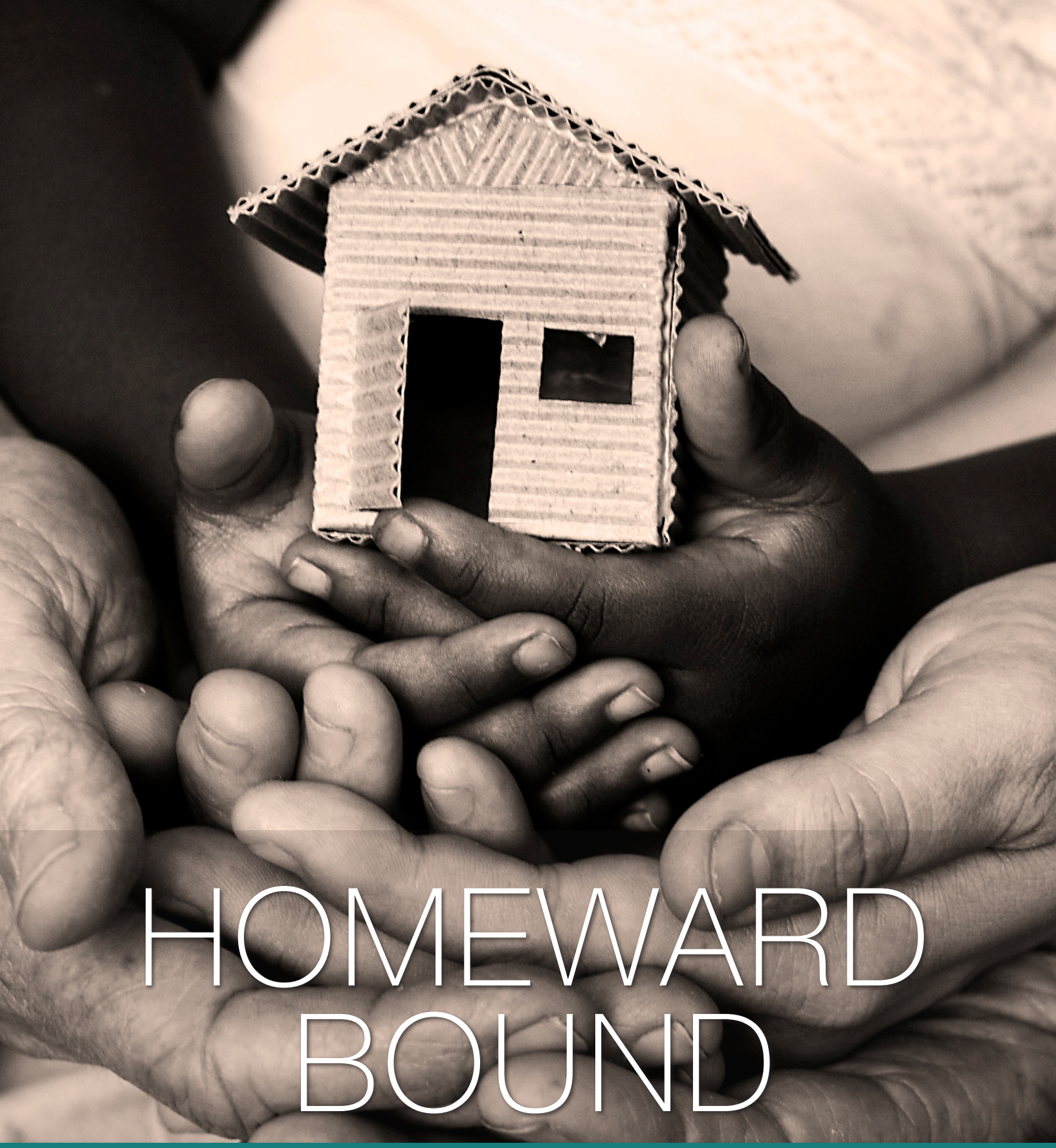

HOMEWARD BOUND

2015 POLICY AND RESOURCE GUIDE FOR
Housing Homeless Floridians

Federal Policies and Programs

McKinney-Vento Homeless Assistance Act

Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act

United States Interagency Council on Homelessness (USICH)

Opening Doors

Emergency Solutions Grant (ESG)

Continuum of Care (CoC)

Runaway and Homeless Youth Act (RHYA)

Rural Housing Stabiility Assistance Program (RHSP)

Homeless Assistance Activities and Models

Housing First (HF)

Permanent Supportive Housing (PSH)

Rapid Re-Housing (RRH)

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Transitional Housing (TH)

Coordinated Entry (CE)

Homeless Management Information System (HMIS)

Point-in-Time (PIT) Count

Florida Policies and Programs

Challenge Grant

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Homeless Subpopulations

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

flhousing.org
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How to Use This Guide

This guide addresses policies and resources for homeless assistance at both the federal and state levels. The introduction gives a broad historical overview of the national response to homelessness, followed by a discussion of Florida's evolving homeless assistance framework. The next section presents national and state data on homelessness trends over time, followed by a brief discussion of federal and state definitions of homelessness. The main body of the guide consists of an encyclopedia of terms referring to federal and state policies, programs, and best practices for addressing homelessness. Each entry is cross-referenced with links to other entries, and has its own list of resources for further reading. The Appendix lists additional resources for homeless service providers, housing providers, and advocates.

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

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

preface

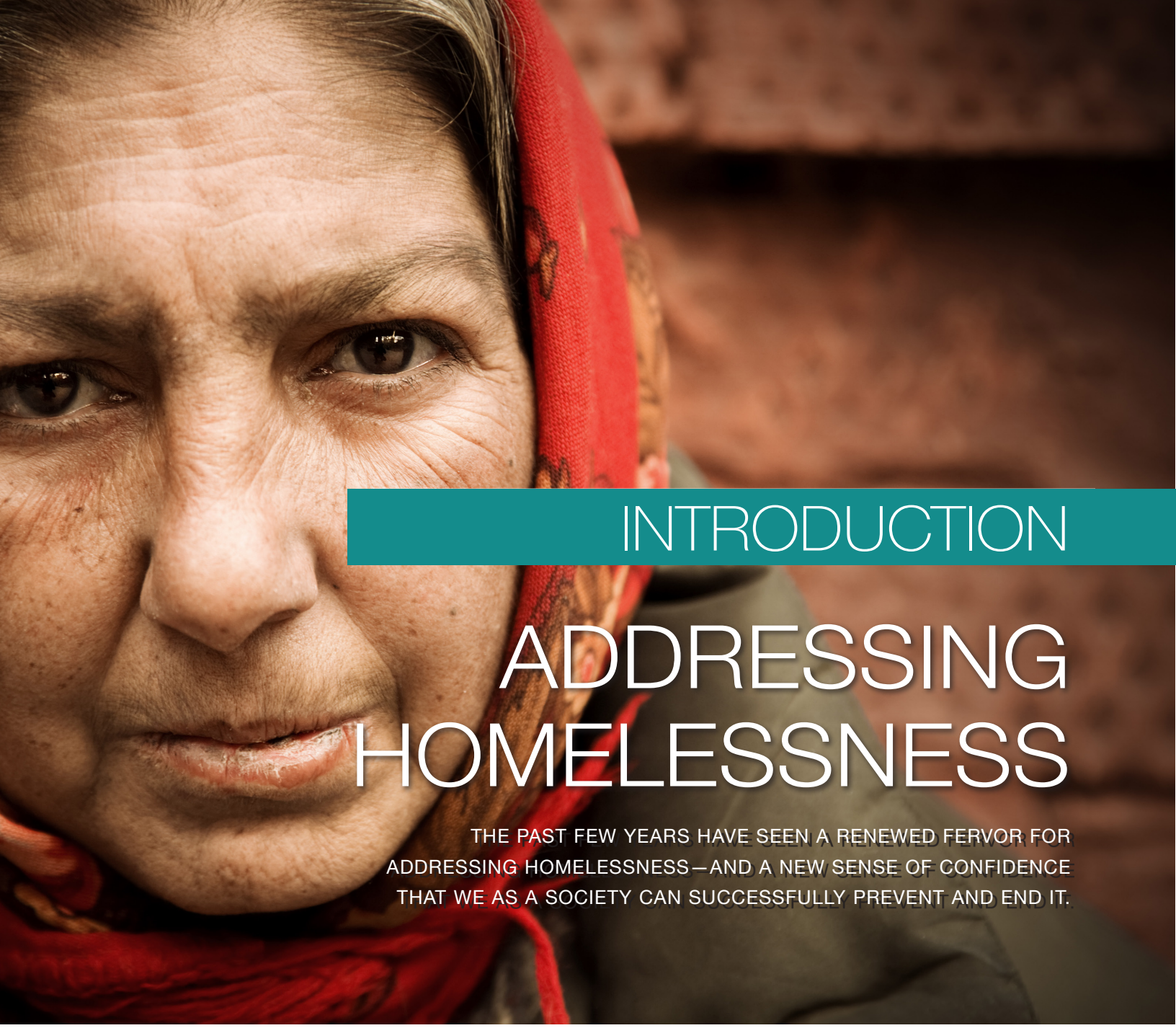
Of all the hardships that low-income Americans face, homelessness is among the most extreme, and has an unparalleled power to shock the public conscience. This is especially true in Florida, where palatial residences and tourist attractions stand in sharp contrast with a homeless population of 41,542 people—the 3rd highest of any state. Contrary to popular belief, Florida's homeless problem is not driven by economically unstable individuals and families migrating to Florida to take advantage of the nice weather—year after year of state data shows that most homeless Floridians have lived in their communities for a year or more. At the national level, the homeless population declined by 11% between 2007 and 2014, as Congress, federal agencies, and homeless service providers have increasingly invested in "Housing First" programs.

In 2014, for the first time in almost a decade, Florida's homeless population decreased significantly, by over 13%. However, Florida still has the third highest homeless population in the nation, and the third highest rate of unsheltered homeless at 52%. Approximately 21,700 individuals are staying on our streets and in our woods, without any kind of housing at all. If Florida can continue to move the needle on homelessness, it will be an achievement of national significance.

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

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

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



INTRODUCTION

ADDRESSING HOMELESSNESS

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

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

FEDERAL HOMELESS ASSISTANCE: A BRIEF HISTORY

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

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

HOMELESS ASSISTANCE AS WE KNEW IT: THE HOUSING READY MODEL

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

Most communities adopted a "Housing Ready" model of assistance, which is a linear model of homeless service provision that dominated through the 1990s and early 2000s. The archetypal client would enter emergency shelter for initial stabilization, be accepted into a Transitional Housing (TH) program after an initial period of sobriety, and "graduate" to permanent housing after completing the TH program and saving up enough money for relocation costs. McKinney-Vento-funded TH programs to serve clients for up to 24 months, and many (though by no means all) are congregate facilities that require residents to accept mental health/substance abuse treatment, participate in life skills training classes, and abide by various house rules.[6] It was typical for homeless housing and shelter programs to require participation in program services (e.g. recovery groups, budgeting classes) and to maintain barriers to entry into programs, such as sobriety.

THE ASCENDANCY OF "HOUSING FIRST"

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

The term "Housing First" was probably coined in 1988 by Beyond Shelter, a nonprofit in Los Angeles, CA, that offered "rapid re-housing" services to homeless families.[9] "Housing First" was researched and popularized by Dr. Sam Tsemberis, a psychiatrist and founder of Pathways to Housing. The Housing First (HF) approach prioritizes rapid placement into permanent housing; there are no requirements for service participation and no preconditions (e.g., no sobriety or income requirements). HF is recognized as an evidence-based practice by SAMHSA and HUD encourages all projects to adopt Housing First.

In practice, many programs that initially explicitly used a Housing First model were PSH programs targeted to single adults experiencing homelessness who have severe mental illness and other impairments. While HF programs vary in the details, they usually entail assisting homeless clients into permanent housing as quickly as possible after referral and helping clients connect to needed and desired support services. The unifying factor in true HF programs is that clients are not required to participate in treatment or services as a condition of remaining in their housing.

Compared to homeless individuals, household heads in families experiencing homelessness have fewer problems with severe mental illness or chronic substance abuse on average, and are less likely to need intensive and ongoing supportive services.[10] As a result, many advocates have promoted a "Rapid Re-Housing" (RRH) model for families and individuals with low to moderate barriers to housing stability. Rapid Re-Housing is another application of Housing First, in that it prioritizes rapid movement into permanent housing with few barriers and individualized voluntary support.

