Opening Doors – Connecticut
Framework for Preventing and Ending Homelessness
OPENING DOORS – CONNECTICUT
FRAMEWORK FOR PREVENTING AND ENDING HOMELESSNESS

PARTNERSHIP FOR STRONG COMMUNITIES
NOVEMBER 2011

DEDICATION

Opening Doors - Connecticut is dedicated to the memory of
Bob Hohler
1933-2011

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Executive Summary

In June 2010, the United States Interagency Council on Homelessness (USICH) issued the first comprehensive plan to prevent and end homelessness. This plan, Opening Doors, provides a road map for joint action by 19 federal agencies and local and state partners to align housing, health, education and human services to prevent Americans from experiencing homelessness.

Central to this comprehensive effort is a greater emphasis on helping people secure and retain safe, stable housing. From years of practice and research, we know that housing is an essential platform for human and community development.

Following the release of Opening Doors, conversations ensued about the possibility of creating a similar framework for Connecticut. Opening Doors – CT formally was launched in March 2011 with the first of a series of six “listening session” – facilitated conversations among practitioners and policymakers in the fields of homeless services, health care, criminal justice, family and youth programs, community engagement, employment, and housing. A summary of the feedback given during the listening sessions can be found in Appendix A. Through these sessions and an on-line survey instrument, over 250 stakeholders from across the state provided practical advice on potential Connecticut-based strategies for preventing and ending homelessness. Also examined was extensive public comment provided the federal Opening Doors process from a 2010 stakeholders meeting held in the Northeast.

Context for the Opening Doors – CT Framework

Opening Doors - CT embraces the vision, core values, and goals laid out in the federal Opening Doors plan. We also use the same starting year as the Opening Doors plan, which is 2010, and adopt its initial five- year planning timeframe of 2010-2014.

Vision

No one should experience homelessness – no one should be without a safe, stable place to call home.

Core values

• Homelessness is unacceptable. It is solvable and preventable.
• There are no “homeless people,” but rather people who have lost their homes who deserve to be treated with dignity and respect.
• Homelessness is expensive. Invest in solutions.

Goals

• Finish the job of ending chronic homelessness in 5 years
• Prevent and end homelessness among Veterans in 5 years
• Prevent and end homelessness among families, youth and children in 10 years
• Set a path to ending all types of homelessness.

Opening Doors - CT is guided by a set of key principles:

• Stable housing is the foundation.
What happens at the ground level matters.
Collaboration is fundamental to our success.
Our strategies and solutions must be driven in a way that puts the person or family facing homelessness at the center.
Strategies must be implementable, user-friendly, cost-effective, and scalable.

What do we know about homelessness in Connecticut?
On any given day, there are approximately 3,800 men, women and children staying in Connecticut emergency shelters and transitional housing programs. This is not a finite population. Over three times as many people (13,400) have at least one episode of homelessness during the year than those who are homeless at any given point in time. With the exception of a core of households who are homeless for long periods of time, there is a tremendous fluidity of people moving into and out of homelessness – some for the first time, some repeatedly over time.

Homelessness is a situation that people find themselves in; it is not a characteristic of the people experiencing it. Effectively addressing homelessness means facilitating the transitions of people out of this situation, preventing their return to it, and preventing people from becoming homeless in the first place. Connecticut and national data help us better understand who is most impacted by homelessness and who is most likely to fall within its grasp.

Opening Doors – CT attempts to capture in one document the homeless and at-risk populations in a series of charts based upon data collected through the Point in Time annual count of people who are homeless and through the CT Homeless Management Information System. There follows a discussion of the costs of homelessness such as the utilization of more expensive state services and the reasons why people find themselves homeless in the first instance. This analysis then leads to a description of the housing assistance necessary over a five-year period in order to respond to the challenges we face.

What needs to happen?
The framework of Opening Doors-CT is divided along the same lines as the federal plan:

- Increase access to stable and affordable housing
- Retool the homeless crisis response system
- Increase economic security
- Improve health and housing stability
- Increase leadership, collaboration, and civic engagement

Within each of the principles, above, the framework establishes objectives and offers ideas, concepts and collaborations that should be considered and acted upon.

The Framework calls for increasing leadership, collaboration and civic engagement through an expanded and recommitted Reaching Home initiative. Reaching Home currently is the campaign to end long-term homelessness by creating 10,000 units of supportive housing over a ten-year period. To date, the campaign has led to the creation of over 4,500 such units. By using an expanded framework of the Reaching Home initiative to incorporate the work of the Opening Doors – CT framework, Connecticut is well positioned to make the plan to end homelessness a reality.
Opening Doors - Connecticut
Summary of Strategy Ideas

INCREASE ACCESS TO STABLE AND AFFORDABLE HOUSING AND SUPPORTIVE HOUSING

Strengthen our housing delivery system; create supportive and affordable housing at a scale sufficient to meet the need
- Expand and target rent subsidies.
- Stimulate the development of supportive housing and of mixed income communities that include units affordable to households with extremely low incomes.
- Embed strategies to end homelessness within cohesive State and municipal housing policies that set clear outcome targets.
- Aggressively leverage and compete for Federal rent subsidies, housing development dollars, and service funding linked to housing.

RETOOL THE HOMELESS CRISIS RESPONSE SYSTEM

Recalibrate our response to housing loss
- Within an overall policy framework support community or regional-level development of a coordinated system of response centered on homelessness prevention, housing assistance, and housing stabilization.
- Target housing assistance to those most likely to enter or remain in shelter or in unsheltered settings.
- Strengthen the capacity of Connecticut’s HMIS system to meet the expanded data-matching, reporting and research needs identified in the Opening Doors-CT process.
- Align state and local activities.

INCREASE ECONOMIC SECURITY

Foster housing retention through income growth and employment
- Link workforce system resources (skill & job development) with the housing assistance system to create effective pathways to employment for vulnerable populations.
- Align public and private sectors to ensure effective systems coordination with shared goals.
- Expand income growth for persons with disabilities.

IMPROVE HEALTH AND HOUSING STABILITY

Reduce medical vulnerability and frequent use of health care systems
- Align state and local strategies to support the goals of improved access to health care and effective use of appropriate types of health services.
- Maximize the use of existing and new health sector resources to address both the housing and service needs of extremely vulnerable populations.
- Implement housing-based approaches to align with the health reform goals of prevention, greater access, better quality and lower cost.
- Expand use of HMIS to support new targeting approaches and to collect and disseminate quality data about use of healthcare systems.

Support the housing stability of vulnerable families, children and youth
- Assess the feasibility of deploying a “systems navigator” function that will align and coordinate services at the individual family level across sectors and at different levels of service delivery.
- Incentivize the creation of service-supported affordable housing for families.
- Develop targeted outreach strategies to identify youth and young adults without permanent housing and connect them to the housing and support they need; develop partnerships with school systems in this effort.
- Expand the range of housing options for youth and young adults facing housing loss.

Break the cycle of homelessness and re-incarceration
- Target housing resources and other supports to prevent and end homelessness among people leaving incarceration.
- Align housing resources and other supports to prevent and end homelessness among people leaving incarceration.

INCREASE LEADERSHIP, COLLABORATION, AND CIVIC ENGAGEMENT

Lead, manage and monitor the change process
- Reaching Home 2.0 would become the leadership structure for planning and oversight of Opening Doors - CT that builds upon existing partnerships between the public, private, and nonprofit sectors.
- Develop operational plans at the state and local level with specific actions linked to resources and responsible parties.
- Create opportunities to ensure that the voices of people who have experienced homelessness and people working on the front lines of service delivery are heard.
- Develop outcome measures at both the system level and at the program level.
- As the State looks at its overall use of data and use of technology, consider the creation of a human services data warehouse to provide a platform for integrating key data across HMIS and human services.
What unites us all, what powers us all, is the vision of a society where everyone has a place that they can call home – safe, decent, affordable places in healthy, economically sound and supportive communities. At the center of everything we do is the idea of individual empowerment, of helping people to help themselves by getting access to the tools and means to achieve.

Robert Hohler
Executive Director, Melville Charitable Trust
2004

Introduction

In June 2010, the United States Interagency Council on Homelessness (USICH) issued the first federal comprehensive plan to prevent and end homelessness. This plan, Opening Doors, provides a road map for joint action by 19 federal agencies and local and state partners to align housing, health, education and human services to prevent Americans from experiencing homelessness. As the most far-reaching and ambitious plan to end homelessness in our nation’s history, Opening Doors calls for a fundamental shift in how the federal government and communities across the country respond to homelessness.

Central to this shift is greater emphasis on helping people secure and retain safe, stable housing. From years of practice and research, we know that housing is an essential platform for human and community development. Stable housing is the foundation upon which people build their lives – absent a safe, decent, affordable place to live, it is next to impossible to achieve good health, positive educational outcomes, or reach one’s economic potential. For many people living in poverty, the lack of stable housing leads to costly cycling through crisis-driven systems like foster care, emergency rooms, psychiatric hospitals, emergency shelters, domestic violence shelters, detox centers, and jails. By the same token, stable housing provides an ideal launching pad for the delivery of health care and other social services focused on improving life outcomes for individuals and families. More recently, researchers have focused on housing stability as an important ingredient for the success of children and youth in school.

Connecticut has made remarkable strides in advancing housing-based solutions to homelessness – most significantly through the creation of close to 4,500 units of permanent supportive housing, most of it targeted to people with disabilities who have long histories of homelessness. But there is much more work to be done, and on a broader scale. In 2010, 13,401 people in Connecticut used emergency shelters at some point during the course of the year; one out of seven was a child. The challenge offered by Opening Doors is to address concurrently the needs of the variety of households who face homelessness every day, including families with children, youth, Veterans, and chronically homeless adults.

Opening Doors is already forging new partnerships between agencies like HUD, HHS, Education, and the U.S. Department of Labor that will translate into new opportunities for states in addressing
homelessness. The Homeless Emergency and Rapid Transition to Housing (HEARTH) Act, passed by Congress in 2009, is also providing new incentives and guidance to local communities in re-organizing their homeless services. The landmark Affordable Care Act is providing new opportunities to enhance supportive housing services by expanding Medicaid eligibility to most low-income individuals under age 65 and by supporting demonstration projects to improve health care for vulnerable populations.

With preparation, Connecticut can take advantage of these and other opportunities to significantly move the needle on ending homelessness. With this in mind, the Partnership for Strong Communities, working in tandem with the Connecticut Coalition to End Homelessness (CCEH), the Corporation for Supportive Housing, the Connecticut Housing Coalition, the Connecticut AIDS Resource Coalition, NAMI of Connecticut, and other leading intermediaries and advocates, has developed this framework named, Opening Doors – Connecticut. Opening Doors - CT has been a collaborative effort intended to engage, guide, and support the efforts of Connecticut government, communities, philanthropy, providers, and advocates in formulating and implementing strategies to prevent and end homelessness. The purpose of the effort is to foster change leading to deep impacts: substantial reductions in the number of people falling into homelessness, substantial reductions in the number of people returning to emergency shelters, and substantial reductions in the length of time people are homeless. In the last section of this document is a proposed re-structuring of the Reaching Home Campaign, which was launched in 2004 to build political and civic support for ending long-term homelessness through the expansion of supportive housing. This re-structuring is designed to ensure momentum for the broader effort, foster collaboration within and between the various sectors and systems that deliver needed services and work on solutions to prevent and end homelessness, and ensure that the issues and ideas presented in this framework are fully developed and implemented.

Opening Doors - CT kicked off in March 2011 with a series of six roundtable “listening sessions”, facilitated conversations among practitioners and policymakers in the fields of homeless services, health care, criminal justice, family and youth programs, community engagement, employment, and housing. In addition to these sessions, we invited broad input through an on-line survey. Through these means, over 250 stakeholders from across the state provided practical advice on effective Connecticut-based strategies for preventing and ending homelessness. We also examined the results of the extensive public comment provided to USICH in 2010 from stakeholders in the Northeast as part of the federal Opening Doors development. A summary of what we learned through this input process appears in Appendix A.

The second step in Opening Doors - CT was the development of this Framework, designed to provide a common understanding of the issues and a guide for devising effective strategies at the state and local level. The Opening Doors - CT Framework is, in a sense, an extension of the federal Opening Doors, building upon its work to recommend ideas that are more Connecticut-specific. The first section of this Framework summarizes what we know about homelessness in Connecticut, and includes a projection of housing needs among families, Veterans, and chronically homeless adults over the initial five year Opening Doors planning timeframe (2010-2015). The second section describes the current systems in place that significantly impact, or are impacted by, homelessness, and identifies what needs to change if we are to be successful in reaching our goals. This section also offers ideas for how we collectively organize as a state to undertake the work ahead.
The next step in Opening Doors - CT will be one of rolling up our collective sleeves and getting on with the hard business of making change. Going it alone is not an option. Opening Doors is rooted in the primacy of collaboration based on shared goals – across and within government; between the public and private sectors; across disparate systems such as housing, health care, behavioral health, workforce, and criminal justice; between providers of services at ground level; and, most of all, partnerships with the very people who are experiencing housing loss. That is why it is proposed that Reaching Home become the vehicle through which this work of collaboration proceeds, which is described more fully in this Framework.
Context for the Opening Doors-Connecticut Framework

Opening Doors - CT embraces the vision, core values, and goals laid out in the federal Opening Doors plan. We also use the same starting year as the Opening Doors plan, which is 2010, and adopt its initial five-year planning timeframe of 2010-2014.

Vision
No one should experience homelessness – no one should be without a safe, stable place to call home.

Core values
- Homelessness is unacceptable. It is solvable and preventable.
- There are no “homeless people,” but rather people who have lost their homes who deserve to be treated with dignity and respect.
- Homelessness is expensive. Invest in solutions.

Goals
- Finish the job of ending chronic homelessness in 5 years.
- Prevent and end homelessness among Veterans in 5 years.
- Prevent and end homelessness among families, youth and children in 10 years (by 2020).
- Set a path to ending all types of homelessness.

Opening Doors - CT is guided by a set of key principles
- Stable housing is the foundation.
- What happens at the ground level matters.
- Collaboration is fundamental to our success.
- Our strategies and solutions must be driven in a way that puts the person or family facing homelessness at the center.
- Strategies must be implementable, user-friendly, cost-effective, and scalable.
What do we know about homelessness in Connecticut?

(Editor’s note: This section is drawn in large part from Portraits of Homelessness in Connecticut, issued February 2011 by the Connecticut Coalition to End Homelessness (www.cceh.org) and data from the Connecticut 2009 and 2010 Sheltered Point in Time Homeless Counts (CT PIT), and from the Connecticut Homeless Management Information System (CT HMIS), also managed by CCEH.

On any given day, there are approximately 3,800 men, women and children staying in Connecticut emergency shelters and transitional housing programs. This is not a finite population. Over three times as many people (13,400) have used shelter at least once during the year than those who are homeless at any given point in time. With the exception of a core of households who are homeless for long periods of time, there is a tremendous fluidity of people moving into and out of homelessness – some for the first time, some repeatedly over time.

Homelessness is a situation that people find themselves in; it is not a characteristic of the people experiencing it. Effectively addressing homelessness means facilitating the transitions of people out of this situation, preventing their return to it, and preventing people from becoming homeless in the first place. Connecticut and national data help us better understand who is most impacted by homelessness and who is most likely to fall within its grasp.

While the majority of people who are homeless in Connecticut are White, people who are Black and people who are Latino are disproportionately represented among the homeless population. While Blacks represent only 10.4% of the population in Connecticut, 36% of emergency shelter clients overall report as Black or African American. Hispanic/Latino persons of any race represent 12.3% of the Connecticut population, but comprise 28% of all emergency shelter clients. Young, single-parenting Black and Latina women are significantly overrepresented among homeless families in Connecticut.

Among people using shelter during 2010, 60% were adults without accompanying children, and 40% were adults and children in households with dependent children.¹

The terms “single adults” and “adults without children” are sometimes used in this Framework to refer to individuals age 18 and over who do not have children living with them; however, this does not mean that they do not have children. Family separations are unfortunately all too common among homeless families. A national study reported that 60% of all homeless women had children below 18 years, but only 65% of those women lived with any of their children (and often not all of their children); forty-one percent of all homeless men had minor children, but only 7% lived with any of them.²

¹Counts of people who are in Connecticut shelters and transitional housing programs are always an underestimate of homelessness because they are limited by the number of beds in these settings. They do not capture the number of people turned away and those who do not seek shelter. They also do not include people living in doubled up housing situations with family or friends.

These numbers are consistent with other studies, in which large numbers of homeless individuals and families report children living elsewhere, most often with relatives, but sometimes in foster care. Homless families are far more likely to become separated from children than housed families, and homelessness can make the reunification of separated families more difficult. This is particularly true if, after separation, parents lose access to income and housing supports that allow them to create a suitable environment for their children. Because separation from the family of origin in childhood is one predictor of homelessness among adults, the patterns of family separation are not only costly to families and government in the short term, but may also entail future costs.

Due to changes in HMIS data collection methods from 2009 to 2010, we are not able to reliably compare annual homeless estimates between these two years. However, CT PIT data indicates that overall there was a 3% increase in the number of sheltered homeless persons counted at a single point in time between 2009 and 2010 (a 4% increase in the number of households).

**Single adults.** Over 8,120 adults without children used Connecticut shelters or transitional housing in 2010. Adults without children use emergency shelter more often than do families, and are more likely to live on the streets. Most single shelter users are male (69%), and most stay in shelter for less than three months. However, a significant number of single adults – around 10% - remain in shelter for six months or longer. Single adults counted in emergency shelters or transitional housing were most

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4 Shinn, M.B., et.al. (2005)
### CT Point in Time Count of Homeless Persons - 2009

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<th>Date of point-in-time count: 01/28/2009</th>
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<th>Unsheltered</th>
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### CT Point in Time Count of Homeless Persons - 2010

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<td>1. Number of Households with Dependent Children:</td>
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<td>1a. Total Number of Persons in these Households (adults and children):</td>
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</tr>
<tr>
<td>2. Number of Households without Dependent Children:</td>
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<tr>
<td>2a. Total Number of Persons in these Households:</td>
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<tr>
<td>3. Total Households (add lines 1 and 2):</td>
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<tr>
<td>3a. Total Persons (Add Lines 1a and 2a):</td>
<td>2314</td>
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</table>

### Percent Change from 2009 to 2010

<table>
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<tr>
<th>CT Point in Time Count</th>
<th>Sheltered</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Emergency</td>
</tr>
<tr>
<td>1. Number of Households with Dependent Children:</td>
<td>-2%</td>
</tr>
<tr>
<td>1a. Total Number of Persons in these Households (adults and children):</td>
<td>-1%</td>
</tr>
<tr>
<td>2. Number of Households without Dependent Children:</td>
<td>-5%</td>
</tr>
<tr>
<td>2a. Total Number of Persons in these Households:</td>
<td>-6%</td>
</tr>
<tr>
<td>3. Total Households (add lines 1 and 2):</td>
<td>-5%</td>
</tr>
<tr>
<td>3a. Total Persons (Add Lines 1a and 2a):</td>
<td>-4%</td>
</tr>
</tbody>
</table>
likely to be 40-49 years old (30%). At any one time, 15-20% of homeless single adults are unsheltered, living outdoors or in cars or abandoned buildings.\(^5\)

During the 2010 PIT count, 60% of single shelter users reported that they had been without a permanent place to live before. Among all adults without children who used shelter during 2010, over one in four had been in shelter the previous year. One in three had entered shelter from a doubled up situation, staying with a family member or friend.

Homeless adults without children report higher rates of illness and disability than families with children. More than half of adults without children (54%) reported having at one time been “in hospital, detox, or rehab for substance abuse”, as compared to 13% of adults with children. More than one in three adults without children reported a history of hospitalization for mental health issues (38%), compared with 16% of adults with children.

**Families.** Families made up about 28% of total households using emergency shelter and transitional housing in Connecticut last year, but comprised 40% of the total people served by these programs. This includes over 1,900 children. In total, there were 3,116 families served by shelters and transitional programs over the course of the year, compared to only 440 served at a single point in time.

Homeless families are more similar to other poor families than they are to homeless adults without children. Family stays in shelter are shorter than for households without children. Over a third of people in families (39%) stayed in Connecticut emergency shelters for 30 nights or fewer; over three-quarters stayed 90 nights or fewer (nights were not necessarily consecutive). Only 7% slept in shelters for more than 6 months’ worth of nights. Most families in shelter came from housed situations, with half “doubled up” (staying in the home of a family member) or coming directly from housing that they rented or owned (28%).

Only one in ten adults in families that stayed in shelters in 2010 also had stayed in shelter the year before - but this underrepresents the significant housing instability among vulnerable families. Homeless episodes are typically part of a longer period of residential instability marked by frequent moves, short stays in one’s own housing, and doubling up with relatives and friends. Over half (54%) of families surveyed in the 2010 CT PIT count reported having been without a ‘permanent place’ before – half of these (27%) were without permanent housing at least twice before. Shelter use is one indicator of housing instability, but it does not tell the full story.

Housing stability means not simply staying put, but having the freedom to stay put for as long as one likes, as well as the freedom to plan one’s moves to maximize their benefits. Moving to take advantage of better housing or a better school district would not be considered housing instability. Unplanned, involuntary, or forced moves (such as having to move because the rent cannot be paid, or under threat of eviction, or because of domestic violence) present special challenges for the wellbeing of children, including disruptions in education. Evidence from the Women’s Employment Study found that children who underwent involuntary moves were significantly more likely to register excessive

\(^5\) 16.8% of homeless adults without children were unsheltered in 2009, per CT PIT.
school absences or to increase the frequency with which they were absent after the move, as compared with voluntary movers.⁶

According to the Connecticut Department of Education (DOE), 2,387 homeless children and youth attended Connecticut public schools during the 2008-2009 academic year. This includes students identified as living doubled up (not a homeless category in HMIS), in shelters, or in hotels or motels, and those who are with their families and those who are unaccompanied. This number is likely an undercount, as student homelessness is often unreported; it also does not include pre-school age children and those who are homeless outside the academic year.⁷

As the National Alliance to End Homelessness has reported, “the threat of homelessness looms constantly over most poor families who struggle to meet their rent or mortgage payments, but there are risk factors or predictors of homelessness that suggest that some families affected by the affordable housing crisis are more likely to become homeless than others. Families that become homeless tend to share certain characteristics: they have extremely low incomes, tend to have young children and be headed by a younger parent, lack strong social networks, and often have poor housing histories or move frequently.”⁸

Data in Connecticut bears this out. The majority of families with children who use Connecticut shelters are headed by young single mothers (18-29 years of age), with children under the age of 5. Given the high incidence of homelessness among youth who have aged out of the foster care system, it is likely that some of the young mothers were raised in the foster care system, although specific numbers are not known.

Another factor that looms large for homeless families is trauma and domestic violence. Last year, 41% of homeless adults with children in Connecticut reported that they believed that domestic violence had directly contributed to his or her current homelessness.⁹ Survivors of interpersonal violence often experience high rates of depression, post-traumatic stress disorders, substance use, and health complications as a result of the abuse.

Youth. Unaccompanied homeless youth are identified as youth ages 12-24 with no familial support or permanent residency. There is no reliable or consistent data on the numbers of unaccompanied homeless and vulnerable youth in Connecticut. Part of the reason for this is that homeless youth rarely use the shelter system, often due to concerns about personal safety, and are more likely to “couch surf” in the homes of friends or acquaintances. Nevertheless, data from CT HMIS for 2010...

