GLHRN CoC Grant Application

(One project per application)

FUNDING__2018 HUD NOFA
CoC Program interim rule at 24 CFR 578

GRANT PERIOD_____2019-20__

Application due to matt.stevenson@lansingmi.gov by 12 noon Friday, August 17, 2018

Application organization must have tax-exempt status under 501(c)(3) of the IRS

Date of Application: ___8/16/2018_____

PART I: Program Information

Renewal ○ **Reallocation Project** ○ **Non-DV Bonus Project** ● **DV Bonus Project** ○

Consolidation ○ **Transition** ○ **Expansion** ●

Organization: ___Advent House Ministries, Inc._____

Contact Person: _Susan Cancro_____ Title: __Executive Driector_____

Telephone: __517-485-4722_____ Email: _secancro@adventhouse.com___

Project Grant Name: _Fresh Start Expansion + Bonus_ Minimum # Units (see table):___12__

Renewal only: Previous Year Award Amount: $_____Amount Requesting: $145,655.00_

Circle the Program Component for Which You Are Requesting Funds:

*Permanent Supportive Housing * Transitional Housing * Rapid Rehousing * Joint TH-RRH
* DV-RRH * DV-Joint TH-RRH * DV-Coordinated Entry * HMIS * Coordinated Entry

A. Are other funds leveraged with the requested funds?

Yes: __X_ No: ___ If yes, please identify the amounts and source for all leveraged funds.

Amount $ 13201___Source: AHM admin and supportive svcs. costs and value of other partner svcs.

Amount$ 5400 ___Source: _Advent House Ministries cost of utilities for office/meeting space_

Amount $ 17813___Source: _ Northwestminster donated use of office/meeting space

B. This grant requires a 25% cash or in-kind match. Please describe in detail:

a) type (cash or in-kind); b) Source of match; c) Amount, and how it will be documented.

C. Does/Will the agency follow the Orders of Priority as defined in CPD-16-11 (See Exhibit A of this application)? Yes: _X_ No: ___

D. How many households will be housed during the funding year? _12__

Part II: Narrative

Please be concise. Use bullets where possible.

1. Describe the **target population** for the Project. Specifically identify who the project will serve. i.e. individuals; families; chronic; Special populations. What is the **average acuity** level?

   If the Project has admission preferences for different sub-populations, please explain.

   The Fresh Start Rapid Re-housing (RRH) Program targets clients who fall between a VI-SPDAT score range of 4-7 for individuals, and 4-8 for families. Although a higher SPDAT score can indicate a necessity for enrollment into a PSH program, AHM understands that research suggests anyone can benefit from RRH. AHM works in cooperation with the CEA to ensure that Housing First options are available to any household that meets the minimum HUD regulated eligibility criteria for RRH and may include households that meet the criteria for PSH when PSH units are not available.

   AHM Fresh Start Program will prioritize special populations, including victims of domestic violence, young adult heads of household, and veterans.

2. Provide examples of how the **Project outcomes** will contribute to improving the CoC's system-wide performance, as measured by HUD's system performance measures below:

- Reducing the length of time people are homeless:
  - RRH operates with the understanding that housing is the solution to homelessness, and thus is designed to be a quick intervention for clients to become housed within 30 days or less. By utilizing a housing first approach, we reduce the wait time for housing by first prioritizing housing placement before working to address the factors that originally led to their homelessness.
  - After a referral from the CEA, clients are contacted and met with to develop their unique and individual housing plan. Everyone is supplied with landlord resources and active assistance in locating viable permanent housing, as well as an assessment of other housing-related needs to facilitate effective reduction of time in shelter or on the street.
  - AHM works to identify every client's potential tenant screening barriers and housing retention barriers. This information is added to a service plan that is developed to assist in the housing process.
  - Advent House represents Ingham County in the tri-county PATH outreach initiative. This puts us on the front line of addressing street homelessness and assists us with working side by side w/ the CEA, which is beneficial in accessing housing services including our and other PSH programs.
- Increasing discharges to permanent housing:
  - The progressive case management and assistance that every client receives employs client-centered and strength-based approaches. The ultimate end goal for each client is achieving housing stability through their unique and individualized service plans. This results in a successful discharge to PH.
  - Prior to discharging, case managers and clients work together to make connections for a warm handoff to mainstream community resources. This assists the client throughout their temporary enrollment in the RRH program in ensuring a successful transition to PH.
  - Advent House programs work closely with CoC partners to ensure clients have access to all possible permanent voucher options, including project based subsidies and HCV opportunities offered through area HCV administrators.
- Preventing returns to homelessness (reducing recidivism):
  - Through an intensive step-down approach to the progressive case management all clients receive, clients can self-identify and build upon strengths to address barriers to stable housing. By setting and achieving goals, clients learn how to better advocate for themselves and sustain their housing.