RRH programs provide just enough assistance to quickly stabilize these families in permanent housing—outreach to landlords, security and utility deposits, moving costs, temporary rental subsidies, and temporary case management addressing behaviors that directly affect a client's housing stability. [11] In early 2009, HUD created a Homelessness Prevention and Rapid Re-Housing Program (HPRP), a 3-year demonstration. HUD's most recent analysis shows that HPRP was highly successful.[12] Several communities also report that RRH programs have lower costs, higher rates of exits to permanent housing, and lower rates of return to homelessness after 12 months than TH programs. As the RRH model spreads, some homeless assistance providers are expanding it beyond its original focus to serve high-barrier households until they can obtain permanent supportive housing, or find another affordable living situation with adequate community supports.[13]

THE FEDERAL GOVERNMENT CODIFIES SYSTEMS APPROACHES AND HOUSING FIRST: THE HEARTH ACT, OPENING DOORS, AND BEYOND

The growing emphasis on Housing First and prevention culminated in the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, which reauthorized and updated the McKinney-Vento Act for the first time since 1992. The Emergency Shelter Grant was renamed the "Emergency Solutions Grant," and its funding priorities shifted from emergency shelter toward homelessness prevention/diversion and Rapid Re-Housing (RRH). The competitive grant programs, meanwhile, were consolidated into a single, more flexible "Continuum of Care" program, and RRH was added as an eligible activity. The application and scoring process were revised to emphasize outcomes, including reductions in total homeless populations and returns to homelessness. The HEARTH Act also created a new Rural Housing Stability Program (RHSP), in which rural communities can compete more effectively for funding.[14,15]

The Obama administration followed up in 2010 with Opening Doors: Federal Strategic Plan to Prevent and End Homelessness, the first comprehensive planning document for federal homeless assistance policy. Chronic homelessness had declined by one-third in the preceding five years, and Opening Doors built on the momentum by pledging to end chronic and veteran homelessness by 2015, and family and youth homelessness by 2020. Similar to the HEARTH Act, Opening Doors embraced Housing First, and provided guidance for homeless assistance providers to coordinate more effectively with mainstream social services.[16] It drew on emerging federal programs, including HPRP and HUD-Veterans Affairs Supportive Housing (HUD-VASH). In the latter program, the VA provides social services to qualified veterans while HUD provides a housing voucher.[17] Around the same time Opening Doors was released, Congress authorized the VA to create the Supportive Services for Veteran Families (SSVF) program, which provides homelessness prevention and rapid re-housing assistance to veteran families that are at risk of homelessness or literally homeless.[18]

The HEARTH Act, Opening Doors, and recently released HUD rules all promise to change the process of homeless assistance as well as the substance. In particular, HUD's interim Continuum of Care rule requires CoCs to implement "Coordinated Entry" for intake and referral of homeless clients. In many communities, the homeless assistance network has been fragmented, and people experiencing homelessness must approach multiple providers before finding one who will accept them. Coordinated entry is intended to make the homeless assistance system easier to access, and to connect people experiencing homelessness with the most appropriate intervention. Ideally, coordinated entry should result in more efficient use of homeless assistance funding by reserving intensive resources (i.e. PSH) for those with the greatest needs and reduce the length of time that people are homeless.[19,20] HUD's CoC program requires system-wide standards, a CoC-wide governing board, and measurement of system-wide performance and outcome measures. The shift from siloed individual programs to a well-coordinated crisis response system is already in process.

REMAINING CHALLENGES

With Housing First and a strong emphasis on system coordination, this generation's push to end homelessness might actually be successful. As one example, the 100,000 Homes Campaign was launched in 2010, and met its goal of housing 100,000 of the most vulnerable people experiencing homelessness by June 2014.[21] However, challenges remain at all levels, from federal policy to local implementation. As always, federal funding is stretched and uncertain. Although Congress has been relatively generous with McKinney-Vento funding in the past few years, the current funding is barely enough to cover renewals for projects that have already been developed.[22,23] Some of the "mainstream" resources we need to create paths out of homelessness, such as public housing, the Community Development Block Grant (CDBG), and community health centers, have seen significant cuts.[24] Others, such as Temporary Assistance for Needy Families (TANF) and Medicaid, receive non-discretionary federal funds and can grow with demand. However, recent cuts to the Supplemental Nutrition Assistance Program (SNAP, or "food stamps"), show that even these programs are vulnerable.

In many communities, the homeless assistance network has been fragmented, and people experiencing homelessness must approach multiple providers before finding one who will accept them.

The new federal approach to homelessness is also pushing communities to reconsider the role of Transitional Housing (TH). While the limited scholarly research finds that most TH clients who complete their programs are satisfied with their experience and find permanent housing, many programs are flawed because they screen out the hardest-to-serve clients are common, especially single adults.[25,26] Further, studies have shown that TH is much less expensive than Rapid Re-Housing, and the primary outcomes, including permanent housing stability rates, are similar. TH providers can stay competitive and protect their investments by "retooling" their programs—tailoring them to populations that need them most, eliminating requirements for sobriety and treatment participation, and/or changing their service models and repurposing their buildings.[27,28]

Advocates for people experiencing homelessness have also struggled with the role of supportive services and how to pay for them. In Permanent Supportive Housing programs, McKinney-Vento grants are a critical funding source for support services. However, beginning in 1999, HUD established requirements and incentives for CoCs to shift spending from supportive services toward housing. The HEARTH Act shifts funding priorities even further toward housing. Medicaid is another vital funding source, but not all services are eligible for reimbursement, and not all people exiting homelessness would necessarily qualify for it. While other federal funds exist, particularly from the Department of Health and Human Services (HHS), none has been sufficient to fill the gap left by shifting McKinney funds.[29] This is particularly concerning to advocates for homeless families, who fear that RRH and mainstream services will be insufficient to replace the services that families with intermediate needs—those who do not qualify for PSH—have traditionally received from Transitional Housing programs.[30,31,32] However, evidence from communities that have embraced RRH for moderate- and even high-barrier families suggests that RRH provides adequate supports and assistance to help households achieve housing stability.[33]

HOMELESS ASSISTANCE POLICY IN FLORIDA

Similar to that of the federal government, Florida's homeless assistance policy has evolved in recent years. State-level planning, coordination, data collection, and policy development are conducted by the Office on Homelessness, a division created within the Department of Children and Families (DCF) by state legislation in 2001. Before then, Florida had some statutory language on the state definition of homelessness, the functions of local homeless coalitions recognized by DCF, and assistance programs for people who were experiencing of at risk of homelessness. However, the state's homeless assistance network was underdeveloped and fragmentary—state agencies did not coordinate on homeless policy, many Continuums of Care were not applying for or winning federal CoC grants, and existing shelter beds served less than 1/3 of the homeless population.[34,35]

The 2001 legislation sought to fill this vacuum. The new Office on Homelessness would be led by a Council on Homelessness, a 15-member board (later increased to 17) including representatives from relevant state departments and affiliated agencies, statewide nonprofits with an interest in homelessness, and governor's appointees. The Council's role is to develop policy recommendations and report to the governor on homelessness trends. The new law defined local Continuums of Care and vested them with responsibilities similar to those dictated by HUD. DCF-recognized CoC lead agencies would be eligible for funding from two major new state programs—the Challenge Grant and the Homeless Housing Assistance Grant. The Challenge Grant funds a wide array of services in a CoC's plan, including prevention, outreach, emergency and transitional shelter, permanent housing, and supportive services, while Homeless Housing Assistance Grants fund construction and rehabilitation of permanent and transitional housing. A $5 million annual transfer from the Local Housing Trust Fund (which funds local State Housing Initiatives Partnership, or SHIP, programs) to DCF was authorized to help fund these new programs. Other changes in the 2001 legislation included discharge planning requirements to help medical, mental health, and substance abuse facilities avoid discharging patients into homelessness; identification of homeless persons as a high-priority population for housing funded by the State Apartment Incentive Loan (SAIL) program; and a requirement that local State Housing Initiatives Partnership (SHIP) programs include partnerships with advocates for the homeless, elderly, and migrant farmworkers.[36]

Florida has made considerable progress on homeless service delivery since 2001. The number of Continuums of Care increased from 21 to 28 by 2009.[37] Every CoC has successfully applied for HUD funding, and the aggregate level of funding has increased significantly, over $84,000,000 in 2014. The number of beds for people experiencing homelessness increased by 74% between 2001 and 2012, with permanent housing beds comprising the majority of the increase.[38] The Florida Housing Finance Corporation (FHFC), in awarding SAIL funds, HOME Investment Partnerships Program (HOME) funds from HUD, and federal Low Income Housing Tax Credits (LIHTC or Housing Credits), has increasingly prioritized developments that serve people experiencing homelessness.[39]

In the past few years, Florida's homeless assistance system has experienced both losses and gains. In 2010, the State Legislature discontinued the practice of transferring funds from the Local Housing Trust Fund to DCF for homeless assistance, corresponding to sweeps of the State and Local Housing Trust Funds to fill budget deficits related to the recession.[40] This change contributed to the Legislature's defunding of the Homeless Housing Assistance Grant and Challenge Grants in 2012. However, in 2013, the Legislature approved two statutory changes that the Council on Homelessness had advocated for years: the state's Emergency Financial Assistance for Housing Program (EFAHP) was replaced with a more flexible Homelessness Prevention program, and Continuum of Care lead agencies were permitted to use up to 8% of their Challenge Grant awards (when available) for administrative costs.[41,42,43]

The 2014 legislative session saw a revival of state support for homeless assistance. Senator Jack Latvala and Representative Kathleen Peters introduced companion bills to revive Challenge Grant funding and provide a basis for DCF to determine awards to CoCs. The bills also extended the Department of Economic Opportunity (DEO)'s training and technical assistance program for affordable housing development to CoCs, and required that Challenge Grant recipients include a coordinated entry system in their CoC plans. In addition, funding for CoC lead agencies was increased so those agencies would have increased capacity to plan systems improvements. Latvala and Peters originally included provisions in their respective bills to dedicate 4% of Local Housing Trust Fund revenues annually for homeless assistance.[44,45] These provisions were stripped from the version of the House bill that was sent to the governor, but were included as non-recurring funding in the appropriations bill signed by the Governor.[46,47,48]

MOVING FORWARD

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

TRENDS

NATIONAL & STATE HOMELESSNESS

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

Since the early 2000s, federal officials have sought to standardize the process of counting people experiencing homelessness. In 2004, HUD first released data collection standards for computer-based Homeless Management Information Systems (HMIS) at the Continuum of Care level.[49] That same year, HUD refined the standards for "Point-in-Time" (PIT) counts of homeless populations to allow only scientific, statistically reliable counting methods. PIT comparisons across years and communities must still be done with care, since different numbers may reflect differences or changes in count methodologies, severe weather in a CoC on the night of the count, an increase in homelessness due to natural disasters, or other unforeseen factors. Nonetheless, PIT counts are an illuminating and commonly used benchmark for examining trends in homelessness.[50]

