in Rochester and Monroe County

Rochester and Monroe County have made significant efforts to address homelessness in the jurisdiction. The community has targeted its resources to develop a sizable inventory of Housing First Permanent Supportive Housing programs for persons with disabilities. The inventory of and investments in transitional housing are small compared to other communities, which is a positive.

Lengths of stay in shelter and transitional housing are short. For example, 25% of families and 41% of single adults stay in shelter for less than a week. Sixty-two percent of families and 88% of single adults leave transitional housing in less than 6 months. The plan that follows seeks to build upon these successes as well as other emerging best practices in ending homelessness.

As background, below are data on the prevalence of homelessness in the area and the current system size and inventory of resources.

- Prevalence of Homelessness in Rochester/Monroe County
  According to data from the Homeless Management Information System (HMIS), in calendar year 2011, Rochester and Monroe County served:

  - 640 Families with Dependent Children
  - 1,161 Single Men aged 25 and older
  - 693 Single Women aged 25 and older*
  - 206 Single Young Adults aged 18-24

  * This proportion of single women in the single adult population (37%) is higher than most other communities where the rate of females is about 30% of the total single adult population.

- System Capacity and Inventory
  According to the 2011 Housing Inventory Chart prepared for HUD by the Continuum of Care, the system included:

  - Emergency Shelter*
    - 87 units for Families with Dependent Children (approximately 270 beds)
    - 191 beds for Single Adults
    - 47 beds for Single Youth
    - Total of 508 beds

  - Transitional Housing*
    - 53 units for Families with Dependent Children (non-youth beds – approximately 150 beds)
    - 13 units for Youth with Dependent Children (approx. 26 beds)
    - 37 beds for Single Adults (non-Veterans)
    - 39 beds for Single Adults Veterans through the Grant and Per Diem program
    - 31 beds for Single Youth
    - Total of 282 beds

  - Permanent Supportive Housing (PSH)*
    - 384 units for Families with Dependent Children
    - 770 units for Single Adults
    - Total of 1,154 units
    - No units are currently designated for Single Young Adults

    *It is important to note that these numbers fluctuate based on demand and family size as a number of programs serve both singles and families.

Best Practices in Homeless Services

Introduction

During the past decade, homeless systems across America have been radically transforming the way they deliver services -- moving from managing homelessness to ending it. Communities have embraced new approaches such as Housing First[1] and Rapid Rehousing[2] which have proven to quickly end people's homelessness permanently, while saving money in the process.

Research has documented the effectiveness and efficiency of these interventions and the evidence continues to build. Traditional approaches to the issue such as endless engagement by street outreach workers and assisting people to become "housing ready" have been abandoned. We have learned that the most effective approaches move people out of the crisis of homelessness as rapidly as possible and provide services and supports in their homes to help them achieve housing stability.

Additionally, the body of research supporting social services practice interventions that enhance and amplify these housing approaches such as Critical Time Intervention[3], Stages of Change[4] and Supported Employment[5] has been growing.

Finally, the Federal Strategic Plan to End Homelessness, *Opening Doors* and the HEARTH (Homeless Emergency Assistance and Rapid Transition to Housing) Act (which re-authorizes McKinney Vento funding from HUD) have created new goals and outcomes for communities to use to measure their progress in solving homelessness. They explicitly promote Rapid Rehousing and Permanent Supportive Housing and HUD will evaluate communities (and distribute funding) based on their success at reducing the numbers of homeless people,

[1] Ana Stefancic, Sam Tsemberis 2007. "Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four Year Study of Housing Access and Retention". Springer Science + Business Media, 2007.

[2] Tatjana Meschede, Sara Chaganti, Alexis Mann. 2012. "Rapid Re-Housing and Short-Term Rental Vouchers for Homeless Families: Summary Report of a Pilot". The Institute on Assets and Social Policy the Heller School for Social Policy and Management at Brandeis University.

[3] Herman, D., Conover, S., Gorroochurn, P., Hinterland, K., Hoepner, L., Susser, E. (2011). A randomized trial of critical time intervention in persons with severe mental illness following institutional discharge. *Psychiatric Services*. Jul;62(7):713-9.

[4] Nigg, C. R., Burbank, P. M., Padula, C., Dufresne, R., Rossi, J. S., Velicer, W. F., Laforge, R. G., & Prochaska, J. O. 1999. Stages of change across ten health risk behaviors for older adults. *The Gerontologist, Vol. 39,* pp. 473-482.

[5] Drake RE, Becker DR, Clark RE, Mueser KT., "Research on the individual placement and support model of supported employment". *Psychiatric Quarterly* 1999 Winter; 70(4):289-301.

reducing the length of time people spend in the crisis of homelessness and success at increasing incomes and exits from homeless systems to permanent housing.

Rochester and Monroe County have embraced these new housing approaches and practice strategies, creating Housing First Permanent Supportive Housing and Rapid Rehousing responses. The recommendations to follow seek to build on the progressive approach the community has been engaged in.

Recommendations for Best Practices

- Continue to implement diversion as the first response to a housing crisis and use the Shinn-Greer Tool as a way to prioritize services.

  In some communities (including Rochester) attempts to divert households have been the first response when a household is seeking an emergency shelter arrangement. In Cleveland, which implemented diversion at the front door of shelter when they began HPRP in 2009, 25% of families and about 20% of single adults have been diverted. In the United Kingdom, about 50% of households are diverted.

  Diversion may include one-shot financial assistance, mediation services and/or assistance with relocation and housing start up costs, but most importantly if it is located at the front door to shelter, it prevents the household from entering the homeless system. It is prevention targeted to those most likely to become homeless.

  It is important to note that the Prevention efforts under HPRP are viewed by HUD and other national groups and advocates as having been ineffective and not the best use of resources. This is because these resources were not necessarily targeted correctly (households would not have become homeless without the assistance.)

  However, communities must focus on diversion in order to decrease the numbers of homeless people and be successful in achieving this goal of the HEARTH Act. During the last year, researchers Beth Shinn and Andrew Greer of Vanderbilt University completed research that has validated a quick screening tool to prioritize households for prevention services that are most likely to be homeless. A brief write-up is included in Appendix 2 and the scoring elements have been incorporated in the sample Diversion Interview included in Appendix 5. Also, see Appendix 3 for a description of successful diversion and prevention programs.

- Adopt a rapid exit/housing first approach for the entire system.

  The new HEARTH outcomes require that all communities work to exit people as quickly as possible from the crisis of homelessness. (The federal goal is that no one is homeless for more than 30 days.) Additionally, HEARTH focuses on permanent housing exits and low rates of returns to homelessness once people leave the system. (The target is that less than 5% of people become homeless again.) In order to achieve these goals, the primary focus of the system must be on securing housing exits from the moment a person presents with a housing crisis.

  The evidence cited above supports a rapid exit strategy for homeless systems. Both Rapid Rehousing and Housing First have proven that people can be stabilized once housed. Additionally, there is no empirical evidence that services while homeless or prior to being housed improve housing outcomes. Housing Planning must begin day 1 of every homeless episode and all services should be directed to achieving this goal. All programs must focus on securing housing, income and benefits and should be evaluated accordingly. Providing services once people are housed is critical in making this approach successful.

- Increase Rapid Rehousing.

  Rapid Rehousing (RR) has been a resounding success in communities across the country. For a relatively small investment, (average expenditures are in the range of $1,000 to $4,000 per household), the results have been remarkable, often with 90-95% of households successfully ending their homelessness permanently. The average costs of shelter and transitional housing are often much higher with far less success. A number of key stake holders noted that Rochester's own Rapid Rehousing program under the HPRP initiative was a great and effective resource. The City and County should seek to continue this service.

  The National Alliance to End Homelessness reports the following data on costs for RR in an issue briefing they prepared called *Rapid Re-Housing: Successfully Ending Family Homelessness*. "In Alameda County, California, the cost for each successful exit from homelessness to rapid re-housing is $2,800. In contrast, the cost is $25,000 for each successful exit from transitional housing and $10,714 from emergency shelter. In the State of Delaware, the cost of a successful exit to permanent housing

with rapid re-housing is $1,701, compared to $6,065 for emergency shelter and $15,460 for transitional housing."

Rapid rehousing offers both one-time and time-limited financial assistance to help with debts, security costs, rents and other related housing costs. Rental assistance is usually limited to between 3 and 18 months and authorized in 90 day increments. Housing location services are a key component as are case management support services. Case management focuses on helping increase income and housing stabilization and is also time-limited. This model is sometimes referred to as Transition in Place because the services and financial assistance transition out while the household remains in the dwelling unit. See Appendix 3 for a description of some Rapid Rehousing program models.

- Use Progressive Engagement in Providing Services.

  Progressive engagement is a new approach with growing support whereby people are provided with the minimum amount of assistance required to move them to permanent housing and then given additional assistance if the initial support is inadequate. This approach is based on the fact that we do not have validated instruments to predict who needs what level of service in order to maintain housing. Thus, in progressive engagement, the provision of service is based on need, as opposed to a guess. This strategy allows for customized assistance while preserving the most intensive interventions for those with the highest barriers to housing success.

  Progressive engagement will be an important principle when implementing the Coordinated Intake/Access process. Many communities have spent enormous amounts of time trying to identify the criteria to determine who gets which level of service. These efforts have mostly been for naught as the predictive tools needed do not exist (except for Diversion and the Shinn-Greer screener as noted above).

  Finally, progressive engagement recognizes people's resilience, skills and abilities to manage their lives.

- Implement a Housing Stabilization Case Management Approach using Critical Time Intervention (CTI).

  Critical Time Intervention (CTI) is a well-researched approach to case management practice that "manualizes" a time-limited intervention to stabilize people in housing. CTI emphasizes a focus in assessment and service planning on key issues related to housing stability as well as connections to community

resources and natural supports. The practice is implemented in three phases of decreasing service intensity that begin when a person is housed lasting for a total of approximately nine months. See www.criticaltime.org for more information.

CTI has been implemented with a variety of populations moving from various settings into community-based housing of varying types. The practice has broad applicability and can be adopted and adapted as Rochester and Monroe County implement rapid rehousing and housing first strategies.

- Improve practice and capacity in Permanent Supportive Housing (PSH) model

  Target PSH to the People with the Highest Needs. This community has created over 1,100 units of PSH and is to be commended for it. Going forward, in order to achieve the goals of this plan, improved targeting will be needed to ensure that the people with the highest needs are accessing this resource. A number of stakeholders reported that the units are being used as a substitute for Section 8 and not necessarily serving people with long-standing, serious disabilities, especially in the family units. Coordinated intake/access will provide a mechanism to manage this targeting process.