- Increasing client income:
    - All clients participate in creating a service plan to help guide the progressive case management that they receive. Financial stability is a key factor in that service plan to ensure they can meet their permanent housing needs once the limited program funded financial assistance is done.
    - AHM understands that in a RRH program referrals to employment or income building resources are essential. In addition to familiarity with local employment resources, AHM has experience from past and current programs with successful employment resource utilization. If employment is not an option, referrals to a SOAR specialist, Disability Appeals Advocates, or the VOA Ability Law Clinic may be appropriate.

3. Using Exhibit B-Describe the Project's implementation of the **Housing First** approach. Include 1) eligibility criteria; 2) process for accepting new clients; 3) process and criteria for exiting clients as it pertains to substance use, income, criminal records (with exceptions for restrictions imposed by federal, state, or local law or ordinance), marital status, familial status, actual or perceived sexual orientation, gender identity. Include descriptions of program policies and procedures to address situations that may lead to termination. How will the project assist clients in finding decent housing?

    1) Eligibility Criteria:

    Eligibility will be solely determined by what is defined as appropriate under minimum HUD guidelines for RRH enrollment. Clients will not have preconditions or barriers to entry based on things like sobriety, criminal history, or service participation requirements.

    2) Process for Accepting New Clients:

    After receiving a referral from the CEA, the program supervisor will review to ensure the client/household meets the minimum eligibility criteria. As soon as eligibility is confirmed, a case manager reaches out to the client to set up the initial meeting to enroll and develop their housing plan.

    3) Process and Criteria for Exiting Clients:

    In RRH, exit planning begins at entry. The client and case manager work together to create an exit plan that moves toward housing stability and is reviewed continuously throughout enrollment. In the event of a compliance concern, case managers will make every effort possible to address the matter with a focus on promoting stability skill-building and avoiding program discharge..

4. Explain how the **needs assessment** process ensures that participants are directed to appropriate services. How are participants connected to **mainstream resources**? Are there **MOUs or letters of commitment**? (These must be dated between May 1, 2018 and September 18, 2018.) Include collaborations with other programs or agencies. For renewals, how successful have these collaborations been?

(See Mainstream Resources definition in glossary)

Advent House works together with CEA staff to ensure all RRH referrals meet the minimum program eligibility criteria. Attention is paid to the SPDAT score of the referral which has a likely correlation between vulnerability and need. Typically an appropriate RRH referral would fall between the SPDAT scores of 4-7 for individuals, and 4-8 for families, but an understanding that anyone could benefit from RRH will allow for the referral of other qualified households..

Once enrolled clients can receive the following services: (1) an individualized housing identification plan, (2) financial assistance for rent and move-in costs, and (3) linking/referrals to appropriate community supports to stay housed.

Advent House regularly collaborates with the following: the Department of Health and Human Services, the Financial Empowerment Center, family and parenting resources, the Volunteers of America Medical and Dental Clinics, Community Mental Health, Mid-Michigan Recovery Services, Michigan Rehabilitation Services, Sparrow Health Systems, Child & Family Charities, local Veterans Affairs resources, local Domestic Violence resources, as well as other area resources. These partnerships have been vital to the success of our program participants.

5. How will clients be assisted in maximizing their ability to live independently? What **criteria** are used to evaluate participants' readiness to "graduate" or **transition** from the project to other permanent housing?

An important part of successful progressive case management is the individualized evaluation of which skills and tools are necessary for long-term housing stability. Whether it is learning housekeeping tips, receiving budgeting assistance, or addressing mental health concerns, Advent House Ministries utilizes harm reduction and trauma-informed-care models to best assist clients.

Advent House Ministries creates a service plan for all program participants, with the end goal being a discharge to PH. Case managers continually review progress, and keep the exit date flexible to support movement towards stability.

6. CoC policies require that participants be **referred from the Coordinated Entry Agency** (CEA). What is your estimate of the % of referrals you accept from the CEA? Please explain how you track/verify this information.

The RRH Fresh Start Program receives 100% of its referrals from the CEA. In the coming grant year Fresh Start will continue our collaboration with the CEA and area agencies, as described above, to ensure that we are reaching out to the most at-risk among those who are in shelter. This program will remain in regular contact with Coordinated Entry Agency staff both by phone and email for individual client needs; Coordinated Entry Agency staff is on-site at Advent House Ministries, Inc. on a weekly basis, as Advent House Ministries is a contact location for Coordinated Entry Agency in the community at large.