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⁷ At this time, DOE data on homeless children and youth is not integrated with the CT HMIS system and cannot be compared to CT HMIS data on homeless children and youth due to differences in definitions, time period of data gathering, and other factors.


⁹ 2010 CT PIT
found a total of 1,312 emergency shelter users between the ages of 18 and 24 over the course of the year (this includes both unaccompanied youth as well as youth in families).

Homeless youth share many characteristics and experience similar problems to those of homeless adults. They often have a history of academic and school behavior problems, come from low-income communities, and are at risk for a variety of mental health problems, including mood disorders, suicide attempts, and post-traumatic stress disorder. Most cite family conflict as a significant contributor to their homelessness.

Like homeless adults, a disproportionate segment of homeless youth reports a history of out-of-home care placement. The percentage, which report being placed in foster care or an institutional setting varies across studies, but estimates range between 21% and 53%. Anywhere from 15% to 39% of homeless adults have lived in foster care as children, compared with much lower rates for low-income individuals. Youth who “age out” of foster care are expected to live independently once they leave the child welfare system but often lack the financial, social and personal resources needed to succeed.

A significant percentage of homeless youth are pregnant or parenting. Research suggests that approximately 10% of both street and shelter female youth are currently pregnant.

Two sub-populations of youth particularly vulnerable to housing instability and homelessness are those with criminal justice involvement and lesbian, gay, bisexual and transgender youth (LGBT). Compared to heterosexual homeless youth, LGBT homeless youth leave home more frequently and are exposed to greater victimization while on the streets, as well as physical and sexual abuse from caretakers.

Households experiencing chronic homelessness. Chronically homeless households are those who experience repeat episodes of homelessness or episodes of long duration. Although chronically homeless individuals represent a small share of the overall homeless population, they use more than half of all shelter services. Many chronically homeless individuals have significant barriers to housing stability, which may range from limited income to chronic disabling conditions or former criminal justice involvement. They often cycle between homelessness, hospitals, jails and other institutional care and commonly have complex medical problems, serious mental illness and/or alcohol or drug addiction.

By Federal definition, a chronically homeless household is “an unaccompanied homeless individual (18 or older) with a disabling condition or a family with at least one adult member (18 or older) who has a disabling condition who has either been continuously homeless for a year or more OR has had at least

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The 2010 CT PIT reported 595 chronically homeless adults without children in emergency shelters and 28 adults in families, or approximately 20% of all sheltered households. Many chronically homeless adults are unsheltered, living outdoors or in cars or abandoned buildings. The most recent data on unsheltered persons was the 2009 PIT, which reported that 260 chronically homeless adults without children and 2 adults with children were unsheltered, together representing 28% of all chronically homeless adults.

<table>
<thead>
<tr>
<th>CT Point in Time Count - Homeless Subpopulations 2009 and 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults only, except g. below. Unsheltered persons were not counted in 2010</td>
</tr>
<tr>
<td>-------------------------------------------------------------------</td>
</tr>
<tr>
<td>a. Chronically Homeless</td>
</tr>
<tr>
<td>a1. single adults who are chronically homeless</td>
</tr>
<tr>
<td>a2. adults in families who are chronically homeless</td>
</tr>
<tr>
<td>b. Severely Mentally Ill</td>
</tr>
<tr>
<td>c. Chronic Substance Abuse</td>
</tr>
<tr>
<td>d. Veterans</td>
</tr>
<tr>
<td>e. Persons with HIV/AIDS</td>
</tr>
<tr>
<td>f. Victims of Domestic Violence</td>
</tr>
<tr>
<td>g. Number of Unaccompanied Youth</td>
</tr>
</tbody>
</table>

**Veterans.** Veterans have long-represented a sizable percentage of the homeless population. At any one time, about 11% (462) of homeless adults in Connecticut are Veterans. Close to one in four are unsheltered, living outside or in cars or abandoned buildings. There is not consistent data on the number of Veterans who experience homelessness in Connecticut over the course of the year. The U.S. Department Veterans Affairs (VA) is currently working with HUD to integrate its data system on homelessness with HUD’s HMIS system. The VA CHALENG report, which uses different definitions of

13 U.S. Department of Housing and Urban Development [Docket No. FR-5415-N-17] Notice of Funding Availability (NOFA) for the Continuum of Care Homeless Assistance Program

14 Since chronically homeless adults are more likely to be homeless at a single point in time than other persons, point in time counts over-represent the percentage of all homeless persons who experience chronic homelessness. The percentage of chronically homeless adults to total homeless adults over course of year is closer to 10%.

15 Based on CT PIT2009: 462 Veterans were counted among 4206 homeless adults
homelessness than HUD’s HMIS system, estimates that there are more than 800 Veterans in Connecticut who are homeless over the course of the year.

Veterans who end up homeless often return from conflict with post-war challenges that can inhibit their re-entry into civilian culture. These include emotional trauma, mental illness, physical injuries and addictions. Veterans make up close to 20% of the chronically homeless adult population; they are most often male, Vietnam-era Veterans over the age of 50. However, the “new generation” of Veterans experiencing homelessness are younger soldiers returning from Iraq and Afghanistan, female Veterans, and families of Veterans suffering from economic hardship.

**Contributing Factors to Homelessness**

Most often, people who experience homelessness face multiple barriers to economic and health security and few resources and support networks in the community. The most common contributors to homelessness in Connecticut are these:

**Inadequate income.** Persons experiencing homelessness typically have incomes below half the federal poverty level.\(^{16}\) This equates to an annual income of less than $7,300 for a family of two. The economic downturn has pushed more families into poverty and many more into joblessness and economic strife. Only 21% of adults using shelters in 2010 reported having income from employment. Close to 30% reported income from Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Forty-five percent reported no financial resources whatsoever.

**High cost of housing.** The lack of affordable housing is the primary cause of homelessness among families in Connecticut, as it is in the U.S. This is both because there is an inadequate supply of affordable housing and because incomes are so low that families cannot pay for the housing that is available.\(^{17}\)

Despite the economic downturn and a record number of foreclosures, Connecticut remains an expensive state to buy or rent housing. The National Low-Income Housing Coalition found that in 2010 a family in Connecticut would have to work fulltime, year-round at $23 an hour ($47,843 per year) to afford the fair market rent on a two-bedroom apartment (this figure is $35/hour in Fairfield County). The housing cost burden wage of $23 is thirty-five percent higher than the mean wage in Connecticut of $17.01, and close to three times Connecticut’s minimum wage of $8.25.\(^{18}\)

The 2009 American Community Survey of the US Census reports there are 92,266 renter households with extremely low incomes in Connecticut who pay more than half of their income for housing costs. Their average housing cost burden is 84% of income. For every 100 of these households, there are only

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38 affordable rental units available. “Extremely low income” is defined as an income at or below 30% of Connecticut’s median income. This is about the same as the federal poverty level.19

Such housing cost burdens leave almost no room for other necessities such as food, clothing, transportation, utilities and healthcare. If an unexpected problem arises, such as a job loss, medical expense or significant car repair, a household can quickly fall into financial crisis.

One result of the high cost of living in Connecticut is that residents tend to move from place to place more often. Mobility rates for urban Connecticut are between 45% and 80%.20 Homelessness has a tragic tendency to reinforce itself – families that have experienced high rates of housing instability have a compromised environment for learning and earning. Students who experience high mobility have lower levels of educational achievement in math and reading.

**Interpersonal violence.** Domestic violence is a leading precursor to housing instability and homelessness among families. Survivors of interpersonal violence, particularly those with limited resources, often have to choose between living with or near their abusers or becoming homeless. Many survivors become homeless after fleeing an abusive relationship or after being evicted for reasons related to the abuse, such as police involvement or property damage. Abusers often control finances to maintain control in relationships, which means survivors may lack steady income, landlord references and good credit, all of which are necessary to find new housing.

**Disabling health conditions.** Homelessness is directly associated with poor health outcomes. People living in shelters or on the streets are extremely vulnerable to health risks and have great difficulty maintaining compliance with health care treatment regimens. Chronic and disabling medical conditions are rising among the homeless population as they are in the general population. This is expected to take on increasing prominence for homeless service and health systems as the homeless population continues to age. Mental and physical health problems are exacerbated by living on the streets and in shelters. Health conditions that require ongoing treatment — such as diabetes, HIV/AIDS, addiction and mental illness — are difficult to treat when people are living in shelter or on the streets.

**Re-entry and criminal justice involvement.** Housing problems and homelessness are common among individuals leaving the corrections system. They tend to have limited or low incomes and, due to their criminal history, are often unable to obtain housing and employment through channels that are open to other low-income people. Criminal background checks are frequently employed by landlords, and these can make it challenging for formerly incarcerated people to secure housing. People re-entering the community from jails or prisons often have no other choice than to turn to emergency shelters. It is estimated that one in five people who leave prison becomes homeless soon thereafter, if not

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immediately. Shelter use, both before incarceration and after release, is associated with an increased risk of return to prison. Many people with mental health and substance use issues cycle between homelessness and incarceration for months or years at great public expense.

**Cost of Homelessness**

The costs to society of homelessness and housing instability are reflected in many sectors:

**Health care**

- Chronically homeless adults often have serious health conditions - such as mental illness, a substance use disorder, or a chronic health problem - that present persistent obstacles to maintaining housing. The chronic nature of their homelessness is associated with more severe symptoms of alcohol abuse, schizophrenia, and personality disorder; poor health conditions; increased risks of HIV-infection; and premature death.\(^\text{22}\)

- Repeated hospital visits account for disproportionate costs and time for emergency departments, drain health care resources, and increase stress on emergency department staff.\(^\text{23}\) Numerous studies have documented reductions in avoidable emergency room visits, inpatient hospitalization for medical or psychiatric care, and use of sobering centers once people with serious health conditions are stably housed.\(^\text{24}\)

**Schools**

- Homeless school age children are more likely than similar age children in the general population to have emotional problems such as anxiety, depression, and withdrawal, and to manifest aggressive behavior.\(^\text{25}\)

- Because many homeless children have such poor education experiences, their future productivity and career prospects may suffer. This makes the effects of homelessness much longer lasting than just the time spent in shelters.

- Repeated school mobility leads to decreased academic achievement, impacting both the child’s and the school’s overall performance.\(^\text{26}\) Almost half of homeless children attend two different

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\(^{24}\) Summaries of outcomes from cost studies with citations and links to published research are available in a paper by Dennis Culhane “Ending Chronic Homelessness: Cost-Effective Opportunities for Interagency Collaboration” which can be found at [http://documents.csh.org/documents/policy/UpdatedCostMatrixSept09.pdf](http://documents.csh.org/documents/policy/UpdatedCostMatrixSept09.pdf)


schools in one year. As a result, three-quarters of homeless children perform below grade level in reading, and more than half perform below grade level in math.  

Foster care

- Approximately one-third of children in foster care have a homeless or unstably housed parent.
- Children placed in foster care are at higher risk of experiencing homelessness in the future.
- The cost of placing two children from a family experiencing homelessness in foster care is about $34,000 per year.  

Neighborhoods and downtown business districts

- The visibility of homelessness on the street may discourage shoppers from visiting downtown areas and contribute to perceptions that neighborhoods or downtown districts are unsafe or undesirable.

Jails, court systems and community safety

- Prisons and jails treat more people with mental illness than hospitals and residential treatment facilities combined, making our jails and prisons the primary provider of mental health care in the US. 43% of defendants with mental health disorders were homeless when committing the crime for which they were arrested.
- The cycle of arrest, removal, incarceration, and re-entry is predominantly concentrated in the poorest communities and neighborhoods.

Shelters

- The annual cost of an emergency shelter bed in Connecticut is approximately $8,760. For a family of three, this is an annual cost of $26,280, or $2,190 per month. In many parts of the state, this is twice the fair market rent on a two-bedroom apartment.


• People who are turned away from shelters because the shelters are full or for other reasons often seek refuge in abandoned buildings, cars, parks, under bridges, or other spaces not meant for habitation.

The State and local governments feel the impact of homelessness and housing instability directly in their budgets, by paying for increasingly expensive costs that could have been avoided: Medicaid, behavioral health, and uncompensated care funding for inpatient and acute health services; foster care placements; school transportation; recidivism through jails and courts; and subsidies for shelters and specialized homeless services. Unless interrupted, the multi-generational cycle of housing instability continues to take its toll in human and financial terms, as homeless children become homeless adults.

**How many people will need housing assistance during the Opening Doors timeframe? (2010-2014)**

Central to efforts to prevent and end homelessness is stable housing. But that doesn't mean that everyone who is facing homelessness will need the same kind of assistance to access and sustain permanent housing. Some people will just need help staying where they are, which could involve legal assistance to prevent an eviction, help covering back utility payments, or short term rental assistance to get them over the hump of a personal crisis. Others will need small amounts of financial help, such as help with a security deposit or funds to move into a safe apartment and prevent entry into shelter. Many families and individuals in shelter or likely to return will need a rent subsidy or access to housing with affordable rents. They may also need help in securing an apartment and making connections to community resources that will support them in their new home. Families and individuals who have been homeless frequently, particularly those with disabilities, will often need permanent supportive housing, which combines an affordable apartment linked to an array of flexible supports and services designed to meet their individual needs.

While housing assistance can take a variety of forms, depending on individual needs, there are four primary vehicles for the delivery of this assistance at the community level:

**Prevention** strategies are designed to keep people in their housing or otherwise avert their entry into emergency shelter. Prevention efforts include a wide range of activities: mediation services that help families negotiate with their landlord, financial assistance to help people pay for back rent or utilities, budgeting and credit counseling, and emergency assistance in food, clothing and transportation vouchers. Prevention can also involve helping people move directly from a doubled up situation, an institutional discharge, or a finalized eviction into housing of their own, without ever having to become homeless.

**Rapid re-housing** approaches are designed to help people transition more rapidly out of the shelter system. These strategies include crisis intervention, re-housing as quickly as possible, follow-up case management, and housing support services to prevent the reoccurrence of homelessness. What differentiates this approach from shelter or transitional housing is that there is an immediate and primary focus on helping people quickly access and then sustain permanent housing. Rapid re-housing programs typically provide one-time or short-term financial assistance (e.g., money to pay security
deposits, moving costs, etc.) often coupled with a few months (or longer) of rental assistance and services that focus on stabilizing the family or individual and linking them with a community-based support system.

**Affordable housing** strategies are designed to ensure the long-term affordability of housing and its access by persons who are homeless or who are most likely to become homeless. Housing affordability may be provided through long-term rent subsidies that provide a monthly supplement to fill the gap between affordable and actual rent (e.g., the subsidy pays the difference between 30-40% of tenant income and actual rent). Affordability may also be created through the provision of an operating subsidy that enables the owner of the housing to cover the difference between a rent level that is affordable to the tenant and what it costs to operate the housing. Affordable housing needs may be met through a combination of improved access to existing units of affordable housing and the creation of additional housing resources. New housing resources may include rental assistance vouchers and development of permanent housing which includes units subsidized and available to households with no or limited incomes. In some cases the affordable housing will be connected to service coordination or mainstream employment and youth programs, or coupled with the provision of time-limited services that help tenants connect to ongoing community supports.

**Permanent supportive housing** strategies go one step further and ensure the provision of affordable housing that offers supportive services aimed at helping the individual or family maintain housing stability and achieve personal goals in areas such as health, employment, and community integration. Supportive housing may include apartments located at a single site (i.e., multiple units located within a single building or apartment development) or units scattered throughout the community. It can be created through the construction or acquisition of buildings or through access to existing housing using tenant-based subsidies or other funding mechanisms.

As a starting point for Opening Doors - CT, we sought to estimate the number of households who will need these four types of assistance over the initial five-year time span of Opening Doors in order to end Veteran and chronic homelessness by 2015 and family homelessness by 2020. To develop these estimates, we drew from Connecticut PIT Count and HMIS data and available research, and developed the estimates below. In addition to Veterans, families, and chronically homeless adults, we also identified the housing assistance needs among a subset of homeless adults without children based on health-related vulnerability. This includes homeless adults with disabilities or HIV/AIDS, older adults and vulnerable youth.

A full description of the assumptions underlying all these need estimates appear in Appendix B.
### CONNECTICUT STATEWIDE

#### Estimated Needs for Housing Assistance Over Five-Year Timeframe - Opening Doors Connecticut

<table>
<thead>
<tr>
<th>Estimated needs for housing assistance, by type, among targeted households who will experience homelessness (unless prevented)</th>
<th>2012-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Families with Children</td>
</tr>
<tr>
<td>Prevention Strategies*</td>
<td>520</td>
</tr>
<tr>
<td>Rapid Re-Housing*</td>
<td>920</td>
</tr>
<tr>
<td>Deeply Affordable Housing**</td>
<td>360</td>
</tr>
<tr>
<td>Permanent Supportive Housing</td>
<td>590</td>
</tr>
<tr>
<td>Estimated need that could be met through turnover of existing supportive housing units</td>
<td>(400)</td>
</tr>
<tr>
<td>Need for new Supportive Housing</td>
<td>190</td>
</tr>
<tr>
<td>Estimated Total Targeted Households</td>
<td>2,390</td>
</tr>
<tr>
<td>Needing Housing Assistance 2012-2016</td>
<td>6,840</td>
</tr>
</tbody>
</table>

*Does not assume permanent rent subsidies connected with prevention and rapid re-housing.

**Deeply affordable housing refers to subsidized rental housing that is affordable to persons living in deep poverty and targeted to households experiencing homelessness. Affordable housing and permanent supportive housing options can take the form of scattered subsidized apartments or the development of buildings through new construction or rehabilitation. The affordable housing numbers presented here do not include rent subsidies needed to prevent homelessness or that may be used in conjunction with rapid re-housing or permanent supportive housing. These numbers also do not encompass the need for affordable housing among low income households who are not experiencing homelessness. Significantly increasing the availability of rental housing that is affordable to households with the lowest incomes would be the most effective strategy for preventing and ending homelessness. The need for affordable housing in Connecticut is much larger than the number of affordable housing units needed to serve households who have become homeless.

^The permanent supportive housing figures for “other adults without children” represent approximately 50% of estimated total adults without children who will experience homelessness (if not prevented). Does not include chronically homeless adults. Includes persons with behavioral health and primary health care needs, older adults, and vulnerable youth. The provision of supportive housing is a means to better address the housing and service needs of vulnerable adults and is a means to prevent chronic homelessness. If these units are provided, it is possible that fewer units of permanent supportive housing will be needed than estimated above in the Chronically Homeless Adults column. However, because we do not have reliable full year data on the number of adults without children who experience chronic homelessness over the course of the year, the projections above are already fairly conservative.

Most homeless adults without children do not need permanent supportive housing. The majority exit homelessness quickly, often with support from family, friends, and other community resources, but many do return. Effective prevention, rapid re-housing, and affordable housing assistance could further reduce the number of individuals experiencing or returning to homelessness. In order to keep the focus on targeted households, the prevention, rapid re-housing, and deeply affordable housing numbers in this column reflect only the need among Other Adults without children who are Veterans.

^^^5% of homeless Veteran households are estimated to be families with children. 30% of homeless Veteran households are estimated to be chronically homeless adults. The number of permanent supportive housing units for Veterans assumes that 5% of these units would be for Veteran families; of the remainder, 50% would be for chronically homeless Veteran adults and 40% would be for other homeless Veteran adults without children needing supportive housing and not yet chronically homeless.

^^The unaccompanied homeless youth population includes children and youth under 18 who are not residing with their legal guardians and young adults ages 18 through 21 who are not residing with families and who are experiencing poverty and homelessness. Obtaining accurate data on the prevalence and service needs of unaccompanied homeless youth is difficult. A Homeless Youth Study, in the planning stages, will conduct key-informant interviews with youth identified by community partners as “homeless, unaccompanied, and/or throw-away” and service providers currently working with this group. Using the qualitative information collected from the key informants, a quantitative measure will be constructed to “count” the challenges, resources, and needs of this group in an attempt to describe the experience of these young people and affect policy.
What does Connecticut's system for addressing homelessness look like now, and what needs to change?

The strategies of the federal Opening Doors plan are organized around five themes:

- Increase access to stable and affordable housing
- Retool the homeless crisis response system
- Increase economic security
- Improve health and stability
- Increase leadership, collaboration, and civic engagement

We have adopted these themes as a framework for briefly examining the current systems in place that significantly impact, or are impacted by, homelessness, and identifying what needs to change if we are to be successful in reaching the four goals of the plan. These ideas are by no means an exhaustive list, and should not be viewed as prescriptive, but rather as a way to focus and consider potential strategies that move us from where we are to what we all want to do: put in place the framework to prevent and end homelessness in Connecticut.

While we have suggested a number of ideas, we have not laid out how it should be done, or even precisely by whom or to what degree. This is deliberate. The next step of the Opening Doors - CT effort will be, through a reconstituted Reaching Home campaign (Reaching Home 2.0), to engage, guide, and support the efforts of Connecticut government, communities, philanthropy, providers, and advocates in a process to answer these questions. As a guiding framework, Table 1 of the section on Laying the Groundwork for Action shows how different population groups are targeted within each of the strategies. Table 2 of that section shows what systems would most likely be involved. Through the planning and implementation process, the feasibility of the strategies will be assessed, with some strategies taking longer to operationalize. We recognize that some strategies may prove not to be feasible to implement at scale.
Opening Doors - Connecticut
Summary of Strategy Ideas

INCREASE ACCESS TO STABLE AND AFFORDABLE HOUSING AND SUPPORTIVE HOUSING

Strengthen our housing delivery system; create supportive and affordable housing at a scale sufficient to meet the need

Expand and target rent subsidies.

Stimulate the development of supportive housing and of mixed income communities that include units affordable to households with extremely low incomes.

Embed strategies to end homelessness within cohesive State and municipal housing policies that set clear outcome targets.

Aggressively leverage and compete for Federal rent subsidies, housing development dollars, and service funding linked to housing.

RETOOL THE HOMELESS CRISIS RESPONSE SYSTEM

Recalibrate our response to housing loss

Within an overall policy framework support community or regional-level development of a coordinated system of response centered on homelessness prevention, housing assistance, and housing stabilization.

Target housing assistance to those most likely to enter or remain in shelter or in unsheltered settings.

Strengthen the capacity of Connecticut’s HMIS system to meet the expanded data-matching, reporting and research needs identified in the Opening Doors-CT process.

Align state and local activities.

INCREASE ECONOMIC SECURITY

Foster housing retention through income growth and employment

Link workforce system resources (skill & job development) with the housing assistance system to create effective pathways to employment for vulnerable populations.

Align public and private sectors to ensure effective systems coordination with shared goals.

Expand income growth for persons with disabilities.

IMPROVE HEALTH AND HOUSING STABILITY

Reduce medical vulnerability and frequent use of health care systems

Align state and local strategies to support the goals of improved access to health care and effective use of appropriate types of health services.

Maximize the use of existing and new health sector resources to address both the housing and service needs of extremely vulnerable populations.

Implement housing-based approaches to align with the health reform goals of prevention, greater access, better quality and lower cost.

Expand use of HMIS to support new targeting approaches and to collect and disseminate quality data about use of healthcare systems.

Support the housing stability of vulnerable families, children and youth

Assess the feasibility of deploying a “systems navigator” function that will align and coordinate services at the individual family level across sectors and at different levels of service delivery.