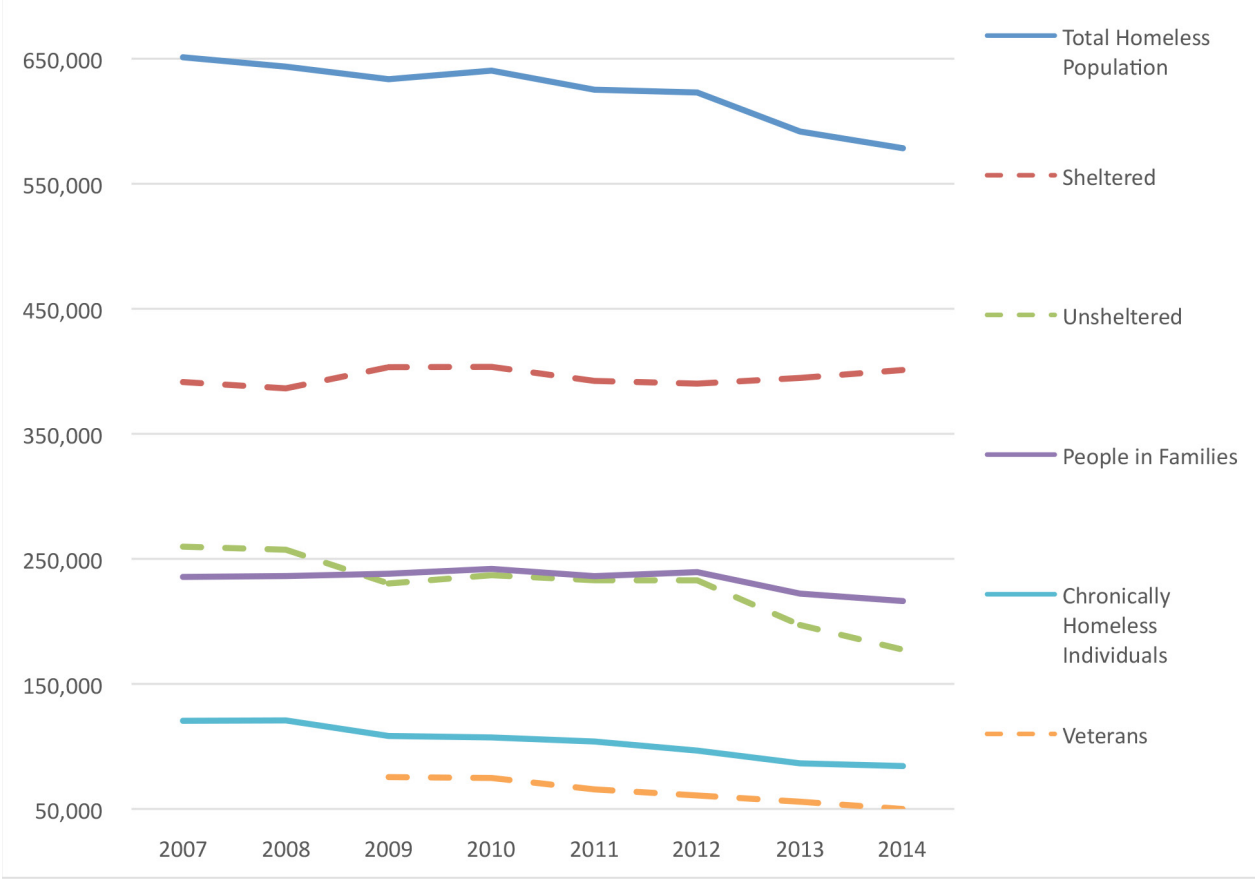
In their PIT counts, CoCs count people who meet HUD's definition of "literally homeless." This includes the "unsheltered" homeless population—those living outdoors or in cars, abandoned

buildings, or other places not meant for human habitation—and people living in emergency shelters, transitional housing, safe havens, and motels paid for by government or charitable organizations. It does not include people who are doubled up with family and friends, or living in a motel paid for on their own. States or local continuums of care, for their own planning and awareness-raising purposes, may choose to count people who are precariously housed but not literally homeless. However, these individuals are typically considered by HUD when determining a CoC's level of need for homeless assistance funds.[51,52] The next section contains a more detailed description of various definitions of homelessness.

Figures 1 and 2 show trends in the total homeless population and selected subpopulations in the United States and Florida, respectively, according to PIT counts. Table 1 shows the percent changes in homelessness in the U.S. and Florida. At the national level, the total homeless population dropped from 671,888 to 578,424 people between 2007 and 2014. This 11% decrease was driven by an even sharper (32%) decline in the number of unsheltered homeless people, while the number of sheltered homeless people actually increased by 2%. Veteran homelessness decreased by 33% between 2010 (the first year for which an estimate of the total homeless veteran population was available for the U.S. and all states)[53] and 2014, while chronic homelessness among individuals declined by 30% between 2007 and 2013. Family homelessness decreased at a slower but still substantial rate (8%).

Florida's homeless population decreased by 14% between 2007 and 2014, from 48,069 to 41,542 people, a stronger decrease than the nation as a whole. As Figure 2 shows, homelessness during the period shown peaked in 2010 and declined thereafter, corresponding with the peak of the economic recession and the slow recovery thereafter. The unsheltered homeless population decreased by 21%, while the sheltered population decreased by 3%. Compared to the nation, homelessness among people in

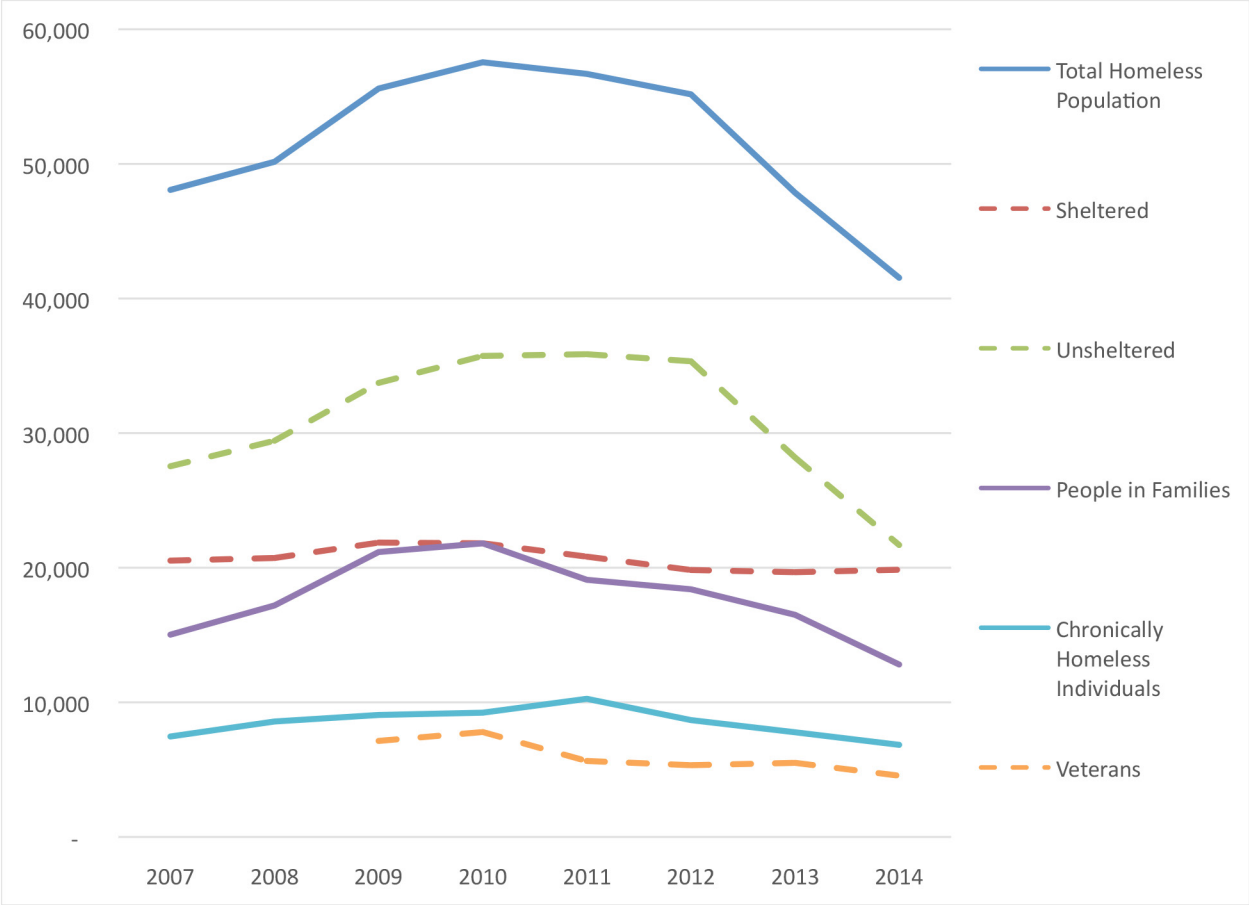
Figure 1. Homeless Population And Selected Subpopulations In The United States.



Source: HUD PIT Count data 2007 to 2014

families and veterans experienced stronger decreases in Florida (15% and 42%, respectively), while the number of chronically homeless individuals experienced a more modest decrease (8%). As Figure 2 shows, it was not until 2014 that Florida saw substantial decreases in its homeless population and subpopulations below pre-recession levels. Sustained state-level funding for homeless assistance will help Florida's communities keep the momentum going.

Figure 2. Homeless Population and Selected Subpopulations in Florida.



Source: HUD PIT Count data 2007 to 2014

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

Homeless Population Category	United States	Florida
Total Homeless Population (2007-2014)	-11%	-14%
Sheltered Homeless (2007-2014)	2%	-3%
Unsheltered Homeless (2007-2014)	-32%	-21%
Persons in Families (2007-2014)	-8%	-15%
Chronically Homeless Individuals (2007-2014)	-30%	-8%
Veterans (2010-2014)	-33%	-42%

Source: HUD PIT Count data 2007 to 2014
https://www.hudexchange.info/resource/4074/2014-ahar-part-1-pit-estimates-of-homelessness/

THE DEFINITION OF HOMELESSNESS

DEFINITION OF HOMELESSNESS

HUD uses the following definition of "homeless" (abridged for clarity):

1. An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

a. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, [etc.];

b. An individual or family living in a supervised ... shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or ... government programs ...; or

c. An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

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

Individuals and families who meet Category 1 of HUD's homeless definition are considered "literally homeless", and Continuums of Care (CoCs) count them in annual Point-in-Time (PIT) counts. The federal HEARTH Act of 2009 increased the time to imminent loss of housing in Category 2 from 7 to 14 days, and added the Category 3 definition of homelessness (families and youth who are defined as homeless under other federal statutes and are living unstably). After the HEARTH Act passed, HUD published its final rule defining homelessness in December 2011.

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

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

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

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

The Runaway and Homeless Youth Act defines a homeless youth as one who cannot live safely with a relative and has no safe alternative living arrangement. The other six statutory definitions include language similar to HUD's "literally homeless" category, and expand upon it to varying degrees to include those who are precariously housed. The homelessness definition in the Education for Homeless Children and Youths (ECHY) Act, administered by the U.S. Department of Education, is particularly important. It includes "children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; [or] are living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations." Every state must have a coordinator to ensure ECHY implementation, and each school district must have a liaison to help identify homeless students and help them overcome barriers to enrolling and staying in school, including lack of transportation, immunizations and identification documents.

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

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

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

a. Is sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;

b. Is living in a motel, hotel, travel trailer park, or camping ground due to a lack of alternative adequate accommodations;

c. Is living in an emergency or transitional shelter;

d. Has a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings;

e. Is living in a car, park, public space, abandoned building, bus or train station, or similar setting; or

f. Is a migratory individual who qualifies as homeless because he or she is living in circumstances described in paragraphs (a)-(e).