  Build PSH Provider Capacity. The turnover rate reported in the Continuum of Care's 2011 AHAR (Annual Homeless Assessment Report) for PSH projects for single adults is 33%, which is high as compared to the national average of 12%. Further analysis revealed that about 40% of these exits are negative, with people going to unknown destinations, temporary housing arrangements, hospitals, jail or prison. A number of providers and other community stake holders reported that PSH providers are having difficulty with housing stabilization supports for tenants. Further training and program development in the Housing First model and how to assist tenants to meet tenancy obligations and reduce barriers to successful housing stability is needed. Training in the CTI model described above would also be beneficial. Additionally, programs receiving public funding should be evaluated on their rates of success on quality housing exits (see recommendation below).

  Integrate Supported Employment in PSH Programs. As noted in the introduction to this section, Supported Employment has demonstrated success in engaging persons with disabilities and high needs in competitive jobs. This model emphasizes access to competitive employment based on client choice and a "work first", as opposed to job readiness, approach. Key to its success is the

provision of "follow along supports" once people are employed. PSH is uniquely positioned to implement this approach given the ongoing services provided.

Implement "Moving On from PSH" Interventions. Unlike single adults, family units are turning over at a very low rate (close to zero). New York City has successfully implemented programs to assist people in moving on from PSH after they have stabilized and if they are interested. These initiatives have required designated affordable housing units and/or set asides of Housing Choice Vouchers given the high cost market and very low incomes of the people moving on from PSH. Given the preciousness of this resource and the need to generate greater positive turnover, the community should consider implementing a "Moving On" initiative.

- Implement data driven decision-making and evaluation through measurement of outcomes.

  As noted in the introduction, the current focus in homeless services is on the achievement of outcomes including reductions in the numbers of homeless people, rapid access to permanent housing, low rates of returns to homelessness and success in increasing incomes through employment and the receipt of public benefits. Additionally, cost effectiveness is a priority given the limit on available resources.

  In order to achieve these outcomes, communities are adopting data driven decision-making processes using their Homeless Management Information Systems (HMIS) and other local databases. They are looking at outcomes on these indicators for the system as a whole as well as by sub-populations (e.g., families, single adults, young adults etc.). Additionally, these analyses are "drilling down" to evaluate various system components (e.g., shelter, RR, transitional housing and permanent supportive housing) as well as individual programs within these cohorts.

  Rochester recently changed HMIS administrators and should request and receive regular reports on key indicators and compare changes over time. Additionally, individual programs that are publicly supported should be evaluated and funding made contingent upon successful achievement of benchmarks for these outcomes. It is important to note that HUD has stated publicly that the outcomes and benchmarks for transitional housing should be the same as for Rapid Rehousing programs. (Mark Johnston, HUD Assistant Secretary Remarks at NAEH Conference, 2012)

Measures and indicators to track include:

- Reductions in shelter/street census – this is a system indicator, all of the others can be reviewed on system, component and individual program levels.
- Reductions length of stay/time homeless
- Reductions in returns to homelessness
- Increased exits to permanent housing
- Increases in income
- Increase in rates of receipt of public benefits

The community will need to establish benchmarks/standards for each indicator. An example of an evaluation framework is attached in Appendix 4.

Additionally, evaluation should look at cost per permanent housing exit. This is calculated by dividing the total annual program budget by the number of people who exit to permanent housing in a year.

- Ensure Leadership and Accountability for this plan

  Every community in America that has successfully implemented an ambitious plan such as this one has had an identified leader who is accountable and responsible for its implementation. Without leadership and clear responsibility it will be extremely difficult, if not impossible, to successfully execute the plan. The community wants to continue to build on its successes and be model for other jurisdictions and will be one if provided with the required leadership.

SPOE/Coordinated Access to Homeless Resources

Background, Definitions and Goals

Coordinated Assessment is now a requirement for all US Department of Housing and Urban Development ESG (Emergency Solutions Grant) funded programs (including Prevention/Diversion) and for all CoC funded projects. Coordinated intake was a requirement for the ARRA Prevention and HPRP funds released in 2009 and almost universally, communities found it improved access to services. The State of NY has required coordinated access to housing and community services funded by the Office of Mental Health for about a decade through its Single Point of Entry/Access (SPOE/SPOA) program. The authors prefer the term "coordinated access" as this is the initial step in the process as described below.

Coordinated intake/access:

- Defined as a common set of processes across a system to access a defined set of resources. It consists of 4 major processes – access, assessment, assignment/referral to services and accountability/oversight.
- Includes common assessment and decision-making procedures that are standardized within a community. Intake may be conducted at one or more locations and can include virtual locations – e.g., telephone, online.
- Assesses eligibility and needs of persons presenting for homeless assistance and seek to rapidly end people's homelessness and connect them with permanent housing as quickly as possible.
- Seeks to ensure a match between the intervention provided and the applicant's needs
- Can ensure that persons served are eligible and that priority populations are served.
- Can improve program and system outcomes and provides an opportunity to create common goals across individual programs.
- Enables the system to determine and address the needs of all homeless households, not just those who are able to access programs. Without coordinated intake, communities have found that they are dealing with a significant number of households that need services but are unable to obtain them.
- Enables communities to focus on diversion and apply progressive engagement strategies.
    - Progressive engagement is a new approach with growing support whereby people are provided with the minimum amount of assistance required to move them to permanent housing and then given additional assistance if the initial support is inadequate. This approach is based on the fact that we do not have validated instruments to predict who needs what level of service in order to maintain housing. Thus, the provision of service is based on need, as opposed to a guess.

Monroe County currently has a number of elements of a coordinated access process in place as DHS reviews eligibility for applicants for shelter and transitional housing for all programs that will receive per diem payments from the county. The County also attempts to divert a diversion

Common elements of Coordinated Access include:

- Access/application process
- Assessment protocols (including client preferences)
- Eligibility standards for programs
- Eligibility determination process
- Vacancy information
- Prioritization standards
- Referral process
- Quality assurance to set policy, ensure process is implemented as planned and to identify any changes needed

Recommendations for Coordinated Intake/Access in Rochester/Monroe County:

To the greatest extent possible, learn from and build upon existing systems and processes already in place at MC DHS.

- Given the new regulations, the Coordinated Access system should address the following:
  - Diversion
  - Emergency Shelter
  - Transitional Housing
  - Rapid Rehousing
  - PSH
  - Safe Haven
  - However, beginning with only one or two parts of the system will allow for testing and refining processes before broader implementation.

- See Appendix 5 for a flow chart for the Coordinated Access process.

- There is a movement in government and support among the provider community to expand access to services through the use of phone and web-based interviews and eligibility determinations.
  - Use 211 or create a dedicated phone-based team to conduct the initial diversion screening and shelter assessment. This phone service could be operated by DHS or nonprofit staff during business hours and a nonprofit for after-hours calls.
  - Use the web to publicize this number, provide links to resources for housing emergencies and locations to obtain services.

- Applicants for assistance could also present at any shelter and be diverted or assessed for shelter need.

- Create standard assessment forms and protocols that would be used for all applicants for homeless assistance. These would include both HMIS and DHS required data elements.
  - Incorporate these assessment forms into the HMIS.
  - Implement a multi-level assessment process that begins with a diversion interview and, if the household cannot be diverted, leads to a shelter intake.
    - The initial diversion interview should include the required HMIS data elements and focus on diversion where possible. See Appendix 6 for a sample Diversion Interview.
      - The initial interview could be conducted over the phone by 211 or some other entity that can operate a phone and web- based service. To ensure consistency, this phone/web-based system would be administered by one agency.
      - Diversion interviews could also be conducted at DHS or at shelters where staff have been trained in completing the interview.
      - Diversions may require a short time in shelter until arrangements can be made to return the household to where they were or assist with other arrangements. In this case, the shelter intake would be conducted. (See below.)
      - The diversion interview would result in a scoring to prioritize those households most likely to enter shelter using the Shinn-Greer Screener domains described in Appendix 2.
    - The shelter intake would collect basic information to address emergency needs and make the best placement. This assessment could be conducted over the phone, at DHS or at any other shelter where staff have been trained on the assessment.
      - See Appendix 7 for a draft Shelter Intake form.
      - This shelter intake should inquire into the household's own plan for resolving their housing crisis as well as cause of homelessness and basic housing and homelessness history.
      - The intake would conclude with any additional data required by DHS or HMIS.
  - After 7 -10 days, conduct a more in-depth or comprehensive assessment
    - For those applicants that have been in shelter before, conduct this more in-depth assessment sooner and determine what happened to cause a repeat episode of homelessness

- The comprehensive assessment would identify barriers to housing access and stability which would inform the service plan for the household going forward and assist in determining the housing option and support services to be provided.

- Similar to the facilitated intake to Medicaid, nonprofits in the community could collect the required intake information for eligibility screening and package it to send to DHS for final approval if the household is placed in a DHS bed.
  - DHS will still conduct final approval for applicants for shelter and transitional housing funded with their resources.
  - For sanctioned households, the same information would be collected but not forwarded to DHS, rather just to the receiving agency.
  - DHS would train providers in completing the application.

- To avoid the use of hotels, create overflow centers that are attached to shelter programs.
  - Establish overflow beds for youth and young adults, single men, and single women and families with children.
  - These overflow beds should be used for persons who present after regular business hours so as to avoid having to make hotel placements.
  - Overflow units for families should be able to accommodate households with a male head of household and adolescent boys.
  - Vacancy information should be reported regularly by all shelters and would preferably be maintained n the HMIS
  - For after hours shelter needs, applicants could be screened by phone and if not diverted, be directed to shelters with overflow capacity.
  - A van service would be available to transport as needed to the overflow shelters.

- Standardize the intake criteria process for referrals to programs.
  - To the greatest extent possible, intake criteria for all programs in a cohort (e.g., shelter, TH, PSH) should have the same intake criteria.
  - Referrals would need to be responded to by the receiving agency in a specified time frame.
  - Programs could decline to accept referrals but this would trigger a case conference with the intake center, the receiving program and DHS. (see below)
  - Ideally, the coordinated intake would manage referrals to all components of the homeless system – prevention/diversion, shelter, transitional housing and permanent supportive housing. Applicants would need to use the intake centers to access

any of these program types. This essentially closes the side doors of the system, thereby preventing people who are not homeless from using homeless resources.

- Monroe County may want to start the Coordinated Intake process with only parts of the system (e.g., diversion/prevention and shelter) and then expand to other components once the assessment tools and referral processes have been fine-tuned.

- Implement a progressive engagement approach in determining housing exit strategies.
  - For applicants that can return to the last place they stayed or have any income or have had income within the last year, provide rapid rehousing assistance with initial assistance ranging from one time financial assistance and/or services to up to 3 months of rental support. Additional assistance and support for periods beyond 3 months would be authorized on a quarterly basis, depending on need.
  - The exceptions to this would be people who have failed with this type of assistance in the past or have known serious disabilities that will require long-term supports in order for the person/household to meet the obligations of tenancy.
  - Transitional housing would be reserved for those individuals/households that are in a transition in their lives – young adults, people in early recovery from substance abuse

- Implement Case Conferences for Households that are rejected from programs they are referred to or who fail and need to re-enter shelter.
  - Case conferences should include the relevant intake center staff, DHS, the Youth Bureau (where appropriate) and staff from the program that is declining to accept the referral or that served a household that failed.
  - Case conferences would allow all parties to share their knowledge of the barriers and issues facing the household and to jointly develop plans to provide services. This mechanism assists in creating a sense of being part of a systemic response to the needs of homeless households.