Incentivize the creation of service-supported affordable housing for families.

Develop targeted outreach strategies to identify youth and young adults without permanent housing and connect them to the housing and support they need; develop partnerships with school systems in this effort.

Expand the range of housing options for youth and young adults facing housing loss.

Break the cycle of homelessness and re-incarceration

Target housing resources and other supports to prevent and end homelessness among people leaving incarceration.

Align housing resources and other supports to prevent and end homelessness among people leaving incarceration.

INCREASE LEADERSHIP, COLLABORATION, AND CIVIC ENGAGEMENT

Lead, manage and monitor the change process

Reaching Home 2.0 would become the leadership structure for planning and oversight of Opening Doors - CT that builds upon existing partnerships between the public, private, and nonprofit sectors.

Develop operational plans at the state and local level with specific actions linked to resources and responsible parties.

Create opportunities to ensure that the voices of people who have experienced homelessness and people working on the front lines of service delivery are heard.

Develop outcome measures at both the system level and at the program level.

As the State looks at its overall use of data and use of technology, consider the creation of a human services data warehouse to provide a platform for integrating key data across HMIS and human services.
Increase Access to Stable and Affordable Housing and Supportive Housing

Fundamental to ending homelessness is the availability of rental housing that is affordable to households with extremely low incomes. These are incomes below 30% of area median income (AMI), a level that ranges from a low of $24,200 (family of 4) in Windham to a high of $37,700 in Stamford.

The National Low Income Housing Coalition reports that there were 128,577 Connecticut households with extremely low incomes in 2009. Of these, 79% (92,266) were “severely burdened,” meaning they spend more than half their income on rent and utilities. For every 100 Connecticut households with extremely low incomes, there are only 38 affordable and available rental units. Some of these units provide permanent supportive housing targeted to people experiencing, or at risk of, homelessness. As of February 2011, there were more than 4,500 units of supportive housing across Connecticut, including close to 200 units targeted specifically to homeless Veterans.

The affordability of housing to households with extremely low incomes can be achieved through the provision of a rent subsidy or through some form of operating subsidy that enables the owner of the housing to cover the difference between a rent level that is affordable to the tenant and what it costs to operate the housing. Rent subsidies can either be tenant-based or project-based.

Three primary rent subsidy programs operate in Connecticut: the HUD Section 8 program, the State Rental Assistance Program (RAP), and the HUD Shelter Plus Care (S+C) program. The waiting lists for all of these subsidy programs are long and favor those in a stable housing situation. Because an individual or family experiencing housing instability and homelessness moves frequently, the odds are against their securing a rent subsidy if and when they come up on a waiting list, because they likely will have moved in the meantime.

Additionally, individuals who have faced long-term homelessness often face barriers that preclude them from accessing subsidized housing, such as poor credit history, previous incarceration, or active substance use. These barriers can sometimes prevent vulnerable individuals and families who need housing the most from even getting on a waitlist, never mind making it to the top of the list.

At any given time, public housing authorities (including the Connecticut Department of Social Services) face multiple demands to direct subsidies to particular projects, programs, or special initiatives and to still make vouchers accessible to the general public. Without an overarching vision and set of guiding principles, a housing authority has no framework from which to make decisions for deploying this precious resource. The key is striking a balance between subsidy targeting and open access in order to achieve greater impact.

32 Permanent supportive housing inventory compiled by Partnership for Strong Communities and updated by Corporation for Supportive housing February 2011.
Beyond the issue of subsidy deployment is subsidy scarcity. There are simply not enough rent subsidies available to address the housing needs of the thousands of Connecticut families with the very worst case housing needs. And for persons in need of supportive housing, rent subsidies are only half the equation – the other half is services.

Rent subsidies are of limited use in communities where there are few apartments available in which to use them or the existing housing stock is in poor condition or inaccessible to transportation and other services. The development of mixed income rental housing and supportive housing through new construction or building renovation addresses this issue. While development of housing takes time, new housing also brings with it the opportunity to make an even greater impact in the lives of the tenants and the surrounding community by using the housing as a place for hosting or co-locating programs in health, recreation, financial asset-building, skill-building, child care or employment.

The primary developer of housing that includes units serving extremely low income households in Connecticut is the nonprofit community (including public housing authorities), both because it is within their mission to do so and because they often have the greatest experience navigating myriad public-sector financing systems for multifamily rental housing. More recently, some for-profit developers have agreed to establish set-asides of units serving very low-income households because of public incentives.

Over the past few years, the Connecticut Housing Finance Authority (CHFA) and the Connecticut Department of Economic and Community Development (DECD) have offered incentives in their scoring of funding applications to development projects that target units to households with incomes below 25% AMI or to homeless households receiving services. However, these incentives are not linked to the requisite rent subsidies and service funding to make the units work for their intended purpose. Developers also face unpredictability in the state housing finance process. Rather than each project having to navigate multiple sources of gap funding with separate processes, a process that puts the development in the middle and brings the resources to it would create greater efficiencies for the both project and the funders.

**Objective: Strengthen our housing delivery system; create supportive and affordable housing at a scale sufficient to meet the need**

**Expand and target rent subsidies**

1. Create new rent and operating subsidies.

2. Maximize the impact of rent subsidies by linking them to State and local prevention, rapid re-housing, and permanent supportive housing initiatives.

3. Utilize project-based rent subsidies in mixed income housing that provides set-aside units for households with extremely low incomes and for households receiving supportive housing services.
Stimulate the development of supportive housing and of mixed income communities that include units affordable to households with extremely low incomes

1. Provide flexible, debt free capital.
2. Link capital, project-based subsidies, and services funding for the development of new permanent supportive housing.
3. Streamline the funding process at the State level.
4. Build capacity to develop and operate units at the local level.

Embed strategies to prevent and end homelessness within cohesive State and municipal housing policies that set clear outcome targets

1. Establish clear statewide and municipal housing policies that incorporate benchmarks for preventing and ending homelessness and that are used to align and target State and municipal housing resources that may be administered by multiple departments and agencies.

Aggressively leverage and compete for Federal rent subsidies, housing development dollars, and service funding linked to housing
Retool the Homeless Crisis Response System

Connecticut’s current homeless service system is comprised of these elements:

- **Street outreach.** Street outreach workers build trusting relationships with homeless individuals living on the streets that gradually lead to their acceptance and openness to seeking help. It is an essential component in addressing chronic homelessness. Outreach programs have various levels of funding and composition depending on the community. The Connecticut Department of Mental Health and Addiction Services (DMHAS) uses federal and state funds to contract with a network of organizations to provide homeless outreach services.

  The U.S. Department of Veterans Affairs (VA) system in Connecticut has ramped up its outreach to homeless Veterans through drop-in services at shelters and soup kitchens, clinics at its medical centers, a VA Connecticut homeless hotline and national call center, and other strategies as part of its plan to end Veterans homelessness.

- **Emergency shelters.** Connecticut’s 2,189 state-funded emergency beds are spread among 24 shelters for homeless adults without children, 10 for homeless families, and 18 that serve a mixed population of both. In 2010, most Connecticut shelters operated above capacity. Shelters have differing admission criteria, services, length of stay policies, and philosophies. Many in-shelter services were developed out of necessity when mainstream and community-based organizations failed to sufficiently meet the complex needs of homeless individuals.

  The state-funded domestic violence shelter system is operated separately from emergency shelters, primarily taking referrals from domestic violence hotlines, local police and other service providers. There are 18 domestic violence shelters providing 226 beds. Length of stay is limited to 60 days.

- **Transitional housing** programs are intended to facilitate the movement of homeless individuals and families to permanent housing within 24 months. There are 75 HUD and State-funded transitional housing programs, 13 specifically for families, 47 for single adults, and 15 for a mix of both. Some of these programs are comprised of single buildings, some as scattered apartments. In the newest model, “transition in place,” the services transition away but the client stays in the housing, eventually assuming the lease as the transitional housing unit becomes their permanent home.33 More than 2,248 adults and children utilized HUD-funded transitional housing programs in Connecticut in 2010 (17% of all sheltered homeless persons).

  The Veterans Administration currently funds 158 privately-operated transitional housing beds in Connecticut that serve Veterans, all within single buildings.

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33 This is similar to the medium-term rental assistance and services model in some rapid re-housing programs.
Prevention and Rapid Re-Housing[^34]. Connecticut currently has three such programs using State-administered funds: Housing First for Families is a small program of the CT Department of Social Services (DSS) designed to help families find housing and re-house families who are targeted for re-unification with their dependent children upon placement in housing. DSS’s Beyond Shelter Connecticut operates in twelve locations and provides up to one year of coordinated follow-up services to households transitioning from homelessness to permanent housing. It does not offer rental assistance. The Homelessness Prevention and Rapid Re-Housing Program (HPRP) is a 3-year (2009-2012) Federal stimulus act program operating in five Connecticut cities and six regions and providing housing assistance and services for both prevention and rapid re-housing.

Of these three programs, HPRP is the most comprehensive in scope and scale. The United Way of Connecticut’s statewide 211 system, which has provided universal screening services for HPRP, received over 47,000 requests for housing or shelter services during the program’s first year. While HPRP is a time-limited program, this intensive experiment in delivering prevention and rapid rehousing services statewide holds important lessons for future work of this kind.

The VA has developed an operational plan for enhancing and expanding its homelessness prevention activities. Components of this plan include engagement of soldiers returning from Iraq and Afghanistan and their families who are homeless or at risk; expanded legal support to Veterans through the CT Veterans Legal Center to prevent evictions and foreclosure; intervening with jail diversion for Veterans facing charges or re-entering the community after incarceration; expansion of the HUD-VASH (Veterans Affairs Supportive Housing) case management program to ensure housing stability for previously homeless Veterans; and a new Veteran Families Program that will help community agencies provide housing assistance to Veteran households.

Historically, Connecticut’s first emergency shelters were created to serve as temporary safe harbors for increasing numbers of deinstitutionalized people and others turning up on Connecticut’s streets. During the 1980s, in city after city across the United States, people died in the cold. Faith communities and social service organizations mobilized, and cots and mattresses turned up in church basements, firehouse floors and town-owned property all over Connecticut. More and more communities were pressed to create new emergency shelters in response to the mounting crisis. By 2010, there were 2,189 emergency shelter beds and 1,472 transitional housing beds across Connecticut.

Most shelters and transitional programs were originally conceived as primarily responding to the needs of people while they are in housing crisis. But the term “housing crisis” implies a single precipitating event that results in housing loss and entry into a shelter. In reality, shelter use is more often a stop (often repeated) in a longer experience of housing instability, which may include stays with relatives or friends and frequent moves from place to place. Because housing loss is so intertwined with issues of income, health, safety, social and family supports, and the cost of housing, resolving housing loss is usually not as simple as providing a family with a referral to an apartment.

[^34]: See the section on “How many people will need housing assistance during the Opening Doors timeframe (2010-2014)” for a description of Prevention and Rapid Re-Housing Strategies.
There is now increasing agreement that getting back into a stable housing situation is the first essential piece to addressing these other issues – after all, it is difficult to get back on your feet when the ground is made of quicksand. The second piece is doing what it takes to stay there. Yet, too often, our concept of the homeless assistance system as one of crisis response means we focus considerable attention on the role and function of temporary settings such as emergency shelters and transitional programs but miss the boat in dedicating the resources and attention needed to get people into stable permanent housing and help them stay there.

If we reframe the homeless assistance system as a housing assistance system, then we organize our attention and resources around the end goal and not around the crisis. Shelters would continue to serve their essential functions of safety and comfort, but as a temporary resource while work is happening to help the family or individual get into stable housing as quickly as possible and to help them stay housed.

Recalibrating the homeless assistance system means adjusting methods, priorities, roles and relationships at the local level. What form this will take will vary community by community, but there are some basic principles that apply. The goal is to shift the balance of the system overall toward greater housing-focused responses.

Based on national best practices, we have illustrated the five elements essential to making the shift:

1. Pull together housing subsidies and other resources that can be immediately available
2. Establish a centralized, or at least a coordinated, intake system
3. Provide an immediate assessment of housing needs
4. Provide housing assistance
5. Provide housing stabilization supports

The demands of the recalibration process are challenging, particularly at a time when the shelter system is operating above capacity and hundreds of people are turned away from shelter every day. Addressing an issue this complex can only happen by tapping the brainpower, skills and resources of many people and disciplines working in tandem at the community level within a consistent policy framework. It is not the sole responsibility of traditional providers of homeless services.
Pull together housing subsidies and other resources that can be immediately available

Set up points of entry (centralized or coordinated intake system)

Provide an immediate assessment of housing needs

Provide housing assistance

Provide housing stabilization supports

Options:
- single physical location
- single virtual location (phone or web-based)
- multiple locations

Entry points have these attributes:
- Easily accessible for people who need immediate assistance
- Uniform - people get same assessment and assistance no matter when or where they make first contact
- Resources are immediately available (either directly or via referral) to prevent or respond to a homeless episode
- Data sharing agreements and referral protocols are in place between entry points and the providers of housing assistance services

What will it take to immediately house the individual or family?
What is the client requesting?
Assessment is not intended to develop a service plan - asks for only as much information as is necessary to make referrals to the appropriate intervention
The referral itself is fast, seamless, and easy for client to navigate

Typical forms of assistance:
Financial assistance for security & utility deposits or arrears, moving costs, etc.
Rental assistance - temporary or long-term
Assistance in finding and securing an apartment
Outreach & mediation with landlords or legal services to prevent eviction

Options for providing "just enough" assistance:
- Progressive engagement: start with small amount of assistance; then incrementally add assistance as needed as client needs become clear over time
- Triage: conduct in-depth housing barriers assessment to determine tier of assistance to be provided. Those with highest barriers receive most intensive package of assistance, those with lowest barriers receive least intensive package, etc.

Flexible and individualized case management designed to assist the client in becoming stable in their housing.
Focus is on service coordination and connecting the client to community services - organizing and coordinating the resources that touch that particular client.
May also include helping client build skill sets around maintaining housing, employment, health and social connections.
Stabilization supports step down to lower levels of intensity based on individual need.
If client is placed in permanent supportive housing, there may be a "hand off" to the supportive housing provider.

Pool of rent subsidy vouchers
Unit set-aside agreements within existing housing
Cadre of willing landlords
Funding pool for short-term financial assistance
Security deposit resources
Designated providers of housing assistance with staff trained and ready to deliver services
Legal service and financial counseling providers willing to partner
Fiduciaries and protocol for management and deployment of vouchers and financial assistance resources
over time:
New affordable housing and supportive housing units
Transitional beds converted to permanent housing
Objective: Recalibrate our response to housing loss

Within an overall policy framework, support community or regional-level development of a coordinated system of response centered on homelessness prevention, housing assistance, and housing stabilization.

The following are potential elements of a coordinated system, some of which may need further evaluation:

1. Local leadership and decision-makers need to be involved in designing an integrated model.

2. Create formal partnerships and delineated roles – which parts happen by traditional homeless service providers, which happen by other community or statewide agencies.

3. Dedicate staff in order to coordinate the process: to forge and sustain partnerships, facilitate meetings, track outcomes, and keep everyone on task.

4. Enlist support:
   - Best practice support: coaching, problem solving, sharing between communities
   - Data support – to calibrate progress toward outcomes, conduct data matching to target highly vulnerable individuals for assistance

5. Pull together resources: rent subsidies, flexible funds for financial assistance to be used with prevention and rapid re-housing strategies, staff dedicated and skilled in providing housing placement and stabilization supports, willing landlords.

Target housing assistance to those most likely to enter or remain in shelter or in unsheltered settings

1. Analyze and adopt sets of key risk factors for different populations (youth, families, Veterans, individuals, etc.) to more accurately triage and target homelessness prevention and re-housing programs to clients most likely to enter or remain in shelter.

   Develop the key risk factors through a collaborative effort of state agencies, non-profits operating statewide, and local and regional service providers. These risk factors would then help to establish priorities for funding by the State and alignment of various programs within different agencies.

   The actual use of the risk factors for targeting would primarily happen at the local level, although cross-system data matching at the State level could help in identifying individuals and families with multiple risk factors (the FUSE initiative is an example).

2. Use a data driven approach to target and place highly vulnerable individuals into permanent supportive housing.
   - Establish data tracking on length of homelessness in order to identify and target chronically homeless individuals.
• Improve access to supportive housing by encouraging the use of data for the prioritization and targeting of people who are high utilizers of resources (jails, hospitals, detox, etc.).

• Use a standardized vulnerability index tool across outreach programs to identify and prioritize for supportive housing those with highest mortality risk.

• Create statewide or regional centralized waiting lists and referral systems for supportive housing.

• Train shelter providers, supportive housing providers, and homeless outreach workers on Housing First strategies and strategies for engaging and overcoming service resistance among chronically homeless individuals.

• Map out the housing placement process at the local/regional level for people experiencing chronic homelessness to track and reduce the number of steps and days from homelessness to housing placement.

Strengthen the capacity of Connecticut’s HMIS system to meet the expanded data-matching, reporting and research needs identified in the Opening Doors – CT process

Connecticut is fortunate to have one of the few statewide Homeless Management Information Systems (HMIS) in the country. CT HMIS documents the number of people who come in contact with State-funded emergency shelter and transitional housing programs, as well as people who come in contact with other residential assistance programs funded by HUD, such as HUD-funded transitional housing, permanent supportive housing, and services-only initiatives. The CT Coalition to End Homelessness (CCEH) oversees management of the CT HMIS data system, and, through a consultant, provides technical support to localities. HMIS is funded by grants from HUD, the State of Connecticut, and user fees. Demands on the HMIS system are high and will increase significantly over the next few years as communities need timely data to recalibrate programs. This is likely to place considerable pressure on CCEH staff time and resources.

There is a need to strengthen the capacity of the CT HMIS system to monitor progress under HEARTH, synthesize and analyze data, conduct data matching for targeting of program interventions, provide regular benchmark reports to the state and local communities, and serve as a resource for research and program evaluation.

Align state and local activities

1. Develop a shared set of guiding principles for moving to a coordinated system of response that is centered on homelessness prevention, housing assistance, and housing stabilization.
2. Adopt a common set of outcome benchmarks with the three HEARTH Act outcomes and the four Opening Doors goals as the core (overall reductions in homelessness, reductions in shelter lengths of stay, reductions in returns to shelter.)

3. Develop a uniform housing needs assessment tool that would be embedded in HMIS.

4. Work to answer the question, “what would a state-wide centralized intake process that links statewide (211), VA, and regional points of entry look like, who takes the lead in development of it, and who ultimately manages the system?”
Increase Economic Security

There is a substantial body of research and practice that documents the connection between poverty, housing instability and poor health. Insufficient income and lack of affordable housing ensure the continuation of a costly yet avoidable cycle of institutional or high-cost ‘care’ and social disengagement.

The current array of programs and agencies that support income and provide employment services for homeless and vulnerable populations are defined by a complex set of distinct federal and state funding programs and policies:

- **Income support** programs provide direct financial assistance to a narrowly defined set of eligible populations (often tied to presence of a disability, or family with dependent children). These are primarily federally funded programs disbursed either directly to eligible individual recipients (such as Supplemental Security Income –SSI) or as a block grant administered by the state (such as Temporary Assistance for Needy Families - TANF).

- **Workforce development** programs are funded primarily with federal funds that are administered through five regional Workforce Investment Boards (WIB’s). Eligibility for these services is determined primarily by income, with additional consideration based on training needs. Primary populations served are youth, dislocated workers and disadvantaged adults. Demand for One Stop job support services vastly exceeds the system’s capacity to deliver.

Given the complexity of program entry requirements (eligibility determination and the application process), the “self-serve” nature of the mainstream workforce system can make it very difficult for people experiencing homelessness to negotiate the resources and services available through this system. The first step is securing, or retaining, stable housing. But once in housing, people often need assistance in both accessing the services of the One Stop System as well as other supports that will help ensure their success in employment.

Recent promising practices and priorities in workforce development tend to emphasize the importance of linking education and training more closely to jobs. These approaches generally involve a combination of:

1. **Education and training** (often through community colleges) that give workers a post-secondary credential

2. **Direct ties to employers** in industries that provide well-paying jobs in key sectors (such as health care, construction, retail trade, etc.). The direct involvement of employers, plus the

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availability of jobs at the end of training, help improve the match between the skills acquired and the demand side of the labor market.  

3. **A range of additional supports and services** to help workers deal with problems that arise (such as child care and transportation)

In some cases, there is a nonprofit organization that serves as a labor market intermediary to bring together workers, employers, training providers and sources of supports needed to make this process work. Intermediaries help overcome employer resistance to hiring workers by providing more information on positive worker skills and attributes, and by screening applicants they refer to these employers. If the basic skills of workers are not sufficient for their participation in the needed occupational training, the potential workers take remedial skill-building programs, which may include a program to build employment “soft skills”. Intermediaries provide not only job placements with employers but in some cases post-employment services to support job retention.

Another promising practice is transitional jobs for adults who have little formal work history. These provide 6-12 months of paid experience in nonprofit or for-profit settings. Transitional job strategies incentivize employers to “try out” individuals that they might otherwise reject, particularly persons with criminal justice histories, persons with disabilities disengaged from the labor market, and persons needing more skill development. They also provide a time-limited opportunity to try out someone’s job performance abilities and skills (and to provide additional supports to the person during this period as part of a skill development component). Individuals who “make it” in transitional jobs stand a much better chance of being hired by the employer. At minimum, transitional jobs provide job experience that can act as a bridge to another job.

The VA system has a variety of programs to assist Veterans in securing employment and stable income supports. The VA-CT Homeless Program partners on a regular basis with the Veteran Benefits Administration to conduct benefit workshops for Veterans to discuss eligibility and enter claims. Vocational support is provided by the VA CT Supportive Employment program. The program has employment specialists embedded within the VA Homeless Program. These specialists are Veterans who have experienced job loss and/or homelessness.

An increasing number of providers of affordable and supportive housing have formed direct collaborations with workforce systems and individual employers to increase rates of employment and job retention among their tenants, including formerly homeless individuals. These efforts offer some instructive lessons on successfully forging these housing-employment collaborations:

1. Make sure the right people are at the table

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36 An example of this is the Jobs Funnel, which is a pre-employment preparation, job training and placement service for Hartford and area residents seeking employment in the construction fields. The name “Jobs Funnel” is taken from a process individuals go through – funneled into the system to gain specific work competencies and trade-related certifications.

• At minimum, involve the One-Stop operator, the housing service provider, the local office of the Bureau of Rehabilitation Services, and the lead vocational staff at the local behavioral health agency.

• Director level representatives need to be the participants in the planning and design of the effort, and high-level relationships must be an ongoing part of the project, from program design to implementation. This participation can be institutionalized via a steering committee.

2. Take time to talk goals and learn cultures

• Define shared goals, and understand organizational cultures upfront (what is each organization’s target population, eligibility criteria, policies and regulations?). The key to success is to find commonalities and work from there. Spend time up front cross-training direct care staff.

3. Don't forget accountability: draw up an MOU

• A memorandum of understanding can lay out agreements on the roles of each partner in providing services, staffing, financial commitments, and how the partners will communicate. Two specific ideas are: Director communication via a monthly interagency meeting, which includes reports on program activities and outcomes. Direct care staff holding bi-weekly case meetings.