7. How will the project **engage those with the most severe needs or vulnerabilities, disabilities or limited English proficiency** per the GLHRN CoC/HUD prioritization policy? Describe any Outreach efforts. Reaching participants throughout the County that may not otherwise have known of the Project?

At present eligible clients are referred to AHM RRH entry by the CEA. Anyone who meets the minimum HUD RRH program criteria is eligible, and AHM is committed to serving those most vulnerable in our community. Occasionally staff will receive a call or a walk-in self-referral. Staff makes time to assess the need, and refers back to the CEA as appropriate.

Accommodations are met whenever necessary, as client needs vary depending on disability severity. In instances where English proficiency is an issue, translator services are engaged to ensure all clients are able to receive the same level of care.

8. Are there any **outstanding Civil Rights matters** or financial obligations to the federal government? Yes _____ No__X__ Please explain your experience in managing federal grants. (50 words or less)

9. Who is the agency contact person knowledgeable about **Fair Housing** and HUD priorities? Name:_Susan Cancro or Maureen Nagy_____ Contact #_517-485-4722___

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ONLY Renewal Projects, complete questions 10-12

10. Are the agency **reports turned in on time** (%)? Is the agency **HMIS data error free** (%)? Are the agency monthly Financial Status Reports correct (%)?

11. **Project cost-effectiveness** – what was the average cost per person or family served in your project? (Take the cost to run the project including match divided by the actual number of households served per project year).

12. Attach the agency's response letter to **any findings or concerns** identified by the City during the **last monitoring/site visit** of the agency. Please provide any CAP (Corrective Action Plan) requested by the City or CoC if applicable.

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ONLY Reallocation, New Bonus and DV Bonus Projects, complete questions 13-17

13. Attach (one page or less) the general Objectives/Mission of the Organization and the Organization's **experience in providing the services** for which funding is being requested, including populations served.

MISSION: In service to social justice, **Advent House Ministries, Inc. (AHM)** brings together people of all faiths to cultivate a community of hope and to nurture stability of self among those who struggle in poverty.

EXPERIENCE: Advent House Ministries, Inc. (AHM) has been in existence since 1987; we serve those struggling with homelessness and other issues of poverty in the Greater Lansing Area. In the past year we provided rental assistance and case management to over 65 households (including single adults and families) to move from homelessness to housing. We provided over 2100 persons with more than 32,000 meals. We assisted over 120 adults to obtain the life skills and employment readiness needed to find a permanent job after release from prison.. In all programs we maximize the use of mainstream resources and build partnerships to create effective supportive services for severely at-risk individuals and families.

Specific to this application, Advent House Ministries has operated several PSH programs for the past two and a half years, and has gained extensive insight into how best to serve those experiencing homelessness in our community. We are well equipped as housing case managers to add this RRH expansion to our current Fresh Start RRH program. In addition, we have been providing case management as a contractual partner in other supportive housing programs in Lansing. Over 31 years offering service in our community and managing local and federal grants, we have built expertise working with chronically homeless and high acuity adults and families in building life skills, overcoming barriers, and sustaining housing stability.

14. Describe the plan to assist clients with **barriers to housing** (poor rental history, criminal history, bad credit, etc.) to rapidly secure and maintain permanent housing that is safe, affordable, accessible, and acceptable to their needs.

An initial assessment is completed at entry for all clients which addresses tenant screening barriers and housing retention barriers. This allows the case manager to best identify which housing opportunity will be the quickest and preferential fit for every client. Referring clients to a representative payee resource, the financial empowerment center, the Rent Smart program, and other community provided resources are just a few ways that the case manager can help advocate for new leases among the vulnerable populations we serve.

Advent House works to recruit and maintain a robust landlord bank, which is crucial to housing those experiencing homelessness. These landlords are willing to work with us to understand the unique needs of those we serve. They appreciate our support and are willing to participate in creating a housing stability team. The outcome of a positive experience with these landlords provides clients with not only current stable housing, but is able to counterbalance a negative rental history.

15. Describe how the **project design** will fit the needs of project participants: 1) to help maintain housing; 2) to meet other client needs that contribute to instability and homelessness; 3) to **establish performance measures** for housing and income that are objective, measurable, trackable, and meet or exceed any established HUD, HEARTH or CoC benchmarks.

