

# 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](mailto: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 Director

Telephone: 517-485-4722 Email:  
secancro@adventhouse.com

Project Grant Name: Hope Housing Exspansion Minimum # Units (see table): 9

**Renewal only:** Previous Year Award Amount: \$                      Amount Requesting: \$105,870

**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:     No:     If yes, please identify the amounts and sources for all leveraged funds.

Amount \$ 758 Source: Advent House Ministries admin and supportive svcs. costs

Amount \$ 2160 Source: Advent House Ministries cost of utilities for office/meeting space

Amount \$ 8550 Source: Northwestminster donated use of office/meeting space

Amount \$ 15000 Source: Community Mental Health – services to clients from Walnut Prog.

**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.

In-kind match will include the allocated value of office and meeting space donated by Northwestminster Presbyterian Church, in which Advent House Ministries is housed, documented with a Memorandum of Understanding. In-kind match will also include the allocated value of any admin and supportive services not covered with grant funds, as well as use of utilities paid by Advent House Ministries for the office and meeting space. Finally, in-kind match will include services

provided to program participants by Community Mental Health of Clinton/Eaton/Ingham Counties and be documented with a Memorandums of Understanding.

**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?  9

## 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 PSH Hope Housing Program target population is chronically homeless individuals and families. If the by-names list of the chronically homeless has been exhausted at any point in time, this program may also serve individuals and families whose SPDAT scores are 8 and higher. The priority among those needing this service are those who are determined to be chronically homeless; all referrals are processed through the Coordinated Entry Agency. Through our ongoing partnership with Domestic Violence services, Youth outreach, and Veterans' agencies, we will ensure that vulnerable populations who meet the chronically homeless definition and/or have a high SPDAT score are effectively prioritized and engaged in the PSH Hope Housing Program, as appropriate to meet their needs and adhere to program requirements.

AHM would like to note that the initial target population for PSH Hope Housing will include the 9 participants from the previous Walnut St. program who have significant mental health disabilities. We have been involved consistently for the past year with these individuals, and are committed to ensuring their long term housing stability.

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
    - o By utilizing a housing first approach with the most vulnerable clients, we reduce the wait time for housing by first prioritizing housing placement before working to address the factors that originally led to their homelessness.
    - o After referral from the CEA each household is contacted and supplied with landlord resources and active assistance in locating viable permanent housing, as well as assessment of other housing-related needs to facilitate effective reduction of time in shelter or on the street.
    - o 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
    - o The progressive case management 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.
    - o Prior to discharging, case managers and clients work together to make connections for a warm handoff to mainstream community resources. This assists the client while in PSH, and ensures a successful transition to PH.
    - o Advent House programs work closely with CoC partners to ensure clients have access to all possible permanent voucher options, including Move Up Vouchers and HCV opportunities offered through area HCV administrators.
  - Preventing returns to homelessness (reducing recidivism)
    - o Through the intensive step-down case management clients receive, clients can identify their strengths and build upon them 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.
  - A large majority of PSH participants are strong SSI candidates, and if they have not already applied for it will get a referral to a SOAR specialist, Disability Appeals Advocates, or the VOA Ability Law Clinic. Other clients may have an interest in gaining employment, and will receive assistance with resume development, job skills training, and Michigan Works referrals. Advent House Ministries has maintained resources and employment connections from our time with the Good Works Employment Program and current Offender Success program.
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 HUD guidelines for PSH 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 eligible referral from the CEA, the program supervisor will review to ensure the client/household meets the minimum eligibility criteria. If the CoC By-Name-List has determined that all chronic clients have been assisted, eligibility will revert to a “most vulnerable” prioritization.

3) Process and Criteria for Exiting Clients:

Exits can be self-directed by the client when their service goals are met, or suggested through a service plan review initiated by case manager. If there is a compliance concern, case managers will make every effort possible to address the matter before an outcome will result in having to discharge a client.

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 PSH 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. Once enrolled clients receive the following services: (1) comprehensive assessment, (2) individualized case planning, (3) linking/referrals to appropriate community supports, and (4) monitoring (for up to six months after finding permanent housing).

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 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 participates with the CoC Move Up Voucher Committee, and completes an assessment on any current PSH client who is identified as being a potential referral for that voucher. In addition to this, Advent House Ministries has had success with transitioning clients to a Lansing Housing Commission HCVs or project based voucher opportunities. Additionally, clients have the choice to transition to whichever next housing opportunity they feel is the best fit for them with the skills they've acquired.

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 PSH Hope Housing Program receives 100% of its referrals from the CEA. In the coming grant year the PSH Hope Housing Program 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 clients are only eligible for AHM PSH entry if they're referred by the CEA. Anyone who meets the minimum HUD PSH 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 refer 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 the PSH Hope Housing Program for the past two and a half years. In addition, we have been providing case management as a contractual partner in other supportive housing programs in Lansing. We specialize in addressing the unique needs of high-risk (i.e., SPDAT scores of 9 and higher) and chronically homeless individuals and families. 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 that addresses their tenant screening barriers and housing retention barriers. This allows for case managers to assist in drafting a housing plan that will best identify which housing opportunity is 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 work with us and the client to create a housing stability team. The positive experience with these landlords provides clients with not only current stable housing, but is able to counterbalance a negative rent.

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 goal setting that is crucial to 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 this expansion of the Hope Housing Program:

- 85% of participating households will demonstrate improved housing stability, as indicated by these households remaining in, or exiting to permanent housing during the operating year
- 85% of participating households will remain housed for a minimum duration of 6.1 months
- 75% of participating households will maintain or increase their total income (from all sources) as of the end of the operating year or program exit.

- 100% of participants will apply, and acquire, at a minimum, at least one eligible mainstream resource within three (3) months of program enrollment.
- 80% of participating households, who are in the program over three (3) months, will show progress toward completing one or more case plan goals for improved housing and financial stability.

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 Hope Housing 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. As stated above, AHM plans to prioritize the housing needs of the existing residents from the reallocated Walnut Street Program. Also, to facilitate additional 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 60, 120, and 180 days the program will be performing follow-up with enrolled households and will be in process of enrolling additional eligible households as units become available.

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	\$77285.00					
Leasing						
Supportive Services*	\$21174.00					
Operating Costs						
HMIS						
Total Admin	\$7411.00					
Sub Total	\$105870.00					
Cash Match (all line items except Leasing)						
In-Kind Match (all line items except for Leasing)	\$26468					
Grand Total	\$132338.00					
<b>Shaded areas not eligible for funding in designated categories. Match should total 25%</b>						

	*Supportive Service breakdown
Salaries	\$17863
Fringe Benefits	\$1367
Contractual services	
Travel - Client bus passes	\$1944
Supplies/materials	
Utilities	
Repairs/Maintenance	
Financial assistance to clients	
Total	\$21174

Program Income*	
Source	Amount
Admin / supportive services costs	\$758
Utilities for office/meeting space	\$2160
Donated use of office/meeting space	\$8550
CMH services to clients	\$15000
Total	\$26468

\*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