Facility and Program Needs

Background: The community would like to eliminate the use of hotels for emergency placements and to develop an adequate supply of diversion, rapid rehousing or other exit strategies to address the needs of homeless individuals and families. The following describes the methods used to calculate the current gaps in the system and makes recommendations for the number and types of emergency shelter, diversion strategies, rapid rehousing and permanent supportive housing needed.

Objective: Identification of the need for additional or replacement facilities in number of units and number of beds (as compared to the existing inventory) by:

- Type of facility (i.e., emergency placement, rapid rehousing, "housing first" permanent housing)
- Various homeless populations (families, youth, single women, single men)

This section is divided into two parts: 1) emergency placements and 2) shelter diversion and housing strategies

1. **Emergency Placements: Methodology for Calculating Need to Replace the Use of Hotels**

   To calculate the need for additional emergency placement facilities, the following methodology was used:

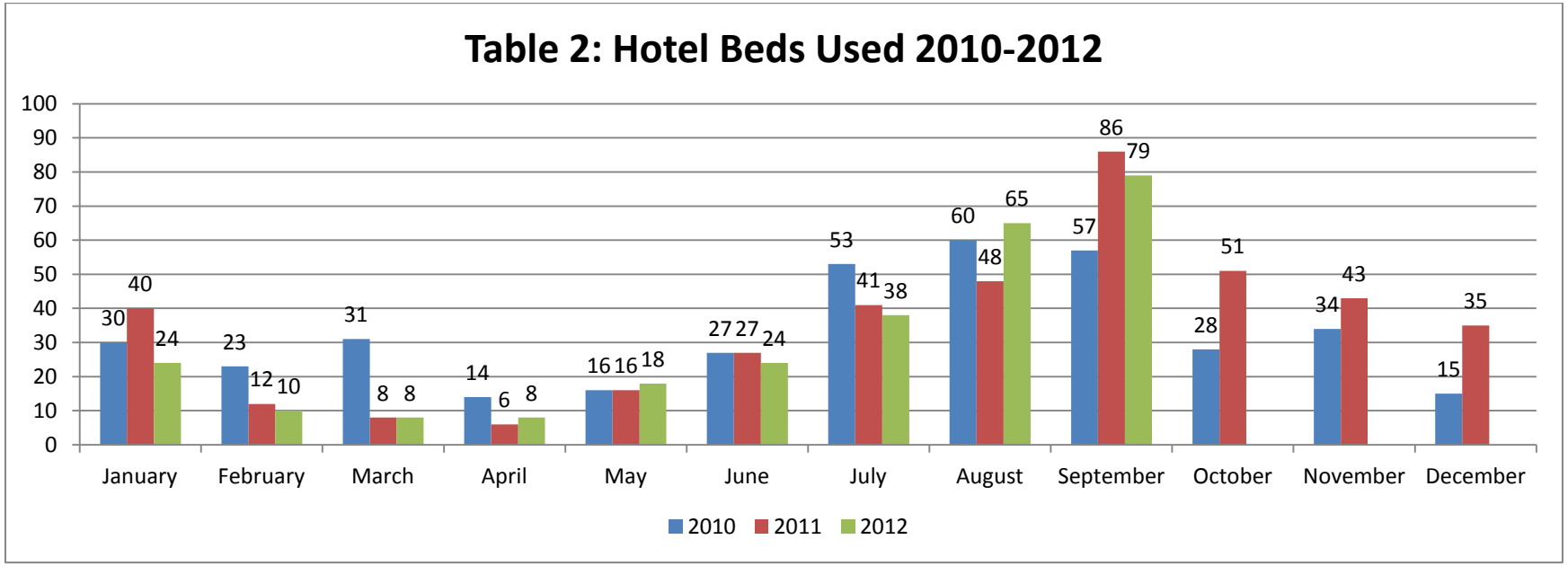
   Using the annual data available from Monroe County Department of Human Services (DHS) for 2010, 2011 and the first nine months of 2012, the consulting team calculated the total number of beds that would be required to replace the number of bed nights spent in hotels.

   - To arrive at this number, the total number of bed nights used each month was divided by the number of days in the month.
   - The use of hotels is about 50% Singles, 50% Families with Children and Couples
   - The table below shows the number of beds that would have been required to meet hotel demand (assuming beds were fully occupied for each month) for this three year period. .

Table 1: Hotel Beds Used 2010-2012*												
Mo/Yr	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
2010	30	23	31	14	16	27	53	60	57	28	34	15
2011	40	12	8	6	16	27	41	48	86	51	43	35
2012	24	10	8	8	18	24	38	65	79			

*Source: Monroe County Department of Human Services, Housing and Homeless Services Report, November 2012

Table 2 shows hotel bed usage for this period in a bar chart.



Analysis:

Over the years, patterns of usage are consistent. There is a spike from July through September, and relatively high use in the fall and winter. The lowest use is between February and June. The use of hotels is about 50% Singles, 50% Families with Children and Couples. Specific findings for each year are below.

2012 Hotel Beds Used (only 9 months of data):

- The lowest number of beds used was 8 in April and the highest was 79 in September.
- For 6 of the 9 months, 24 additional beds would have been adequate to meet demand.

2011 Hotel Beds Used:

- The lowest number of beds used was 6 in April and the highest was 86 in September.
- For 4 months, (February thru May), the system needed less than 20 beds on any given night
- For 4 months, (January, July, August, November), the system needed between 40 and 48 beds on any given night
- If there had been 51 additional beds in the system, the community could have avoided using hotels for 11 of the 12 months in 2011.

2010 Hotel Beds Used:

- The lowest number of beds used was 14 in April and the highest was 60 in August.
- For 9 months, the system needed between 14 and 30 beds on any given night
- For 3 months, the system needed between 53 and 60 beds on any given night
- If there had been 53 additional beds in the system, the community could have avoided using hotels for 10 of the 12 months in 2010.

Recommended approach to eliminate use of the hotels:

- Develop approximately 30-40 year-round and 30-40 overflow shelter beds for a total of about 70 beds. About half of these beds would need to be for singles, the other half for couples and families, preferably by expanding capacity at existing facilities.
    - Alternatively, these units could be developed through the leasing of new structures.
    - These beds would ideally be co-located with shelter intake services.
    - These beds need to be flexible to respond to changes in demand and household configurations.

        - Of the units for single adults, about 2/3 should be for men and 1/3 for women.
        - Beds for families would need to be able to accommodate intact families, families with a male head of household and transgendered individuals.
        - Accommodating different family sizes is also a requirement for these emergency shelter beds.
        - The approximately 40 overflow beds would need to operate between July and December/January.
    - To develop these units rapidly, the consulting team recommends that the County and City look to reconfigure space in existing shelters to increase capacity and/or lease existing structures or units in the community.
        - To build or renovate a new facility (or facilities) is costly, can be difficult to site and takes time to finance and build. The community would like to eliminate hotel use as rapidly as possible and development of new structures/facilities would not be rapid.
        - The shift in emphasis in the system to using diversion will likely result in a reduction in the need for emergency placement beds. However, if the need continues at the present rate, the community could consider creating a new facility/facilities.
- This increase in shelter beds would have met the demand in all of 2012, 11 of the 12 months in 2011 and all of 2010. With increased diversion and rapid rehousing efforts, there should be a decrease in the need for overflow beds going forward.

2. Shelter Diversion and Housing Strategies: Methodology to Project Need for Diversion, Rapid Rehousing/Transition in Place, and Permanent Supportive Housing

Background and Definitions:

As communities across the country have worked to transform their systems to rapidly house homeless households permanently, the interventions that have emerged as best/recommended practices include shelter diversion, rapid rehousing and permanent supportive housing.

> **Shelter Diversion:** A strategy to assist people who are requesting shelter by working with them where they are currently living to find a better permanent housing situation. This can be achieved by the household making other arrangements and organizations providing services and financial supports to resolve the housing crisis. Services include mediation, job trainings and

placement, assistance with benefits, housing location assistance, financial counseling and budgeting, case management, and limited financial assistance.

Rapid Rehousing/Transition in Place: An intervention to quickly exit homeless individuals and families into permanent housing settings from emergency or unstable housing arrangements. Rapid rehousing offers both one-time and time-limited financial assistance to help with debts, security costs, rents and other related housing costs. Rental assistance is usually limited to between 3 and 24 months and generally authorized in 90 day increments. Housing location services are a key component as are case management support services. Case management focuses on helping increase income and housing stabilization and is also time-limited. This model is sometimes referred to as Transition in Place because the services and financial assistance transition out while the household remains in the dwelling unit.

Permanent Supportive Housing: PSH is intended for people with long-term disabilities and provides a subsidized housing unit with ongoing case management support. PSH can be single site (congregate) or scatter site units. Most PSH has adopted a Housing First approach whereby there are low thresholds for entry and a focus on helping the household meet tenancy/lease obligations using harm reduction strategies.

For each of these interventions, the consulting team created estimates of unmet need for each of the program types by each homeless sub-population. The goal is to "right-size" the system so that turnover in capacity is sufficient to meet demand. The following describes the steps in this process.

Introduction to Need Calculations

This section explains the process and results of estimating the unmet need in Rochester for three types of housing interventions for homeless individuals and families.

1) Shelter diversion
2) Rapid rehousing
3) Permanent supportive housing (PSH)

Separate sets of estimates were developed for the following homeless sub-populations:

1) Families with dependent children
2) Single men aged 25 and older
3) Single women aged 25 and older
4) Single young adults aged 18-24

Estimates of unmet need were used to project the number of units/slots of each program type that would need to be added over 5-year period to create sufficient inventory to meet demand and "get to zero" unmet need.

Methodology to Calculate Need

A three-step process was used to generate the estimates of unmet need.

- First, HMIS data from calendar year 2011 were used to calculated "demand" or need for each housing intervention for each sub-population. Demand was assumed to be constant across years for diversion and rapid re-housing. For PSH, demand was assumed to be 20% of those requiring PSH in year 1. Varying proportions of each sub-population were assumed to require each type of housing intervention.
- Second, the "supply" of each type of housing intervention was estimated based on existing inventory, new units under development, and units becoming available through turnover.
- Finally, the estimates of the supply of each program type were subtracted from the demand for each, resulting in estimates of the "gap" or unmet need.
- A baseline unmet need was calculated for each sub-population and intervention, and then the number of units/slots that would need to be added annually and cumulatively to fully address unmet need such that program turnover would meet new demand was projected over a 5-year period.

Assumptions

The following section describes the assumptions that were used with respect to the rates at which each sub-population would need each intervention to create a system where supply meets demand. A fundamental assumption is that a certain percentage of each population uses shelter for a brief period of time and resolve their crisis themselves, not requiring assistance beyond shelter. A full explanation of the proportion of each sub-group requiring each intervention type, which is based on existing evidence, is provided in Appendix 8. PSH turnover rates are derived from actual turnover rates in existing PSH programs in Rochester.