• Choose measures that track the more gradual impacts of the program; track not only employment gains, but also changes in source of income, credentials enrollment and completion, and employment retention. Agree upon common definitions of income data; include income received from informal jobs.

• Use a data system that multiple partners can access and share.

4. Outreach to tenants starts at home

• The best way to reach tenants is to begin outreach at the housing site, where feasible. That means One Stop and BRS staff go to the housing site to make one-on-one contact with tenants. This could be done through informal orientation meetings at the housing site, or career development staff scheduling open-ended time at the housing site, with housing staff introducing them to tenants as they come and go.

5. Prioritize job development in the design and startup phase. Jobs should be available to tenants from the start.

State agencies have also begun to form more strategic alliances to advance connections between housing and employment. An example is the HomeWork collaboration between the Department of Mental Health and Addiction Services, the Corporation for Supportive Housing, and the Bureau of Rehabilitation Services of the Department of Services Social Services. Funded through a federal Medicaid Infrastructure Grant, the initiative targets supportive housing providers and their
employment partners in three cities (Bridgeport, Hartford and New Haven) with a package of staff trainings, benefits coordination services, cross-sector case conferences, and other systems connections. The goal of this work is to expand employment opportunities for persons receiving Social Security benefits to return to work. Successes can generate an incremental revenue stream through the federal Ticket to Work program, which providers can then reinvest in the program.

For people who are chronically homeless and persons with severe disabilities, access to Social Security benefits can be critical to ensure a stable source of income. SSI/SSDI Outreach, Access and Recovery (SOAR) is a technical assistance initiative providing strategic planning and assistance to local providers to increase client access to Social Security benefits.

**Objective:** Foster housing retention through income growth and employment

*Link workforce system resources (skill development, job development) with the housing assistance system to create effective pathways to employment for vulnerable populations*

1. Establish collaborative partnerships between housing organizations and the workforce system to integrate employment services and housing assistance activities at the local level.

2. One approach could be establishing a few initiatives at the local/regional level to test, evaluate and demonstrate collaborative and cross-sector approaches to substantially increase the income of vulnerable populations, based on promising practices and lessons learned. Prioritize initiatives that serve families and individuals entering or in housing who have experienced a high degree of housing instability, with special attention to programs serving ex-offenders, youth, and persons with disabilities. Document outcomes on employment, job retention, and wage gains.

**Align public sector programs to ensure effective systems coordination with shared goals**

1. Develop a common set of outcome benchmarks for measuring progress in income growth and employment among people receiving housing assistance who were formerly homeless.

2. At the state level, undertake a review of program eligibility and termination criteria across the range of State benefit programs that people experiencing or at risk of homelessness may access for employment training and opportunities. Identify changes that should be made to create incentives for work, earning and retaining income while maintaining access to health coverage, housing assistance, child care, etc. until a household is earning enough through employment to be financially stable.

**Expand income growth for persons with disabilities**

1. Create statewide access to effective programs, including Ticket to Work, HomeWork, and SOAR.
Improve Health and Housing Stability

We have divided this theme into three parts, and discuss each in turn:

- Reduce medical vulnerability and frequent use of health care systems
- Support the housing stability of vulnerable families, children and youth and Veterans
- Break the cycle of homelessness and re-incarceration

Objective 1: Reduce medical vulnerability and frequent use of health care systems

Many of Medicaid’s highest cost beneficiaries are individuals with complex and co-occurring health and behavioral health challenges experiencing homelessness and housing crisis. For these individuals, homelessness exacerbates chronic illnesses by increasing exposure to trauma and high-risk behaviors and, in turn, results in social isolation and difficulties accessing the coordinated primary and behavioral health services needed to manage and expedite recovery. In this sense, homelessness serves as a virtual tri-morbidity, imposing additional ill-effects on health status in and of itself.

A significant factor contributing to the unsustainable growth in healthcare spending (particularly Medicaid spending) is the avoidable use of the most costly services by a small subset of individuals with complex health and behavioral challenges, and who, despite their repeated encounters with emergency and inpatient health care services, experience little or no progress in their health and clinical conditions. These individuals are often very poor, homeless or unstably housed, and living alone—they have multiple, co-occurring chronic medical conditions and behavioral health disorders. Adequate housing is a significant determinant of health and health costs. Arguably, homelessness coupled with frequent use of emergency health care services is a substantial driver of increased Medicaid spending in the state overall.

The passage of the Affordable Care Act (ACA) in 2009 has already begun to reshape aspects of our health care system, including service delivery, access, and financing, in ways that are creating unique opportunities to improve health outcomes for extremely vulnerable populations. With a substantial focus on expanded access and quality as core to achieving planned reductions in overall health care costs, there are opportunities at the state and local levels to test and implement new and more effective approaches to addressing the unmet health needs of persons who have not been well served by these systems.

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One of these opportunities is to use Medicaid as a resource to expand services to persons living in supportive housing. Connecticut was the first state under ACA to expand Medicaid eligibility to all low-income adults. By doing so, it has already tackled one of the three challenges involved in leveraging Medicaid for services in supportive housing—how to ensure that supportive housing tenants are eligible recipients. The other two challenges are 1) how to ensure that the services in supportive housing are eligible services and 2) how to ensure that service providers are eligible providers and have the capability to participate in Medicaid.

Service eligibility may be easily determined: the key is defining payment systems for each of the three types of services provided in supportive housing: 1) housing stability supports; 2) case management; and 3) rehabilitation or recovery supports. The Corporation for Supportive Housing has estimated that the majority of service costs in Connecticut supportive housing could potentially be financed through Medicaid under a Home and Community Based Services (1915i) HCBS option.

The second challenge is a bit trickier: national experience has found that even when supportive housing providers offer services that are Medicaid reimbursable, many do not seek reimbursement due to the immense administrative costs and challenges associated with receiving payment. Many providers do not have a history of billing for Medicaid or simply lack the knowledge, infrastructure, and administrative capacity necessary to access Medicaid resources.39 This must change.

**Align state and local strategies to support the goals of improved access to health care and effective use of appropriate types of health services**

1. Institute measures to track health access (as defined by enrollment in Medicaid, Medicare or other health insurance program) across the systems and agencies that work with vulnerable populations.

2. Use data to identify high-cost users. One possible approach is to target groups with greater health needs who are more likely to be disengaged from health services (for example, chronically homeless persons) or use health care resources inappropriately, such as frequent users of emergency room care.

3. Explore Health Homes as another option for linking services to housing for this population.40 Under ACA, states can qualify for enhanced federal funding to set up health homes to better coordinate the care of Medicaid beneficiaries with chronic physical or mental illnesses. States may elect this new option by filing an amendment to their Medicaid State plan.

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40 Rather than being a physical place, health homes are a strategy for helping individuals with chronic conditions manage those conditions better. A health home is a provider or a team of health care professionals that provide integrated health care. This means that if a person is participating in a health home, that person’s health care, from primary care doctor to dentist to behavioral health professional, all share the same information and coordinate treatment based on that information. Health homes operate under a “whole-person” philosophy – caring not just for an individual’s physical condition, but providing linkages to long-term community care services and supports, social services and family services. The integration of primary care and behavioral health services is critical to achievement of enhanced outcomes.
Maximize the use of existing and new health sector resources to address both the housing and service needs of extremely vulnerable populations

1. Develop a financing strategy for new supportive housing that uses Medicaid to pay for eligible support services. Target individuals identified as high users of homeless services and health systems.

   Explore how, in the future, the service model in supportive housing could be assembled in a modular fashion, with direct links to Health Homes, Home and Community Based Services, and funds to pay for housing stability supports.

2. Build the administrative capacity of a cohort of supportive housing service providers to utilize Medicaid.

3. Build collaborations between health, behavioral health and housing systems in order to ensure an integrated system of care.

Implement housing-based approaches to align with the health reform goals of prevention, greater access, better quality and lower cost

1. Establish (or expand) partnerships between housing organizations and healthcare agencies (e.g. between a community health center and a housing authority) to integrate the health services at the housing site or make direct linkages to the community health center through the use of agreements.

2. Consider testing a medical respite model directly linked to permanent supportive housing in one or more communities, through a partnership between a major hospital, a homeless service and housing provider, and state government. Target individuals who are chronically homeless and frequent users of hospital systems.

Expand use of HMIS to support new targeting approaches and to collect and disseminate quality data about use of healthcare systems

1. Explore the use of data-matching between HMIS and selected health system providers, including community health centers and hospitals (inpatient and emergency rooms) to analyze frequent use between the systems and consider how that might relate to state wide technology efforts that are discussed later in this framework.

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41 Medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. Unlike “respite” for caregivers, “medical respite” is short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. These programs are housed in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing. Medical respite care meets the post-hospital recuperative care needs for people who are homeless while reducing public costs associated with frequent hospital utilization. Medical respite needs to be linked directly to permanent housing with services in order to ensure long term stability.
Objective 2: Support the housing stability of vulnerable families, children and youth

For families with high needs, a common complaint is that the families touch so many systems – child welfare, TANF, health, education, shelters, etc. – that they become overly “case managed”, with staff from multiple agencies conducting separate assessments (on both parents and children) creating separate case plans, and keeping separate (and largely duplicative) documentation. Stabilization of these families is everyone’s priority and yet no one’s priority due to lack of coordination. One idea to seriously look at: someone to take the lead to coordinate and help the family navigate the care across these sectors and ensure that the sectors are not working at cross-purposes. This is not a new idea or untested, as described below.

This idea is akin to the “patient navigator” role within health care. The navigator’s role is not one of direct service delivery but rather of coordination of care across multiple sectors.

A similar concept is the Differential Response System, an emerging model at the Connecticut Department of Children and Families (DCF), which is based on the concept of providing an alternative for foster care placement in cases of child neglect where poverty plays a primary role in compromising the safety of children. This alternative is centered on a community-based Services Coordination Model (SCM), which acts as a bridge to the many resources and supports that could be helpful to the family’s current situation and future development. Educating the family on what services are available, helping them to be comfortable accessing services, and teaching the family how to navigate service systems for future needs is one role of the SCM. A case manager and/or family advocate helps the family to make these connections.

A third model is used in children’s mental health. DCF uses a Care Coordination model for a child/youth involved with multiple agencies and identified as needing care coordination independent of any particular service received. Care coordination involves direct client contact by someone who has clinical knowledge but does not function as the clinician on the case. Rather, the Care Coordinator is the architect of the service plan along with the family, using clinical and community systems knowledge to broker and advocate for the plan.

Whether posited as a “systems navigator”, “services coordination model”, or “care coordinator”, the common elements are those of a non-clinical function that assists the family in navigating multiple systems and supports the family in building their own navigation skills and relationships.

Assess the feasibility of deploying a “systems navigator” function that will align and coordinate services at the individual family level across sectors and at different levels of service delivery

1. The assessment would include defining and designing the function and protocol and identifying a set of shared outcomes that can be measured.
2. Consider how this navigator function would be coupled with prevention, rapid re-housing, and permanent supportive housing efforts in designated communities that are targeted to homeless families most likely to enter and return to homelessness.

**Incentivize the creation of service-supported affordable housing for families**

There is a growing recognition that building resident services into existing and new housing serving very low-income families supports the strength of both families and housing communities. These services may include place-based connections to employment, health care, financial literacy, child-care, and other services.

**Youth**

As with families, the systems that interact with homeless and at-risk youth (under 18) and young adults (18-25) have limited capacity to exchange information with each other. These systems - including schools, DCF, DSS, DOE, DOC, DMHAS, employment One Stops, and the homeless services system - tend to be fragmented in their approach to services, and have limited knowledge about the effectiveness and impact of service approaches. Local service providers specializing in youth and young adult services struggle to respond to a growing demand for services; demand far outstrips supply, and training capacity for staff is limited.

**Develop targeted outreach strategies to identify and enumerate youth and young adults without permanent housing and connect them to the housing and support they need; develop partnerships with school systems in this effort**

How youth and young adults are identified will be an essential component of understanding and identifying the most effective and efficient strategies that are most likely to lead to successful results. In looking at target populations, elements of a comprehensive effort would need to examine vehicles for program outreach and access, essential elements for housing and services, mentoring relationships, learning and practicing independent living skills, employment supports, and wellness services. Data matching across relevant state agencies and HMIS could map out the overlapping systems involvement.

**Expand the range of housing options for youth and young adults facing housing loss.**

In addition to gathering data, one approach to consider is the development of “transition in place” housing with services for unaccompanied youth and transitioning young adults who are homeless or at high risk of homelessness.

1. Consider creating a “transition in place” model through a collaborative of agencies, providers, intermediaries and consumers. Encourage alliances with providers of housing and housing subsidies, Job Corps and Youth Build programs.
Develop a way of identifying and tracking unaccompanied youth and document outcomes through a randomized study to compare outcomes for youth in the housing with similar youth not in the program.
Objective 3: Break the cycle of homelessness and re-incarceration

Every month more than 1,000 persons are released from Connecticut prisons. Many inmates experience chronic health or mental health problems, or are confronted with a lack of income and employment options, both of which will increase their likelihood of becoming homeless upon release. An additional problem is that affordable housing opportunities are often not available to persons with criminal justice histories. People who were formerly incarcerated may be deemed ineligible for particular types of housing subsidies, or may face other restrictions that interfere with their ability to access stable housing. The recently released individual must meet requirements of parole or probation rules while also facing the challenge of obtaining living-wage employment with a criminal background. Dealing with the practical challenges of adjusting to life outside of prison is particularly difficult because ex-offenders often have limited social support networks.

When ex-offenders are able to secure permanent, affordable housing linked with appropriate support services—including employment and health—the likelihood of successful reintegration is greatly increased. There are growing numbers of local Reentry Roundtables across the state that have begun to effectively engage the needed partners to plan and implement strategies and approaches to ensure successful reintegration of ex-offenders into their communities. Building on effective approaches tested in Connecticut and nationally, strategies that have impact will reduce recidivism, increase housing stability, and increase income and economic security through employment.

The Frequent Users of Service Enhancement (FUSE) program is a recent approach to targeting permanent supportive housing to persons with frequent admissions to emergency shelters and Connecticut Department of Corrections (DOC) facilities. This program is being expanded to serve persons on probation or parole.

Target housing resources and other supports to prevent and end homelessness among people leaving incarceration

1. Ensure effective transitions from prison and from short-term community programs using a comprehensive approach linked with flexible funding resources.

2. Expanding upon the FUSE model, Identify priority high-needs populations based on data and criteria to be determined, and direct supportive housing with tailored support services to these groups.

3. Explore effective approaches to centralize and simplify access to supportive housing and other affordable housing resources.

Reentry Roundtables are local level coalitions focused on community engagement, advocacy, and forging of partnerships to address common needs and gaps in services for incarcerated individuals returning to their communities. The coalitions are commonly comprised of ex-offenders and representatives of community agencies, which may include the police/sheriff department, district attorney, probation/parole system, court system, municipality, workforce agency, health and human service agencies, and others. At this writing, there are six Reentry Roundtables in Connecticut: Bridgeport, Greater Hartford, New Haven, New London, Waterbury, and Windham.
4. Create effective pathways to employment for ex-offenders

*Align housing resources and other supports to prevent and end homelessness among people leaving incarceration*

1. Define specific measures of system performance that are agreed upon by all stakeholders; ensure that performance measures are tracked within criminal justice system agencies and programs, and by community based providers serving criminal justice populations.

2. Support systems and practice changes through a combination of policy direction and financial incentives at the state and local levels that result in improved reintegration outcomes of persons exiting criminal justice systems and programs.

3. Strengthen local level community collaborations focused on successful reintegration of persons exiting criminal justice systems; support their efforts to align and link with community planning efforts to prevent and end homelessness.
Increase leadership, collaboration, and civic engagement

Reaching the four bold goals of Opening Doors, all towards preventing and ending homelessness among veterans and single adults in five years and families with children in ten years, requires bold leadership, particularly at a time when the State and local communities are struggling with the demands of the economic downturn. This time of struggle also is a time of opportunity: to think differently about how we use our resources, avoid overlap in services, and work in tandem and across systems to achieve results. Collaboration is hard work, particularly as we try to meld the efforts of sectors and agencies with different missions, different rules, and different approaches. Good leadership pushes us to collaborate in spite of these differences, and takes a problem-solving approach based on identifying common ground and driving toward a common purpose.

The participation of leaders from many different sectors – government, philanthropy, the faith community, business, health care, housing, supportive services, etc. – is critically important to building a base of civic support for efforts to prevent and end homelessness. In turn, this civic support can make the difference between support and opposition for local housing efforts, between the success or failure of advocacy efforts, and between the sustainability of new approaches or their early demise. This Framework provides a guide for reaching the goals of Opening Doors, but it does not specify the actions needed to make it happen. The development of actionable strategies is the next step in the process. This process of development itself requires attention: how will we, as a state, organize ourselves to undertake the work ahead? And who will lead this process?

To address that question, it is helpful to understand the existing planning bodies and community networks in Connecticut specifically focused on homelessness. Each of these bodies is designed to change the systems that impact people who are homeless or at risk of becoming homeless:

1. State-level Interagency Council on Supportive Housing and Homelessness

   Established in April 2004 by gubernatorial executive order, the Connecticut Interagency Council on Supportive Housing and Homelessness is comprised of the leaders of ten State agencies.43 The mission of the Council is to develop and implement strategies and solutions to address homelessness, including the development of supportive housing options and other measures designed to:

   - Reduce the number of Connecticut individuals and families that experience homelessness;
   - Reduce the inappropriate use of emergency health care, shelter, chemical dependency, corrections, foster care, and similar services; and

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43 The agency representatives are the Commissioners of the Connecticut Departments of Social Services, Economic and Community Development, Mental Health and Addiction Services, Public Health, Correction, Children and Families, and Veterans Affairs, plus representatives of the Governor’s Office, the Secretary of the Office of Policy and Management or designee, the Director of the Office for Workforce Competitiveness, and the Executive Director of the Connecticut Housing Finance Authority. The Governor appoints two members of the Council to serve as Co-Chairs.
• Improve the health, employability, self-sufficiency, and other social outcomes for individuals and families experiencing homelessness

Under the executive order, the Council was charged with two primary duties:

1) Development of a plan for the creation of an additional 1,000 units of permanent, supportive housing. This plan was developed in 2004 and became the foundation for the state’s Next Steps Supportive Housing Initiative.

2) Identification of other policy reforms, programs and expansions to lessen homelessness in the state. In its report to the Governor in January 2005, the Council recommended actions to remove barriers to effective discharge planning from state-operated or financed institutions such as hospitals and correctional facilities; and expand the supply of affordable housing as a means to prevent and respond to homelessness among very low income individuals and families. Major recommendations included the expansion of rental subsidies and the development of new housing.

Meetings of the full Council have been sporadic over its tenure, but a subcommittee of the Council – the Interagency Working Group on Supportive Housing – is active and meets monthly to address planning and implementation issues related to the State’s collaborative supportive housing initiatives.

2. Continuums of Care

A Continuum of Care is a local or regional system for providing housing and services appropriate to the range of homeless needs in the community, from homelessness prevention to emergency shelter to permanent housing. In 1995, HUD implemented the Continuum of Care approach to streamline the existing competitive funding process under the McKinney-Vento Homeless Assistance Act and to encourage communities to coordinate more fully the planning and provision of housing and services for homeless people. Over the years, Continuums have moved toward significantly greater planning and involve more players.

At present, Connecticut has seven Continuums of Care. The Balance of State (BOS) Continuum covers cities and towns not included within other continuums. The structure of continuums continues to evolve. Two previous continuums (Middlesex County and Norwich/New London) merged into BOS in 2010 and Bristol, New Britain, and Danbury became part of the BOS in 2011. Some city-focused Continuums are thinking about expanding to have a regional scope. Under the HEARTH Act, HUD will be placing greater responsibilities on Continuums to track the performance of homeless services systems within their target areas.

3. Community Plans to End Homelessness

Starting in 2001, the United States Interagency Council on Homelessness challenged states and cities to create ten-year plans to end homelessness as a means to engage civic leadership and community participation in the issue. Since that time, thirteen community or regional plans to end homelessness were developed in Connecticut, with one more in process.
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<thead>
<tr>
<th>Continuums of Care</th>
<th>Community Plans to End Homelessness</th>
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<tbody>
<tr>
<td>South West</td>
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<tr>
<td>Bridgeport/Stratford/Fairfield</td>
<td>Greater Bridgeport Area Ten Year Plan to End Homelessness (2005)</td>
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<tr>
<td>Stamford/Greenwich</td>
<td>Stamford/Greenwich Ten Year Plan: A Different Time, Different Place</td>
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<tr>
<td>Norwalk and rest of Fairfield County</td>
<td>Greater Norwalk Ten Year Plan to Prevent and End Homelessness (2011)</td>
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<tr>
<td>South Central</td>
<td></td>
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<tr>
<td>New Haven</td>
<td>New Haven Ten Year Plan to End Chronic Homelessness (2005) -</td>
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<td></td>
<td>Greater New Haven Regional Alliance</td>
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<td>Meriden-Wallingford Ten Year Plan to End Homelessness (2009)</td>
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<td></td>
<td>Middlesex County Ten Year Plan to End Homelessness (2007) –</td>
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<td>Middlesex County Coalition on Housing and Homelessness</td>
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<td>Eastern</td>
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<td>Next Stop, Home (2006) - Southeastern CT Partnership to End Homelessness</td>
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<td></td>
<td>Greater Windham Region Ten Year Plan to End Homelessness (2007)</td>
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<td>North Central</td>
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<td>Hartford</td>
<td>Hartford’s Plan to End Chronic Homelessness by 2015 (2005) - Journey</td>
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<td>Home (Capitol Region)</td>
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<td></td>
<td>Building Hope Together: New Britain’s Work Plan to End Homelessness</td>
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<td>(2008)</td>
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<td>North West</td>
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<td></td>
<td>City of Danbury Plan to End Homelessness (2006)</td>
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<td></td>
<td>Mayor’s Taskforce to End Homelessness</td>
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<tr>
<td>Waterbury</td>
<td>City of Waterbury Ten Year Plan to End Homelessness (2009)</td>
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<tr>
<td></td>
<td>Northwest Connecticut Ten Year Plan to End Homelessness (in development as of 2011)</td>
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<tr>
<td>Balance of State</td>
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<tr>
<td>All communities not covered by other continuums above</td>
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</tbody>
</table>
Community Plans to End Homelessness, often called “Ten Year Plans,” have served as an important vehicle for engaging municipal leaders, the business community, faith communities, local United Ways and other philanthropy in efforts to end homelessness. In Hartford, a new nonprofit organization – Journey Home - was created to serve as the coordinating body for its plan. Most of the other plans are unstaffed, but are led by local steering committees. Some of the steering committees are highly active, others less so. The few that have staff support report how important it has been to keeping the steering committee focused and on task. Most of the plans focus on similar themes – housing, employment and income, services, civic engagement, and advocacy. Early plans – like those in Hartford and New Haven – were developed specifically to address chronic homelessness. Seven of the plans were developed prior to 2008; three are over halfway through their ten-year timeframe.

Community Plan committees face the challenge of sustaining civic energy as political leaders, economic forces, and volunteers change over time. They also express concern their efforts happen in isolation from other communities and from what may be happening at the state level. Many have expressed an eagerness to use Opening Doors as a means to reinvigorate their plans, bring renewed focus to the issue of homelessness, and serve as the lynchpin between what gets planned on a statewide or regional level and what actually happens on the ground.