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  - Head Start Act: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section9832&num=0&edition=prelim
  - Violence Against Women Act: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section14043e-2&num=0&edition=prelim
  - Public Health Service Act: http://uscode.house.gov/view.xhtml?path=/prelim@title42/chapter6A/subchapter2/partD&edition=prelim
  - Food and Nutrition Act: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title7-section2012&num=0&edition=prelim
  - Child Nutrition Act: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1786&num=0&edition=prelim
  - Education for Homeless Children and Youths: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section11434a&num=0&edition=prelim
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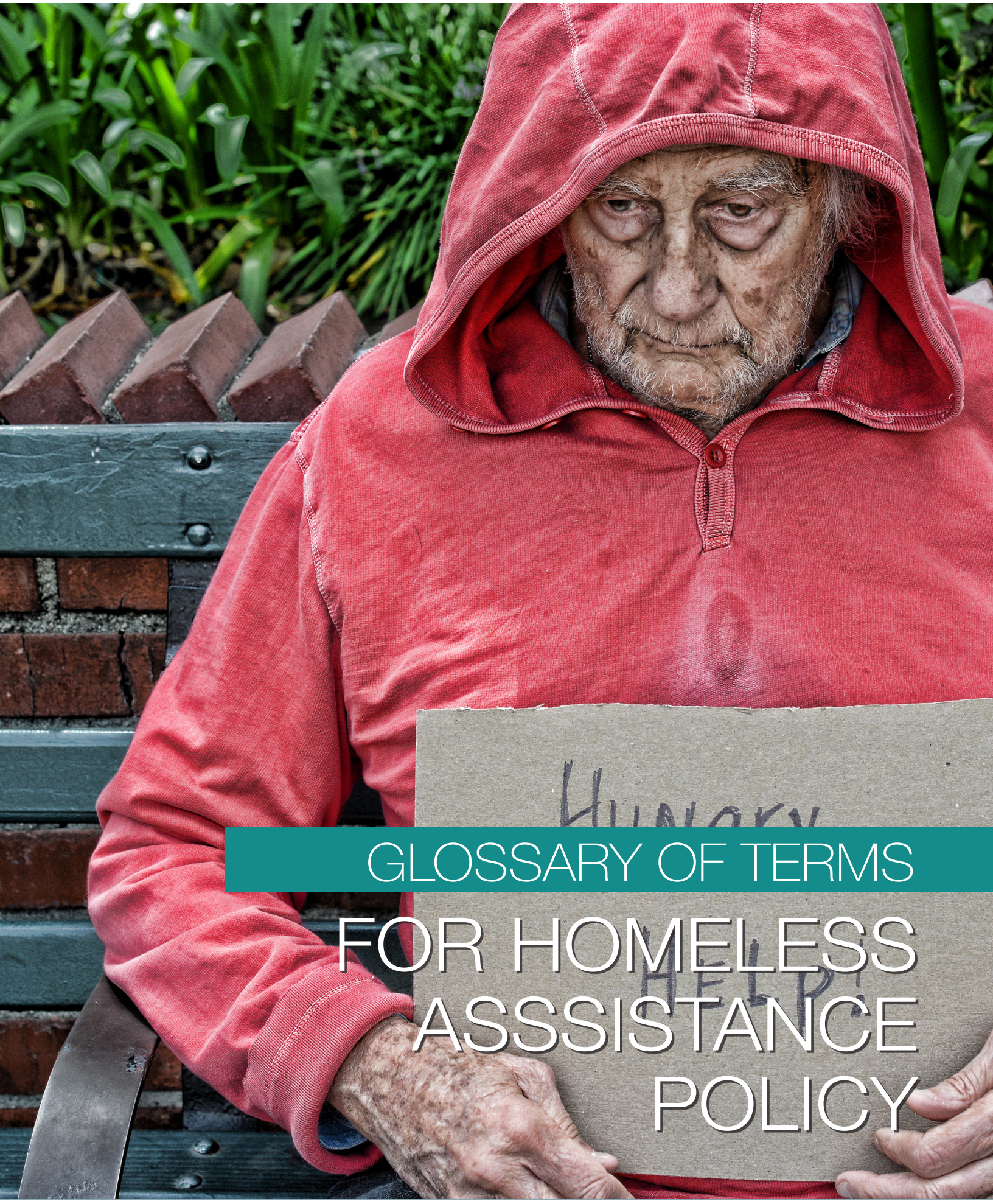

GLOSSARY OF TERMS

FOR HOMELESS ASSSISTANCE POLICY

FEDERAL POLICIES AND PROGRAMS

McKinney-Vento Homeless Assistance Act

The McKinney-Vento Act is the definitive piece of federal legislation for federal assistance to homeless persons. In 2009, the Act was reauthorized and substantially amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. Originally passed as the Stewart B. McKinney Homeless Assistance Act in 1987, this statute responded to the substantial increase in homelessness throughout the 1980s, and included elements of legislation passed in the mid-1980s. The original bill provided for 20 programs to be administered by 9 federal agencies, including funding programs for emergency and transitional shelter, job training, health care, and adult education for the homeless. It built on earlier legislation that made "mainstream" public benefit programs, such as Food Stamps and Medicaid, more accessible to homeless individuals, and created requirements and provisions for homeless children to receive public education. Over the years, some programs have been scaled back or eliminated, and new programs have been added. In 2000, the statute was renamed the McKinney-Vento Homeless Assistance Act.

Before 2009, the last major Congressional reauthorization of the McKinney-Vento act was included in the Housing and Community Development Act of 1992. By this time, the four major programs overseen by HUD were in place: (1) Emergency Shelter Grant (ESG); (2) Supportive Housing Program (SHP); (3) Shelter Plus Care (S+C); (4) Section 8 Moderate Rehabilitation Single Room Occupancy (SRO).

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

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Homeless Emergency Assistance and Rapid Transition To Housing (HEARTH) Act

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

1) The definition of "homelessness" was expanded. At the time of the HEARTH Act's passage, the "homeless" definition already included persons at "imminent risk" of homelessness, defined as facing a loss of housing in 7 days with no alternative housing arrangements or support networks. The HEARTH Act increases the threshold for "imminent risk" from 7 to 14 days. The Act also expands the homelessness definition to include unaccompanied youth and families with children and youth who are defined as "homeless" under other federal statutes, have not lived independently in permanent housing for a "long term period" with "frequent moves" over that period, and will continue to live unstably for an extended period because of disability, a history of domestic violence or childhood abuse, or multiple barriers to employment.

2) The definition of "chronic homelessness" was expanded to include families as well as individuals.

3) The Emergency Shelter Grant was renamed the Emergency Solutions Grant, its share of homeless assistance funding was increased, and its eligible activity requirements were amended to emphasize prevention and Rapid Re-Housing.
   a. HUD must allocate 20% of its homeless assistance funding to the Emergency Solutions Grant program, whereas the previous Emergency Shelter Grant received only 10% of the annual allocation.
   b. The Emergency Shelter Grant program allowed grantees (i.e. state and local governments) to spend a maximum of 30% of their funds on prevention, and only for people with a sudden loss of income. By contrast, the new Emergency Solutions Grant program imposes a 60% spending cap on grantees for street outreach and emergency shelter activities. Additionally, persons defined as "at risk of homelessness" need not have a sudden loss of income, but must have incomes below 30% AMI and unstable living arrangements (including doubling up with others or living in a motel). A "hold-harmless" provision ensures that grantees will not lose funding for emergency shelter, outreach, and related services.
   c. Rapid Re-Housing was added as an eligible activity.
   d. The Emergency Solutions Grant program specifies no spending cap on essential services, such as medical care and employment counseling, for homeless persons in emergency shelters or on the street. The previous Emergency Shelter Grant program had required grantees to spend no more than 30% of funds on essential services.
   e. Emergency Solutions Grant recipients may spend up to 7.5% on administration, compared to 5% under the Emergency Shelter Grant program.

4) HUD's three competitive funding programs are consolidated into one competitive "Continuum of Care" (CoC) Program, which expands eligible activities and emphasizes performance. This element of the HEARTH Act codifies into law the CoC framework that HUD had already been using to award its competitive homeless assistance grants.
   a. The CoC Program combines the eligible activities of the Supportive Housing Program (SHP), Shelter Plus Care Program (S+C), and the Section 8 Moderate Rehabilitation Single-Room Occupancy Program (SRO). Eligible activities are expanded to include limited-term rental assistance and supportive services for Rapid Re-Housing.
   b. The CoC subtitle stipulates that at least 30% of the combined funds appropriated to HUD for ESG and CoC must be used for permanent housing for disabled individuals or households with a head of household who is disabled. Additionally, at least 10% of HUD's combined ESG and CoC funds must be used for permanent housing for families with children. These set-asides apply to the aggregate national use of funds, not to individual CoCs. Housing for homeless families with a disabled adult member contributes to both set-asides simultaneously, so the total HUD funding committed to these set-asides may be less than 40%. Although the combined amount of ESG and CoC funds are used to calculate the set-asides, the actual funds for these activities come from the CoC pool.
   c. Up to 10% of CoC funds may be used for unaccompanied youth and families with children who are defined as homeless under other federal statutes, but only if the community

can demonstrate to HUD that these activities are of equal or greater priority compared to activities for other homeless subpopulations. An exception to this 10% cap is made for communities with a homelessness rate lower than 0.1%.

d. In evaluating funding applications, the emphasis is shifted more toward performance measures, such as the degree of coordination among CoC partners and reductions in homelessness rates, length of homeless episodes, and returns to homelessness. Prior to the HEARTH Act, scoring for CoC funds heavily emphasized community needs, CoC capacity, and the feasibility of individual projects.

e. The lead agency in a CoC, called a Collaborative Applicant in this act, may also apply to or be designated by HUD as a "Unified Funding Agency" (UFA). Under the traditional CoC application process, HUD awards funding directly to each project included in a CoC application. A UFA receives the community's entire CoC allocation from HUD and subgrants it to project sponsors. The UFA is responsible for financial and program oversight of its subgrantees.

f. Project sponsors may use up to 10% of their funding for administrative costs, an increase from 5% for SHP and 8% for S+C.

g. In aggregate, all CoC projects (except those that provide funds for leasing a housing or support service facility) must have a 25% match. For individual projects, the matches may be greater or less than 25%, and may be cash or in kind. Prior to the HEARTH Act, each activity in the competitive grant programs (e.g. construction/rehab, operating expenses) had its own match requirements.

5) HUD offers incentives to "high-performing communities" and those that implement "proven strategies."

a. To be designated as "high-performing," a community must have an average duration of homelessness episodes and a recurrence rate below a certain level, and have effective outreach and data management programs. A high-performing community may allocate its CoC funds however it wishes among CoC activities, and may also fund the prevention and rapid re-housing activities included in the ESG program.

b. "Proven strategies" include Permanent Supportive Housing (PSH) for chronically homeless individuals and families, Rapid Re-Housing for homeless families, and any other strategies that HUD designates on the basis of strong evidence. A community that fully implements a proven

HUD OFFERS INCENTIVES TO "HIGH-PERFORMING COMMUNITIES" AND THOSE THAT IMPLEMENT "PROVEN STRATEGIES"

What is a "High Performing" Community?

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

strategy will receive a bonus, which may be used for any CoC activity and for the ESG program's prevention and re-housing activities.

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

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

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

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

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United States Interagency Council on Homelessness (USICH)

The United States Interagency Council on Homelessness, an independent agency in the Executive Branch of the Federal Government, coordinates the efforts of 19 federal agencies to prevent and end homelessness, as well as forming partnerships with state and local governments and private organizations, conducting research, and offering technical assistance to stakeholders. Originally called the Interagency Council on the Homeless, the agency was created by the Stewart B. McKinney Homeless Assistance Act passed in 1987. USICH's member agencies include the Department of Housing and Urban Development (HUD), the Department of Health and Human Services (HHS), and the Department of Veterans Affairs (VA). The Council became dormant in the mid-1990s, but was revived in 2002 as part of the Bush administration's commitment to end chronic homelessness. In 2010, USICH released *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness..*

Sources:

- USICH. 2012. United States Interagency Council on Homelessness Historical Overview. http://www.usich.gov/resources/uploads/asset_library/RPT_USICH_History_final__2012.pdf. Last accessed 5/29/15.

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

Opening Doors

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

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

USICH issued an amendment in 2012, and has provided annual updates each year since Opening Doors was released. The 2012 amendment revised some of the original plan's objectives to more clearly promote positive educational outcomes among homeless children, and to better serve unaccompanied youth experiencing homelessness. The 2013 update credited Opening Doors with facilitating a 6% decrease in the overall homeless population, including a 24% decrease in Veteran homelessness and a 15% decrease in the chronically homeless population. The update detailed its efforts to help homeless service providers form partnerships with Public Housing Authorities (PHAs) and Temporary Assistance for Needy Families (TANF) to target their resources toward people experiencing or at risk of homelessness, as well as a variety of demonstration programs. Most recently, in 2015 the Obama administration modified the target date for ending chronic homelessness to 2017.

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Emergency Solutions Grant (ESG)

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

ESG has five main eligible activities:

1) Street Outreach: Primarily includes engagement activities, such as identifying and assessing homeless persons on the street, and providing food and clothing; case management; and emergency outpatient medical and mental health care.

2) Emergency Shelter: Primarily includes renovation of existing buildings to serve as shelters; providing essential services such as case management, employment assistance, and substance abuse treatment; and shelter operation, including rent, utilities, and maintenance.

3) Homelessness Prevention: Includes two main types of eligible costs to prevent a household from becoming homeless: housing relocation and stabilization services, and rental assistance. Eligible costs for the former include rental application fees, security and utility deposits, last month's rent, utility payments up to 24 months, moving costs, housing search and placement, mediation with landlords and/or roommates, legal services, and credit repair. Rental assistance may be tenant-based or project-based, and may be short-term (up to 3 months) or medium-term (up to 24 months). Beneficiaries may also receive assistance for up to 6 months of rental arrears. These

4) Rapid Re-Housing: Includes the same eligible costs as Homelessness Prevention but is targeted toward households that are currently homeless to help them move quickly into permanent housing and remain stably housed.

