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: 8/10/2018

PART I: Program Information

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

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

Organization: Volunteers of America Michigan

Contact Person: Elsa Heenan (or Juliana Shaltry) Title: Social Services Senior Manager

Telephone: (517) 574-7785 Email: Elsa.heenan@voami.org

Project Grant Name: VOAMI Ingham County - PSH 1 and PSH 2 Minimum # Units (see table): 24

Renewal only: Previous Year Award Amount: $265,773.00 Amount Requesting: $274,663.00

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

Amount $171,301 Source: VOAMI Ingham County Bonus

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.

Match will be achieved by (1) oversight of the program by senior level management ($12,500 with fringe), which is not covered in the grant award and (2) cash match to uncovered admin fees ($39,590). Match will be documented monthly on the FSR.

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? 24

Part II: Narrative

Please be concise. Use bullets where possible.

1. **Describe the target population for the Project. Specifically identify <u>who</u> 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.

   These Permanent Supportive Housing (PSH) programs serve chronically homeless adults from Ingham County. The majority of participants come from the community's area emergency shelters or, through community outreach efforts, including homeless encampments. In accordance with Continuum of Care (CoC) protocols, participants have been assessed with the Vulnerability Index Service Prioritization Decision Assistance tool (VI-SDPAT) and have a scored above an 8. This assessment tool calculates vulnerability acuity and uses a scale from 0 to 20 with 20 being the most vulnerable with greatest intervention needed. Existing Volunteers of America (VOA) PSH participants have a VI-SPDAT scoring range from 8-17, with an average participant's score of 13.

   VOAMI serves as the Coordinated Entry Agency (CEA) for Ingham County and primarily all referrals to PSH come through the CEA. The CEA screens all persons experiencing a housing crisis, completes an intake, and refers to housing resources based on specific eligibility. VOAMI collaborates with the Tri-County Outreach committee, attending regular meetings on outreach efforts across the tri-county area. VOAMI staff confers and refers with staff from the Program to Assist in the Transition from Homelessness (PATH) who perform daily outreach activities. The PATH program also regularly makes referrals to VOAMI's hotel and shelter programs as well as to the CEA Team.

   For outreach, VOAMI uses the following strategy:

   - Identify and reach homeless individuals and families where they congregate.
   - Refer outreach staff to engage individuals and provide a Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) assessment.
   - Using the VI-SPDAT assessment, applicants are prioritized for Rapid Rehousing (RRH) or a PSH referral. All participants with scores indicating PSH eligibility receive an additional Full-SPDAT assessment and are referred to PSH programs in the community.
   - Keep and maintain a comprehensive by-name list in coordination with the CEA which is administered by the VOAMI Behavioral Health Coordination (BHC) coordinator.
   - Receive all referrals from the CEA, ensuring eligibility for programming.
   - Collaborate in an interdisciplinary approach to care coordination, with a partnership with community agencies performing housing and outreach efforts, including both the Collaborative Agreement to Benefit Homeless Individuals (CABHI) team and the PATH program.

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:**

A. Reducing the length of time people are homeless
B. Increasing discharges to permanent housing
C. Preventing returns to homelessness (reducing recidivism)
D. Increasing client income

Outcomes:

A. <u>In alignment with Program Objective A:</u>

VOA PSH programs are working directly with the VOA BHC program that tracks the most vulnerable in the community based on high VI-SPDAT scores using a by-name-list. These VI-SPDAT assessments are performed through the CEA or, other trained agencies then directly referred to the BHC program. VOA PSH uses this vulnerability by-name-list to house those with the highest acuity including those with both an on-going disability and documented as chronically homeless. This active listing allows our programs to quickly house those who are eligible for PSH when PSH housing resources become available. VOAMI PSH has also been working with other community PSH projects. VOAMI PSH program has worked to transition those at risk of recycling back into homelessness, from other PSH projects, into the VOAMI PSH program.

B<u>. In alignment with Program Objective B:</u>

All VOAMI PSH participants are regularly assessments with the minimum of every six-months as recommended by the Move Up Voucher Triage Committee (MUVTC). These assessments include the Full-SPDAT (SPDAT), Self-Sufficiency Matrix (SSM), and Substance Use Disorder (SUD) assessment tools when necessary, along with continuously working on client centered goals. This Greater Lansing Housing Resolution Network (GLHRN) guided case management is in place to assist clients in stabilizing all areas of their life with the futuristic goal to be eligible for a Move Up Voucher (MUV) program. The MUV program eligibility is determined by community PSH programs presenting cases to the MUVTC relaying the strengths and deficit areas of the possible MUV participant. Once the MUVTC believes that the PSH participant is stable and will successfully live independently of the PSH program, they process through receiving a MSHDA Housing Choice Voucher (HCV).