Families

<u>Demand/Need</u>

- 640 homeless families annually
- Assumed type of housing needed:
    - Diversion – 10% in year 1, add 5% in subsequent years

- Rapid Rehousing – all those not diverted, who use shelter/TH only or targeted for PSH – 43% in year 1
- PSH – 12% of total
- Balance use shelter only

Supply/Existing Units

- Diversion: 0
- Rapid re-housing: 0
- PSH: 485 (Turnover rate=1.1, i.e. each unit serves 1.1 families/year)

Annual Development – Units/Slots Added:

- Maximum number of units/slots added annually for each program type:
  - Diversion: 80
  - Rapid re-housing: 55
  - PSH: 20

Single Men 25+

Demand/Need

- 1,161 homeless single men, 25+ annually
- Assumed type of housing needed:
  - Diversion – 10% in year 1, add 5% in subsequent years
  - Rapid Rehousing – all those not diverted, who use shelter/TH only or targeted for PSH – 24% in year 1
  - PSH – 25% of total
  - Balance use shelter only

Supply/Existing Units

- Diversion: 0
- Rapid re-housing: 0
- PSH: 482 (Turnover rate=1.2, i.e. each unit serves 1.2 persons/year)

Annual Development – Units/Slots Added:

- Maximum number of units/slots added annually for each program type:
  - Diversion: 65
  - Rapid re-housing: 50
  - PSH: 20

Single Women 25+

Demand/Need

- 693 homeless single women, 25+ annually
- Assumed type of housing needed:
  - Diversion – 10% in year 1, add 5% in subsequent years
  - Rapid Rehousing – all those not diverted, who use shelter/TH only or targeted for PSH – 20% in year 1
  - PSH – 35% of total
  - Balance use shelter only

Supply/Existing Units/Slots

- Diversion: 0
- Rapid re-housing:0
- PSH: 248 (Turnover rate: 1.2, i.e., each unit serves 1.2 persons per year)

Annual Development – Units/Slots Added:

- Maximum number of units/slots added annually for each program type:
  - Diversion: 40
  - Rapid re-housing: 25
  - PSH: 20

Young Adults 18-24

Demand/Need

- 206 homeless youth, 18-24
- Type of housing needed:
  - Diversion – 10% in year 1, add 5% in subsequent years
  - Rapid Rehousing – all those not diverted, who use shelter/TH only or targeted for PSH – 10% in year 1
  - PSH – 15% of total

Supply/Existing Units

- Diversion: 0
- Rapid re-housing: 0
- PSH: 0

Annual Development – Units/Slots Added:

- Maximum number of units/slots added annually for each program type:
  - Diversion: 10
  - Rapid re-housing: 10
  - PSH: 10

Housing Need Projections

The table below shows the total number of units/slots needed to close the gap in demand over a five year period. See Appendix 9 for a Housing Production schedule with year by year projections for each housing strategy and each sub-population.

Housing Type	Families	Single Men	Single Women	Young Adults	Totals
Diversion*	192	348	208	62	810
Rapid Rehousing*	275	279	139	21	714
PSH*	20	74	149	127	370
*Diversion and RR are the number of slots required, PSH is number of units					

Costs and Timeline

Cost Assumptions

The consulting team used averages from national or NYS programs to derive the operating costs of each intervention. The estimated annual costs of providing each type of service are below:

- Diversion – $1,000/household
- Rapid Rehousing Families- $3,000/household
- Rapid Rehousing Singles - $2,000/household
- PSH Families Operating Costs
  - Housing - $10,560/household/year (based on average of 2-BR and 3-BR FMR = $880/month)
  - Services - $12,000/household/year
  - Total - $22,560/household/year
- PSH Singles Operating Costs
  - Housing - $7,848/household/year (based on 1-BR FMR of $654/month)
  - Services - $9,000/household/year
  - Total - $16,848/household/year

Cost Totals

Using the need estimates described in the previous section and the cost assumptions listed above, the costs of providing each intervention were calculated. The table below summarizes the total costs for each intervention over a five year period. See Appendix 10 for year by year cost estimates by sub-population and intervention type.

Housing Intervention	Total Units/Slots Added	Costs
Diversion	810	$2,408,000
Rapid Rehousing	714	$4,997,000
PSH*	370	$18,160,512
Totals	**1894**	**$25,565,512**
*PSH costs do not include development costs, only operating and support services		

Capital development costs for PSH are generally in the range of $200,000 - $300,000 per unit depending on the size and number of units in a project. Assuming about half of the PSH to be created will be new units, the capital costs would be approximately $46,250,000 using a base of $250,000 per unit.

Funding Sources for Implementing the Housing and Program Production Targets

There are a range of funding sources that can be used to implement the housing and service strategies described in the Facility and Program Needs section. Rochester, unlike many communities across America, makes investments of local funds in housing solutions, e.g., the City's Affordable Housing Fund.

The vast majority of the costs associated with implementing the housing production targets can be paid for with mainstream federal and state housing and services funds. The table below indicates the housing strategies that some of these key mainstream federal resources have been used to support.

Mainstream Federal Resources that have been used to Fund Homeless Solutions								
	Diversion/ Prevention		Emergency Shelter		Rapid Rehousing		PSH	
Funding Source	Financial Assistance	Services	Operating	Services	Financial Assistance	Services	Operating /Rental Assistance	Services
ESG	X	X	X	X	X	X		
CDBG		X	X	X		X		X
HOME					X		X	
HOPWA	X	X	X	X	X	X	X	X
HUD CoC					X	X	X	X
TANF [6]	X	X			X	X		
Medicaid [7]						X		X
HUD VASH[8]							X	
VA SSVF [9]	X	X			X	X		

State Resources for Support

Additional support using state funds could possibly be secured for services in PSH thru the NYS OMH. Over the last few years, the State has invested funds in tax credit properties to serve people who have mental illness.

The State has also made a commitment to funding services in PSH for high-cost Medicaid users and these options should be explored for Rochester.

[6] TANF may require special approval from the State in order to use funds for these activities
[7] Use of Medicaid in PSH must be approved by the State
[8] Veterans' Administration Supportive Housing Program
[9] Veterans Administration Social Services for Veterans and their Families

The $60 million Medicaid Redesign Team (MRT) Supportive Housing Development Program follows the recommendations of the State's MRT. It provides service funding, rent subsidies and capital dollars to create supportive housing for high-cost Medicaid recipients. The fund could grow to $150 million annually if the federal Center for Medicaid and Medicare Services provides matching funds.

The 2012 State Budget also authorizes a new, ongoing community reinvestment vehicle, the Supportive Housing Development Reinvestment Program. This new program will redirect savings achieved by closing nursing home and hospital beds to build and operate new supportive housing in the community for high-cost Medicaid recipients.

The community can also explore whether Monroe County transitional housing funds could be used for Rapid Rehousing efforts, given that it is a temporary or transitional subsidy and support program. Additionally, while the CoC only invests about $776,000 in transitional housing, given the number of people served and that DHS also provides additional funds for these projects, this is a fairly large investment. Reallocating some of these funds or converting some of these programs to Rapid Rehousing and/or PSH should be explored. This might best be done after an analysis of the outcomes and costs per successful housing exit for the transitional housing programs has been conducted.

Finally, there is interest in exploring how to fund shelter for households that have been sanctioned by DHS. ESG funds are a natural fit for this purpose. To the extent that DHS can separate out these funds from state resources for shelter, this could resolve the problem of serving sanctioned households.

Capital Resources

Sources of capital for acquisition and/or renovation of PSH units include the HUD CoC/HEARTH program, CDBG, HOME, HOPWA, Federal Low Income Housing Tax Credit, and the Federal Home Loan Bank's Affordable Housing Program.

Appendix 1 – Advisory Group Members

Julie Beckley, City of Rochester

Marlene Bessette, Consultant, Continuum of Care

Gillian Conde, DePaul

Dan Condello, Monroe County DHS

Patricia Davis, United Way

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Michael Hennessy, Open Door Mission

Neilia Kelly, Monroe County Office of Mental Health

Florence Koenig, Monroe County Continuum of Care

Rebecca Miglioratti, Monroe County DHS

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Carol Wheeler, City of Rochester

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Appendix 2 - Targeting Homelessness Prevention Services More Effectively

Targeting Homelessness Prevention Services More Effectively: Introducing a Screener for NYC's HomeBase Prevention Services -

Developed by Marybeth Shinn & Andrew Greer, Vanderbilt University

1) What was the pattern of shelter entry over time among families who applied for HomeBase services?

- 12.8% entered shelter within three years of applying
- Most families who entered shelter did so shortly after applying for services

2) Which families were at highest risk of entering shelter?

High Risk of Shelter Entry (Risk Factor):

- Female Head of Household
- Pregnancy
- Child younger than two
- History of public assistance
- Eviction threat
- High mobility in last year
- History of protective services
- High conflict in household
- Disruptions as a child (e.g. foster care, shelter history as youth)
- Shelter history as an adult
- Recent shelter application
- Seeking to reintegrate into community from an institution
- Admin: High number of shelter applications

Reduced Risk of Shelter Entry (Protective Factor):

- Being older
- Having a high school diploma/GED
- Being employed
- Being a leaseholder

Not Predictive of Shelter Entry (Not Statistically Significant):

- Race
- Ethnicity
- Number of children
- Marital status
- Veteran status
- Losing assistance in the last year
- Overcrowding
- Doubled up
- Extremely cost burdened
- High rent arrears
- Home in disrepair
- Subsidy receipt
- Chronic physical health problems
- History of mental health problems
- History of substance abuse
- History of domestic violence
- Any involvement with legal system
- Giving birth as a teenager
- Admin: Previous shelter
- Admin: Exited shelter to subsidy
- Admin: Previously eligible for shelter

3) Is it possible to develop a short screening survey to target services?

- Using the quick screening survey, we would reach 90% of shelter entrants, while the current DHS assessment system reaches 69%.
- A quick screening survey does almost as well as the full survey.

Scoring for Prioritizing Households served in Prevention

1 point
- Pregnancy
- Child under 2
- No high school/GED
- Not currently employed
- Not leaseholder
- Reintegrating into community

2 points
- Receiving public assistance
- Protective services
- Evicted or asked to leave by landlord or leaseholder
- Applied for shelter in last 3 mos

3 points
- Reports previous shelter as adult

Age
- 1 pt: 23 - 28;
- 2 pts: ≤22

Moves last year
- 1 pt: 1-3 moves;
- 2 pts: 4+ moves

Disruptive experiences in childhood
- 1 pt: 1-2 experiences;
- 2 pts: 3+ experiences

Discord (landlord, leaseholder, or household)
- 1 pt: Moderate (4 – 5.59);
- 2 pts: Severe (5.6 – 9)

4) If HomeBase adopted better targeting, how much more effective might it be?