5) Homeless Management Information System (HMIS): The HEARTH Act requires all ESG projects to participate in an HMIS, or data management system used by a local Continuum of Care (CoC) to comply with HUD's data collection requirements.

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

Sources:
- HEARTH Act. 2009. https://www.onecpd.info/resources/documents/HomelessAssistanceActAmendedbyHEARTH.pdf. Last accessed 5/29/15.
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Continuum of Care (CoC)

In the past, a Continuum of Care (CoC) was considered generally a system for planning, coordinating, and delivering services to people in all stages of homelessness. These services include outreach and intake, emergency shelter, transitional housing, and permanent housing, with supportive services at all stages to allow homeless clients to meet their immediate needs and progress toward self-sufficiency.

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

1) By consciously providing services as a part of a continuum, rather than in isolation, homeless assistance providers ideally become knowledgeable about the full menu of services available to their clients, and may quickly and seamlessly make referrals to meet each client's unique needs. Operating as a coordinated continuum also helps providers to avoid duplication of efforts, identify unmet needs, and coordinate with mainstream social services.

2) Under the HEARTH Act, the 2009 bill that reauthorized and amended the McKinney-Vento Act, CoC is a single competitive grant program. Funds may be used for the following, if in accordance with the program regulations and notice of funding availability.
   a. Permanent Housing, including Permanent Supportive Housing (PSH) and Rapid Re-Housing (RRH). Eligible costs include acquisition, rehabilitation, new construction, leasing, rental assistance, operating costs, and supportive services. HUD strongly encourages PSH programs to be targeted to those who are chronically homeless. PSH is available to individuals with disabilities, and to families in which an adult

or child has a disability. RRH is available to individuals or families with or without disabilities, and provides short-term (up to 3 months) or medium-term (3 to 24 months) tenant-based rental assistance and supportive services.

b. Transitional Housing (TH). TH serves homeless households for up to 24 months. Eligible costs include acquisition, rehabilitation, new construction, leasing, rental assistance, operating costs, and supportive services.

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

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

e. Homeless Management Information Systems (HMISs).

HUD CoC funds may also be used to preserve existing permanent housing and support service facilities for which other funding sources are no longer available.

3) Starting in 1994, HUD began requiring agencies to organize themselves into geographically delineated Continuums of Care and submit joint applications for funding, in an effort to encourage planning and coordination of services. To form a Continuum of Care, agencies in a geographic area come together and choose the geographic boundary of the area they serve, the lead agency (known as a Collaborative Applicant in the HEARTH Act) to administer the planning and grant application process, and the stakeholders who should be included in the CoC. A CoC may be a state, city, county, or region, or the "balance of state" not included in local or regional CoCs. CoC service areas are not allowed to overlap.

4) In the past, the Continuum of Care framework for homeless assistance was assumed to be a linear model. The prevailing philosophy among homeless service providers was that clients had to progress through a set of steps to develop the skills needed to live independently. That approach is sometimes referred to as the "Housing Ready" model. Since the early 2000s, the "Housing First" model has replaced the Housing Ready model as the preferred strategy for homeless assistance. The Housing First model directs homeless persons to permanent housing as quickly as possible, without preconditions for sobriety or compliance with treatment or life skills training regimens. Because there is significant evidence to support the efficacy of the Housing First approach to end homelessness, HUD has endorsed Housing First as a best practice.

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Runaway and Homeless Youth Act (RHYA)

RHYA is a federal statute that authorizes funding for outreach, shelter, temporary housing, and supportive services for runaway and homeless youth. Originally passed as the "Runaway Youth Act" in 1974, the statute became the "Runaway and Homeless Youth Act" in 1977. RHYA funds are administered by the U.S. Department of Health and Human Services (HHS) and awarded as competitive grants to qualified public and nonprofit agencies. It is widely recognized that the approaches necessary to end youth homelessness are different from those that address adult homelessness; therefore, the funding and best practices are different from those in HUD programs.

The Runaway and Homeless Youth program administered by HHS includes three main grants, described below.

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

2) Transitional Living Program—Supports temporary housing (up to 21 months) for youth who are between ages 16 and 22 upon entry. Temporary housing arrangements include group homes, maternity homes for pregnant and parenting youth, host family homes, and supervised apartments owned by the program or rented in the community. Transitional living programs also include outreach, medical care, mental health counseling, guidance on education, employment, and life skills, and other activities.

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

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

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Rural Housing Stability Assistance Program (RHSP)

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

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

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

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

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

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

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

Small Communities Given Priority

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

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

3. Short-term emergency lodging in a hotel, motel, or existing emergency shelter. The initial time limit on assistance is 3 months, but assistance may be extended month-by-month if needed. RHSP funding under this activity cannot be used to supplant existing funding for an emergency shelter—it must be used to temporarily increase the shelter's capacity. RHSP communities are expected to use this activity only as a last resort.

4. New construction to develop permanent housing or transitional housing (TH) for people who are experiencing or at risk of homelessness. The applicant must demonstrate that the county lacks adequate units that could be rehabilitated to provide housing at lower cost than new construction.

5. Acquisition, rehabilitation, or leasing of structures to provide supportive services, TH, or permanent rental housing for people who are experiencing or at risk of homelessness.

6. Rental assistance for program participants living in permanent housing or TH, provided they are not already receiving rental assistance from another program. Assistance may be tenant-based or project-based, and may be short-term (up to 3 months), medium-term (3 to 24 months), or long-term (more than 24 months). It may also be used to pay a security deposit and first and last month's rent.

7. Operating costs for permanent housing and TH, provided the project is not already receiving RHSP funds for rental assistance or leasing.

8. Rehabilitation and repairs of severely substandard housing owned by an individual or family at or below 50% of area median income. This activity is available for homeowners in the "worst housing situations," meaning that the home has serious health and safety defects, and at least one major system (e.g. roofing, plumbing) is failing. If the homeowner moves away from the house less than 3 years after the repairs or rehabilitation are complete, he or she must repay the assistance.

9. Supportive services, such as case management, child care, and transportation.

10. Costs associated with acquiring and using federal surplus property, including preparing applications and bringing properties up to code.

11. Capacity building, including staff salaries, training, and travel. A county may use up to 20 percent of its RHSP award for capacity building activities.

12. Data collection costs, including the costs of developing and operating a Homeless Management Information System (HMIS).

13. Administration, up to 7.5% of the county's total RHSP grant.

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

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FLORIDA
POLICIES AND PROGRAMS

Challenge Grant

The Challenge Grant is a relatively flexible source of funding provided by the Florida Department of Children and Families (DCF) to continuum of care lead agencies for a variety of homeless assistance and prevention activities. The Challenge Grant, along with the Homeless Housing Assistance Grant, was created by 2001 legislation that instituted a comprehensive framework for homeless assistance planning and coordination.

Challenge grants may be used to fund housing and service activities in a local CoC's homeless assistance plan. The criteria for awarding grants include both the quality of services and amount of federal funding leveraged by a CoC, and the CoC's level of need for homeless housing and services. Currently, activities funded by Challenge Grants include, but are not limited to the following.

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

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

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

A bill passed by the state House of Representatives in 2014 revived the Challenge Grants, amended the criteria for awarding grants and allowed DCF to specify grant award levels in its solicitations for applications. The bill originally included provisions to transfer 4% of the Local Housing Trust Fund appropriation annually for homeless assistance; of this 4%, 95% was directed to DCF to support homeless service delivery in CoCs, and 5% would be used by DEO to hire a statewide technical assistance provider to work with the CoCs. However, in the 2014 General Appropriation Act signed by the Governor, the transfer of funds from the Local Housing Trust Fund was nonrecurring. At the date of publication of this guide, a 2015 state budget had not yet been sent to the Governor.

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Homeless Housing Assistance Grant

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

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

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

Sources:
- Council on Homelessness [FL]. 2010a. 2010 Report. http://www.dcf.state.fl.us/programs/homelessness/docs/2010CouncilReport.pdf. Last accessed 5/28/15.
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Homelessness Prevention Grant

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

Homelessness Prevention funds may be awarded to families with minor children—including 18-year olds who are in school or a career training program, and have never been married—that are below 200% of the federal poverty level and at risk of homelessness due to a documented financial or other crisis. Families are required to participate in case management, which includes a written plan identifying which costs will be paid by HP assistance and setting a timeline for payments. Eligible uses of funds include up to 4 months of past-due rent, mortgage, and utility payments per family, staff and operating costs for case management, and up to 3% of the lead agency's grant for administration. The lead agency may determine many of the details of participant selection and grant administration, including priorities for selecting families and the maximum award that a family may receive.

"Homelessness Prevention funds may be awarded to families with minor children—including 18-year olds who are in school or a career training program, and have never been married—that are below 200% of the federal poverty level and at risk of homelessness due to a documented financial or other crisis"

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Continuum of Care Staffing Grants

CoC Staffing Grants are funds appropriated by the Florida Legislature to help pay salaries for staff members of Continuum of Care lead agencies. The staffing grants were introduced in 2001, as part of the comprehensive legislation that established a homeless assistance planning framework and created the Challenge Grant and Homeless Housing Assistance Grant. The 2001 statute provided funds for CoC staff through a pre-existing "Grant-in-Aid" program, which was administered by DCF district offices and funded services similar to the Challenge Grant. (The statute for the Grant-in-Aid program still exists, but the program has not been funded since 2008.) The staffing grants were defunded for several years during the economic recession, except for a non-recurring appropriation in 2012. The 2013 General Appropriations Act restored recurring staffing grant funds in the amount of $2 million, and the 2014 General Appropriations Act provided an additional $1 million in non-recurring staffing grant funds.

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HOMELESS ASSISTANCE ACTIVITIES AND MODELS

Housing First (HF)

Housing First is a homeless assistance model centered around placing homeless individuals and families in permanent housing, quickly and without preconditions, and connecting them to the services they need to maintain housing stability and live as independently as possible. The underlying principle is that homelessness is physically and psychologically stressful, and homeless persons can more effectively address issues such as mental illness, addiction, and employment barriers once they are stably housed.

HUD and USICH describe Housing First as follows:

> Housing First is a whole-system orientation, and not a "program," that offers permanent, affordable housing as quickly as possible for individuals and families experiencing homelessness, and then provides the supportive services and connections to the community-based supports people need to keep their housing and avoid returning to homelessness. The approach begins with an immediate focus on helping individuals and families get housing. Income, sobriety and/or participation in treatment or other services are not required as a condition for getting housing. All services are voluntary and are not a condition for retaining housing. Housing provides people with a foundation from which they can pursue other goals. Tenants are assisted in developing or improving skills for independent living while they live in permanent housing instead of requiring them to complete a transitional residential program first.

Since the early 2000s, Housing First has gained popularity as an alternative to the "Housing Ready" model, which assumes that homeless persons must become ready for housing by overcoming addictions, mental illness, and other personal impediments to maintaining stable housing. Under the Housing Ready model, homeless persons are expected to move from emergency shelters to Transitional Housing (TH) programs, which often require residents to participate in treatment and other services, and then into permanent housing. Housing First proponents argue that many TH programs fail to retain high-need clients, and may exhibit "creaming", or selective admission of families with relatively few barriers. Although most households who complete TH programs (which last up to two years) find stable housing, Housing First proponents argue that rapid placement in permanent housing would achieve the same results more cheaply and humanely.

The term "Housing First" was likely coined by Beyond Shelter, a nonprofit organization in Los Angeles, CA, that provides services to poor and homeless families with children. Beyond Shelter's program, started in 1988, provides Rapid Re-Housing (RRH) services to homeless families utilizing a housing first approach.

The first program to use Housing First on a large scale with adults with chronic impairments was Pathways to Housing in New York City. Pathways was founded by Sam Tsemberis, a clinical psychologist and outreach worker who was frustrated with the frequent failure of the homeless assistance system to help people with mental illness. Eligible people experiencing homelessness are referred to Pathways by outreach teams and others, and Pathways maintains relationships with a network of private landlords who lease to its clients. To place a client in housing, Pathways signs a lease and subleases the unit to the client. Each participant is linked with a staff team of professionals in fields such as medicine, psychiatry, and vocational rehabilitation. Program participants are required to pay 30% of their income for rent. A number of Housing First programs around the country use the same basic model that Pathways pioneered, with some variations.

