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: August 13, 2018

PART I: Program Information

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

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

Organization: Mid-Michigan Recovery Services Inc.

Contact Person: Jessica Lamson Title: Executive Director

Telephone: 517.887.0226 x 111 Email: JessicaL@mmrsinc.org

Project Grant Name: Transitions Housing for Men Minimum # Units (see table): 10

Renewal only: Previous Year Award Amount: $140,161 Amount Requesting: $140,161

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: X If yes, please identify the amounts and sources for all leveraged funds.

Amount $_____ Source: _____

Amount$_____ Source: _____

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.

CASH MATCH		IN-KIND MATCH	
Capital Area United Way	$6,000	Greater Lansing Food Bank	$1,200
Mid-State Health Network	$47,312		
Occupancy Charges	$3,125		
Ingham County	$12,000		
		TOTAL	**$69,637**

Our agency has historically received generous monetary grant support through Capital Area United Way, Ingham County Community Grants and in-kind food grant from Greater Lansing Food Bank to

provide some basic shared food staples for the household. We also receive funding through Mid-State Health Network as a Transitional Sober Housing choice for community members who are qualified for supportive housing based on American Society of Addiction Medicine (ASAM) criteria determines need for supportive housing resulting from chronic substance use disorder and co-occurring mental health disorders. In addition, we receive a small amount of client occupancy fees from clients who have established a regular income and contribute a small amount back to assist in paying for rent, utilities and costs for collective incidentals (i.e. toilet paper, paper towels, cleaning supplies and shared household items). Occupancy charges are calculated and established in accordance with 24 CFR 578.77; calculation of occupancy being determined in accordance with section 3(a)(1) of the U.S. Housing Act of 1937 (42 U.S.C. 1437a(a)(1)) and client income is calculated in accordance with 24 CFR 5.609 and 24 CFR 5.611(a).

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

D. How many households will be housed during the funding year? __25__

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.

   Our Transitional Housing project serves the HUD identified special population, individual male gender identified clients diagnosed with chronic substance use disorders. In most cases clients also have co-occurring mental health disorders.

   Clients are pre-screened utilizing the VI-SPDAT in order to prioritize service to the most vulnerable clients, the average acuity level of 7.9 (thorough-out our most recent fiscal year the lowest was a 4 and highest was 11). These individuals may be living on the streets, in places not fit for human habitation and/or living in unsafe households; they may be exiting incarceration without a safe place to return or be doubled-up with other households and facing eviction, abuse, neglect, violence, drug-trafficking and/or human-trafficking occurrences.

   All clients have experienced homelessness and are identified as homeless upon intake. Intake decisions are based on highest acuity also prioritizing service to Veterans. We use a variety of additional pre-screening questions to gain better assessment of substance use history; potential or identified mental and/or physical health concerns and occurrences of unsafe housing or homelessness to ensure appropriateness of services.

   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
   - Increasing discharges to permanent housing
   - Preventing returns to homelessness (reducing recidivism)
   - Increasing client income

   Transitions provides shelter for clients who have barriers to accessing permanent housing, are homeless and have not been successful or have barriers to being successful in other community shelters. The success of sheltering relates to the ratio of clients to staff; providing a supported individualized experience in a more intimate therapeutic environment for this vulnerable sub-population. The longer-term residential nature of this 10-bed facility allows clients to learn and practice life-skills including household management, budgeting and financial management. Healthy social skills are applied in this unique group atmosphere. The program does not have barriers related to Criminal Sexual Conduct (a high need/high risk population) and individualizes services for clients who have barriers specifically related to chronic substance use (i.e. history of trafficking, violence, unit damage and/or community disturbances, non-payment of rent and reliability and accountability related to curfews and or punctuality).

   Transitions provides a longer-term stay than standard shelters. Clients have more time to move beyond addressing basic needs and work on deeper issues that have caused recidivism, discharges or eviction and loss of income and or community/family support.

This supportive longer-term transitional housing choice provides clients with individualized case management and experienced peer support to assist in addressing legal issues; ongoing health concerns, life-skills deficits, financial stability and barriers to employment and securing appropriate income while exploring the most appropriate housing for their needs.

In offering this additional time and supportive service, individuals whose substance use has created barriers to accessing and maintaining safe permanent housing or who have been unable to maintain stability in sobriety are afforded time to explore substance use as an underlying causes to homelessness and support to address barriers to permanent housing. This reduces length of time homeless and alleviates conditions that cause individuals to continue to return to homelessness (recidivism) or to find themselves in un-inhabitable or unsafe living situations.

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?

Transitions program specifically serves male gender identified clients with a history of homelessness and chronic substance use. The program does not discriminate based on 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 or gender identity.

Clients are pre-screened utilizing the VI-SPDAT in order to prioritize service to the most vulnerable clients. These individuals may be living on the streets, in places not fit for human habitation and/or living in unsafe households; they may be exiting incarceration without a safe place to return or be doubled-up with other households and facing eviction, abuse, neglect, violence, drug-trafficking and/or human-trafficking occurrences.

Eligible individuals are assessed with chronic substance use disorders and homeless upon intake. Intake decisions are based on highest acuity -- prioritizing service to Veterans. We use a variety of additional clinical pre-screening questions to gain better assessment of substance use history; potential or identified mental and/or physical health concerns to ensure appropriateness of services.

Through accessing this, transitional sober-housing choice individuals receive necessary time and support in exploring issues related to substance use; including barriers that have caused return to homelessness or unsafe living conditions resulting from substance use. Transitions is a housing-first service provider. We ask clients to abstain from active substance use while in the house, but do not deny access to program based on their ability to maintain stable sobriety. Individuals may come to Transitions having sought medication-assisted treatment; abstinence based recovery or tried methods of harm-reduction in use of substances that have not afforded success in maintaining sobriety and stable permanent housing in the past.