1) to help maintain housing:

We practice progressive case management and the strength-based goal setting to create a foundation for long term housing success. We tailor each service plan to the specific and unique needs of the client. Addressing issues with each client in his/her home environment ensures effective incorporation and implementation of goal strategies. The client is able to work with the case manager to incorporate the change directly within the living environment and affirm success in the implementation of that change.

2) to meet other client needs that contribute to instability and homelessness:

National studies of homelessness have indicated that harm reduction is a proven response to addressing risky behaviors that can lead to housing crises. Harm reduction and trauma-informed care practices are the basis for the AHM approach to case management. This informs our method of goal setting and intensive follow-up with each client. We meet clients "where they're at" and get them to the housing stability they want to achieve.

3) to establish performance measures:

The extended intervention available in a Permanent Supportive Housing program is effective in building strengths to eliminate the underlying causes of homeless, thereby ending homelessness for a participant, individual, or family. Before a discharge to PH, program participants will identify the obstacles and have a strong goal plan, build upon their financial stability, and leave with the experience of having maintained housing for the length of their program enrollment.

The following are measurable outcomes for the Fresh Start Expansion:

- 100% of program participants will receive a full assessment, and obtain and retain supportable permanent housing for a maximum of 6 months.
- 100% of program participants will develop a case action plan including goal setting with assistance from the participant's case manager. Included in each participant's case management process will be referrals to mainstream resources as applicable to each household.
- 70% of program participants will show progress toward achieving one or more functional goals as identified and measured through HMIS self-sufficiency matrix tracking.
- 100% of program participants will receive up to 24 months of case management with a minimum of 1 face to face participant meeting in the unit every month while actively enrolled in the program.

16. Describe a plan for **rapid implementation of the project** documenting how and when the project will be ready to house the first project participant. Provide a detailed schedule of proposed activities for 30 days, 60 days, 120 days, and 180 days, if applicable, after grant award.

The Fresh Start RRH expansion will be implemented within 30 days of grant award as it will be an addition of units to an existing program that is already in full operation. To facilitate referrals and efficient enrollment, we will ensure that the CEA is informed in a timely manner regarding additional unit availability in our program. Within the first 180 days the program will be performing follow-up with enrolled households and will be in process of enrolling additional eligible households.

17. My agency is **willing to be trained** in processes and programs used by the CoC to manage and administer the HUD grant including but not limited to Homeless Management Information System (HMIS), the Coordinated Entry Agency (CEA) and the assessment tool (SPDAT). Agree: ___X_____ Disagree: _____

DV-Bonus applicants only (18 – 20):

18. Do you have a **client-level database** that is capable of meeting HUD's Annual Performance Reporting requirements? (see document on GLHRN website for clarification)
    Yes_____ No _____

19. What are the **issues facing DV survivors in accessing local CoC** permanent housing assistance programs? Support your response with local data.

20. How do you **address/improve safety for the DV populations** you serve?

For further information, please see the HUD Notice of Funding Availability at:
https://www.hudexchange.info/resource/5719/fy-2018-coc-program-nofa/

Part III: Budget
Budget may also be submitted in an Excel Spreadsheet – contact HRCS for document.

	HUD CoC Expenses					
	PH: PSH	PH:RRH	TH	SSO	HMIS	
Rental Assistance		$106328				
Leasing						
Supportive Services*		$29131				
Operating Costs						
HMIS						
Total Admin		$10196				
Sub Total		$145655				
Cash Match (all line items except Leasing)						
In-Kind Match (all line items except for Leasing)		$36414				
Grand Total		$182069				
Shaded areas not eligible for funding in designated categories. Match should total 25%						

	*Supportive Service breakdown
Salaries	$27061
Fringe Benefits	$2070
Contractual services	
Travel	
Supplies/materials	
Utilities	
Repairs/Maintenance	
Financial assistance to clients	
Total	$29131

Program Income*	
Source	Amount
In-kind costs for AHM admin and supportive services and referral and support services from partner agencies	$13201
In-kind use of AHM utilities for office/meeting space	$5400
In-kind use of NWPC building for office/meeting space	$17813
Total	$36414

*Program Income is funds generated by project activities such as participant contributions toward their rent.

HUD Priorities

Strategic Resource Allocation – maximize use of mainstream resources and develop partnerships.
Ending homelessness for all persons.
Creating a systemic response to homelessness.
Using a Housing First approach.

GLHRN Priorities

Prioritize Permanent Housing including PSH and Rapid Rehousing
Prevention of Homeless through intervention
Supportive Services with targeted case management and wrap around services to lead to self-stability
Shelter services
Essential Services for vulnerable sub populations
Prioritize the chronically homeless