The spread in popularity of HF was driven by several lines of evidence. First, research on Pathways and other housing programs for those who are homeless suggest that housing subsidies play a central role in helping homeless persons achieve stable housing. Second, analyses of administrative records have revealed that most people who enter emergency shelters exit homelessness without formal assistance, and do not become homeless again within the study horizons. As a result, a disproportionate share of homeless assistance resources are consumed by the minority of people who are chronically or episodically homeless. Third, the costs of emergency and transitional shelters and crisis services may be largely offset by providing permanent housing and voluntary case management, and are likely to provide substantial savings. Fourth, HUD statistics show that 155,000 people were chronically homeless in 2006—a relatively manageable number, and one that was already dropping due to increased investment in permanent supportive housing (PSH). Fifth, an early Pathways study showed that HF did not increase clients' substance use, as some analysts had feared. Finally, formal surveys and anecdotal evidence showed that homeless people themselves prefer permanent housing to transitional housing.

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CASE STUDY

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

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

The agency's most famous development is 1811 Eastlake, which was developed by the Low Income Housing Institute and serves chronically homeless persons with severe alcoholism. The tenants, on average, have had 16 failed attempts at conventional substance abuse treatment. Residents are not required to participate in services, but they receive plenty of support from a tightly coordinated team of residential counselors, clinical support specialists, and community-based providers. Peer-reviewed studies of 1811 Eastlake have found that their average alcohol consumption decreases over time housed by as much as 50%. Three-fourths of residents stay in their units for at least a year, saving taxpayers about $30,000 per person per year in crisis services like jails and hospitals.

DESC differs from many successful Housing First providers in that it places clients primarily in large developments that it owns and manages. This approach has some drawbacks, such as limiting clients' housing choices. However, on-site staff quickly address problems as they arise, and tenants appreciate the quality, privacy, and independence of their apartments.

For more information:

- Downtown Emergency Service Center, http://www.desc.org/1811.html
- USICH Model Program: 1811 Eastlake, http://usich.gov/usich_resources/solutions/explore/1811_eastlake

Permanent Supportive Housing (PSH)

Permanent Supportive Housing (PSH) is an application of the Housing First model. PSH is typically rental housing with available support services for individuals and families with barriers to living independently, such as mental illness, substance abuse, and physical disability. Unlike TH, PSH is not time-limited and is intended to provide housing as long as the households needs and wants that housing. Synonyms for Permanent Supportive housing include "supported housing" and "service-enriched housing." Although PSH programs vary, the model has several core elements: 1) the client has the same rights as a renter in the private market; 2) to the extent possible, the housing assistance is tenant-based and units are integrated into the community, rather than clustered in project-based housing; 3) ongoing community-based support services such as case management, medical and mental health care, substance abuse treatment, and life skills training, are available; and 4) participation in services is not required to maintain tenancy. PSH is based on the principle that clients should have a choice in the type of housing and services they receive, and that service provision should be "based on mutual trust and respect, rather than on paternalism and coercion."[1] Additionally, the PSH model draws from empirical evidence that clients are more likely to maintain housing stability if they believe they have a choice in their living arrangements.

Permanent Supportive Housing arose in the 1980s as an alternative to institutional or residential treatment facilities for individuals with mental illness and other impairments. Since the late 1990s, numerous academic studies around the nation have demonstrated that PSH improves housing stability and reduces hospitalizations for homeless individuals with mental illness. The positive effect of PSH is most apparent in studies in which control group clients receive no specific housing intervention.

Most PSH programs and scholarly research focus on individuals, but the model is expanding to serve homeless families with high barriers to housing stability. A 2013 study[2] found that families in PSH at the beginning of the study were more likely to maintain housing stability over a 30-month follow-up period than those in emergency shelter or Transitional Housing (TH), although 36% of PSH families remained unstable. The authors suggested that PSH and other homeless assistance programs can improve outcomes and reduce costs by introducing "Trauma-Informed Care" (TIC), a service delivery model that considers the role of past trauma in a client's current struggles, and emphasizes engaging clients in ways that avoid triggering post-traumatic responses.

Since 1987, McKinney (-Vento) funds have been a major source of support for PSH operating expenses, contributing to 61% of the roughly 237,000 PSH beds reported in 2010. In 2008, the federal government revived another PSH funding source that had been previously underutilized: HUD's Section 811 Supportive Housing for Persons with Disabilities program. Section 811 has traditionally provided capital advances for the development of multifamily rental housing for very low-income people with disabilities, and was recently amended to provide Project Rental Assistance (PRA) funds through state agencies. The PRA may provide subsidies to extremely low-income disabled persons in new or existing rental housing.

McKinney-Vento funding is also a critical source for support services, especially in communities with few other resources. However, beginning in 1999, HUD established requirements and incentives for Continuums of Care (CoCs) to shift spending from supportive services toward housing. Medicaid is another critical source of support, but not all services are eligible for reimbursement, and not all people exiting homelessness qualify for it. Homeless assistance providers, advocates, and policy makers hope that the Affordable Care Act, and the Opening Doors plan's emphasis on coordinating with "mainstream" human service programs, will increase funding for PSH services.

"The authors suggested that PSH and other homeless assistance programs can improve outcomes and reduce costs by introducing "Trauma-Informed Care" (TIC), a service delivery model that considers the role of past trauma in a client's current struggles, and emphasizes engaging clients in ways that avoid triggering post-traumatic responses."

[1] Wong et al. 2007
[2] Hayes et al. 2013.

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Rapid Re-Housing (RRH)

Another application of the Housing First approach is Rapid Re-Housing (RRH). RRH is a strategy to help homeless households regain housing stability by helping them to secure permanent housing as quickly as possible. Unlike Permanent Supportive Housing (PSH), RRH assistance is temporary (usually lasting several months), is offered at the minimum level necessary to help a client achieve stable housing, and is targeted toward the issues that directly affect a client's ability to maintain stable housing. RRH is seen as an alternative to long shelter and transitional housing stays for homeless individuals and families who are capable of maintaining stable housing with few or no supportive services. For those with more significant barriers, RRH can provide temporary assistance while the client and his or her case manager develop a permanent support network. In many communities, RRH was pioneered with funding from the Homelessness Prevention and Rapid Re-Housing Program (HPRP), a one-time HUD program created in 2009 by the American Recovery and Reinvestment Act.

Well-designed Rapid Re-Housing programs make a distinction between a client's barriers to obtaining housing and maintaining it, and help clients overcome the first barrier before addressing the second. In other words, a permanent home serves as the platform upon which clients can successfully tackle the issues that might threaten their housing stability. The two main barriers to obtaining housing are financial barriers and tenant screening barriers. RRH programs help clients cover housing start-up costs, including moving expenses, security and utility deposits, and a limited amount of rental and utility costs. In addition, program staff help clients find landlords who will rent to tenants with low or no income, poor credit, past evictions, and/or criminal records. Successful RRH programs are proactive, with housing locators or housing specialists that conduct outreach to landlords and identify appropriate rental units in advance.

To help clients maintain housing stability once they have moved in, RRH program staff make routine follow-up visits to the tenant

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

Overcoming Barriers

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

for a limited period of time, and are available to mediate disputes with the landlord. RRH providers may encourage the tenant to obtain services that would indirectly improve his or her housing stability, such as mental health services or child enrichment activities, but the RRH assistance is not contingent on the client participating in these programs.

Rapid Re-Housing is an alternative to the housing ready models that have been employed in transitional housing (TH) since the 1980s. TH programs are based on the premise that clients need to learn skills for housing retention in a structured environment before living independently. RRH proponents note that most poor families do not become homeless, those who do become homeless usually exit shelters quickly without formal assistance, and those who spend the most time in shelters (including emergency and transitional shelters) are not necessarily the heaviest users of crisis-related social services. Moreover, several studies from the 1990s suggested that housing subsidies are a stronger determinant of housing stability than social services for families leaving shelters. Since annual shelter costs are higher than annual rental subsidies would be, and communities nationwide face a shortage of affordable housing, proponents argue that RRH is a more efficient use of homeless assistance funds than TH.

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

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CASE STUDY

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

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

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

The capstone of the Learning Collaborative was a 100-day challenge to providers to house as many families as possible. Participating agencies housed a total of 545 families, a 52% increase in their average housing placement rate. And the competition brought out true innovation, like the "Home for the Holidays" Christmas campaign in Fredericksburg. Instead of their usual "Adopt-a-Family" campaign to give presents to children in emergency shelters, local nonprofits collected donations to help families pay the first month's rent, security and utility deposits needed to get back into housing.

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

For more information:

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

Homelessness Prevention and Rapid Re-Housing Program (HPRP)

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

HPRP funds were awarded to 535 state and local governments, using the same formula by which Emergency Shelter Grant (ESG) funds are allocated. (In 2009, the HEARTH Act renamed ESG as the "Emergency Solutions Grant.") Most grantees conducted both homelessness prevention and rapid re-housing programs, but the majority of funds were spent on homelessness prevention. For both programs, the two main activity categories were "financial assistance" and "housing relocation and stabilization services." Financial assistance could be short-term (up to 3 months) or medium-term (up to 18 months), and included rental and utility assistance, security and utility deposits, moving costs, and hotel or motel vouchers. Housing relocation/stabilization services included case management, outreach, housing search and placement, legal services, and credit repair, and could last up to 18 months. The most common forms of assistance were rental assistance and case management.

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

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

Achieving Success

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

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CASE STUDY

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

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

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

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

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

For more information:

- National Alliance to End Homelessness: Community Snapshot of Memphis-Shelby County
  http://www.endhomelessness.org/library/entry/community-snapshot-of-memphis-shelby-county

Transitional Housing (TH)

Transitional Housing (TH) provides time-limited housing to homeless persons, coupled with services intended to help them develop the stability and skills needed to maintain permanent housing. Although TH programs vary considerably in housing type, populations served, services offered, and requirements for service participation, they generally offer "smaller facilities, more privacy, and more intensive services with greater expectations for participation"[3] than emergency shelters. As part of the traditional "housing ready" model of homeless assistance, participation in a TH program is often the primary path for homeless persons to obtain housing relocation assistance and associated services, and often includes sobriety and service participation requirements. In the early 2000s, the Housing First (HF) model emerged as a challenge to the TH model. Housing First proponents argue that providers can help homeless persons achieve housing stability more effectively and cheaply by helping them move quickly into permanent housing and providing client-driven support services, without requiring sobriety or service participation.

When the McKinney Homeless Assistance Act was passed in 1987 (renamed the McKinney-Vento Act in 2000), it included a Supportive Housing Program to provide funding for both Transitional Housing and Permanent Supportive Housing (PSH) projects. The growth of TH was also fueled by HUD's introduction of the CoC process for awarding McKinney funds, which allowed suburban and rural communities to compete successfully for funding. Compared to major urban areas, homelessness in these smaller communities was characterized less by single adults than by families, who were less likely to need or be eligible for PSH (which required that the head of household be disabled). Additionally, many homeless assistance providers favored TH because they lacked housing development capacity and found that nonprofit housing providers and public housing authorities were often reluctant to target homeless persons. In 1999, to shift the emphasis of its competitive homeless assistance grants back toward providing permanent housing, Congress began requiring HUD to spend at least 30% of its McKinney funding on permanent housing. Even with this set-aside, the number of TH programs continued to grow through the 2000s. By 2004, the U.S. had over 220,000 TH beds.

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

Although HUD, state and local governments, and service providers have amassed considerable experience with TH programs,

"Although Transitional Housing programs vary considerably in housing type, populations served, services offered, and requirements for service participation, they generally offer 'smaller facilities, more privacy, and more intensive services with greater expectations for participation' than emergency shelters."

there are few formal studies on TH. The studies that do exist report program retention rates ranging from 13% in a program targeting individuals with co-occurring mental health and substance abuse issues,[4] to 77% in a study of 53 family TH programs.[5] Attrition (participants withdrawing voluntarily or being asked to leave) is especially prevalent in programs targeting mentally ill individuals. Among individuals and families that successfully complete TH programs, 70%[6] to 88%[7] attain stable housing. Additionally, many participants express satisfaction with the programs and experience improved income and employment levels. For example, a study comparing demonstration TH housing for AFDC-eligible families to the alternatives (i.e. in emergency shelters and hotels) found higher rates of housing stability, program satisfaction, and other outcomes among the TH participants.[8]

However, several studies cast doubt on the TH model's underlying assumptions. For mentally ill individuals, although program completion has been linked to improvements in housing stability, psychiatric symptoms, and employment, participants do not necessarily improve in all these areas simultaneously. For this population, evidence has mounted in the p st decade that Housing First is more effective at achieving housing stability. For families, meanwhile, a follow-up to the study of 53 TH programs found that program restrictiveness had virtually no effect on graduates' outcomes (including housing stability, employment and education, and the emotional health of mothers and children); and mothers' personal characteristics (including employment and tenure history, mental illness, substance abuse, and encounters with domestic violence or the justice system) seldom had consistent effects on all the outcomes measured. Further, the costs of TH are much higher than housing first rapid re-housing programs.