Model	Risk Criterion	% of Applicants Served	% of Shelter Entrants Targeted for Services
Implicit DHS HomeBase Model	Judged eligible	62%	69%
DHS Full Survey	Cutoff based on % of Applicants	63%	90%
Quick Screening Survey		62%	89%
Quick Screening Survey	5 or more points	68%	92%
Quick Screening Survey	6 or more points	54%	84%
Quick Screening Survey	7 or more points	42%	74%
Quick Screening Survey	8 or more points	31%	61%

Conclusions

- Our short screening survey can predict the likelihood of shelter entry more accurately than current decisions.
- Prediction is hard: Even at the highest levels of risk, most families avoid shelter.
- Any model should be tested periodically to see if it misses vulnerable populations.
- Determination of the proportion of families to serve is a question of available funds and costs, both to the homeless service systems and to society.

Appendix 3 – Best Practices in Rapid Rehousing

New York City Homebase Prevention Program

In response to the growing number of homeless families in New York City, Homebase, administered by the NYC Department of Homeless Services (DHS) was created to provide homeless prevention and diversion services as well as aftercare services for those who have been in shelter. The goals of the program are to help prevent homelessness for those at-risk of homelessness, divert households from shelter, assist in securing stable housing and support those leaving shelter.

Outreach/Intake

- DHS targets high need communities and publicizes the program on billboards, bus shelters, and handed out brochures.
- 311 provides information on the program on-line and by phone
- Homebase conducts outreach to new and formerly homeless households and works at the central DHS shelter intake center. Families who could benefit from diversion services and have income or employment are referred to Homebase.
- Assessment conducted on Homebase clients – identify service needs and homeless risk factors. Flexible service plan is created to meet needs of family.

Services

- DHS staff and neighborhood based nonprofits provide services at 13 offices throughout NYC
- Services include:
    - Housing search and relocation assistance
    - Benefits advocacy (child care, food stamps, tax credits, public health insurance)
    - Employment supports
    - Money management and budgeting workshops
    - Landlord mediation
    - Legal assistance
- Short-term flexible financial assistance is available and can be used for back rent, relocation, food, and other essential necessities
- Average cost of Homebase services is $4,000 per household (approximately 10% of the cost to house a family for one year in shelter)
- Homebase receives priority for Section 8 vouchers

Funding

- $22 million from TANF (federal) and City funding

Outcomes

- More than 15,000 households have received services through Homebase
- 96% of adult families receiving preventive services did not enter the shelter system
- 91% of families with children receiving preventive services did not enter the shelter system

Challenges/Lessons learned

- The service model needs to be revisited and tweaked constantly to ensure that services are target-ing and working for households who are at the highest risk of becoming homeless.
- Collaboration with mainstream resources is key – to be effective, programs need to connect with job centers, courts, etc
- Performance-based contracting helps ensure that program goals are clearly spelled out and achieved by providers.
- Partnering with NY Housing Authority to prioritize Homebase clients for Section 8 took away the in-centive for households to enter shelter to obtain Section 8

Cleveland – Diversion/Prevention Program

The Diversion/Prevention program was created to address the insufficient number of shelter beds to accommodate homeless families seeking shelter. The program was initially designed to serve families but also serves single adults. The flexible program seeks to divert clients from homelessness and to provide prevention services to help clients maintain stable housing.

Intake

- Mental Health Services (MHS) and Cleveland Mediation Center (CMC) staff the two central intake centers where households present for shelter or prevention services; there is one for men and one for single women and families.
- All clients are assessed by MHS staff; all families are also assessed by the diversion specialist and when staffing permits, and if eligible, individuals are also assessed by diversion.
- During the process, the assessors ensure that clients are connected to appropriate services

Services

- Diversion/Prevention services are provided by CMC. CMC has two staff members at each central intake site to work to keep clients in their current housing when possible and assist with medication and financial supports to make this happen.
- Funding is available to help divert clients from homelessness by assisting with rent payments and outstanding utility bills as well as helping ease the financial burden of the household housing the family or individual by purchasing additional furniture or helping with creative solutions to doubled-up households.
- Prevention funding is available for security deposits, rent payments and moving expenses.
- The team works to ensure that clients are able to access community services but the team does not provide on-going case management to clients who have been diverted from homelessness. Once clients are diverted, they may contact central intake as needed but there is no follow-up made by the diversion team. When a client is in need of services and is not appropriate for diversion or prevention, they are referred to shelter and receive case management services.

Funding

- HPRP, private fund raising and income from fee-for-service programs

Outcomes

- The diversion team has been able to divert approximately one-third of the families who would have previously occupied a shelter bed.
- Diversion service provided by Cleveland Mediation Center using progressive engagement approach. Giving 1st month rent and security deposit and only 30% of people came back for a second month of assistance.

Challenges/Lessons learned

- The Diversion program transformed how homelessness was handled in Cleveland and it has been an adjustment for clients and advocates. Clients expect to be housed when they show up to central intake and this is not the case. Central intake is working on communicating this message through 211 and other avenues.
- At Central Intake, they ask about client's plan as soon as they come to shelter and found that most people have a plan to exit shelter when they arrive.
- It is critical that clients are screened properly for mental health issues and are not placed in independent housing without connections to mental health services.
- There is a need for flexible funding for diversion/prevention programs for expenses not allowed by HPRP (e.g. transportation).
- Diversion requires creative problem solving (air mattresses) and flexible funding.

Salt Lake City – Rapid Rehousing

The Rapid Rehousing Program shifted the service model to a progressive engagement approach, with the thinking that most families can initially move out of the shelter with Rapid Rehousing assistance. The team assesses each family's unique situation and tailors housing options to fit each family's specific needs and barriers. Rapid rehousing moves clients quickly into housing providing the supports needed to help them maintain the housing.

Intake/Services

- Intake and Basic Needs Assessment conducted, families meet with DWS Employment Counselor, rapid rehousing assessment is conducted
- Eligibility is based on TANF and HPRP criteria
- Clients are screened in, not out
- 20% exit shelter w/out financial assistance; 80% are appropriate for initial RR assistance
- Once in program, housing plan is created and barriers are addressed
- Rapid Rehousing team: Program Coordinator, Negotiator, Accountant, Data Specialist and 6 Case Managers. Current Shelter Case Management staff shifted gears to be all Rapid Rehousing focused with every family in Shelter
- Progressive Engagement approach – provide only services that are needed and build on them as needed
- Clients receive 2-3 months of assistance and employment support and every month are reassessed and could be approved for additional services and assistance if needed. At reassessment, some clients graduate if they are ready to be on their own, others who need continued assistance go month to month with assistance and those who need longer term assistance are targeted for longer term subsidies and programs
- "Light" case management services are provided, more services are added as needed

Funding - $4,774,787

- TANF: $1.9million
- State HPRP: $1,563,797
- SL County HPRP: $492,810
- SL City HPRP: $820,000

Outcomes

- Out of 627 families in 2 years, only 57 returned to shelter (Only 9%)
- 161 were referred by a partner agency including domestic violence shelters, Family Promise, VOA, local school districts
- Average length in the program is six months
- Average amounts spent per family is $6,883 ($5,308 on direct financial assistance,$1,575 on staffing, relocation, administration)

Challenges/Lessons learned

- Most families move in and out of homelessness quickly and do not return
- Making a family homeless makes their problems worse

Hennepin County – Rapid Rehousing

Hennepin County provides Rapid Exit services to homeless families in County-contracted shelters; the program assists approximately 700 families per year. The Rapid Exit Program for Families in Hennepin County helps homeless families obtain permanent housing and provides the supports needed to help them maintain the housing. These services are provided using a Housing First model; providers work to ensure that families are able to find stable housing with the appropriate services attached.

Intake

- A central intake conducts an assessment of each family's barriers to getting and keeping housing. The Rapid Exit screening is conducted by a not-for-profit provider contracted by the County in one central location in the county building
- Families receive an appointment with Rapid Exit Screener within 2 days of entering shelter
- Rapid Exit Screen is conducted by a paraprofessional who uses a public database to collect data on criminal and eviction history of families before the assessment takes place
- The Rapid Exit Screener meets in person with the family to conduct the assessment. The screen collects information on the following: barriers to housing, education, work history, rent history, credit status, substance use, mental health, legal, physical health, relationships, family of origin
- After the interview, the Rapid Exit Screener evaluates the housing barriers on a scale from 1-5. Level 1 indicates that there is zero to minimal barriers and Level 5 indicates that a family faces severe barriers. Only medium to high barrier families receive rapid exit services.
- Central intake refers families to local not-for profits who provide the housing location and support services

Services

- Local contracted not-for-profits provide housing location and voluntary support services
- Rapid Housing Advocates help the family find housing through their networks of landlords and work closely with landlords to help ensure success with the match
- Six months of stabilization and support are offered to both the family and the landlord

Funding

- $1 million in HPRP funding to serve individuals and families
- Approximately $500,000 each year from a HUD SHP grant that is primarily for families.
- State grant -- Family Homeless Prevention and Assistance Program (FHPAP) from the State of Minnesota

Outcomes

- Since 1995, over 8000 families, with more than 20,000 children, have received Rapid Exit re-housing.
- Two years after program entry, 85% of families in the Rapid Exit Program remained in permanent housing

Lessons learned

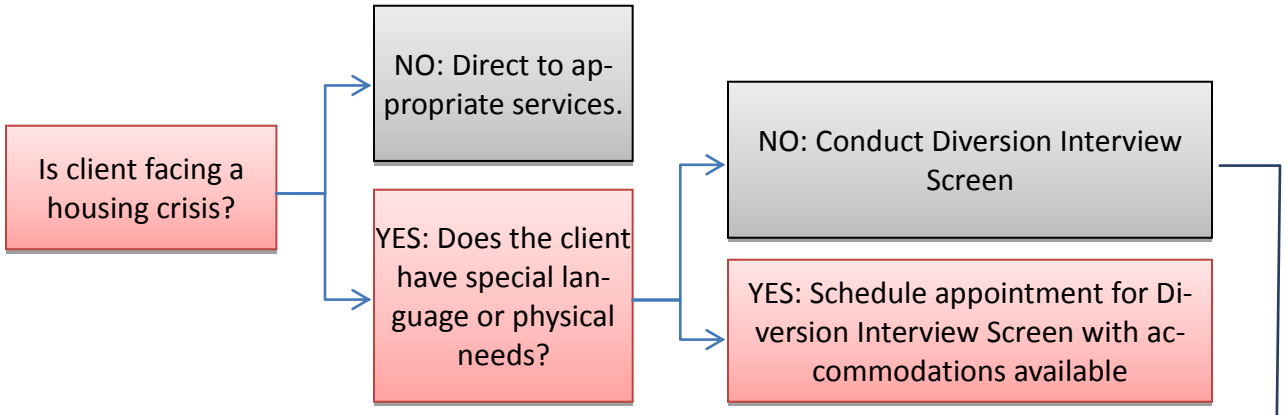
- Housing needs to come first, once people are housed, they feel safe and able to focus on other life goals such as employment and schooling