C. **<u>In alignment with Program Objective C:</u>**

VOAMI Support Specialists have been trained to utilize client-centered case management tools following GLHRN guidelines and Org Code (the creators of the SPDAT). With this in mind, PSH participants' issued life areas, that can result in recidivism back into homelessness, are swiftly addressed with step by step planning. Using this thoughtful methodology, along with the careful consideration of the participant's acuity level, has shown to increase personal insight, open communication lines, and to improve landlord-client relationships resulting ultimately in increased housing stability.

D. <u>In alignment with Program Objective D:</u>

The VOA Ability Benefits Clinic (ABC) is co-located in the VOA campus. With close connection available, the VOA PSH managers have increased their understanding of the

SSI/SSDI processes. Seeking treatment for the area(s) that is identified as a chronic disability remains important in the SSI/SSDI process. PSH participants are strongly encouraged to seek an income source as, we see this a stability factor. Due to the increased knowledge regarding SSI/SSDI applications, we assist in connecting participants to resources that help them address their identified disability along with referring them to either the Social security office and/or, VOA ABC whenever possible. The Financial Empowerment Center (FEC) works with PSH participants on managing their finances, handling their credit, and resolving any past issues with creditors. Some clients can work part-time with accommodations which is strongly encouraged. When working is a possibility, VOA finds that it can increase overall life satisfaction in a participant's life.

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 <u>procedures to address situations that may lead to termination</u>. How will the project assist clients in finding decent housing?**

    1. To be eligible for PSH, a participant must meet the definition of chronicity as defined by HUD which includes one-year of consecutive homelessness in the past three years or four episodes of homelessness, totaling 12 months or more, in the last three years and have a documented disability. The VI-SPDAT scoring above an 8 is also part of the eligibility factors used by the CEA to refer clients to community PSH programs. Beyond these identified criteria, no other factors are considered including income, history of or current SUD, mental health status, criminal background, perceived sexual orientation or gender, or any demographic characteristics.
    2. Participants are prioritized first on length of time homeless and then vulnerability as measured by the Full SPDAT. Persons who are homeless are tracked on a BHC by-name-list and sorted by priority. The CEA team draws names from the list, assists in gathering necessary documentation, including tracking forms for chronic status and disability paperwork, and making referrals to the providers with available units. VOA PSH has also collaborated with Advent House Ministries (AHM) PSH program to accept individuals form their PSH programs who were at risk of returning to homelessness.
    3. While in program, participants are encouraged to work on issues that impact their housing and quality of life. VOAMI case managers use a variety of strength-based and client-centered approaches that maximize on a client's motivation for change. Each participant has an individual case plan, guided by strengths, abilities, needs, and preferences. No participant will be exited from the program for non-safety reasons or for any of the reasons listed in subsection 2 (above) unless it could cause serious injury or death. Participants are allowed to be absent from the program for up to 90 days due to rehabilitation, incarceration or other approved circumstances. VOA seeks every alternative prior to exiting a participant from PSH including intensifying services, enrollment in treatment, housing supports, in-home health supports, and others as identified.

When a PSH participant has had continued and monitored intensified support measures and continues to exhibit behaviors where they are no longer able to maintain safe housing, we take steps to exit them from the program. These overt steps start with a verbal warning about behaviors occurring and a follow up plan to address the issues. The next step is to create a behavioral contract that sets a tone and understanding that if the behaviors continue to occur, they are at risk for exiting the program with a signed statement and plan to remedy the issued area. Participants can receive more than one behavioral contract and can remain in the program. We do not set an ultimate limit on these contracts as, the context and severity are all differing for each individual. The final step in the exit process is to have team meeting where the participant, their support specialist, and the program manager work together to help them remain in housing. This can mean partnering with CEA and local shelters to assist in alternative safe housing options. A final goal plan is created together and if not adhered to, the participant receives an exit letter either by mail or in person, if the client does not regularly check their mail. In the circumstance that a PSH member has been unreachable in their home or via other electronic communications for 90 or more days, the participant is sent an exit letter to their mailing address. All these procedures are documented in MHMIS to allow transparency about these PSH exits. VOA is in the process of creating an exit assessment to gather more information about the exit to help us reduce recidivism into homelessness whenever possible.