4. Reaching Home Campaign

The Reaching Home campaign was officially launched in 2004 to build political and civic support statewide for the creation of 10,000 units of supportive housing in ten years to end chronic homelessness. Led by a steering committee and coordinated by the Partnership for Strong Communities, the campaign has been highly successful in enlisting the support of municipal leaders, legislators, state policy makers, private sector leaders, philanthropy, and others for the expansion of permanent supportive housing. Reaching Home was instrumental in providing needs data and supportive housing targets that were incorporated within many of the Community Plans.

The degree to which local Continuums and their local Ten Year Plans coordinate their efforts varies by community. Some Continuum bodies serve as subcommittees of the Community Plan; others orbit in a separate sphere. Historically, there has been little connection between the State Interagency Council and the Continuums and Community Plans.

This Framework that has been developed through the Opening Doors - CT initiative offers an opportunity for better alignment between all of these various bodies. It also offers an opportunity to ensure that “mainstream” systems - such as primary and behavioral health care, criminal justice, housing, education, workforce, family services, financial and legal services, and child welfare– are active participants in state and local levels of planning. Currently there is not a cohesive set of structures for fostering this alignment and engagement.

A Coordinated Approach: Reaching Home 2.0

A renewed and expanded Reaching Home Steering Committee can be the intersection of the ideas presented in this framework and the entity through which the four bold goals of this Framework can be pursued in a collaborative and coordinated way. Bringing the communities of interest together –
including the “systems” that touch the lives of those at-risk of homelessness and those experiencing homelessness - state and local government, nonprofits working locally and regionally, intermediaries, the business community and individuals who have experienced homelessness can be a catalyst for the changes necessary to end the condition of homelessness that affects too many in this State. It is a condition that shouldn't nor have to exist.

A pictorial of what this could look like: appears on the following page.
Reaching Home 2.0

Helps coordinate, provide guidance to work groups & supports Steering Committee 10-12 people

A broad coalition crossing boundaries and systems; sets direction, advances policy change, oversees work groups, makes connections 35-45 people, meets 4x yr

Work Groups recommend, advance strategies 8-12 people each

Coordinating Committee

Steering Committee

- Housing
- Retooling Crisis System
- Economic Security
- Health & Housing Stability

Opening Doors - Connecticut
Objective: Lead, manage and monitor the change process

Reaching Home 2.0 would become the leadership structure for planning and oversight of Opening Doors – Connecticut that builds on existing partnerships between the public, private, and nonprofit sectors

1. Within this leadership structure, develop structures for strategy development, for tracking progress, and for reporting up (to the state level) and down (to the local level) on progress.

2. Ensure staffing support for the process and structure. Staffing provides the grease to keep things moving and the glue to keep the process on track.

Develop operational plans at the state and local level with specific actions linked to resources and responsible parties

The Framework can provide a useful starting point for workgroups to develop action plans centered on the Opening Doors themes.

Create opportunities to ensure that the voices of people who have experienced homelessness and people working on the front lines of service delivery are heard

Develop outcome measures at both the systems level and at the program level

1. Define and adopt a common set of metrics to measure system performance statewide, including the following HEARTH ACT metrics (at minimum):
   - Reductions in homelessness at a point in time (as measured by the annual PIT count) and annually (as measured by HMIS)
   - Reductions in shelter lengths of stay
   - Reductions in returns to shelter

2. Track progress in ending homelessness and meeting annual performance targets using HMIS.

3. Develop and issue annual performance reports at the State, Regional and local levels.

As the State looks at its overall use of data and use of technology, consider the creation of a human services data warehouse to provide a platform for integrating key data across HMIS and human services.

Some of the potential uses of this type of data warehouse are:

- Analyzing regional or state demographics, trends, and outcomes
- Assessing the use of mainstream services by people experiencing homelessness and housing instability
• Calculating the cost of homelessness
• Measure what interventions work to prevent and end homelessness
• Informing statewide and community plans to prevent and end homelessness

A data warehouse can be a valuable resource for evaluating the intersection of systems of care in order to answer specific research questions, for improving client service, and for avoiding burdensome double entry into multiple systems by exporting existing data.
Laying the Groundwork for Action

This document lays out some of the most detailed analysis of homelessness in Connecticut today and outlines ideas for strategies, systems changes, and a new way of thinking about these here-to-for seemingly intractable issues. There is no reason and no excuse to explain why homelessness in the United States continues to be a national shame. Perhaps some would argue that the ‘economic times we live in’ is not the time for an ambitious and far-reaching agenda. There will always be a reason for ‘this is not the time’. We need to be bolder, more engaged, and smarter than we have ever been.

By this “new way” outlined in this document we are reminded of the fact that Connecticut has always been a leader in so many areas throughout the years. The Reaching Home Campaign to create 10,000 units of supportive housing in Connecticut over ten years was a statement of aspiration, inspiration and a call to action. As a State it called to our better nature and State and local governments, the non-profit communities, builders and local citizens responded in-kind. This is a new and refreshed call to action that we must heed. If not now, when?

Through the planning and implementation process, the feasibility of the strategies offered in this Framework will be used to assist the Reaching Home 2.0 Working Groups in establishing work plans. The following tables provide a guiding framework for the development of these work plans, and may be helpful in setting priorities for action, including timeframes.

None of the ideas and strategies presented in this Framework should be viewed as limiting. While informed by input and information gathered in the Opening Doors – CT process, they are not intended to exclude different approaches.
### INCREASE ACCESS TO STABLE AND AFFORDABLE HOUSING AND SUPPORTIVE HOUSING

Strengthen our housing delivery system; create supportive and affordable housing at a scale sufficient to meet the need

- Expand and target rent subsidies
  - Create new rent and operating subsidies
  - Maximize the impact of rent subsidies by linking them to State and local prevention, rapid-rehousing, and permanent supportive housing initiatives
  - Utilize project-based rent subsidies in mixed income housing that provides set-aside units for households with extremely low incomes and for households receiving supportive housing services.

- Stimulate the development of supportive housing and of mixed income communities that include units affordable to households with extremely low incomes
  - Provide flexible, debt free capital
  - Link capital, project-based subsidies, and services funding for the development of new permanent supportive housing
  - Streamline the funding process at the State level
  - Build local capacity to produce and operate units

- Embed strategies to end homelessness within cohesive State and municipal housing policies that set clear outcome targets
  - Establish clear State and municipal housing policies that incorporate benchmarks for preventing and ending homelessness and that are used to align and target State and municipal housing resources that may be administered by multiple departments and agencies

- Aggressively leverage and compete for Federal rent subsidies, housing development dollars, and service funding linked to housing

### RETOOL THE HOMELESS CRISIS RESPONSE SYSTEM

Recalibrate our response to housing loss

Within an overall policy framework support community or regional-level development of a coordinated system of response centered on homelessness prevention, housing assistance, and housing stabilization, with these potential elements:

- Local leadership and decision-makers need to be involved in designing an integrated model
- Create formal partnerships and delineated roles - which parts happen by traditional homeless service providers, which happen by other community or statewide agencies.
- Dedicate staff in order to coordinate the process: to forge and sustain partnerships, facilitate meetings, track outcomes, keep everyone on task
- Enlist support (with best practices, problem solving, data)
- Pull together resources: rent subsidies, flexible funds for financial assistance, skilled staff, willing landlords

Target housing assistance to those most likely to enter or remain in shelter or in unsheltered settings.

- Analyze and adopt sets of key risk factors for different populations to more accurately triage and target prevention and re-housing programs to clients most likely to enter or remain in shelter
- Use a data-driven approach to target and place highly vulnerable individuals into permanent supportive housing
<table>
<thead>
<tr>
<th>Populations Supported by the Strategies</th>
<th>Chronic Homeless Adults</th>
<th>Veterans</th>
<th>Families with Children</th>
<th>Youth and Young Adults</th>
<th>Set a path for ending all homelessness</th>
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</thead>
<tbody>
<tr>
<td><strong>INCREASE ECONOMIC SECURITY</strong></td>
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<tr>
<td><strong>Foster housing retention through income growth and employment</strong></td>
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<tr>
<td>Link workforce system resources (skill &amp; job development) with the housing assistance system to create effective pathways to employment for vulnerable populations</td>
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<tr>
<td>Establish collaborative partnerships between housing and service organizations and the workforce system to integrate employment services and housing assistance activities at the local level.</td>
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<tr>
<td>Consider establishing a few initiatives to test, evaluate, and demonstrate collaborative and cross-sector approaches to substantially increase the income of vulnerable populations based on promising practices and lessons learned.</td>
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<tr>
<td><strong>Align public and private sectors to ensure effective systems coordination with shared goals</strong></td>
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<tr>
<td>Develop a common set of outcome benchmarks for measuring progress in income growth and employment among people receiving housing assistance who were formally homeless</td>
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<td>At the state level, undertake a review of program eligibility and termination criteria across the range of State benefit programs that people experiencing or at risk of homelessness may access; identify changes that should be made.</td>
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<tr>
<td><strong>EXPAND INCOME GROWTH FOR PERSONS WITH DISABILITIES</strong></td>
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<td>Create statewide access to effective programs, including Ticket to Work, HomeWork, and SOAR</td>
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<tr>
<td><strong>IMPROVE HEALTH AND HOUSING STABILITY</strong></td>
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<tr>
<td><strong>Reduce medical vulnerability and frequent use of health care systems</strong></td>
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<tr>
<td>Align state and local strategies to support the goals of improved access to health care and effective use of appropriate types of health services.</td>
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<tr>
<td>Institute measures to track health access across the systems and agencies that work with vulnerable populations</td>
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<tr>
<td>Identify risk factors as a collaborative effort of state agencies, non-profits operating statewide, and local/regional service providers. This would then help establish priorities for funding and alignment of various programs.</td>
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<td>Strengthen the capacity of Connecticut's HMIS system to meet the expanded data-matching, reporting and research needs identified in the Opening Doors-CT process</td>
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<tr>
<td>Align state and local activities</td>
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<td>Develop a shared set of guiding principles for moving to a coordinated system of response that is centered on homelessness prevention, housing assistance, and housing stabilization</td>
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<td>Adopt a set of common outcome benchmarks with the three HEARTH Act outcomes and the Opening Doors goals as the core</td>
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<td>Develop a uniform housing needs assessment tool embedded in HMIS.</td>
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<td>Design a statewide centralized intake process that links statewide, VA, and regional points of entry.</td>
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**Opening Doors - Connecticut**  
**Objectives and Strategies**

<table>
<thead>
<tr>
<th>Populations Supported by the Strategies</th>
<th>5 years</th>
<th>5 years</th>
<th>10 years</th>
<th>10 years</th>
<th>10 years</th>
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<tbody>
<tr>
<td>Chronically Homeless Adults</td>
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<td>Veterans</td>
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<td>Youth and Young Adults</td>
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</table>

**Use data to identify high cost users. Consider targeting groups with greater health needs who are more likely to be disengaged from health services or to use health care resources inappropriately, such as frequent users of emergency room care.**

**Explore health homes as another option for linking services to housing for this population.**

**Maximize the use of existing and new health sector resources to address both the housing and service needs of extremely vulnerable populations**

**Develop a financing strategy for new supportive housing that uses Medicaid to pay for support services. Target individuals identified as high users of homeless services and health systems.**

**Build the administrative capacity of a cohort of supportive housing service providers to utilize Medicaid.**

**Build collaborations between health, behavioral health, and housing systems in order to ensure an integrated system of care.**

**Implement housing-based approaches to align with the health reform goals of prevention, greater access, better quality and lower cost.**

**Consider testing a medical respite model linked to supportive housing in one or more communities, in partnership between a major hospital, a homeless service and housing provider, and state government. Target individuals who are chronically homeless and frequent users of hospital systems.**

**Establish (or expand) partnerships between housing organizations and healthcare agencies (e.g. between a community health center and a housing authority) to integrate the health services at the housing site or make direct linkages to the community health center through the use of agreements.**

**Expand use of HMIS to support new targeting approaches and to collect and disseminate quality data about use of healthcare systems.**

**Explore the use of data-matching between HMIS and selected health system providers, including community health centers and hospitals (inpatient and ED) to analyze frequent use between the systems.**

**Support the housing stability of vulnerable families, children and youth.**

**Assess the feasibility of deploying a “systems navigator” function that will align and coordinate services at the individual family level across sectors and at different levels of service delivery.**

The assessment would include defining and designing the function and protocol and identifying a set of shared outcomes that can be measured.

**Consider how this navigator function would be coupled with prevention, rapid re-housing, and permanent supportive housing efforts in designated communities that are targeted to homeless families most likely to enter and return to homelessness.**

**Incentivize the creation of service-supported affordable housing for families.**

**Develop targeted outreach strategies to identify youth and young adults without permanent housing and connect them to the housing and support they need; develop partnerships with school systems in this effort.**

**Expand the range of housing options for youth and young adults facing housing loss.**

**Consider the development of a “transition in place” housing model through a collaborative of agencies, providers, intermediaries and consumers.**

**Encourage alliances with providers of housing and housing subsidies, Job Corps, and Youth Build programs.**
# Opening Doors - Connecticut

## Objectives and Strategies

### Break the cycle of homelessness and re-incarceration

- **Target** housing resources and other supports to prevent and end homelessness among people leaving incarceration
  - Ensure effective transitions from prison and from short-term community programs using a comprehensive approach linked with flexible funding resources
  - Expanding upon the FUSE model, identify priority high-needs populations based on data and criteria to be determined, and direct supportive housing with tailored support services to these groups
  - Explore effective approaches to centralize and simplify access to supportive housing and other affordable housing resources
  - Create effective pathways to employment for ex-offenders

### Align housing resources and other supports to prevent and end homelessness among people leaving incarceration

- Define specific measures of system performance that are agreed upon by all stakeholders; ensure that performance measures are tracked.
- Support systems and practice changes through a combination of policy direction and financial incentives at the state and local levels that result in improved reintegration outcomes.
- Strengthen community collaborations focused on successful reintegration; support their efforts to align and link with community planning efforts to prevent and end homelessness

### Increase Leadership, Collaboration, and Civic Engagement

- **Lead, manage and monitor the change process**
  - *Reaching Home 2.0 would become the leadership structure for planning and oversight of Opening Doors - Connecticut that builds upon existing partnerships between the public, private, and nonprofit sectors*
    - Within this leadership structure, develop structures for strategy development, for tracking progress, and for reporting up (to the state level) and down (to the local level) on progress.
    - Ensure staffing support for the process and structure.
  - Develop operational plans at the state and local level with specific actions linked to resources and responsible parties.
  - Create opportunities to ensure that the voices of people who have experienced homelessness and people working on the front lines of service delivery are heard.
  - Develop outcome measures at both the system level and at the program level.
    - Define and adopt a common set of metrics to measure system performance statewide, including the HEARTH ACT metrics
    - Track progress in ending homelessness and meeting annual performance targets using HMIS.
    - Develop and issue annual performance reports at the State, Regional and local levels

As the State looks at its overall use of data and use of technology, consider the creation of a human services data warehouse to provide a platform for integrating key data across HMIS and human services.

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<table>
<thead>
<tr>
<th>Populations Supported by the Strategies</th>
<th>5 years</th>
<th>5 years</th>
<th>10 years</th>
<th>10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronically Homeless Adults</td>
<td>*</td>
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<tr>
<td>Veterans</td>
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<tr>
<td>Families with Children</td>
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<tr>
<td>Youth and Young Adults</td>
<td>*</td>
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<tr>
<td>Set a path for ending all homelessness</td>
<td>*</td>
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</tbody>
</table>

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* * * * *
## Resource Opportunities

*Prepared July 2011 (subject to change as programs and resources change)*

<table>
<thead>
<tr>
<th>Program</th>
<th>Purpose</th>
<th>Application Limits</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capital Funding Sources for Housing</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Connecticut Housing Finance Authority</strong></td>
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<tr>
<td>CT Supportive Housing Initiative funding</td>
<td>Combined RFP for capital financing, project-based rental assistance, and support service funding for permanent supportive housing development projects (alternatively, RFP may be for rental assistance and support service funding only for scattered site leasing of existing rental units). RFPs are issued periodically by CHFA on behalf of collaborating State agencies, including DMHAS, DSS, DCF, DECD, OPM, CHFA and others. Last RFP was issued August 2011.</td>
<td>Application requirements are laid out in the RFPs that are issued.</td>
<td>Projects must serve, at least in part, persons who are homeless and have special needs. Specific priority populations laid out in the RFP.</td>
</tr>
<tr>
<td>Federal Low Income Housing Tax Credits (LIHTC - 9%)</td>
<td>Allocation of federal tax credit which provides a dollar for dollar reduction in federal tax liability for eligible applicants/owners who develop qualified low income rental housing projects. Available to project owners who acquire, construct, and/or rehab rental housing reserved for low-income households. LIHTC application rounds held annually.</td>
<td>See annual Qualified Allocation Plan for rating and ranking criteria.</td>
<td>Projects must contain a minimum number of low income units (20% at 50% of area median income (AMI) or below or 40% at 60% AMI or below).</td>
</tr>
<tr>
<td>Federal Low Income Housing Tax Credits (LIHTC - 4%)</td>
<td>As-of-right tax credits used in conjunction with tax-exempt bond financing. See description under 9% credits above.</td>
<td>See annual Qualified Allocation Plan for rating and ranking criteria.</td>
<td>Projects must contain a minimum number of low income units (20% at 50% of AMI or below or 40% at 60% AMI or below).</td>
</tr>
<tr>
<td>State Housing Tax Credit Contribution Program</td>
<td>Funding for housing sponsored by non-profit developers in CT. Awardees receive tax credits which can then be sold to state business firms in return for cash contributions to the housing program. Annual funding rounds held by CHFA.</td>
<td>No more than $500,000 in tax credits per nonprofit applicant per year. Total funding pool in 2011: $10 million</td>
<td>Projects must benefit very low, low and moderate-income families.</td>
</tr>
<tr>
<td>Program</td>
<td>Purpose</td>
<td>Application Limits</td>
<td>Population</td>
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<tr>
<td>CHFA Multi-Family Mortgage Loans</td>
<td>Mortgage financing to assist in obtaining financial feasibility for affordable multifamily rental housing developments. Finances new construction and/or moderate or substantial rehab of existing structures. Interest rates based on CHFA source of funds, which are either tax exempt bond proceeds, taxable bond proceeds, or non-bond proceeds.</td>
<td>For-profit and non-profit developers and owners of housing development that have established a qualified development team may apply.</td>
<td>Developments must provide at least 20% affordable housing for people with low incomes.</td>
</tr>
<tr>
<td><strong>Connecticut Department of Economic and Community Development</strong></td>
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</tr>
<tr>
<td>Affordable Housing Program (aka “Flexible Housing Program”)</td>
<td>Loans, loan guarantees, deferred loans or any combination thereof for the development and preservation of affordable housing. Source of funding is State general obligation bonds. Open application process; eligible applicants can apply for funding at any time of year. DECD’s ability to make awards is subject to availability of funds and bond commission approval.</td>
<td>Eligible applicants are municipalities, nonprofit organizations, local housing authorities, and for-profit developers. New construction and rehabilitation are eligible, as are multifamily rental and homeownership.</td>
<td>Projects must serve households with incomes at or below 100% AMI.</td>
</tr>
<tr>
<td>Housing Trust Fund Program</td>
<td>Gap financing, grants, loan guarantees, low- and no-interest loans for the creation of affordable housing for low and moderate-income households. Primary source of funds is State general obligation bonds. Competitive application process; DECD solicits applicants up to twice each year. DECD’s ability to make awards is subject to availability of funds as allocated to the program by the State bond commission.</td>
<td>Eligible applicants are municipalities, nonprofit organizations, local housing authorities, for-profit developers, community development financial institutions, and CHFA. New construction and rehabilitation are eligible, as are multifamily rental and homeownership.</td>
<td>Projects must serve households with incomes at or below 120% AMI.</td>
</tr>
<tr>
<td>State of Connecticut HOME Program</td>
<td>Federally funded program administered by DECD. Loans and/or grants to eligible applicants to undertake acquisition, new construction or rehabilitation of rental or homeownership housing serving low income households.</td>
<td>Eligible applicants are municipalities, non-profit organizations, community housing development organizations, for-profit developers, individuals. HOME subsidy cost per unit for project location applies.</td>
<td>Must serve households at or below 80% of AMI; rental projects must primarily serve households at or below 50% and 60% AMI.</td>
</tr>
<tr>
<td>Neighborhood Stabilization Program (NSP)</td>
<td>See Municipalities.</td>
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<tr>
<td>Small Cities Community Development Block Grant (CDBG)</td>
<td>Federally-funded grants to support capital, community development, economic development, and housing services for the benefit of low and moderate income persons.</td>
<td>Restricted to the 147 Connecticut communities that do not receive a direct allocation of CDBG funds directly from HUD. New construction of permanent housing not eligible (rehabilitation is eligible).</td>
<td>Must benefit low or moderate income persons or areas.</td>
</tr>
<tr>
<td>Program</td>
<td>Purpose</td>
<td>Application Limits</td>
<td>Population</td>
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</tr>
<tr>
<td><strong>Municipalities</strong></td>
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</tr>
<tr>
<td>HOME Program</td>
<td>Federally funded program allocated to and administered by six cities: Bridgeport, Hartford, New Britain, New Haven, Stamford and Waterbury. Loans and/or grants to eligible applicants to undertake acquisition, new construction or rehabilitation of rental or homeownership housing serving low income households. Applications taken on a rolling basis; awards subject to availability of funds.</td>
<td>Applicant eligibility may vary depending on community. See local consolidated housing plan submitted to HUD. HOME subsidy cost per unit for project location applies.</td>
<td>Must serve households at or below 80% of AMI; rental projects must primarily serve households at or below 50% and 60% AMI.</td>
</tr>
<tr>
<td>Community Development Block Grant (CDBG)</td>
<td>Federally-funded grants to support capital, community development, economic development, and housing services for the benefit of low and moderate income persons.</td>
<td>Applicant eligibility may vary depending on community. See local consolidated housing plan submitted to HUD. New construction of permanent housing not eligible (rehabilitation is eligible).</td>
<td>Must benefit low or moderate income persons or areas</td>
</tr>
<tr>
<td>Neighborhood Stabilization Program (NSP)</td>
<td>Authorized by the US Housing and Economic Recovery Act of 2008, NSP was established to provide emergency assistance to state and local governments to assist in the redevelopment of foreclosed and abandoned properties that might otherwise become sources of abandonment and blight. NSP funds in Connecticut flow through DECD and are awarded to ten CT communities based on need formula: Bridgeport, Waterbury, New Haven, Stamford, Hartford, Meriden, New Britain, Danbury, New London and Norwich.</td>
<td>Funds for purchase and redevelopment of foreclosed homes and residential properties; establishing land banks for foreclosed homes; demolishing blighted structures; and redeveloping demolished or vacant properties. NSP has been used to rehabilitate foreclosed multifamily properties for supportive housing.</td>
<td>At least 25% of NSP funds must serve households with incomes at 50% or less of AMI; preference given to these projects.</td>
</tr>
<tr>
<td><strong>US Department of Housing and Urban Development (HUD)</strong></td>
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</tr>
<tr>
<td>Supportive Housing Program</td>
<td>Capital funding for property acquisition, rehab, or new construction for supportive housing serving homeless persons.</td>
<td>$400,000 maximum for capital</td>
<td>homeless persons with disabilities</td>
</tr>
<tr>
<td>Program</td>
<td>Purpose</td>
<td>Application Limits</td>
<td>Population</td>
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<tr>
<td>Section 811 (as amended by Frank Melville Supportive Housing Investment Act of 2010)</td>
<td>Section 811 provides interest-free capital advances to nonprofit sponsors to help them finance the development of rental housing with the availability of supportive services for persons with disabilities. The capital advance can finance the construction, rehabilitation, or acquisition with or without rehabilitation of supportive housing. The capital advance is linked to a project rental assistance contract that runs for 20 years (30 in the case of LIHTC projects). Annual funding rounds. The Frank Melville Supportive Housing Investment Act of 2010 made important changes to the Section 811 program in order to provide incentives to leverage other sources of capital for 811 units. This means that nonprofits can now use Section 811 funding to create small set-asides of permanent supportive housing units within rental developments that provide housing for households without disabilities. Under the new law, no more than 25% of the units in any Section 811 multifamily project may have an occupancy preference for people with disabilities. Processing of 811 assistance may be delegated to state or local housing agencies. The program also now provides for project based rental assistance not linked to a HUD capital advance. This is described in the section on Operating Funding for Housing.</td>
<td>Program regulations are expected to be issued in late 2011. HOME program cost limits apply unless waived.</td>
<td>Assisted units must serve only very low income (at or below 50%AMI) households with at least one non-elderly adult with disabilities between the ages of 18-61. Specific disability targeting is not allowed, but projects can restrict (with HUD permission) occupancy to people with disabilities who can benefit from the supportive services offered in connection with the housing.</td>
</tr>
<tr>
<td>Choice Neighborhoods</td>
<td>Competitive grants to assist in the transformation, rehabilitation, and preservation of public housing and privately owned HUD-assisted housing. HUD’s new Choice Neighborhoods Initiative (CN) is “designed to promote a comprehensive approach to transforming distressed areas of concentrated poverty into viable and sustainable mixed-income neighborhoods”. Building on the HOPE VI Program, Choice Neighborhoods will link housing improvements with a wider variety of public services including schools, public transit and employment opportunities. The Norwalk Housing Authority was one of the first PHAs nationwide to receive a Choice Neighborhoods planning grant.</td>
<td></td>
<td>Households with low incomes and others</td>
</tr>
<tr>
<td>Federal Home Loan Bank</td>
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<tr>
<td>FHLB Affordable Housing Program</td>
<td>Gap financing via a subsidized loan and/or direct subsidy (grant) for projects serving low income households. Funding rounds held 1-2 times per year.</td>
<td>Annual caps on the amount of direct subsidy/project (typically $400,000); maximum $800,000 total request/project. 1-2 funding cycles per year specify application and ranking criteria. Applications are made in partnership with a FHLB member financial institution.</td>
<td>At least 20% of rental units must be for households earning 50% or less of AMI. Developments serving homeless, special needs receive additional points in scoring process.</td>
</tr>
</tbody>
</table>
## Operating Funding Sources for Housing