Appendix 4 – Sample Outcome Based Evaluation Model

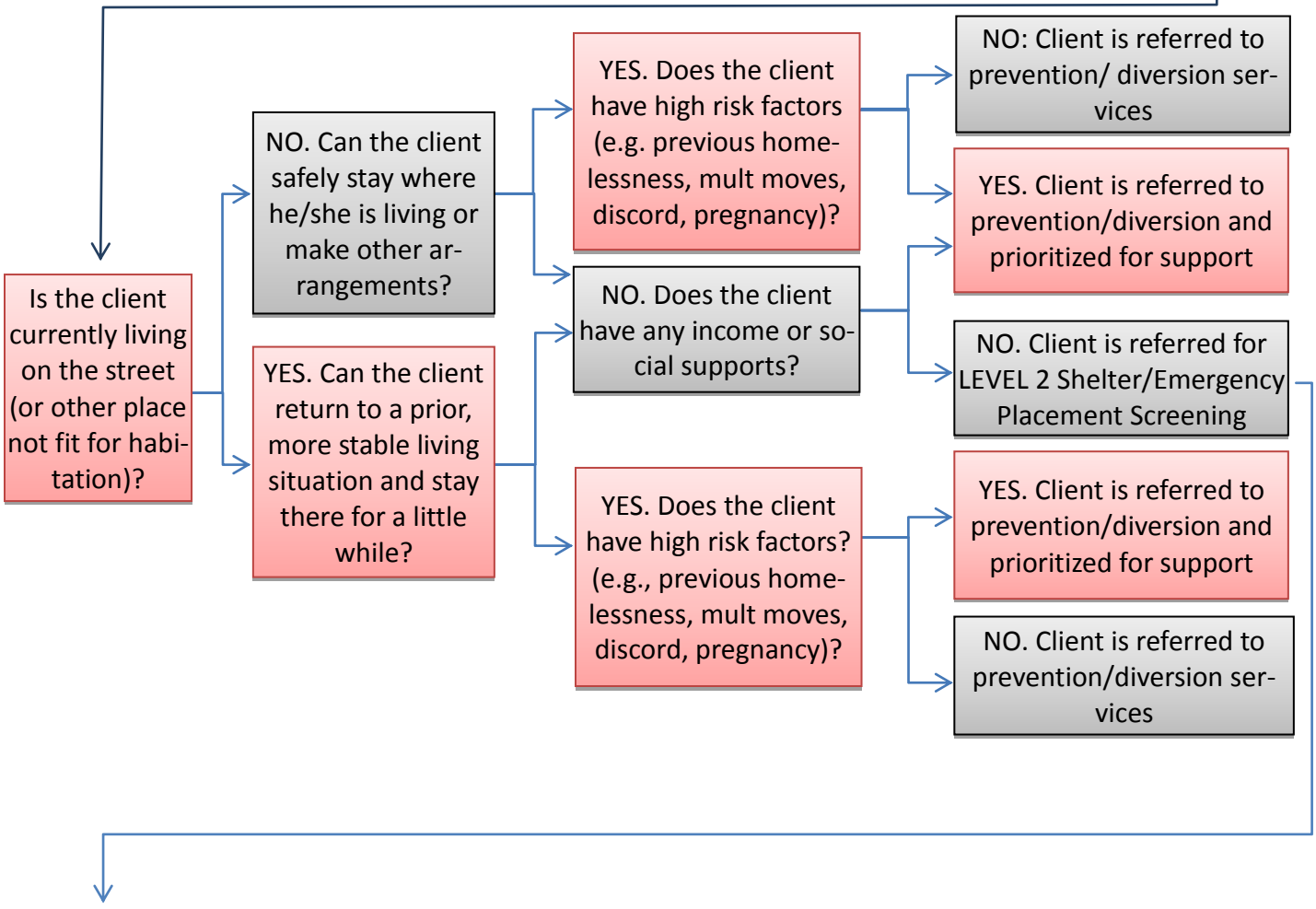
Program/Component Outcomes				
Criteria	**Standard**	**Points**	**Scoring**	**Source**
Occupancy/Average Bed Utilization Rate	90%	8	90% and > = 8 75-84% = 4 Below 75%=0	HMIS
PSH Programs: Length of stay 7 months or longer for leavers	85%	8	85 and > = 8 78-84=4 Below 77%=0	HMIS
TH and Safe Havens: Leavers who exit to permanent housing	75%	8	75% and >=8 65-74%=4 Below 65%=0	HMIS
SSO Programs: Leavers who exit to permanent housing	20%	8	20% and >=8 10-19%=4 Below 10%=0	HMIS
Leavers who Exit to Shelter, Streets or Unknown	10% or less	8	Up to 10%=8 11-20%=4 Over 20%=0	HMIS
Health Insurance at Program Exit (Includes Medicaid, Medicare, VA Health Care)	30%	7	30% or > = 7 20-29% = 4 Below 20% = 0	HMIS
Food Stamps Rate for Leavers	50%	7	50% or > = 7 35-49% = 4 Below 35%=0	HMIS
Employment Rate for Leavers	25%	8	25% or > = 8 20-24% = 4 Below 20% = 0	HMIS
Income Amounts Maintained or Increased for Leavers	85%	7	85% or > = 7 75 – 84% = 4 Below 75% = 0	HMIS
Leavers with Non Cash Financial Resources	75%	7	75% or > = 7 65-74% = 4 Below 65% = 0	HMIS
Total		**60**		

Appendix 5 – Coordinated Access and Intake Flow Chart

Pre-Screening (By phone, at DHS, and shelters that have received training)

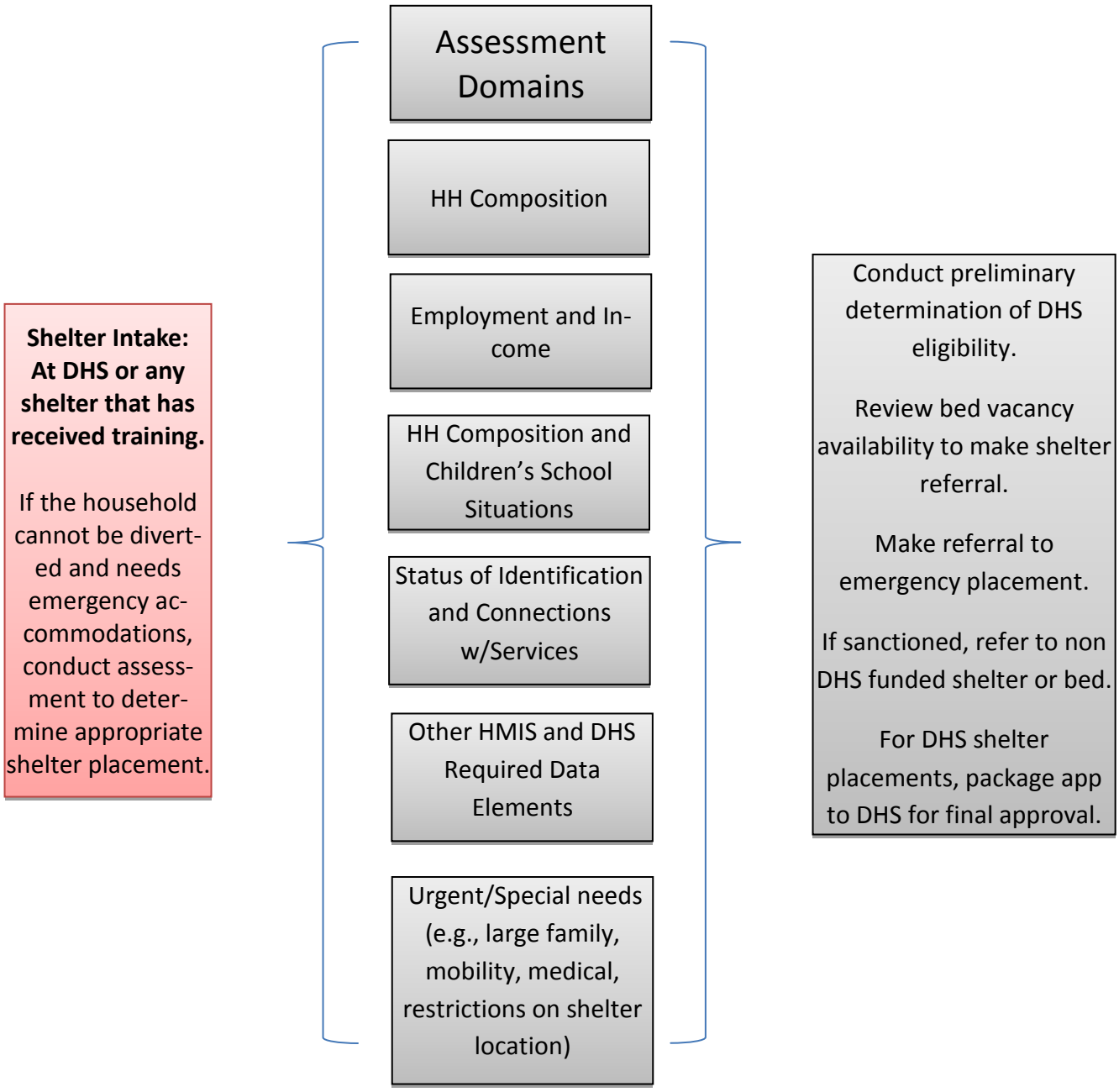


Level 1 Screening: Diversion (DHS, over the phone)