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)

VOA provides assessments, through the CEA Team, to individuals in all Ingham County community shelters, including a Full-SPDAT, to ensure persons are directed to appropriate supports and housing options based on acuity and service need as well as preference. The PSH program receives all referrals from the CEA and makes interagency and intra-agency referrals designed to address the underlying causes of homelessness as well as threats to sustainability. VOAMI facilitates an interdisciplinary (IDT) meeting each week, hosting partnering agencies in the engagement and service of homeless individuals and families to aid in service connection and resource application. Partnering agencies have all signed QSOBBA documentation are instrumental in housing persons experiencing homelessness through the wrap-around services and coordination. Partner agencies include Community Mental Health (CMH), The Veterans Administration (VA), Sparrow Health, Justice in Mental Health Organization (JIMHO), Department of Health and Human Services (DHHS), Mid-Michigan Recovery Services (MMRS), Advent House Ministries (AHM), City Rescue Mission (CRM), Financial Empowerment Center (FEC), City of Lansing (COL), and Spartan Street Medicine outreach.

VOA provides integrated care and co-located services to include medical, dental, Social Security income filing assistance, access to food and basic needs, and a variety of third-party providers offering on-site office hours. VOA partners closely with DHHS to provide benefits to consumers. DHHS is on-site weekly at VOA to help families with their benefits, process

SERs, and answer case questions. CMH is also on-site once a week for questions related to insurance or to enroll in ACCESS mental health help.

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?**

The MUVTC has worked together in deciding which life factors to review that seemingly facilitate overall stability. Move Up Voucher (MUV) criteria factors were based on an 8-Domain of wellness model that has shown that when these areas are sufficiently stabilized, a person is able to function at a higher level leading to greater independence. These stabilization factors include emotional, environment, financial, intellectual, occupational, physical, social, and spiritual domains. Another criteria piece was having lived in a PSH program for a two-year period to allow the MUVTC to assess stabilizing factors over time using the SPDAT and the SSM assessment tools. Those presented by support specialists staff or PSH management to the MUVTC were collectively reviewed with areas feedback from the committee about areas they felt needed to be more stabilized before offering a MUV to the participant. The support specialist or manager would then have the opportunity to create a plan with the PSH participant to work on this area(s) and to present after this factor showed improvement with documentation. The committee also voted to allow those who had transitioned into independence 6-months of continued support through contact, group meetings, and assistance with any renewal paperwork or connection to vital services.

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.**

VOA PSH primarily utilizes the BHC by-name list for enrolling participants. Clients on this list are directly referred from the CEA. It is estimated that 98% of participants who are in the VOA PSH 1 and PSH 2 program were referrals from the CEA. The other 2% percentage represents referrals for transitioning from another community based PSH program.

We continue to track this information through MHMIS and utilizing the BHC by-name listing. Within the MHMIS system, and through coordinated referrals, we are able to attest to the eligibility criteria for VOA PSH programs with documented disability letters and VI-SPDAT/SPDAT scoring stored in this management system.

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?**

VOA receives referrals for PSH through the Ingham County CEA. Participants come from the community's area emergency shelters or, through community outreach efforts, including homeless encampments. In accordance with Continuum of Care (CoC) protocols,

participants have been assessed with the Vulnerability Index Service Prioritization Decision Assistance tool (VI-SDPAT) and have a scored above an 8.

For outreach, VOAMI uses the following strategy:

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8. **Are there any outstanding Civil Rights matters or financial obligations to the federal government? Yes _____ No_☑_ 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: Sharon Dade_____ Contact #: __517-202-3504____

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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 (%)?**

VOA agency reports are turned in on time as directed. However, we continue to work toward increased reporting accuracy. VOA MHMIS data has a low data error rate. This data is monitored regularly and remedied swiftly when any issues arise.

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).**

The cost of the programs, with match, is $294,347.00. PSH 1 and PSH 2 have 26 participants. The average cost per person is $11,321.04.

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.**

(Attached action response)

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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.

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.

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	195,924.00					
Supportive Services*	54,794.00					
Operating Costs	6,165.00					
HMIS						
Total Admin	17,780.00					
Sub Total	274,663.00					
Cash Match (all line items except Leasing)	19,684.00					
In-Kind Match (all line items except for Leasing)						
Grand Total	294,347.00					
Shaded areas not eligible for funding in designated categories. Match should total 25%						

	*Supportive Service breakdown
Salaries	49,749.00
Fringe Benefits	5,045.00
Contractual services	
Travel	
Supplies/materials	
Utilities	
Repairs/Maintenance	
Financial assistance to clients	
Total	54,794.00

Program Income*	
Source	Amount
Total	

*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