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

[3] Barrow and Zimmer 1999.
[4] Rahav et al. 1997, in Barrow and Zimmer 1999.
[5] Burt 2006.
[6] Matulef et al. 1995, in Barrow and Zimmer 1999.
[7] Rog et al. 1995, in Barrow and Zimmer 1999.
[8] Roman and Zhu 1996 and Nathan et al. 1995, in Barrow and Zimmer. "AFDC" is "Aid to Families with Dependent Children," which became "Temporary Assistance for Needy Families" (TANF) in 1996.

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CASE STUDY

COMMUNITY CONNECTIONS JACKSONVILLE REPURPOSES TRANSITIONAL HOUSING

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

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

In 2013 and 2014, CCJ began phasing out two of their three transitional housing programs. New clients with relatively low barriers were admitted and clearly informed that the programs would be closing soon. Clients with greater needs were referred to programs that could serve them better. CCJ expects to receive Rapid Re-Housing funds in late autumn 2014. As Housing and Supportive Service Director Will Evans says, "We got tired of managing homelessness and decided to end it. As I tell my staff, 'Our business is to put ourselves out of business.'"

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

For more information:

- Presentation from the National Alliance to End Homelessness 2014 National Family and Youth Conference http://b.3cdn.net/naeh/f3b6b54fd5822f1ae9_40m6bcg71.pdf

Coordinated Entry (CE)

Coordinated Entry, sometimes referred to as coordinated intake and assessment, is a system for matching presenting clients with the most appropriate housing intervention for that client, and prioritizing those with the greatest need. HUD requires that Continuums of Care (CoCs) implement the practice, and that all homeless assistance providers receiving Emergency Solutions Grant (ESG) and CoC Program funds participate in the system. CE works best when all homeless assistance programs participate. In CE, the intake worker immediately refers the client to the most appropriate program for his or her immediate needs after only one assessment. As the client progresses to different stages of the homeless assistance system, the assessments become increasingly more comprehensive, an approach known as "progressive engagement."

The entry point to the homeless assistance system may be centralized or decentralized, and may use physical or virtual intake centers. In one central intake model, a client enters the system at one physical location, although there may be different intake facilities for different subpopulations (e.g. individuals and families). This model is most likely to succeed in small communities or those with efficient public transportation. Alternatively, a CE system may use a telephone hotline, such as 2-1-1. Decentralized models include multiple intake centers throughout the community, and a "no wrong door" approach in which every provider is able to conduct intake and assessment. CE is typically facilitated through the CoC's HMIS, whether there is a centralized or decentralized.

HUD advises that the assessment questions at the entry point should be relatively simple, rather than "a full psychosocial evaluation."[9] The intake worker will generally refer the already housed or lowest-need clients to homelessness prevention or shelter diversion programs. If emergency shelter is necessary, the shelter will help the clients minimize their stay by assessing them for Rapid Re-Housing (RRH) eligibility. Clients who do not qualify for RRH are further assessed for more intensive alternatives, such as Permanent Supportive Housing (PSH), substance abuse treatment, or Transitional Housing (TH). This pattern of assessments that become increasingly detailed depending on the client's level of need, known as "progressive engagement," spares lower-need clients the burden of lengthy assessments. Additionally, because clients referred to providers have already been assessed using standards agreed upon by all providers in the community, individual programs can accept clients quickly without spending excessive staff time and money on their own assessments.

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CASE STUDY

MONTGOMERY COUNTY, OH, USES "FRONT DOOR ASSESSMENT" TO MATCH THE RIGHT PEOPLE TO THE RIGHT PROGRAMS

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

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

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

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

For more information:

- USICH Model Program: Front Door Assessment
  http://usich.gov/usich_resources/solutions/explore/front_door_assessment
- Montgomery County, OH Homeless Solutions Plan
  http://www.mcohio.org/services/fcfc/homeless_solutions.html

Homeless Management Information System (HMIS)

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

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

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

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

Going forward, HMIS will also be used by CoCs to generate and report to HUD certain "System Performance Measures." HUD, HMIS software providers, and CoCs have begun to work to implement the newly required performance measures. The new system-wide measures operationalize, among other things: length of time people remain homeless in the CoC, employment and income growth of people who are homeless, the number of first-time homeless, and successful placement into and retention in permanent housing.

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Point-in-Time (PIT) Count

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

In most cases, CoCs are required to conduct their Point-in-Time count on a single night between January 22nd and 31.st HUD chose this timeframe because homeless people are more likely to use shelters in the winter, and thus are easier to count. Public concern about homelessness also tends to be greatest in the winter, and PIT counts can raise awareness and increase political will to improve the homeless assistance system. By requiring that most CoCs conduct their PIT counts at roughly the same time, HUD allows PIT data from different communities to be compared more easily, and minimizes the chance that multiple CoCs will count people who are migrating from one community to another.

HUD began requiring CoCs to conduct Point-in-Time counts in 2003. Before then, some CoCs conducted their own local homeless

counts using a variety of methods, while others estimated their homeless populations by extrapolating data from other communities. In 2004, HUD refined its Point-in-Time requirements, stipulating that communities only report unsheltered homeless people that they had actually counted, or extrapolated using statistically reliable methods.

For both its sheltered and unsheltered homeless populations, a CoC is required to collect both "population" and "subpopulation" data. CoCs must count both the number of individuals and the number of households in each of three population categories:[10]

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

CoCs must also count the number of people in different age group, gender, ethnicity, and race categories specified by HUD. Further, CoCs are required to report separate population data for veteran households.

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

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

HUD provides a Metholodogy Guide, which includes an overview of the PIT Count process and specific guidance for the sheltered and unsheltered components of the Count.

For each PIT count component, a CoC may use a combination of methods that best reflects its unique local circumstances. The methods for unsheltered counts are more complex, due to the inherent difficulties in locating, characterizing, and avoiding double-counting of people who are not staying in shelters. By contrast, sheltered counts can be greatly simplified by a community's Homeless Management Information System (HMIS), if the providers of a majority of shelter beds participate in HMIS (i.e. the "bed coverage" rate is high) and the data quality is good. Both the sheltered and unsheltered count have two main elements: a "basic count" of all homeless individuals encountered on the night of the count; and collection of population and subpopulation data for all, or a statistically representative sample, of those counted.[11] Population and subpopulation data may come from interviews of sheltered and unsheltered homeless persons using a standard survey instrument or, for sheltered homeless persons, HMIS data or individual client surveys filled out by shelter providers.

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

[10] An unaccompanied homeless person counts as a household.

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

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HOMELESS SUBPOPULATIONS

Chronic Homelessness

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

1) Is literally homeless (i.e. living in a place not meant for human habitation, an emergency shelter, or a safe haven);

2) Has been homeless for at least 1 year, or on at least 4 separate occasions (≥15 days each) in the past 3 years; and

3) Has a head of household with a disability, which may include mental illness, a substance abuse disorder, a physical disability, etc.

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

In 2014, 99,434 people, or about 17% of the total homeless population, were chronically homeless. About 2/3 of those who were

chronically homeless were living in unsheltered areas (e.g., streets, woods). The average chronically homeless person resembles the "Skid Row" image that comes to mind when many people think of homelessness—he is male, between the ages of 35 and 54, unsheltered, and likely to suffer from multiple disabilities, such as co-occurring mental illness and substance abuse. Outreach workers engage these individuals by making persistent contact and gradually building a rapport. Research shows that Housing First (HF) model is best for promoting housing stability and reducing use of crisis services among those who are chronically homeless.

Research in the late 1990s and early 2000s showed that the chronically homeless account for a disproportionate number of days spent by clients in homeless shelters, and cycle through costly public crisis systems, such as jails, emergency rooms, and mental health treatment facilities. Since then, a combination of federal incentives, national initiatives, and local efforts has contributed to a 30% decline in the population of chronically homeless individuals between 2007 and 2014.

"IN 2014, 99,434 PEOPLE, OR ABOUT 17% OF THE TOTAL HOMELESS POPULATION, WERE CHRONICALLY HOMELESS. ABOUT 2/3 OF THOSE WHO WERE CHRONICALLY HOMELESS WERE LIVING IN UNSHELTERED AREAS (E.G., STREETS, WOODS). THE AVERAGE CHRONICALLY HOMELESS PERSON RESEMBLES THE "SKID ROW" IMAGE THAT COMES TO MIND WHEN MANY PEOPLE THINK OF HOMELESSNESS."

Why Aren't They Seeking Services?

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

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CASE STUDY

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

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

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

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

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

For more information:

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

HUD-VASH

The Department of Housing and Urban Development and Veterans Affairs Supportive Housing (HUD-VASH) program is a collaboration between HUD and the VA to provide housing vouchers with "wraparound" support services for the most vulnerable homeless veterans. HUD-VASH was created in 1992, and provided vouchers and case management for about 1,700 veterans with severe mental health or substance abuse problems. Although veterans were required to agree to a treatment plan prior to program admission, treatment participation was not required for voucher retention. In 2008, the federal government revived HUD-VASH, and has provided new funding for the program every year since then. Since 2008, over 58,000 vouchers have been awarded. HUD-VASH plays an important role in meeting the national goal of ending veteran homelessness by 2015, set forth in the 2010 Opening Doors plan.

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

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

Although HUD-VASH has always been a low-demand program, HUD and the VA have explicitly adopted a Housing First approach for the program. To ensure that the neediest veterans are helped and maximum public savings achieved, priority is given to the chronically homeless, as well as women, families with dependents, the disabled, and veterans of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF). HUD-VASH likely plays a role in the 33% decline in veteran homelessness between 2009 and 2014, but room for improvement remains. A recent VA-sponsored study found that HUD-VASH participants who receive Rapid Re-Housing (RRH) assistance, using an inventory of pre-inspected apartments, are more likely to find permanent housing and maintain it for 12 months than those who search for housing on the open market after receiving a voucher.

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Supportive Services for Veteran Families (SSVF)

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

SSVF is available to very low-income (≤50% of area median income) veteran families that are "occupying permanent housing," a partly counterintuitive term that includes three separate categories. Category 1 includes families who are currently residing in permanent housing, but will imminently become homeless if they do not receive homelessness prevention assistance. Category 2 includes families who are homeless and are scheduled to enter permanent housing in the next 90 days, but will lose this hous-

ing and become homeless without Rapid Re-Housing (RRH) assistance. Category 3 families have exited permanent housing to search for housing that is more responsive to the family's needs and preferences, and are likely to remain homeless without RRH assistance. Although the official wording of Category 2 implies that it can only be used for homeless veterans who arranged to enter permanent housing before applying for SSVF, in practice this is not the case. Category 2 applies to veterans who exited permanent housing more than 90 days ago, and who would not have access to permanent housing but for this program.

SSVF grantees may use funds for outreach, case management, and assisting clients in obtaining benefits from the VA and other mainstream agencies. If necessary, grantees may provide clients with time-limited financial assistance for housing stabilization expenses, including current rent and arrears, security and utility deposits, moving expenses, transportation, and child care. Although SSVF does not explicitly provide recurring rental subsidies to clients once they are current on their rent, as HPRP did, its use in practice is similar. (For example, if a veteran receives assistance with his/her current rent and one month of arrears, s/he can receive assistance with up to three more months of rent in a 12-month period if s/he cannot pay it otherwise.) Each SSVF Notice of Funding Availability (NOFA) issued thus far has required that grantees limit their funding to families who would become or remain homeless "but for" SSVF. Additionally, the NOFAs have prioritized specific populations, such as households that are extremely low-income (≤30% area median income), have at least one dependent, have a veteran who served in Iraq or Afghanistan and/or is female, or live in rural or tribal areas.