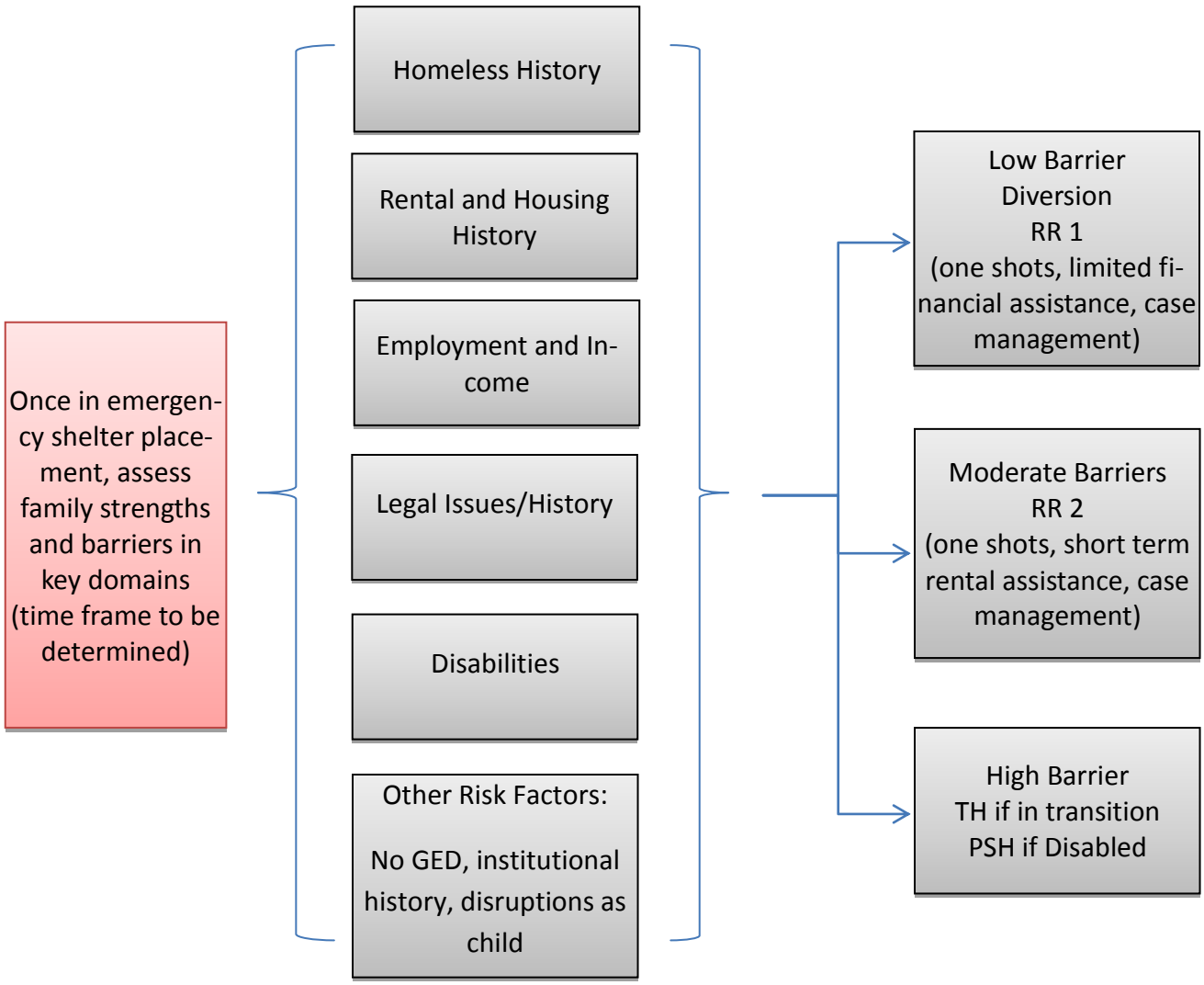
Level 2 Screening: Initial Intake for Shelter/Emergency Placement

Conducted at DHS, any shelter or over the phone. Application information forwarded to DHS for final approval. Sanctioned households would be referred to shelters not receiving DHS funding. Shelters with overflow beds or other designated shelters would conduct after hours shelter screening.



Level 3 Next Step Screening: Strengths/Barriers Assessment

Conducted by all shelters. Training provided by DHS.



Appendix 6 – Pre-Screen and Diversion Interview

Instructions: The following set of questions is meant to assess whether a household can be diverted from or needs entry to emergency shelter. It is meant to be an exploration of the housing crisis and options available to the household. While it collects basic data elements, it is meant to be more of a conversation than a questionnaire to determine whether the family can be diverted from entering the shelter system. Where the term "you" is used, it refers to the Head of Household (HoH) unless otherwise indicated. Interviewers instructions are in bold and italics. Interviewers should not ask questions when the information has already been obtained, so these questions may need to be re-ordered to integrate 211's standard intake process if they are administering the interview.

Pre-Screening

What type of help is the person seeking or the reason for or circumstances that led him/her to call/come here today?

> ***Is the HH at imminent risk of homelessness? Use HUD definitions for categories. Make this determination based on the nature of the caller/presenter's request.***

If person indicates they are in imminent risk of becoming homeless or in need of shelter, ask the following:

> Is there an adult (18 or older) in the household who is fluent in English?
>
> If not, primary language spoken by HoH?
>
> → ***If non-English speaking, secure translation service.***
> → ***If English speaking adult in HH, proceed to Diversion Interview***

Diversion Interview

Basic Household Information:

> Name, DOB, Gender of HoH
>
> How many people are in your household?
>
> How many in HH under 18 years old?

Recent Housing History:

> Do you have a place to stay tonight? Y or N

If not, where did you stay last night? ***(Do not read responses. Ask question and then choose one)***

- ☐ Rental by client, no housing subsidy – client is lease holder
- ☐ Rental by client, with housing subsidy
- ☐ Owned by client
- ☐ Staying or living in a family member's room, apartment or house
- ☐ Staying or living in a friends room, apartment or house
- ☐ Permanent housing for formerly homeless persons (such as SHP, S+C, SRO)
- ☐ Hotel or motel
- ☐ Transitional housing for homeless persons (including homeless youth)
- ☐ Place not meant for habitation (e.g. a car, abandoned bldg, bus/train/subway station/airport or anywhere outside)
- ☐ Other

How long have you been there?

☐ One week or less ☐ More than one week, but less than one month ☐ One to three months ☐ More than three months, but less than one year ☐ One year or longer ☐ Don't Know

Do you have any income?

If yes, how much and what is the source: employment, TANF, child support, etc.

If the family is living in a place not meant for human habitation, go to the <u>Previous Housing History</u> Section

When do you have to leave?

What is the PRIMARY reason you have to leave this housing? ***(Do not read responses. Ask questions and then choose one)***

☐ Eviction ☐ Unable to pay rent ☐ Utility shut off ☐ Domestic Violence ☐ Unsafe situation ☐ Fire ☐ Condemned property ☐ Foreclosure (renter) ☐Foreclosure (owner) ☐Overcrowded ☐ Conflict with others ☐ Moved from out of town ☐ Discharge from program ☐Physical illness ☐ Discharge from hospital ☐ Jail/Prison release ☐ Substance Use ☐Mental Illness

☐Other (describe):

If you are staying with someone, what is your relationship?

Did or do you pay anything to live there?

If so, how much?

Could you and your family safely stay there if we gave you some help to make permanent housing arrangements? ☐Yes ☐ No

If no, why not? What would it take for you to be able to continue staying there?

If person indicates possibility of staying there, read the "Closing for the Diversion Screening", ask the summary questions at the end and refer to diversion/prevention services. If not, continue with the following questions:

Previous Housing History:

Where did you live before the place you stayed last night?

How long there?

If you were staying with someone, what is your relationship?

What is the Primary Reason you left?

Were you paying anything to live there?

Could you and your family safely stay go back there if we gave you some help to find a permanent place to live? ☐Yes ☐ No

If no, why not? What would it take for you to be able to go back there?

If person indicates possibility of staying there, read the "Closing for the Diversion Screening", ask the summary questions at the end and refer to diversion/prevention services. If not, continue with the following questions:

Alternate Housing Arrangements:

What other places have you lived during the past year? How many times have you moved in the past year?

Is there any other place you and your family could stay for a few days if we were able to give you some help to find a permanent place to live? ☐Yes ☐ No

If yes, what would it take for you to be able to go and stay there?

If person indicates possibility of temporary arrangements, read the "Closing for the Diversion Screening", ask the summary questions at the end and refer to diversion/prevention services. If not, continue with the following questions:

Supports:

Has anyone been helping you recently? ☐Yes ☐ No

If yes, could you stay with him/her/them temporarily? ☐Yes ☐ No

What would it take for you to be able to stay there?

Do you have income or resources to meet you own emergency? ☐Yes ☐ No

If person indicates possibility of temporary arrangements or has any income, read the "Closing for the Diversion Screening", ask the summary questions at the end and refer to diversion/prevention services.

If not, explain that you will be referring the household to shelter and have another set of questions to help determine the best option.

→ ***Go to Level 2 Emergency Placement Screening.***

Closing for Diversion Screening:

Read the following: "In order to best serve your family, there are a few additional questions we'd like to ask. This will help us to insure that you get the things you need". The interviewer should not ask those questions that have already been answered.

How old are you (head of household)?

Gender of head of household: (should have been gleaned from the interview)

Any children under the age of 2 in the family? ☐Yes ☐ No

Do you have a HS Diploma/GED?

Have you ever applied for shelter before? ☐Yes ☐ No

If yes, when?

Have you ever been in a shelter? ☐Yes ☐ No

If yes, how many times?

When was the last time?

Were you in shelter as a child or a youth?

Were you ever in foster care when you were growing up?

Do you or does anyone in the family have any special needs or medical conditions?

Are you or is anyone in the family pregnant?

Family Diversion Priority Score using the Shinn/Greer Screener:

This screener was developed by Shinn and Greer to determine those families who request prevention services that are most likely to enter shelter. Upon completion of the interview, the assessor should score those families that are being referred for diversion/prevention based on the information presented. A household scoring 5 or more points should be prioritized for services.

1 point – Any of the following for the HoH
- Pregnancy
- Child under 2
- No high school/GED
- Not currently employed
- Not leaseholder
- Reintegrating into community

2 points – Any of the following
- Receiving public assistance
- Protective services
- Evicted or asked to leave by landlord or leaseholder
- Applied for shelter in last 3 months

3 points
- Reports previous shelter as adult

Age
• **1 pt**: 23 - 28 years; • **2 pts**: ≤22 years

Moves last year
• **1 pt**: 1-3 moves; • **2 pts**: 4+ moves

Disruptive experiences in childhood
• **1 pt**: 1-2 experiences; • **2 pts**: 3+ experiences

Discord (landlord, leaseholder, or household)
• **1 pt**: Moderate (4 – 5.59); • **2 pts**: Severe (5.6 – 9)

Total: ☐

Appendix 7 – Shelter Intake Assessment and Eligibility Review

Instructions: The interviewer should have access to the information captured during the Diversion Screening as well as shelter stay history from HMIS. The Emergency Placement Intake captures additional information about the household in many of the areas that were explored in the diversion screening and is used to determine basic needs and the best shelter option available for the household.