Clients assessed as appropriate for this program will self-certify their ability to maintain adherence to safety guidelines, and program guidelines, which include:

- Not bringing illegal substances or alcohol in the residence and or not appearing in a state so altered that they cannot maintain good conduct.
- Adhering to probationary or legal terms
- Adhering to curfew
- Participating in regular house meetings and individual meetings with the case manager.
- Progress toward self-identified goals
- Participation in maintaining shared household management responsibilities and respectful and regular communication with staff and other participants.

Discharges are based upon blatant disregard of safety; violence; theft; substance use related health concerns causing hospitalization and/or need for more intensive services. Discharges may also occur if the client has exhibited a pattern of disregard of program guidelines and shared household duties or is unwilling or unable to make progress toward self-identified goals intended to assist them to access permanent housing. The case manager and peer coach continually work with the clients assessing their progress, assisting with problem-solving, providing life-skills education, connecting them to resources and or supports to assist with building stability and overcoming crises or barriers. The program provides for some case management support for up to six (6) months post discharge.

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)

Clients are pre-screened using the VI-SPDAT and specialized pre-screening questions related to substance use, physical health, mental health, legal, and homeless history.

Upon intake to Transitions, the case managers orients the client to the residence, reviewing the guidelines and basic expectations and addressing the primary basic needs (food, toiletries and clothing, assigning them a bedroom and securing bedding and linens). The case manager then works with the client to complete a more detailed needs assessment using motivational interviewing to gain appropriate understanding of background related to clients history in order to identify barriers and emergent issues. The client identifies personal goals to work toward in addressing barriers to securing permanent housing. The case manager and other staff work with clients on at least a weekly basis to assess the clients progress and assist them in working on objectives; making any necessary adjustments or additions to ensure continued progress toward securing housing. Clients are directly connected to Coordinated Entry Agency and staff works with collaborative bodies including Greater Lansing Homeless Resolution Network, Mid-State Health Network, Veterans Services, CEI-CMH, Ingham Health Department, MDHHS, and other individual agencies to connect clients with a variety of services and supports in service to their specific needs. Warm referral relationships have been

established with Peckham, Michigan Works (including the Financial Empowerment Center), Food Bank, St. Vincent DePaul, Forest Community Health Center, Lending a Helping Hand or 2, Christian Services and Capital Area Community Services to name a few.

2. 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?

Clients have met goals related to overcoming identified barriers; increasing and establishing regular income; demonstrating household and budget management competency and accountability and increased problem solving skills.

Upon successful discharge case manager does an exit interview completing a follow-up SPDAT to assess acuity and ensure client's progress toward stability. Case manager provides client with follow-up resources, does a 30-day, 90-day and 180 day follow-up call to check-in on client and ensure that transition has continued to progress smoothly; addressing any follow-up needs.

Program Goals	Key Action Steps	Outcomes and Measures
To provide housing intervention services and connect community members to the Coordinated Entry Agency as they reach out for Transitional Housing Services	• Provide VI-SPDAT and additional needs assessment to at least 60 individuals providing	Community members will • be connected to Coordinated Entry • Ensure prioritization of most vulnerable in assessing and providing housing services
To help individuals struggling with chronic substance use to obtain safe and stable housing.	Provide transitional shelter services to 25 individuals. • Individuals will receive life skills instruction and training • Individuals will receive employment assistance or help applying for SSI/SSDI as applicable • Individuals will be connected to Coordinated Entry and be provided housing resources.	• 85% of individuals will discharge to a safe stable home. • 82% will show positive movement in life skills areas between intake and discharge. • 50% will demonstrate an increase in income between intake and discharge. • 50% will increase income
Assist individuals in maintaining safe and stable housing.	• Attempt follow-up at 30, 90 and 180 days post discharge.	• Follow-up surveys

3. 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.

Transitions program coordinator tracks referrals utilizing HMIS and regularly connects with the Coordinated Entry Agency and regular referral sources to communicate vacancies and wait list information. Transitions case manager connects clients to Coordinate Entry Agency within14 days of

program intake. Referrals are as follows: 60% come from treatment providers; 30% from justice system (jails and/or probation officers) and 10% come from community resources (including Coordinated Entry Agency.

4. 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?

Program works with CABHI and PATH programs as well as Coordinated Entry to ensure prioritization of clients utilizing the coordinated entry best practices determining housing accutity based on VI-SPDAT and SUD chronicity based on additional health assessments.

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)

5. Who is the agency contact person knowledgeable about **Fair Housing** and HUD priorities? Name: Jessica Lamson Contact # 517.887.0226

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ONLY Renewal Projects, complete questions 10-12

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

7. **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).

   The cost per individual served is approximately $5,408.

8. 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.
   N/A

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

9. 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.

10. 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.

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.

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.

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: _____ 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						
Leasing			14,400			
Supportive Services*			116,895			
Operating Costs			4,083			
HMIS						
Total Admin			4,783			
Sub Total			140,161			
Cash Match (all line items except Leasing)			54,037			
In-Kind Match (all line items except for Leasing)			1,200			
Grand Total			195,398			
Shaded areas not eligible for funding in designated categories. Match should total 25%						

	***Supportive Service breakdown**
Salaries	98,588
Fringe Benefits	16,997
Contractual services	
Travel	
Supplies/materials	1,310
Utilities	
Repairs/Maintenance	
Financial assistance to clients	
Total	116,895

Program Income*	
Source	**Amount**
Fees	3,125
CAUW	6,000
HUD	140,161
GLFB	1,200
Ingham Co.	12,000
MSHN	47,312
Total	$209,798

*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