### Connecticut Department of Social Services

<table>
<thead>
<tr>
<th>Program</th>
<th>Purpose</th>
<th>Application Limits</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rental Assistance Program (RAP)</strong></td>
<td>RAP is the major state-funded program for assisting very low income families to afford decent, safe, sanitary housing in the private market. RAP certificates are funded by DSS and administered statewide by DSS and its agent, J. D’Amelia &amp; Associates (JDA). Subsidy recipients pay 40% of income toward housing costs.</td>
<td>Individual households can apply for tenant-based certificates when DSS waiting lists are opened. Demand for RAPs exceeds supply; long waiting lists are common. Close to half of DSS’s RAPs are allocated to specific collaborative State programs serving specific target populations. These programs include the Supportive Housing Initiative (see CHFA), Money Follows the Person, and DCF’s Supportive Housing for Families program. As in the Supportive Housing Initiative, RAPs can be used for project-based operating assistance at the discretion of DSS.</td>
<td>Households with incomes at or below 50% AMI</td>
</tr>
</tbody>
</table>

### Public Housing Authorities (PHAs) (includes CT Department of Social Services)

<table>
<thead>
<tr>
<th>Program</th>
<th>Purpose</th>
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<th>Population</th>
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</thead>
<tbody>
<tr>
<td><strong>HUD Section 8 vouchers</strong></td>
<td>The Section 8 Rental Voucher Program increases affordable housing choices for very low-income households by allowing families to choose privately owned rental housing. The PHA pays the landlord the difference between 30 percent of household income and the fair market rent (FMR).</td>
<td>HUD allows housing authorities the discretion to project-base up to 20% of their Section 8 vouchers for affordable housing projects. Provision of these vouchers is at the discretion of the housing authority. To date, some CT PHAs (including DSS) have project-based a limited number of Section 8 vouchers for permanent supportive housing.</td>
<td>Households with incomes at or below 50% of AMI</td>
</tr>
<tr>
<td>Program</td>
<td>Purpose</td>
<td>Application Limits</td>
<td>Population</td>
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<tr>
<td><strong>State of Connecticut HOME Program</strong></td>
<td>Federally funded program administered by DECD primarily used for capital (see Capital section). However, HUD allows participating jurisdictions the discretion to use HOME funds to provide financial assistance to individual households in order to enable them to rent market-rate units. These rental subsidies are known as &quot;tenant-based rental assistance&quot; or TBRA. Eligible TBRA activities include rental assistance programs, self-sufficiency programs, homebuyer programs, targeted population programs, anti-displacement assistance programs, and security deposit programs.</td>
<td>HOME TBRA contracts with individual households may not exceed two years but are renewable.</td>
<td>Must serve households at or below 80% of AMI</td>
</tr>
</tbody>
</table>

<p>| <strong>US Department of Housing and Urban Development (HUD)</strong> | | | |
| <strong>Shelter Plus Care</strong> | Rental subsidies for housing serving persons who are homeless and disabled. Subsidies can be tenant-based, sponsor-based, or project-based. HUD issues annual NOFAs; applications are through local Continuums of Care. | Eligible applicants are units of government and housing authorities. DMHAS is the largest administrator of Shelter Plus Care subsidies in Connecticut. | Homeless disabled, with preference for chronically homeless households |
| <strong>Supportive Housing Program</strong> | See Supportive Housing Program under Services Funding. | | |
| <strong>Veterans Affairs Supportive Housing (VASH)</strong> | The HUD-VASH voucher program combines HUD housing choice voucher rental assistance for homeless veterans with case management and clinical services provided by Veterans Affairs at its medical centers and in the community. | VASH vouchers are administered by local housing authorities. The designation of housing authorities in CT that administer VASH vouchers can change annually. VASH vouchers can be project-based similar to the Section 8 program. Project-basing must be approved by the administering housing authority, the local VA, and by HUD. | Homeless Veterans referred by the VA |
| <strong>Family Unification Program (FUP)</strong> | The HUD Family Unification Program provides Section 8 Housing Choice Vouchers for families involved with the child welfare system and youth transitioning from foster care. Supportive services must be provided by the Public Child Welfare Agency to FUP youths for the entire 18 months in which the youth participates in the program. DSS (as the State’s PHA) and DCF (as the Public Child Welfare Agency) currently use FUP vouchers in tandem with DCF’s Supportive Housing for Families program. | Eligible applicants are public housing authorities. PHAs must administer the FUP in partnership the Public Child Welfare Agency (DCF) who would be responsible for referring FUP families and youths to the PHA for determination of eligibility for rental assistance. | 1. Families for whom the lack of housing is a primary factor in the imminent placement of the family’s children in out-of-home care or the delay in the discharge of the children to the family from out of home care. 2. Youth 18-21 who left foster care at age 16 or older and who lack adequate housing. (vouchers limited to 18 months) |</p>
<table>
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<tr>
<th>Program</th>
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<tbody>
<tr>
<td><strong>Section 8 Section 811 (as amended by Frank Melville Supportive Housing Investment Act of 2010)</strong></td>
<td>Traditionally a program providing capital linked to rental assistance for the creation of supportive housing exclusively for people with disabilities, the program is changing due to the Frank Melville Supportive Housing Investment Act of 2010. In addition to the changes described in the Capital section above, the program will provide for project based rental assistance not linked to a HUD capital advance. This will allow for the integration of supportive housing units within larger multifamily housing projects (new or existing) where the development costs are paid for from other public or private sources. Assisted units must be operated as supportive housing for not less than 30 years.</td>
<td>Eligible applicants are state housing finance agencies and “other appropriate entities” as will be laid out in program regulations to be issued in late 2011. Requires a partnership be established between the housing agency applying for the rental assistance and the state Medicaid agency. No more than 25% of total dwelling units in assisted projects may be used for supportive housing or have an occupancy preference for people with disabilities. Program regulations are expected to be issued in late 2011.</td>
<td>Households with extremely low incomes at or below 30% of AMI</td>
</tr>
<tr>
<td><strong>HUD/HHS Families Initiative</strong></td>
<td>Under a new initiative in the planning stages, HUD and HHS would combine housing vouchers with funding from mainstream programs to serve homeless or at-risk families with children. HUD will provide Section 8 vouchers targeted to communities with high concentrations of families experiencing homelessness. Applicants will need to demonstrate how they are coordinating these vouchers with assistance and services administered by the State and available through TANF and other HHS-funded programs. Local homeless liaisons in schools would help identify families.</td>
<td>This is a Signature Initiative outlined in the federal Opening Doors plan. Program guidelines have not been issued as of this date.</td>
<td>Homeless and at-risk families</td>
</tr>
<tr>
<td><strong>HUD/HHS Chronic Homelessness Initiative</strong></td>
<td>Under a new initiative in the planning stages, HUD and HHS would connect housing vouchers with health and social services provided through Medicaid and wraparound services funding through SAMHSA. The goal is to help 4,000 people experiencing chronic homelessness move off the streets and out of shelter, and to test and evaluate replicable models for using Medicaid to finance health care and related services for those in permanent supportive housing.</td>
<td>This is a Signature Initiative outlined in the federal Opening Doors plan. Program guidelines have not been issued as of this date.</td>
<td>People experiencing chronic homelessness</td>
</tr>
</tbody>
</table>

**Prevention and Rapid Re-Housing Funding Sources**

CT Department of Social Services
### Program Summary

<table>
<thead>
<tr>
<th>Program</th>
<th>Purpose</th>
<th>Application Limits</th>
<th>Population</th>
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</thead>
<tbody>
<tr>
<td><strong>Homelessness Prevention and Rapid Re-Housing Program (HPRP)</strong></td>
<td>A Federal stimulus act program administered by DSS and by the five ESG entitlement communities. DSS HPRP funds are used by six regional programs to provide temporary financial assistance and housing stabilization supports to homeless and at-risk households. The program is due to expire in 2012.</td>
<td></td>
<td>Households with incomes at or below 50% of AMI who are homeless or at risk of homelessness.</td>
</tr>
<tr>
<td><strong>Emergency Solutions Grant (ESG)</strong></td>
<td>Formerly known as the Emergency Shelter Grant Program, the Emergency Solutions Grant is a HUD-funded program administered by DSS and five entitlement communities in CT (Bridgeport, Hartford, New Britain, New Haven, and Waterbury). Under the HEARTH Act, at least 40% of ESG funds must dedicated to prevention and rehousing activities, including short/medium term rental assistance and housing relocation/stabilization assistance to homeless or at risk households. No more than 60% of ESG funding can be used to support shelter activities. Previously, up to 20% of ESG funds could be used for shelter. A greater portion of HUD homelessness assistance funds will be going into ESG (20%, up from 10%).</td>
<td>Watch for HEARTH Act regulations to be issued by HUD. ESG must be matched dollar for dollar with state or local funds.</td>
<td>Persons who are homeless or at risk of homelessness.</td>
</tr>
<tr>
<td><strong>Homelessness Prevention and Rapid Re-Housing Program (HPRP)</strong></td>
<td>A Federal stimulus act program administered by DSS and by the five ESG entitlement communities. DSS HPRP funds are used by six regional programs to provide temporary financial assistance and housing stabilization supports to homeless and at-risk households. The program is due to expire in 2012.</td>
<td></td>
<td>Households with incomes at or below 50% of AMI who are homeless or at risk of homelessness.</td>
</tr>
<tr>
<td><strong>State-funded programs:</strong> Eviction and Foreclosure Prevention Program (EFPP), Security Deposit Guarantee Program (SDGP), Beyond Shelter, Housing First for Families</td>
<td>DSS funds a variety of nonprofits to deliver prevention and rapid re-housing services through the Eviction and Foreclosure Prevention Program (rent bank, conflict resolution, mediation); Beyond Shelter (housing search, mediation, and outreach to property owners), and Housing First for Families (housing search and re-housing assistance for reunifying families). DSS also funds the Security Deposit Guarantee Program, which guarantees up to 2 months of security deposit for eligible households.</td>
<td>Eligibility requirements vary by program</td>
<td></td>
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</tbody>
</table>

### CT Department of Mental Health and Addiction Services

<table>
<thead>
<tr>
<th>Program</th>
<th>Purpose</th>
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<tbody>
<tr>
<td>Housing Assistance Fund Program</td>
<td>A state-funded rental assistance program which provides for a monthly housing subsidy payment to persons with a psychiatric disorder on a temporary basis while an individual/family is on a waiting list for permanent state and/or federal subsidy.</td>
<td></td>
<td>Persons with a psychiatric disorder on subsidy waiting list</td>
</tr>
<tr>
<td>Program</td>
<td>Purpose</td>
<td>Application Limits</td>
<td>Population</td>
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<tr>
<td><strong>Municipalities</strong></td>
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</tr>
<tr>
<td>Emergency Solutions Grant (ESG)</td>
<td>See narrative under CT Dept. of Social Services, above.</td>
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</tr>
<tr>
<td><strong>US Department of Housing and Urban Development (HUD)</strong></td>
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<tr>
<td>Supportive Housing Program (SHP)</td>
<td>Under the HEARTH Act, SHP funds will now be able to be used in part to provide rehousing services for homeless households, including housing search, mediation, outreach to property owners, credit repair, providing security or utility deposits, rental assistance for a final month at a location, assistance with moving costs or other activities that are effective in moving people immediately into housing or who have moved into permanent housing in the prior 6 months. SHP funds are awarded through annual competitive NOFAs issued by HUD.</td>
<td>Watch for HEARTH Act regulations to be issued by HUD, possibly late 2011.</td>
<td>Homeless households</td>
</tr>
<tr>
<td><strong>US Department of Veterans Affairs (VA)</strong></td>
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<tr>
<td>Supportive Services for Veteran Families (SSVF) Program</td>
<td>Under this new (2011) program, VA awards grants to private nonprofit organizations an consumer cooperatives who will provide supportive services to very low income Veteran families residing in or transitioning to permanent housing. Grantees provide outreach and case management services and assist participants to obtain VA benefits and other public benefits, including services relating to health care, financial planning, transportation, legal services, housing counseling, temporary financial assistance, and daily living services.</td>
<td>Eligible applicants are nonprofit organizations and consumer cooperatives.</td>
<td>Single veteran or a family in which the head of household or spouse is a Veteran; incomes at or below 50% AMI</td>
</tr>
<tr>
<td><strong>Transitional Housing</strong></td>
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<tr>
<td>U.S. Department of Health and Human Services Family and Youth Services Bureau</td>
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<tr>
<td>FYSB Transitional Living Program</td>
<td>Supports projects that provide long-term residential services to homeless youth ages 16-22. The services offered are designed to help them make a successful transition to self-sufficient living. Living accommodations may include host-family homes, group homes, maternity group homes, or supervised apartments owned or rented in the community. Grants are via NOFA and run for 5 years.</td>
<td></td>
<td>Homeless youth ages 16-22</td>
</tr>
</tbody>
</table>
### U.S. Department of Justice (DOJ)
#### Office of Violence Against Women

<table>
<thead>
<tr>
<th>Program</th>
<th>Purpose</th>
<th>Application Limits</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transitional Housing Assistance Program</strong></td>
<td>Grant funds may be used to provide transitional housing, rental assistance, and/or supportive services only to victims of sexual assault, domestic violence, dating violence, and/or stalking who are homeless or in need of transitional housing or other housing assistance as a result of fleeing a situation of sexual assault, domestic violence, dating violence, or stalking, and for whom emergency shelter services or other crisis services are unavailable or insufficient. Programs may offer individualized services such as counseling, support groups, safety planning, and advocacy services, as well as practical services such as licensed child care, employment services, transportation vouchers, telephones, and referrals. Grants are awarded via NOFA and run for 36 months.</td>
<td>Eligible applicants are states, units of local government, Indian tribes, and nonprofit, nongovernmental organizations that have a documented history of effective work concerning sexual assault, domestic violence, dating violence, and/or stalking.</td>
<td>Victims of sexual assault, domestic violence, dating violence, and/or stalking and their children and dependents.</td>
</tr>
</tbody>
</table>

### US Department of Veterans Affairs (VA)

<table>
<thead>
<tr>
<th>Program</th>
<th>Purpose</th>
<th>Application Limits</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grant and Per Diem Program</strong></td>
<td>Offered annually by the VA Health Care for Homeless Veterans Programs to fund community agencies providing services to homeless Veterans. Funds transitional housing (up to 24 months) or service centers. The grant component funds up to 65% of the cost of construction, renovation, or acquisition of a building for use as service centers or transitional housing for homeless Veterans. Grant recipients are the priority for receipt of Per Diem funds, which cover operational costs up to a maximum per diem amount per day per Veteran housed. Watch for annual NOFAs.</td>
<td>Eligible applicants are community agencies serving homeless Veterans.</td>
<td>Homeless Veterans</td>
</tr>
</tbody>
</table>

### Service Funding Sources for Supportive Housing and Housing Sustainability

#### Targeted Programs (programs specifically targeting persons who are homeless)

#### CT Department of Mental Health and Addiction Services
#### CT Department of Social Services

<table>
<thead>
<tr>
<th>Program</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CT Supportive Housing Initiative funding</strong></td>
<td>See Capital section under CHFA.</td>
</tr>
<tr>
<td>Program</td>
<td>Purpose</td>
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<tr>
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</tr>
<tr>
<td><strong>US Department of Housing and Urban Development (HUD)</strong></td>
<td></td>
</tr>
<tr>
<td>Supportive Housing Program</td>
<td>Services and operating funds for supportive housing serving homeless persons.</td>
</tr>
<tr>
<td><strong>US Department of Veterans Affairs</strong></td>
<td></td>
</tr>
<tr>
<td>Veterans Affairs Supportive Housing (VASH)</td>
<td>The HUD-VASH voucher program combines HUD housing choice voucher rental assistance for homeless veterans with case management and clinical services provided by Veterans Affairs at its medical centers and in the community.</td>
</tr>
<tr>
<td><strong>US Department of Labor</strong></td>
<td></td>
</tr>
<tr>
<td>Homeless Veterans Reintegration Program (HVRP)</td>
<td>Purpose of HVRP is to provide services to assist in reintegrating homeless veterans into meaningful employment within the labor force. Grantees provide an array of services utilizing a case management approach that directly assists homeless veterans as well as provide critical linkages for a variety of supportive services available in their local communities. The program is “employment focused” and veterans receive the employment and training services they need in order to re-enter the labor force. Job placement, training, job development, career counseling, resume preparation, are among the services that are provided.</td>
</tr>
<tr>
<td><strong>US Department of Health and Human Services</strong></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
<td>Through CABHI, SAMHSA seeks to increase the number of individuals who are chronically homeless placed in permanent housing that supports recovery through comprehensive treatment and recovery services for behavioral health. It also seeks to increase capacity for community-based providers to enroll individuals who are chronically homeless in mainstream programs and obtain reimbursement for behavioral health. To achieve this goal, SAMHSA funds will support three primary types of activities: 1) behavioral health, housing support, and other recovery-oriented services not covered under a State’s Medicaid plan; 2) coordination of housing and services for chronically homeless individuals and families at the State and local level which support the implementation and/or enhance the long-term sustainability of integrated community systems that provide permanent housing and supportive services; and 3) efforts to engage and enroll eligible persons who are chronically homeless in Medicaid and other mainstream benefit programs (e.g., SSI/SSDI, TANF, SNAP).</td>
</tr>
<tr>
<td>Program</td>
<td>Purpose</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Selected Mainstream Programs</strong></td>
<td>(programs not tied to homelessness or housing status)</td>
</tr>
<tr>
<td><strong>CT Department of Social Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Temporary Assistance for Needy Families (TANF)</strong></td>
<td>The Federal TANF program provides block grants to states to fund programs that provide services and benefits to “needy” families (defined as financially deprived according to income and related criteria). In addition to the basic time-limited income support program called Temporary Family Assistance, DSS uses TANF funds and required State “maintenance of effort” funds for a variety of programs, including case management services through the DCF Supportive Housing for Families program and the Next Steps Supportive Housing Initiative, child care assistance, energy assistance, and employment services.</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>Medicaid is a state administered health insurance program combining federal and state dollars and available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Each state sets its own guidelines regarding eligibility and services. Medicaid is a potential funding source for services in supportive housing.</td>
</tr>
<tr>
<td><strong>Money Follows the Person (MFP)</strong></td>
<td>The MFP program is a program of the federal (HHS) Centers for Medicare and Medicaid Services designed to assist States in rebalancing their long-term care systems and help Medicaid enrollees transition from institutions to the community. The intent is to increase Home and Community Based Services (HCBS) through Medicaid and reduce the use of institutionally-based services; eliminate barriers in State law, Medicaid plans, or budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long-term care in the settings of their choice; strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions; and ensure that procedures are in place to provide quality assurance and continuous quality improvement of HCBS. 43 states, including CT, are currently implementing MFP Demonstration Programs. Connecticut is using the program to transition 700 Medicaid-eligible elderly and people with disabilities from nursing facilities or other institutions back into the community to receive support and services at home. The State is matching the program with Rental Assistance Program (RAP) certificates to ensure housing affordability.</td>
</tr>
<tr>
<td>Program</td>
<td>Purpose</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>Vocational Rehabilitation and Supported Employment</td>
<td>The Bureau of Rehabilitation Services (BRS) of DSS administers the federal Dept. of Education's Vocational Rehabilitation and Supported Employment programs. The programs are designed to create opportunities that enable individuals with significant disabilities to work competitively and live independently.</td>
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<tr>
<td>CT Department of Labor</td>
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<tr>
<td>Workforce Investment Act (WIA)</td>
<td>The Workforce Investment Act of 1998 (WIA) reformed federal employment, training, adult education, and vocational rehabilitation programs by creating an integrated &quot;one-stop&quot; system of workforce investment and education services for adults, dislocated workers, and youth. The purpose is to promote an increase in the employment, job retention, earnings, and occupational skills improvement by participants. Funds are allocated by the US Department of Labor to the State, which allocates the funds to regional workforce development boards.</td>
</tr>
<tr>
<td>CT Department of Mental Health and Addiction Services</td>
<td></td>
</tr>
<tr>
<td>Community Mental Health Services Block Grant and Substance Abuse and Prevention Treatment Block Grant</td>
<td>During federal fiscal years 2012 and 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) will work with states to plan for an transition their federal block grants toward four purposes. Two of these are: 1) to fund priority treatment and support services for individuals without insurance or who cycle in and out of health insurance coverage; 2) to fund priority treatment and support services not covered by Medicaid, Medicare or private insurance and that demonstrate success in improving outcomes and/or supporting recovery. This may present an opportunity to target a portion of block grant funds for interventions to address the needs of persons experiencing chronic homelessness.</td>
</tr>
<tr>
<td>U.S. Department of Justice (DOJ)</td>
<td></td>
</tr>
<tr>
<td>Second Chance Act</td>
<td>Signed into law in 2008, the Second Chance Act was designed to improve outcomes for people returning to communities from prisons and jails. The act authorizes federal grants to government agencies and nonprofit organizations to provide employment assistance, substance abuse treatment, housing, family programming, mentoring, victims support, and other services that can reduce recidivism. Since its passage, DOJ has issued a number of solicitations for grants in various areas, including juvenile offender reentry, adult offender reentry, reentry courts, family-based offender substance abuse treatment, and others. Watch for periodic NOFAs, usually listed at the website for the National Reentry Resource Center.</td>
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Appendix A

What have we learned about essential elements to prevent and end homelessness in Connecticut?