Household Information:

1. Review/discuss what led to the family coming to shelter and what their plan is for future living arrangements.
    a. If needed: Where household stayed the night before
    b. Last permanent residence information
2. Household Information for all members
    a. Total number of adults and total number of children under 18
    b. name, gender, DOB, phone number, SSN, race, ethnicity, relationship to head of household, name and address of schools children attend for all household members
3. Income sources and amounts for all family members
4. Emergency Contact Name and phone
5. Has anyone in the household served in the military?
    a. Name and when served

Assess Immediate Needs:

6. Are there restrictions on where you can live?
7. Any urgent or emergency needs?
8. Any special needs or medical conditions?
    a. HH member Name(s) and condition
9. Anyone on medication?
    a. Name(s) and medication(s)
10. Any HH member have a physical problem that limits mobility, ability for self-care?
    a. Name and mobility problem
11. Anyone in the HH have a disabling condition that prevents working or functioning well?
    a. Name and disabling condition
12. Does anyone in the HH have any active orders of protection against an abuser/batterer?
    a. If yes, name of filer and name of respondent
13. Government Issued ID for the head of household?
14. Government issued ID for other household members?
    a. Name of members with no ID
15. Residency Status

16. Do you or does anyone in the HH have a case manager or worker at any social service agency?
    a. Worker name and phone number

DHS Eligibility Screening:

17. Is the individual eligible for DHS placement? (i.e., are they currently sanctioned from Housing or TA?)
    a. If they are eligible, contact shelters to place the household in DHS supported shelter bed.
    b. If not, refer to shelter that serves sanctioned households

Appendix 8 – Explanation of Demand/Need Assumptions

Table 1- Families

Housing Type	% Requiring Intervention	Rationale
Diversion	10% in year 1 Increase by 5% in subsequent years	• The most recent version of the Annual Homeless Assessment Report to Congress[1] found that 25% of persons in families who stayed in emergency shelters had stays that lasted longer than a week, but less than a month. Half of this group (i.e. 12.5%, but rounded down to 10% for simplification) will be assumed to require diversion assistance in year 1, with the goal of serving the whole group by year 5 by increasing % receiving assistance in years subsequent to year 1.
Rapid Re-housing	43%	• The most recent version of the Annual Homeless Assessment Report to Congress[1] found that 41% of persons in families who stayed in emergency shelters had stays that lasted between 1 month and 6 months. This is target group for rapid re-housing.
Permanent Supportive Housing	12%	• A study[2] on homeless families in four jurisdictions conducted by Department of Housing and Urban Development (HUD) found that an average of 12% of homeless families are repeat users of more than one program type. These families were found to have higher costs on average than other homeless families and thus may be families most in need of PSH

Table 2- Single Men, 25+; Single Women, 25+; Young Adults, 18-24

Housing Type	% Requiring Intervention	Rationale
Diversion	**Men, 25+:** 10% in year 1 **Women, 25+:** 10% in yr1 **Young Adults:**10% in yr1 All groups increase by 5% in each subsequent year	• The most recent Annual Homeless Assessment Report to Congress[1] found that 27.8% of individuals who stayed in emergency shelters had stays that lasted longer than a week, but less than a month. Half of this group (i.e. 13.9%, but rounded down to 10% for simplification) will be assumed to require diversion assistance in year 1, with the goal of serving the whole group by year 5 by increasing % receiving assistance in each year.
Rapid Re-housing	**Single Men, 25+:** 24% **Single Women, 25+:** 20% **Young Adults, 18-24:** 10%	• The most recent version of the Annual Homeless Assessment Report to Congress[1] found that 29% of persons in families who stayed in emergency shelters had stays that lasted between 1 month and 6 months. This is target group for rapid re-housing. Proportions adjusted downward for young adults based on findings from a HUD study that showed youth ages 18-24 spent significantly less time in residential homeless assistance programs.
Permanent Supportive Housing	**Single Men, 25+:** 25% **Single Women, 25+:** 35% **Young Adults:** 15%	• Using shelter data from New York and Philadelphia, a study by Kuhn and Culhane[3] found that 10% of shelter users were episodic (i.e. multiple stays of varying duration) and 10% were chronic (i.e. one stay of long duration). Both the chronic and episodic shelter users (i.e. 20% of shelter users in total) are assumed to require permanent supportive housing and the proportions are adjusted upwards for men and women ages 25+ to reflect assumed higher rates of disability and hence need among these older groups, and adjusted downward for young adults to reflect assumed lower rates of disability among these younger adults.

Appendix 9 – Production Tables: Projected Need and Cost for Subpopulations, by Year and Program Type

Table 1-Projected Need and Cost for Families, by Year and Program Type

Year 1

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	64	0	64	64	$64,000	0
Rapid rehousing	275	0	55	55	$165,000	220
PSH	77	485	69	20	$451,200	9

Year 2

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	96	64	96	32	$96,000	0
Rapid rehousing	275	55	110	55	$330,000	165
PSH	24	505	51	0	$451,200	0

Year 3

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	128	96	128	32	$128,000	0
Rapid rehousing	275	110	165	55	$495,000	110
PSH	15	505	51	0	$451,200	0

Year 4

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	160	128	160	32	$160,000	0
Rapid rehousing	275	165	220	55	$660,000	55
PSH	15	505	51	0	$451,200	0

Year 5

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	192	160	192	32	$192,000	0
Rapid rehousing	275	220	275	55	$825,000	0
PSH	15	505	51	0	$451,200	0

Table 2-Projected Need and Cost for Men 25+, by Year and Program Type

Year 1

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	116	0	65	65	$65,000	51
Rapid rehousing	279	0	50	50	$100,000	229
PSH	302	482	116	20	$336,960	186

Year 2

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	174	65	130	65	$130,000	44
Rapid rehousing	279	50	100	50	$200,000	179
PSH	246	502	120	20	$673,920	126

Year 3

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	232	130	195	65	$195,000	37
Rapid rehousing	279	100	150	50	$300,000	129
PSH	186	522	124	20	$1,010,880	62

Year 4

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	290	195	260	65	$260,000	30
Rapid rehousing	279	150	200	50	$400,000	79
PSH	122	542	122	14	$1,246,752	0

Year 5

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	348	260	348	88	$348,000	0
Rapid rehousing	279	200	279	79	$558,000	0
PSH	60	556	111	0	$1,246,752	0

Table 3-Projected Need and Cost for Women 25+, by Year and Program Type

Year 1

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	69	0	40	40	$40,000	29
Rapid rehousing	139	0	25	25	$50,000	114
PSH	243	248	70	20	$336,960	173

Year 2

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	104	40	80	40	$80,000	24
Rapid rehousing	139	25	50	25	$100,000	89
PSH	222	268	74	20	$673,920	148

Year 3

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	139	80	120	40	$120,000	19
Rapid rehousing	139	50	75	25	$150,000	64
PSH	197	288	78	20	$1,010,880	119

Year 4

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	173	120	160	40	$160,000	13
Rapid rehousing	139	75	100	25	$200,000	39
PSH	168	308	82	20	$1,347,840	86

Year 5

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	208	160	208	48	$208,000	0
Rapid rehousing	139	100	139	39	$278,000	0
PSH	135	328	135	69	$2,510,352	0

Table 4 - Projected Need for Youth 18-24, by Year and Program Type

Year 1

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	21	0	10	10	$10,000	11
Rapid rehousing	21	0	10	10	$20,000	11
PSH	31	0	20	20	$336,960	11

Year 2

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	31	10	20	10	$20,000	11
Rapid rehousing	21	10	20	10	$40,000	1
PSH	42	20	24	20	$673,920	20

Year 3

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	41	20	30	10	$30,000	11
Rapid rehousing	21	20	21	1	$42,000	0
PSH	51	40	28	20	$1,010,880	27

Year 4

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	52	30	40	10	$40,000	12
Rapid rehousing	21	21	21	0	$42,000	0
PSH	58	60	32	20	$1,347,840	32

Year 5

	Need	Inventory	Available Inventory (Factoring In Turnover & Units Under Development)	Under Development	Cost	Unmet Need
Diversion	62	40	62	22	$62,000	0
Rapid rehousing	21	21	21	0	$42,000	0
PSH	63	80	63	47	$2,139,696	8

Appendix 10 – Cost Projections by Year

Total New Units and Estimated Operating Costs Over 5 Years

The tables below aggregate information across each of the sub-populations and intervention types to provide a summary of the projection of the total number and units/slots needed to address unmet need over a 5-year period as well as the estimated total operating cost of adding these unit/slots over the same period. The table indicates addressing total unmet need over a 5-year period is projected to require the addition of **1,894** additional program units/slots across all program types at an estimated cost of **$25.57 million.**

	Diversion		RR		PSH		Totals	
Sub-Population	Units	Cost	Units	Cost	Units	Cost	Units	Cost
Families	192	$640,000	275	$2,475,000	20	$2,256,000	**487**	**$5,371,000**
Single Men, 25+	348	$998,000	279	$1,558,000	74	$4,515,264	**701**	**$7,071,264**
Single Women, 25+	208	$608,000	139	$778,000	149	$5,879,952	**496**	**$7,265,952**
Young Adults 18-24	62	$162,000	21	$186,000	127	$5,509,296	**210**	**$5,857,296**
Totals	**810**	**$2,408,000**	**714**	**$4,997,000**	**370**	**$18,160,512**	**1,894**	**$25,565,512**

Costs per Year by Intervention

	Year 1		Year 2		Year 3		Year 4		Year 5		Overall Total	
	Units Added	Cost of New & existing units	Units Added	Cost of New & existing units	Units Added	Cost of New & existing units	Units Added	Cost of New & existing units	Units Added	Cost of New & existing units	Units Added	Cost of New & existing units
Diversion												
Families	64	$64,000	96	$96,000	128	$128,000	160	$160,000	192	$192,000	192	$640,000
Men, 25+	65	$65,000	130	$130,000	195	$195,000	260	$260,000	348	$348,000	348	$998,000
Women, 25+	40	$40,000	80	$80,000	120	$120,000	160	$160,000	208	$208,000	208	$608,000
Young Adults 18-24	10	$10,000	20	$20,000	30	$30,000	40	$40,000	62	$62,000	62	$162,000
Total Diversion	**179**	**$179,000**	**326**	**$326,000**	**473**	**$473,000**	**620**	**$620,000**	**810**	**$810,000**	**810**	**$2,408,000**
Rapid Rehousing												
Families	55	$165,000	110	$330,000	165	$495,000	220	$660,000	275	$825,000	275	$2,475,000
Men, 25+	50	$100,000	100	$200,000	150	$300,000	200	$400,000	279	$558,000	279	$1,558,000
Women, 25+	25	$50,000	50	$100,000	75	$150,000	100	$200,000	139	$278,000	139	$778,000
Young Adults 18-24	10	$20,000	20	$40,000	21	$42,000	21	$42,000	21	$42,000	21	$186,000
Total Rapid Rehousing	**140**	**$335,000**	**280**	**$670,000**	**411**	**$987,000**	**541**	**$1,302,000**	**714**	**$1,703,000**	**714**	**$4,997,000**
PSH												
Families	20	$451,200	20	$451,200	20	$451,200	20	$451,200	20	$451,200	20	$2,256,000
Men, 25+	20	$336,960	40	$673,920	60	$1,010,880	74	$1,246,752	74	$1,246,752	74	$4,515,264
Women, 25+	20	$336,960	40	$673,920	60	$1,010,880	80	$1,347,840	149	$2,510,352	149	$5,879,952
Young Adults 18-24	20	$336,960	40	$673,920	60	$1,010,880	80	$1,347,840	127	$2,139,696	127	$5,509,296
Total PSH	**80**	**$1,462,080**	**140**	**$2,472,960**	**200**	**$3,483,840**	**254**	**$4,393,632**	**370**	**$6,348,000**	**370**	**$18,160,512**
Overall Total	***399***	***$1,976,080***	***746***	***$3,468,960***	***1084***	***$4,943,840***	***1415***	***$6,315,632***	***1894***	***$8,861,000***	***1894***	***$25,565,512***