In Fiscal Years 2012 and 2013, the first two years of the program, nearly 100,000 veterans and their family members received assistance. Of those participants who have exited the program, 86% and 84% exited to permanent housing in the first and second years, respectively. Permanent housing exit rates were higher for families with children, which were more likely to receive homelessness prevention assistance.

SSVF has grown considerably since it was first implemented. In FY 2012, about $60 million was awarded to 85 grantees. By FY 2014, this amount had increased to nearly $300 million awarded to 301 grantees. An additional "surge" of $300 million in non-recurring funds was made available in early 2014 to 76 high-priority Continuums of Care. Further, on 5/9/14, the VA issued a proposed rule to replace the current SSVF rule. The new rule, which was finalized in 2015, extended the time limits for certain benefits, including rental assistance.

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

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Grant and Per Diem (GPD) Program

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

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

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Youth Homelessness

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

Over the course of a year, an estimated 500,000 to 1.7 million youth become homeless for at least one night. The 2014 Point-in-Time (PIT) counts identified 45,205 unaccompanied homeless youth, in addition to 149,097 children who were part of a homeless family, but this is believed to be an undercount for a variety of reasons. For example, homeless youth tend to frequent different locations than the older homeless individuals captured in PIT counts, and are less likely to admit that they are homeless. In 2012, the United States Interagency Council on Homelessness (USICH) launched the Youth Count! initiative, in partnership with other federal agencies, to develop and test new Point-in-Time count methodologies for youth in nine participating communities.

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

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

The Education for Homeless Children and Youth program ap-

plies to all children and youth, whether or not they are staying with a parent or guardian. By contrast, the programs authorized by the Runaway and Homeless Youth Act (RHYA) largely target unaccompanied youth. The U.S. Department of Health and Human Services (HHS) administers funds that support outreach, shelter and supportive service facilities, and transitional living programs for unaccompanied homeless youth.

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

The Framework provides a road map for disseminating screening and assessment tools that identify "risk factors" and "protective factors" among homeless and at-risk youth, and service providers are advised to use Trauma-Informed Care and Positive Youth Development approaches. Trauma-informed care, as discussed above and in the Permanent Supportive Housing and Rapid Re-Housing sections, sensitizes service providers to the role that trauma plays in a youth's thought and decision-making processes. Service providers are also trained to avoid communication styles that trigger post-traumatic responses. While Trauma-Informed Care helps youth to heal from past trauma, the Positive Youth Development approach helps youth identify personal strengths, form relationships, and find opportunities to contribute to society.

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

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CASE STUDY

EMMAUS PLACE IN MIAMI

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

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

The Act also provides a safety net for foster youth who may be unable or unwilling to enroll in school, and thus would be ineligible for programs such as Emmaus Place. In general, youths are eligible for continued foster care up to age 21 (or 22 for those with disabilities) if they are in school, employed, or enrolled in a program designed to eliminate barriers to employment. However, exceptions are made for young adults with documented physical, intellectual, emotional, or psychiatric impairments.

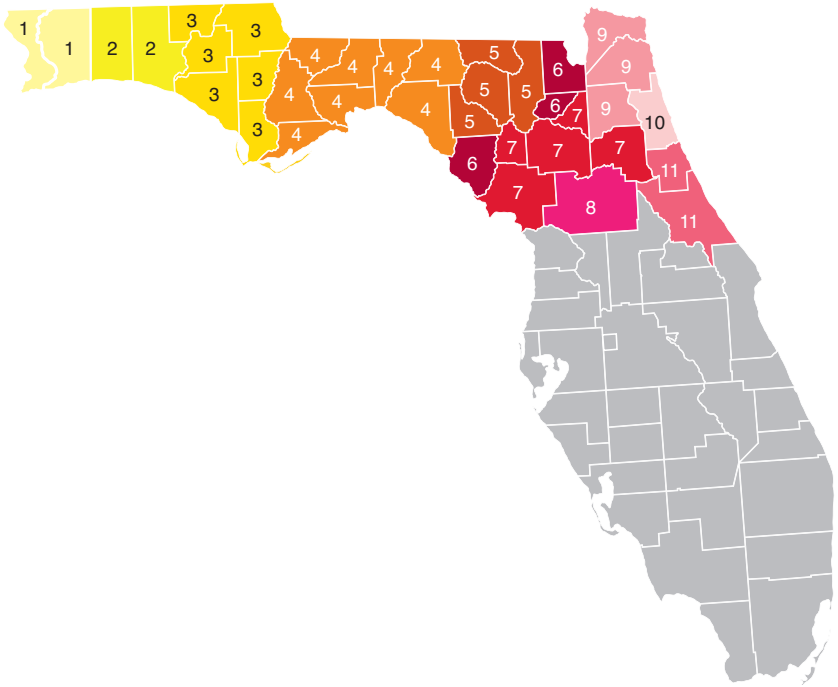
For more information:

- Camillus House
  http://www.camillus.org/main/emmaus-place/#.VBSfSBYXPk8
- Casa Valentina
  http://www.casavalentina.org/portal/our-program#.VBSZNxYXPk8
- Florida Housing Coalition: Senator Detert is Successful Champion for Youth Aging Out of Foster Care
  http://www.flhousing.org/wp-content/uploads/2013/06/Senator-Detert-is-Successful-Champion-Vol-29-No-2-June13-11.pdf

CONTINUUMS OF CARE IN FLORIDA

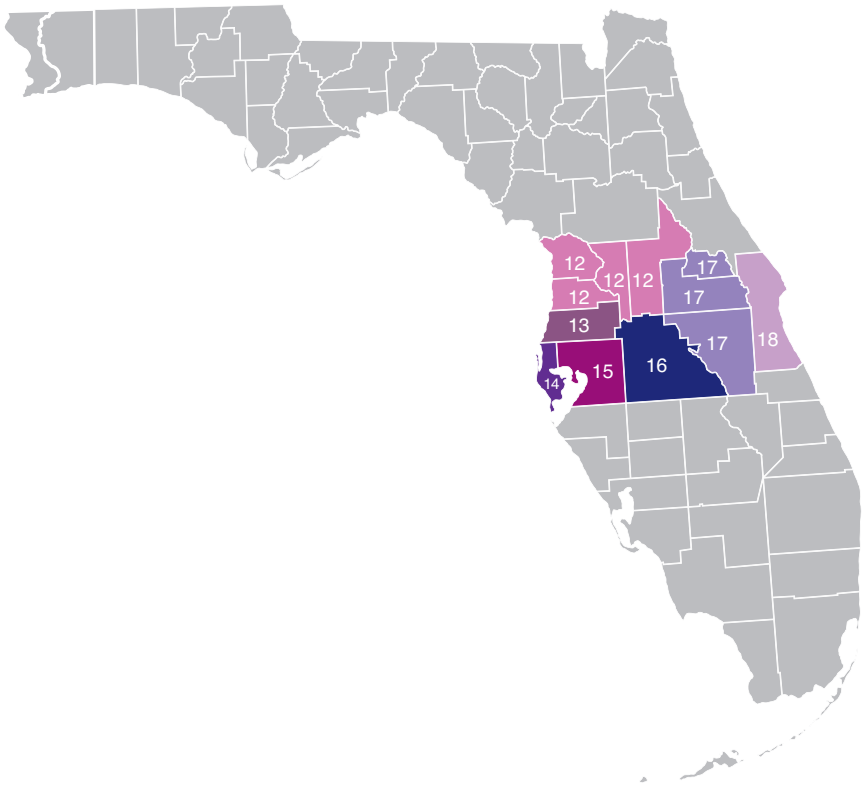
CONTINUUMS OF CARE IN NORTH FLORIDA

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



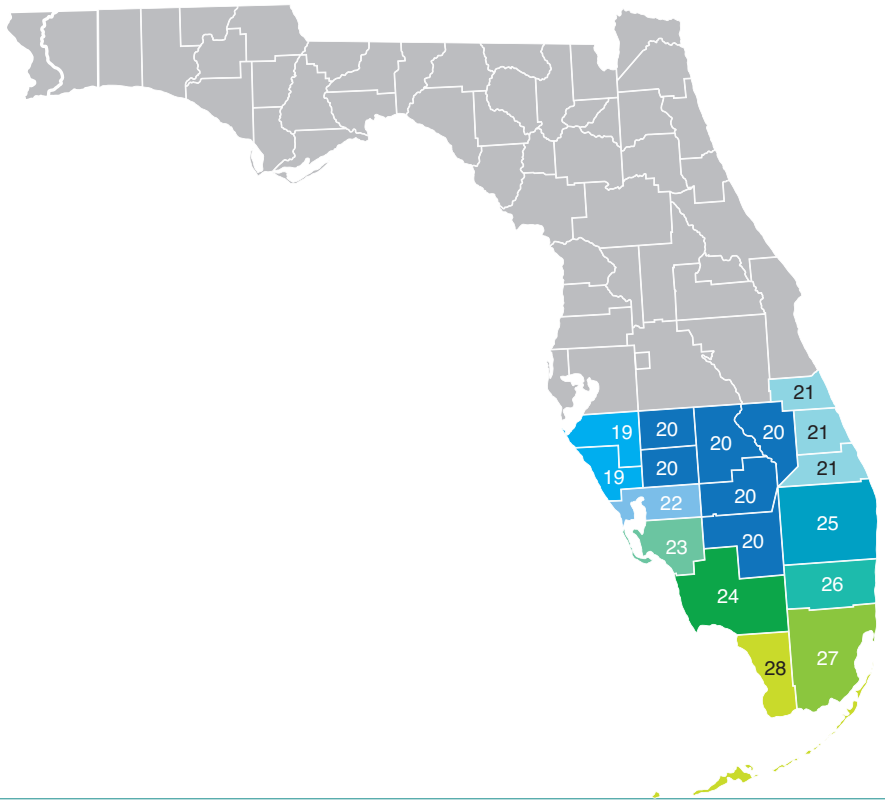
CONTINUUMS OF CARE IN CENTRAL FLORIDA

	AGENCY	COUNTIES SERVED
12	Mid-Florida Homeless Coalition http://www.midfloridahomeless.org/	Citrus, Hernando, Lake, Sumter
13	Coalition for the Homeless of Pasco County http://www.pascohomelesscoalition.org/	Pasco
14	Pinellas County Homeless Leadership Board http://www2.pinellashomeless.org/	Pinellas
15	Tampa Hillsborough Homeless Initiative www.thhi.org	Hillsborough
16	Homeless Coalition of Polk County http://www.polkhomeless.org/	Polk
17	Homeless Services Network of Central Florida http://www.hsncfl.org/	Orange, Osceola, Seminole
18	Brevard County Housing and Human Services Department http://www.brevardcounty.us/HumanServices/CommunityResources/CareCoalition	Brevard



CONTINUUMS OF CARE IN SOUTH FLORIDA

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



appendix

GENERAL INFORMATION AND REFERENCE FOR HOMELESS ASSISTANCE

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

MAJOR FEDERAL HOMELESS ASSISTANCE PROGRAMS

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

Emergency Solutions Grant (ESG)	https://www.onecpd.info/esg/
Continuum of Care (CoC)	https://www.onecpd.info/esg/
Homeless Management Information System (HMIS)	https://www.hudexchange.info/hmis/
HUD Homeless Assistance Programs Overview	https://www.hudexchange.info/homelessness-assistance/
Rural Housing Stability Assistance Program (RHSP)	https://www.onecpd.info/rhsp/

U.S. DEPARTMENT OF VETERANS AFFAIRS (VA)

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

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

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

PROGRAMS FOR RUNAWAY AND HOMELESS YOUTH

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

FLORIDA PROGRAMS FOR PEOPLE EXPERIENCING HOMELESSNESS

Florida Housing Coalition: Technical Assistance and Training for Florida CoCs	http://www.flhousing.org/
Office on Homelessness, Department of Children & Families	http://www.myflfamilies.com/service-programs/homelessness

ACCESSING MAINSTREAM BENEFITS

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

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

flhousing.org
Tallahassee: 850.878.4219

The Florida Department of Economic Opportunity assists the Governor in advancing Florida's economy by championing the state's economic development vision and by administering state and federal programs and initiatives to help visitors, citizens, businesses, and communities.

floridajobs.org
Tallahassee: 850.245.7105

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