During the Opening Doors - CT roundtable “listening sessions” held in the Spring of 2011, practitioners and policymakers in the fields of homeless services, health care, criminal justice, family and youth programs, community engagement, employment, and housing offered their views and practical advice on preventing and ending homelessness in Connecticut. Their input was complemented by additional information garnered through an on-line survey posted during April 2011 and by extensive public comment provided to USICH in 2010 from stakeholders in the Northeast as part of the federal Opening Doors development.

While the comments were diverse (and all were valuable), there were several themes that were remarkably consistent across the various disciplines represented by the commenters:

1. Preventing and ending homelessness is a shared responsibility
   - Housing loss is intertwined with issues of income, health, safety, social and family supports, and other factors. Solving an issue this complicated can only happen by tapping the expertise and resources of many disciplines working in tandem. It is no longer seen as the sole responsibility of the homeless services system.

2. Housing, housing, housing
   - Housing is the first step: it must be available in order for other interventions to work.
   - Housing subsidies are essential.
   - We need better strategies to eliminate barriers to housing access, such as overarching management of coordinated housing applications and placement, and shared waiting lists.
   - State level policy needs to prioritize and allocate state housing resources (rent subsidies, capital, etc.) based on desired outcomes, and connect these resources with those from other systems (e.g., education, human services, transportation, energy, criminal justice).
   - Local housing authority participation in efforts to end homelessness is essential.
   - As some larger housing authorities have learned, all affordable housing benefits from connecting tenants to community services and supports.
   - Take advantage of current opportunities to reuse underutilized, blighted and abandoned REO/foreclosed properties.

3. Differentiate our services to households faced with housing loss based on their individual needs and preferences
   - People have the right to decide their own fate or course of action; “success” does not look the same for everyone.
   - Not everyone needs housing with intensive services – many people just need a home, access to health care, and help with employment. Create multiple pathways of response geared to level of need.
• While we may need to better standardize our systems\(^1\), the services we provide must remain person-centered.
• Pay attention to the issue of substance addiction. Ensure that staff members across agencies are trained in working with people with addictions.

4. **Target assistance to households with the greatest needs**
• Focus prevention services particularly on young parents with children who are at risk, families with multiple health care interventions, homeless “couch hopping” youth, and youth transitioning from foster care and the criminal justice system.
• Also target housing assistance to households who are frequent users of systems, such as shelters, criminal justice, and emergency health care.
• Identify frequent users of systems at the community level and through cross-system data matching, as was done in the FUSE initiative.\(^2\)
• Assertively reach out to and proactively engage highly vulnerable populations.

5. **Make better and more efficient use of data**
• Households confronted by homelessness frequently move from one community to another, and are often served by multiple systems (shelters, hospitals, child welfare, schools, mental health, criminal justice). Integrated data systems are needed to access centralized, easily accessible information to better serve the needs of clients.\(^3\)
• Each data system should have within it a set of common data elements that allow data to be fed into a master system and cross referenced, including federally required data elements.
• Ensure that the restructuring of the CT Department of Social Services’ data system takes into account the data needs of other state agencies.
• Break down walls in HMIS that make it difficult for localities to access information in a timely way. Communities want to use HMIS for data matching with housing authorities and other systems, and to see when people are moving between shelters.

6. **Hold ourselves accountable for housing stability**
• Reframing the role of the service system in the life of the person confronted by homelessness means being accountable for the client’s stability in housing. Expectations then shift to looking at the long-term needs of the person.

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\(^1\) Recommendations for standardized systems included 1) devising a uniform assessment tool (i.e., a form used to identify the needs of a family or individual for housing and other services) that would be used by shelters, housing assistance programs, and other human service programs; 2) establishing common data elements across human service programs that would feed into a central data warehouse; and 3) creating uniform reporting formats among funding agencies, which would enable service providers to spend more time delivering services and less time meeting myriad documentation requirements.

\(^2\) The Frequent User Service Enhancement (FUSE) initiative provides supportive housing for a set number of individuals in targeted communities who have cycled in and out of jail, shelter, emergency health care, and other public systems. Participants in the program were identified through data matching between HMIS and the Department of Corrections.

\(^3\) A recommended model for this is the e-health initiative of the CT Department of Public Health, which will provide health information exchange among hospitals and other health care providers through on-line accessibility to electronic health records.
• Service staff needs to be skilled and effective at organizing and coordinating the resources that touch that person, and track what happens after a referral.4 A possible model is that of a cross-systems navigator (described in this document in the Section “Improving Health and Housing Stability”).
• Look at the important role of mentors and peer specialists in providing support.
• Match resources with accountability standards and measures, and align incentives tied to performance toward desired outcomes. Track performance data and get the information to the providers of services regularly.
• Standards of care are needed, as well as technical assistance to support providers in meeting these standards. The standards should cross-geographical lines and span categorical funding requirements.

7. Forge alliances that bring better service to the person and community

• Proactively engage other sectors that are serving the same people, but in different ways; establish formal processes to coordinate services in ways that take best advantage of the strengths and resources of each partner.5
• Start by forming the relationship; get to know the director of the other organization, identify shared interests and what each can bring to the table.
• Inter-organization collaboration requires a clear delineation of roles and the target population(s) to receive services, an effective system to identify the individuals or families, a tight referral process, and a system of accountability.
• When there are several organizations involved, it is important to designate a lead entity with a comprehensive view. The purpose of the lead is to orchestrate the many players in the system and make everyone more successful. It helps if the lead has clout through controlling the funding that agencies receive.
• Collaborations can create efficiencies for the client, but they take time and resources to manage for the organizations involved.
• Effective collaborations have ripple effects: they establish a foundation of relationships upon which new initiatives can be built.
• Devise ways to better coordinate the work of the State Interagency Council on Supportive Housing and Homelessness with that of local municipalities and community plans to end homelessness (aka “ten year plans”).

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4 As one listening session participant put it “if I had all the money in the world, I would have every family that requires services be assigned a case manager who is not part of any of us – their only job is to bring all the systems together to develop a strategy for this family to move through the system.”

5 There were many examples given of this kind of cross-sector collaboration, including: 1) an employer working with a youth services agency – one provides the jobs and job training, the other provides the job readiness and job retention supports; 2) a developer of affordable housing working with a human services agency – one provides a set-aside of apartments, the other refers tenants and provides housing stabilization supports; 3) a hospital working with an emergency shelter – the hospital provides coordinated discharge planning for homeless individuals and health care navigation post-release, the shelter provides respite care beds leading to housing placement for the individuals who are discharged; 4) a housing authority and hospital co-developing properties to provide affordable units and remove blight in the neighborhood surrounding the hospital; 4) Connecticut’s State-led supportive housing initiatives, which involve funding collaborations between human service and housing agencies.
8. **Don’t make employment an afterthought**
   - Securing affordable housing is not the end in itself, but rather a stable platform for pursuing other goals, such as income growth. Recognize that the majority of people, once housed, are capable of working. Understand the employment issues the person faces.
   - Focus employment efforts on skill building targeted to specific industries and occupations.
   - Develop linkages to the training programs and job placement services of workforce investment boards and the Bureau of Rehabilitation Services (BRS).

9. **Take advantage of opportunities presented by health care reform**
   - Look for opportunities to tap into Medicaid to expand resources for supportive housing services.
   - Explore the potential for enhancing health care through structured partnerships between providers of housing assistance and community health centers.

10. **Speak plainly**
    - We need to create basic messages to engage broader constituencies about our efforts to prevent and end homelessness, and identify expanded ways to disseminate information to people not involved in the field of homeless services. Take inspiration from anti-stigma campaigns.
Appendix B  
(August 2012 Revision)

Major Assumptions Used in Estimating Needs for Housing Assistance during the Plan Timeframe

Overview

1. Currently available Connecticut data about homelessness is used to estimate needs during the initial 5-year plan timeframe of 2012-2016. The primary sources of data used were the 2010, 2011 and 2012 Statewide Point in Time (PIT) Homeless Counts, and 2010 and 2011 annual homelessness data through the Connecticut Homelessness Management Information System (HMIS). Where Connecticut data is not available, national data is used to help form estimates.

2. Based on national research about the dynamics of homelessness, the plan assumes that many households will be homeless for a short time and will exit homelessness without receiving additional housing assistance. Others will be able to exit (or exit more quickly) with short-term housing assistance.

3. Our estimates assume that by 2012 we begin to prevent homelessness for a growing number of households who would have become homeless. While prevention efforts were already underway in 2010 and 2011 through programs such as the federal Homelessness Prevention and Rapid Re-Housing Program (HPRP), the impact of these efforts appears to have been largely offset by the rising numbers of people who were at risk of homelessness during the economic downturn. We do not have state or national data to determine the net effect of these prevention strategies.

4. The plan primarily focuses on the goals of ending or reducing chronic homelessness and homelessness among families with children, youth and Veterans. As part of this focus, we have identified the need for a supportive housing among both persons currently experiencing chronic homelessness and among non-chronically homeless adults without children who have health-related vulnerabilities (estimated at 10%), in order to prevent their entry into chronic homelessness. This includes homeless adults with disabilities, older adults and vulnerable youth. Because non-chronically homeless adults without children represent the largest number of homeless households, there will be only modest reductions in the total number of households without children experiencing homelessness each year in Connecticut as result of this new supportive housing.

5. The unaccompanied homeless youth population includes children and youth under 18 who are not residing with their legal guardians and young adults ages 18-21 who are not residing with families and who are experiencing poverty and homelessness. At this point in time, there is limited data on the number of unaccompanied youth. For that reason, we are not yet able to accurately project housing assistance needs among this population.

6. A chronically homeless adult is defined here as an unaccompanied homeless individual (18 or older) with a disabling condition who has either been continuously homeless for a year or more OR has had at least four episodes of homelessness in the past three years.

Dynamics of Homelessness

We developed estimates of needs for housing assistance over the initial 2012-2016 timeframe of the Opening Doors-CT plan based on several assumptions. These assumptions were incorporated into a set of Excel spreadsheets, or “timelines”, to calculate our housing estimates. These timelines appear in Attachments C-F of this Appendix. There were separate spreadsheets developed for families, chronically homeless adults (and adults at risk of chronic homelessness), and Veterans (while there is a separate sheet for Veterans, the numbers for Veterans are also incorporated within the other three spreadsheets). In each spreadsheet, we estimated the number of households entering homelessness and exiting homelessness, and the impact of interventions – such as shelter and transitional housing only, prevention assistance, rapid re-housing, permanent supportive housing, and targeted affordable housing
– on these entries and exits. The methodology and assumptions we used in deriving these estimates are described below. The assumptions are also summarized on Attachment B.

ENTRIES INTO HOMELESSNESS

The timelines include estimates of the number of households who are homeless at the beginning of the year and the number who become homeless during the year. The total of these two numbers is the estimated number of households who experience homelessness during the year.

1. **Estimated number homeless beginning of year – 2010**: For 2010 the estimate of the number of households homeless at the beginning of the year is based on the point in time (PIT) count of sheltered persons conducted during January 2010 combined with the 2009 PIT count of unsheltered persons (the 2010 PIT count did not include unsheltered persons).

2. **Number entering homelessness** is the number of households who enter homeless shelters or transitional housing programs during the year, who were not homeless at the time of the PIT count. It includes all households who become homeless after living in housing or after discharge from an institutional setting. This includes households homeless for the first time as well as those who have prior episodes of homelessness if they become homeless again after losing housing or leaving institutional settings.

Our estimates for 2010 and 2011 are based on the number of households who used shelter and transitional housing during those years (based on CT HMIS data for the federal fiscal years), minus the number of households who were homeless at the beginning of each year (based on that year’s PIT). We used this information as the basis for estimating the number of households who will enter homelessness in each year of the plan (unless prevented, as described further below). The number of households projected to be homeless in FFY2012 plus the number of households expected to enter homelessness during 2013 - 2016 equals the total number of households who will need assistance in the first 5 years of the plan.

These estimates of households entering homelessness do not include people who are doubled up if they do not enter homeless shelters or transitional housing or if they have never become unsheltered (e.g., living outdoors, in cars, etc.).

The wide disparity between the number of households using shelters over the course of the year and the number using shelters at a given point in time (a 3 to 1 ratio) is due in part to shelter capacity limits (i.e., a fixed number of available shelter beds) and to time limits on length of stay in many shelters. The number of people entering shelter is limited by the number of shelter beds available. Several shelters reported that they were operating over capacity in 2010.

We do not have data that allows us to estimate the impact of the current economic downturn on the number of homeless families and adults without children. We do know that the number of sheltered people experiencing homelessness over the course of the year increased 8% from 2010 to 2011.

Historically, CT HMIS has not yielded reliable data on the number of adults experiencing chronic homelessness over the course of the year. Therefore, our projections assume that the number of new entrants into chronic homelessness is largely offset by the number of people who leave chronic homelessness due to incarceration, hospitalization, or death. In our projections, we have used the CT point in time figure for 2010 as our starting point and that of 2011 as our end point to estimate the number of new entrants into chronic homelessness. We have also assumed that up to 10% of non-chronically homeless individuals without children are at risk of chronic homelessness, and have estimated the need for permanent supportive housing to prevent their entry into chronic homelessness.
PREVENTION OF HOMELESSNESS

We assume that well-targeted and effective prevention strategies could begin to reduce the number of family and Veteran households who experience homelessness and reduce the number of homeless adults who become chronically homeless. Prevention assistance is targeted to persons facing housing instability who are at risk of losing their housing and require temporary assistance to prevent this or to move to another home. This may take the form of housing assistance (such as rent or utility arrears, security deposits, or short-term rental assistance), legal or mediation services, moving assistance, credit repair, counseling, and other supports.

Assuming the availability of resources for prevention strategies, we estimate the following:

1. For families with children, we estimate that 7% of those who would otherwise become homeless during the year could instead be assisted through prevention interventions in 2012 and they do not become homeless. For each following year, we estimate that up to 15% of families (who would otherwise enter homelessness) could receive prevention assistance and do not become homeless.

   In addition, we estimate that up to 10% of homeless families who otherwise would have entered the shelter system would be prevented from doing so if they were the recipient of supportive or affordable housing assistance in a prior year which has prevented their return to homelessness. (The provision of supportive and affordable housing is described below under Exits from Homelessness.)

2. For adults without children experiencing chronic homelessness, we estimate that up to 40% who would otherwise enter homelessness during the year would be prevented from doing so if they were the recipient of supportive housing assistance in a prior year which has prevented their return to homelessness.

   Chronic homelessness can also be prevented through 1) better discharge planning to facilitate direct access to supportive housing when homeless people with disabilities leave hospitals, treatment facilities, or jails/prisons, and through 2) outreach efforts that help homeless adults with disabilities access supportive housing directly from the streets or shelter. Prevention of this kind has been assumed within the permanent supportive housing figures for Other Adults without Children.

3. For Veterans, we estimate that 7% of those who would otherwise become homeless could instead be assisted through prevention interventions in 2012 and they do not enter homelessness. For each following year, we estimate that up to 15% of Veterans (who would otherwise enter homelessness) would receive prevention assistance each year and do not become homeless.

   In addition, we estimate that up to 20% of Veterans who otherwise would have entered the shelter system would be prevented from doing so if they were the recipient of supportive or affordable housing assistance in a prior year which has prevented their return to homelessness.

   In order to keep the focus on targeted households, the prevention figure for Other Adults without Children on the Connecticut Statewide summary table reflects only the need among those adults who are Veterans. This is estimated at 95% of the Veterans prevention figure; the remaining 5% are assumed to be Veteran families.

Without an adequate supply of affordable housing for families and individuals with the lowest incomes, it is very difficult to target available housing resources more narrowly to those who will become homeless in order to prevent homelessness. If affordable housing is only available to households who are in shelters, it may create unintended consequences, including incentives for households in precarious housing situations (e.g. doubled up or living in hotels) to enter shelters to get housing assistance. Another unintended consequence could be a reduction in the number of households who leave shelters quickly without assistance if the household determines it is in their best interest to stay in shelter or transitional housing in order to qualify for affordable housing assistance.
EXITS FROM HOMELESSNESS

1. **HOUSEHOLDS LEAVING HOMELESSNESS WITH SHELTER OR TRANSITIONAL HOUSING ONLY.** National research and Connecticut data indicate that more than half of all homeless people exit homelessness quickly after short stays in shelter, and typically without receiving any housing assistance. The reported reasons for exits are varied: moved in with family/friends; secured their own housing; reached time limits on shelter length of stay; failed to comply with program regulations; relapse; etc. Most will not return to homelessness within the next year or two, but some may have additional episodes of homelessness during the year or in future years if they are unable to maintain housing, especially if affordable housing options are not available.

Close to 1,535 families and 9,850 single adult households in Connecticut used shelters and transitional housing programs during the course of a year in FFY11, based on HMIS data. The vast majority exited without additional housing assistance of any kind.

Seventy-six percent (76%) of persons in households with children and 49% of adults without children who used shelters in FFY2011 were new to shelter. This is consistent with national data. HUD’s March 2010 report, “Costs Associated with First-Time Homelessness for Families and Individuals” indicates that, for the communities studied, 58-72% of first time homeless families used emergency shelter only once in the 18-month period of the study; 50%-65% of first time homeless adults without children used emergency shelters only.

a. **Families:** During the plan timeframe, we estimate that at least 45% of families entering homelessness during the year will exit shelters and transitional housing quickly without additional housing assistance, often with support from family, friends, and other community resources. We also estimate that as many as 20% of families experiencing homelessness at a point in time will exit homelessness without additional housing assistance after extended stays in transitional housing programs.

The actual percentage of families that exited shelters without housing assistance in 2010 is estimated at about 64%. Many of these families likely returned or will return to homelessness (CT HMIS data found that 10% of homeless adults in families served by homeless shelters in 2010 were also served by Connecticut shelters in 2009). With effective prevention, rapid re-housing, and housing assistance, the number of families churning through the shelter system will drop over time.

b. **Chronically homeless adults.** We estimate that 5% of homeless adults experiencing chronic homelessness will leave homelessness due to incarceration, hospitalization, death, or other factors.

c. **Veterans:** Currently, many homeless Veterans (a group that includes a mix of adults without children, families, and chronically homeless persons) are served in transitional housing programs that receive VA funding, and these programs are effective for many people. We estimate that about 20% of Veteran households who become homeless each year will utilize shelters or transitional programs only briefly and exit homelessness without additional housing assistance. We also estimate that approximately 15% of those homeless at a point in time will exit homelessness without additional housing assistance after extended stays in transitional housing programs.

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1 “Housing assistance” can range from short-term assistance [e.g., funding for security deposit, payment of back rent or utilities, moving cost assistance, help with paying rent for a month or two], to medium term [rental assistance from several weeks to several months], to long-term [such as provision of an ongoing rental subsidy or access to housing with affordable rents]. Assistance may also include help in finding and securing housing and supportive services or case management that support housing stability.

Housing Assistance

2. Households leaving homelessness with rapid-rehousing assistance (one time, short-term or medium-term assistance). Many people can exit homelessness with one-time or short-term assistance (e.g., money to pay rental deposits or other move-in costs associated with moving from shelter to permanent housing; this may include a month or two of rental assistance) and in some cases medium term assistance (several weeks to several months) that will allow an individual or family to obtain needed housing quickly. Assistance may include help in finding and getting housing and time-limited supportive services or case management that facilitates linkages to ongoing support in the community, as needed. The availability of employment opportunities and effective supports in the community would enhance the ability of assisted households to maintain stability without long-term housing assistance.

Assuming the availability of resources for rapid re-housing strategies, we estimate the following:

a. Families: We estimate that up to 35% of families that enter homelessness could exit quickly with rapid re-housing assistance.

b. Veterans: We estimate that 15% of homeless Veteran households could exit homelessness with rapid re-housing assistance.

In order to keep the focus on targeted households, the rapid re-housing figure for Other Adults without Children on the Connecticut Statewide summary table reflects only the need among those adults who are Veterans. This is estimated at 95% of the Veterans prevention figure; the remaining 5% are assumed to be Veteran families.

3. Households leaving homelessness with permanent supportive housing. Permanent supportive housing is affordable housing where tenants can access supportive services aimed at helping them maintain housing stability and achieve personal goals in areas such as health, employment, and community integration. Supportive housing includes units located at a single site (i.e., multiple units located at a single building or apartment development) or can be scattered throughout the community. It can be created through the construction or acquisition of buildings or through access to existing housing through tenant-based subsidies or other funding mechanisms.

During the plan’s timeframe, some supportive housing opportunities will become available through anticipated turnover as current tenants move out of existing supportive housing. We estimate that 7% of existing supportive housing units turn over each year, based on recent experience and data. Households who move out are most likely to do so within the first year or two, so turnover rates are higher in new projects. In older supportive housing projects, turnover rates are often lower as more units are occupied by long-term tenants who are less likely to move out.

a. Families. Most homeless families do not need supportive housing if they have access to affordable housing and effective support services in the community. However, research indicates that some homeless families have long and protracted spells of homelessness, and that others return to homelessness after being rehoused. The size of this subgroup is not known, but the data suggest that families who experience repeated spells of homelessness are likely to have greater needs than the “typical” homeless family served in the emergency shelter and transitional housing system. Heads of household in some of these families may qualify as chronically homeless, and often face challenges related to substance use and/or mental health disorders, as well as trauma resulting from being a victim of physical violence and/or sexual abuse.3

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We estimate that approximately 11% of homeless families need supportive housing. This includes families that have experienced multiple episodes of homelessness, and some families that include a parent with a disability (e.g. mental illness or complex and poorly managed health conditions), and some homeless families involved with the child welfare system who have high needs for ongoing supportive services.

a. **Chronically homeless adults.** Virtually all chronically homeless adults need supportive housing. Given the extraordinarily high costs of health care and other public expenditures for emergency responses to chronic homelessness, supportive housing is a cost-effective solution.

b. **Adults without children who are not chronically homeless.** For individuals with disabilities or other health challenges who need more intensive support services linked to housing to achieve and maintain stability, permanent supportive housing is appropriate. Currently, over a third of all existing supportive housing in Connecticut is serving homeless individuals with disabilities, without limiting eligibility to persons who are chronically homeless. Adding additional units of supportive housing for homeless individuals with disabilities, and targeting supportive housing opportunities based on health-related vulnerability or avoidable health care costs is a cost-effective strategy to prevent people from becoming chronically homeless.

We estimate that 10% of homeless adults without children who are not chronically homeless need permanent supportive housing, based on health-related vulnerability and the potential for avoidable health care costs. This includes some homeless adults with HIV/AIDS or other disabilities (such as mental illness, chemical dependency or other chronic conditions), some unaccompanied transition-age youth (age 18-24), and some homeless adults over the age of 50, with some adjustment for overlap between these groups.

c. **Veterans.** Some Veterans with disabilities have experienced chronic homelessness and others face significant barriers to housing stability because of mental illness, including PTSD, and other challenges. These Veterans need supportive housing. We estimate that 35% of homeless Veterans will need permanent supportive housing during the plan’s timeframe. This includes households served through HUD-VASH vouchers, through newly created permanent supportive housing that carries other subsidies, and through turnover in these subsidies and units.

4. **Households leaving homelessness with deeply affordable housing.** People experiencing homelessness generally have incomes below 30% of area median income; most have incomes below 15% of area median income (about half of the federal poverty level). Housing that is affordable to households at this extreme poverty income level requires some form of public subsidy to either write down the cost of the rent or to cover the difference between 30-40% of tenant income and actual rent. New housing resources may include rental assistance vouchers and the development of permanent housing which is subsidized and available to households with no or limited incomes. In some cases the housing will be connected to service coordination or mainstream employment and youth programs, or coupled with the provision of time-limited services that help tenants connect to ongoing community supports.

Strategies to increase access to mainstream housing programs and to create additional affordable housing will help to meet the affordable housing needs for homeless households who do not need supportive housing and do not exit homelessness quickly on their own or with rapid re-housing assistance.

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4 CT 2009 PIT found that 10% of sheltered adults in families were chronically homeless, but also found that at least 13% had been without a permanent place to live at least 3 or more times previously in the past three years. A 2010 HUD cost study found that families with repeated stays in homeless programs also tended to have high rates of involvement with the child welfare system or criminal justice system. US Department of Housing and Urban Development, “Costs Associated with First-Time Homelessness for Families and Individuals”, 2010.

a. **Families:** Most homeless families have characteristics that are not substantially different from other poor families who are not homeless – and for the vast majority of homeless families, a housing subsidy or access to deeply affordable housing will prevent or end their homelessness. We estimate that close to 10% of homeless families with children will need affordable housing alone (i.e., exclusive of rapid re-housing or other housing assistance) in order to exit homelessness during the plan’s timeframe. A portion of this need can be met by removing barriers and improving access to existing housing programs, but achieving the plan’s targets will also require the creation of additional housing affordable to families at the lowest income levels who are homeless or at imminent risk of homelessness.

b. **Veterans:** We estimate that 10-20% of homeless Veterans need access to affordable housing in order to exit homelessness.

In order to keep the focus on targeted households, the deeply affordable housing figure for **Other Adults without Children** on the Connecticut Statewide summary table reflects only the need among those adults who are Veterans. This is estimated at 95% of the Veterans prevention figure; the remaining 5% are assumed to be Veteran families.

5. **NUMBER LEAVING HOMELESSNESS:** The number of households leaving homelessness is the sum of all households exiting homelessness through the means described above.
## CONNECTICUT STATEWIDE

### Estimated Needs for Housing Assistance Over Five-Year Timeframe - Opening Doors Connecticut

| Estimated needs for housing assistance, by type, among targeted households who will experience homelessness (unless prevented) | 2012-2016 |
|---|---|---|---|---|
| | Families with Children | Chronically Homeless Adults without Children | Other Adults without Children\(^a\) (Vets + Prevention of Chronic Homelessness) | Total Targeted Households |
| Prevention Strategies* | 520 | 240 | 760 | 250 |
| Rapid Re-Housing* | 920 | 160 | 1,080 | 170 |
| Deeply Affordable Housing** | 360 | 310 | 670 | 330 |
| Permanent Supportive Housing | 590 | 1,770 | 3,410 | 5,770 |
|   Estimated need that could be met through turnover of existing supportive housing units | (400) | (800) | (2,230) | (2,420) |
|   Need for new Supportive Housing | 190 | 970 | 2,180 | 3,340 |
| Estimated Total Target Households Needing Housing Assistance 2012-2016 | 2,390 | 1,770 | 4,120 | 8,280 |
| Estimated Persons in these households | 6,840 | 1,770 | 4,120 | 12,730 |

*Does not assume permanent rent subsidies connected with prevention and rapid re-housing.

**Deeply affordable housing refers to subsidized rental housing that is affordable to persons living in deep poverty and targeted to households experiencing homelessness. Affordable housing and permanent supportive housing options can take the form of scattered subsidized apartments or the development of buildings through new construction or rehabilitation. The affordable housing numbers presented here do not include rent subsidies needed to prevent homelessness or that may be used in conjunction with rapid re-housing or permanent supportive housing. These numbers also do not encompass the need for affordable housing among low income households who are not experiencing homelessness. Significantly increasing the availability of rental housing that is affordable to households with the lowest incomes would be the most effective strategy for preventing and ending homelessness. The need for affordable housing in Connecticut is much larger than the number of affordable housing units needed to serve households who have become homeless.

^The permanent supportive housing figures for "other adults without children" represent approximately 10% of estimated total adults without children who will experience homelessness (if not prevented). Does not include chronically homeless adults. Includes persons with behavioral health and primary health care needs, older adults, and vulnerable youth. The provision of supportive housing is a means to better address the housing and service needs of vulnerable adults and is a means to prevent chronic homelessness. If these units are provided, it is possible that fewer units of permanent supportive housing will be needed than estimated above in the Chronically Homeless Adults column. However, because we do not have reliable full-year data on the number of adults without children who experience chronic homelessness over the course of the year, the projections above are already fairly conservative.

Most homeless adults without children do not need permanent supportive housing. The majority exit homelessness quickly, often with support from family, friends, and other community resources, but many do return. Effective prevention, rapid re-housing, and affordable housing assistance could further reduce the number of individuals experiencing or returning to homelessness. In order to keep the focus on targeted households, the prevention, rapid re-housing, and deeply affordable housing numbers in this column reflect only the need among Other Adults without children who are Veterans.

^\(^{a}\) 5% of homeless Veteran households are estimated to be families with children. 30% of homeless Veteran households are estimated to be chronically homeless adults. The number of permanent supportive housing units for Veterans assumes that 5% of these units would be for Veteran families; of the remainder, 60% would be for chronically homeless Veteran adults and 40% would be for other homeless Veteran adults without children needing supportive housing and not yet chronically homeless.

^\(^{b}\) The unaccompanied homeless youth population includes children and youth under 18 who are not residing with their legal guardians and young adults ages 18 through 21 who are not residing with families and who are experiencing poverty and homelessness. Obtaining accurate data on the prevalence and service needs of unaccompanied homeless youth is difficult. A Homeless Youth Study, in the planning stages, will conduct key-informant interviews with youth identified by community partners as "homeless, unaccompanied, and/or throw-away" and service providers currently working with this group. Using the qualitative information collected from the key informants, a quantitative measure will be constructed to "count" the challenges, resources, and needs of this group in an attempt to describe the experience of these young people and affect policy.
<table>
<thead>
<tr>
<th></th>
<th>Families with Children</th>
<th>Chronically Homeless Adults without Children</th>
<th>Other Adults without Children</th>
<th>Veterans (Homeless households headed by a Veteran; includes households with and without children)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point in Time (2010)</strong></td>
<td>451</td>
<td>767</td>
<td>2,244</td>
<td>461</td>
</tr>
<tr>
<td><strong>2010 Annual</strong></td>
<td>1,169</td>
<td>1,080</td>
<td>8,286</td>
<td>800</td>
</tr>
<tr>
<td>Number entering homelessness unless prevented (2010 annual minus 2010 PIT)</td>
<td>718</td>
<td>313</td>
<td>6,042</td>
<td>339</td>
</tr>
<tr>
<td>% who are Families</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Prevention/Diversion through short and medium term interventions**

<table>
<thead>
<tr>
<th></th>
<th>Families with Children</th>
<th>Chronically Homeless Adults without Children</th>
<th>Other Adults without Children</th>
<th>Veterans (Homeless households headed by a Veteran; includes households with and without children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% expected to receive this assistance in 2012</td>
<td>7%</td>
<td>n/a</td>
<td>n/a</td>
<td>7%</td>
</tr>
<tr>
<td>Annual increase (&quot;ramp up&quot;)</td>
<td>7%</td>
<td>n/a</td>
<td>n/a</td>
<td>7%</td>
</tr>
<tr>
<td>% that could potentially be prevented/diverted from entering homelessness with this assistance if resources were available</td>
<td>15%</td>
<td>n/a</td>
<td>n/a</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Prevention through long-term interventions**

<table>
<thead>
<tr>
<th></th>
<th>Families with Children</th>
<th>Chronically Homeless Adults without Children</th>
<th>Other Adults without Children</th>
<th>Veterans (Homeless households headed by a Veteran; includes households with and without children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% that could potentially be prevented from entering or re-entering homelessness due to placement in permanent supportive housing or permanent affordable housing</td>
<td>20%</td>
<td>40%</td>
<td>n/a</td>
<td>20%</td>
</tr>
</tbody>
</table>

**Exits with shelter or transitional housing only**

<table>
<thead>
<tr>
<th></th>
<th>Families with Children</th>
<th>Chronically Homeless Adults without Children</th>
<th>Other Adults without Children</th>
<th>Veterans (Homeless households headed by a Veteran; includes households with and without children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% entering homelessness who are likely to exit after brief stays with shelter or transitional housing only estimated % in 2012</td>
<td>45%</td>
<td>0%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>% homeless at beginning of year leaving with shelter or transitional only after extended stays</td>
<td>64%</td>
<td>n/a</td>
<td>70%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

**Exits with Housing Assistance**

<table>
<thead>
<tr>
<th></th>
<th>Families with Children</th>
<th>Chronically Homeless Adults without Children</th>
<th>Other Adults without Children</th>
<th>Veterans (Homeless households headed by a Veteran; includes households with and without children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% expected to receive this assistance in 2012</td>
<td>9%</td>
<td>n/a</td>
<td>n/a</td>
<td>9%</td>
</tr>
<tr>
<td>Annual increase (&quot;ramp up&quot;)</td>
<td>3%</td>
<td>n/a</td>
<td>n/a</td>
<td>2%</td>
</tr>
<tr>
<td>% that could potentially exit homelessness with this assistance if resources were available</td>
<td>35%</td>
<td>n/a</td>
<td>n/a</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Permanent Supportive Housing**

<table>
<thead>
<tr>
<th></th>
<th>Families with Children</th>
<th>Chronically Homeless Adults without Children</th>
<th>Other Adults without Children</th>
<th>Veterans (Homeless households headed by a Veteran; includes households with and without children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of homeless households who need Permanent Supportive Housing (PSH)</td>
<td>11%</td>
<td>100%</td>
<td>10%</td>
<td>35%</td>
</tr>
<tr>
<td>Number of existing PSH units (2011)</td>
<td>995</td>
<td>1,579</td>
<td>2,051</td>
<td>132</td>
</tr>
<tr>
<td>PSH turnover rate</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Affordable Housing**

<table>
<thead>
<tr>
<th></th>
<th>Families with Children</th>
<th>Chronically Homeless Adults without Children</th>
<th>Other Adults without Children</th>
<th>Veterans (Homeless households headed by a Veteran; includes households with and without children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable Housing need / target population(s)</td>
<td>10%</td>
<td>n/a</td>
<td>10-20%</td>
<td>Veterans who do not exit homelessness on their own or with other types of assistance</td>
</tr>
</tbody>
</table>

---

**Notes:**
- Families with Children: Families with at least one child under 18.
- Chronically Homeless Adults without Children: Adults who have been homeless for at least 1 year and have four or more episodes of homelessness in the past three years.
- Other Adults without Children: Adults without children.
- Veterans (Homeless households headed by a Veteran; includes households with and without children): Households headed by a Veteran, including those with and without children.
- Prevention/Diversion: Interventions aimed at preventing homelessness or diverting individuals from entering homelessness.
- Exits with shelter or transitional housing only: Exits where individuals leave with shelter or transitional housing only.
- Exits with Housing Assistance: Exits where individuals receive housing assistance, either permanent supportive housing or permanent affordable housing.
- Permanent Supportive Housing: Housing that provides ongoing support services and is designed for individuals who are vulnerable and at risk of homelessness.
- Affordable Housing: Housing that is affordable to low-income households, typically defined as affordable if it costs no more than 30% of a household’s income.
### 5-Year Plan Timeframe

#### Families with children

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated number homeless beginning of year (PIT)</td>
<td>451</td>
<td>484</td>
<td>449</td>
<td>459</td>
<td>440</td>
<td>368</td>
<td>300</td>
<td>242</td>
<td>191</td>
<td>144</td>
<td>96</td>
<td>48</td>
</tr>
<tr>
<td>Add:</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Number entering homelessness</td>
<td>718</td>
<td>1,051</td>
<td>896</td>
<td>698</td>
<td>539</td>
<td>539</td>
<td>539</td>
<td>539</td>
<td>539</td>
<td>539</td>
<td>539</td>
<td>539</td>
</tr>
<tr>
<td>Number expected to enter homelessness during the year (if not prevented)</td>
<td>718</td>
<td>1,051</td>
<td>1,018</td>
<td>918</td>
<td>718</td>
<td>718</td>
<td>718</td>
<td>718</td>
<td>718</td>
<td>718</td>
<td>718</td>
<td>718</td>
</tr>
<tr>
<td>Number prevented from becoming homeless</td>
<td>-</td>
<td>-</td>
<td>71</td>
<td>129</td>
<td>108</td>
<td>108</td>
<td>108</td>
<td>108</td>
<td>108</td>
<td>108</td>
<td>108</td>
<td>108</td>
</tr>
<tr>
<td>Number prevented from returning to homelessness</td>
<td>-</td>
<td>-</td>
<td>51</td>
<td>92</td>
<td>72</td>
<td>72</td>
<td>72</td>
<td>72</td>
<td>72</td>
<td>72</td>
<td>72</td>
<td>72</td>
</tr>
<tr>
<td>Subtract:</td>
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<td></td>
</tr>
<tr>
<td>Number leaving homelessness</td>
<td>686</td>
<td>1,086</td>
<td>887</td>
<td>717</td>
<td>613</td>
<td>604</td>
<td>596</td>
<td>590</td>
<td>587</td>
<td>587</td>
<td>587</td>
<td>587</td>
</tr>
<tr>
<td>Number leaving with shelter or transitional only after brief stays</td>
<td>460</td>
<td>823</td>
<td>448</td>
<td>314</td>
<td>242</td>
<td>242</td>
<td>242</td>
<td>242</td>
<td>242</td>
<td>242</td>
<td>242</td>
<td>242</td>
</tr>
<tr>
<td>Number leaving with shelter or transitional only after extended stays with rapid rehousing</td>
<td>90</td>
<td>97</td>
<td>46</td>
<td>8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>with permanent supportive housing</td>
<td>70</td>
<td>70</td>
<td>131</td>
<td>131</td>
<td>109</td>
<td>101</td>
<td>93</td>
<td>86</td>
<td>83</td>
<td>83</td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td>New PSH units needed (subsidies or new units)</td>
<td>-</td>
<td>-</td>
<td>78</td>
<td>52</td>
<td>29</td>
<td>19</td>
<td>10</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>PSH turnover</td>
<td>70</td>
<td>70</td>
<td>75</td>
<td>79</td>
<td>81</td>
<td>82</td>
<td>83</td>
<td>83</td>
<td>83</td>
<td>83</td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td>with permanent affordable housing</td>
<td>-</td>
<td>-</td>
<td>75</td>
<td>75</td>
<td>73</td>
<td>73</td>
<td>73</td>
<td>73</td>
<td>73</td>
<td>73</td>
<td>73</td>
<td>73</td>
</tr>
<tr>
<td>Balance:</td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Projected number homeless at end of year</td>
<td>484</td>
<td>449</td>
<td>459</td>
<td>440</td>
<td>368</td>
<td>300</td>
<td>242</td>
<td>191</td>
<td>144</td>
<td>96</td>
<td>48</td>
<td>0</td>
</tr>
<tr>
<td>Number experiencing homelessness during the year</td>
<td>1,169</td>
<td>1,535</td>
<td>1,345</td>
<td>1,157</td>
<td>979</td>
<td>904</td>
<td>839</td>
<td>781</td>
<td>730</td>
<td>682</td>
<td>635</td>
<td>587</td>
</tr>
</tbody>
</table>
### 5-Year Plan Timeframe

#### Chronically Homeless Adults without Children

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated number homeless beginning of year (PIT)</td>
<td>767</td>
<td>964</td>
<td>936</td>
<td>784</td>
<td>594</td>
<td>399</td>
<td>201</td>
</tr>
<tr>
<td>Add:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number entering chronic homelessness</td>
<td>314</td>
<td>251</td>
<td>220</td>
<td>188</td>
<td>188</td>
<td>188</td>
<td>188</td>
</tr>
<tr>
<td>Number expected to enter chronic homelessness during the year (if not prevented)</td>
<td>314</td>
<td>314</td>
<td>314</td>
<td>314</td>
<td>314</td>
<td>314</td>
<td>314</td>
</tr>
<tr>
<td>Number prevented from becoming chronically homeless due to short-term interventions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Number prevented from returning to homelessness due to long-term interventions</td>
<td>-</td>
<td>63</td>
<td>94</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
</tr>
<tr>
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<td>-</td>
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<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
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<td>230</td>
<td>326</td>
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<td>-</td>
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*Hsg goals CT v12CH Timeline8/9/20127:12 PM*
### Reductions in Homelessness Over Timeframe of CT Plan

**Prevention of Chronic Homelessness - 5 Yr**

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<tr>
<td>Number entering homelessness</td>
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<td>6,534</td>
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<tr>
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<td>-</td>
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<td></td>
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<tr>
<td>Number prevented from returning to homelessness</td>
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<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Subtract:</strong></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
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<td>597</td>
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<td>144</td>
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<td>765</td>
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<td>670</td>
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<td>579</td>
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<td>146</td>
<td>186</td>
<td>220</td>
<td>250</td>
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<td>298</td>
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<tr>
<td><strong>with permanent affordable housing</strong></td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
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<td><strong>Balance:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Projected number homeless at end of year</strong></td>
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<td>1,979</td>
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<tr>
<td><strong>Number experiencing homelessness during the year</strong></td>
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<td>8,635</td>
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</table>
## Reductions in homelessness over timeframe of CT Plan

### 5 years

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<tbody>
<tr>
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<td>116</td>
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<td>Add: Number entering homelessness</td>
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<td>258</td>
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<td>Number expected to enter homelessness during the year (if not prevented)</td>
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<td>340</td>
<td>340</td>
<td>340</td>
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<td>472</td>
<td>323</td>
<td>249</td>
<td>223</td>
<td>221</td>
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<td>Number leaving with shelter or transitional only after brief stays</td>
<td>239</td>
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<td>93</td>
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<td>57</td>
<td>46</td>
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<td>66</td>
<td>49</td>
<td>17</td>
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<tr>
<td>with rapid rehousing</td>
<td>31</td>
<td>34</td>
<td>35</td>
<td>36</td>
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<td>33</td>
<td>33</td>
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<td>185</td>
<td>230</td>
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<td>90</td>
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<td>161</td>
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<td>PSH turnover</td>
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<td>69</td>
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<td>65</td>
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<td>65</td>
<td>65</td>
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<tr>
<td>Balance: Projected number homeless at end of year</td>
<td>438</td>
<td>330</td>
<td>116</td>
<td>30</td>
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<td>Number experiencing homelessness during the year</td>
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<td>588</td>
<td>354</td>
<td>251</td>
<td>223</td>
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</table>
Appendix C

Sector Snapshots

The following snapshots were developed as briefing papers for participants in the Opening Doors-CT Listening Sessions. Held in the Spring of 2011, the Listening Sessions were facilitated conversations among practitioners and policymakers in the fields of homeless services, health care, criminal justice, family and youth programs, community engagement, employment, and housing. Each snapshot provides a summary of related best practices and includes a “Follow the Money” section listing resources in Connecticut relevant to the sector.
# Opening Doors-CT

## Sector Snapshot: Crisis Response System

### 1. Follow the Money

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Emergency Shelters</th>
<th>Transitional Housing</th>
<th>HPRP/State Rapid Re-Housing</th>
<th>Eviction &amp; Foreclosure Prevention</th>
<th>Security Deposit Guarantee</th>
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<tbody>
<tr>
<td><strong>FEDERAL</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>ARRA</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>HUD ESG</td>
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<td>HUD HOPWA</td>
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<td>HUD McKinney</td>
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<td>SAMHSA-PATH</td>
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<td>VA</td>
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<tr>
<td><strong>STATE</strong></td>
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<tr>
<td>DMHAS</td>
<td>$3,105,341</td>
<td>$663,000**</td>
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<tr>
<td>DSS</td>
<td>$5,311,253*</td>
<td>$7,393,526</td>
<td></td>
<td>$269,011</td>
<td>$1,380,482</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>$11,110,208</td>
<td>$20,456,515</td>
<td>$17,000,000</td>
<td>$269,011</td>
<td>$1,380,482</td>
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</table>

*Includes DV shelter funding  
**For AIDS Housing programs

### 2. Best Practices—Retooling the Crisis Response System

1. **“Housing First” Strategies**—to prevent homelessness; rapidly return people who become homeless to housing; and minimize barriers to housing access such as pre-conditions on housing readiness
   a. **identify the most vulnerable living on the streets** and connect them to housing  
   b. **homelessness prevention and diversion from shelter** using financial assistance and housing stabilization supports  
   c. **rapid placement of homeless persons into permanent housing** using financial assistance and housing stabilization supports (length of time based on needs of each family)  
   d. **identify families at greatest risk** through data and research-based targeting for prevention and rapid re-housing

2. **Systems of Care**—to better align components of the crisis response system
   a. **create common outcomes** for all sectors of the crisis response system—to more effectively help homeless persons quickly achieve long-term housing—and link with local plans to end homelessness  
   b. **coordinated and centralized referral and intake**—statewide referral through 211 Infoline, plus centralized intake on a regional level using uniform assessment embedded within HMIS  
   c. **strengthen planning for discharges from institutional care** such as foster care, hospitals, and criminal justice facilities; establish statewide pre-release agreement with Department of Correction and Social Security Administration  
   d. **strengthen collaboration with mainstream programs** to ensure continuity of support post-crisis; establish public sector policies that encourage cross-sector partnerships with mainstream systems (e.g. partnerships with local public housing authorities)
3. **Access to Crisis Programs**—improve access by simplifying requirements for access and receipt of services
   a. ensure youth and families of all configurations achieve access
   b. focus on cultural competency to ensure effective services for identified cultural groups (e.g. non-English speaking clients; LGBT youth)
   c. eliminate programmatic requirements that act as barriers for vulnerable populations, including sobriety requirements, mandated treatment for mental illness, mandated service requirements
   d. strengthen links with schools to more effectively identify homeless children; create stronger ties between school homeless liaisons and crisis response systems

4. **Transitional Program Adaptations**
   a. implement transition-in-place models in addition to current models
   b. target higher cost transitional housing to persons with greatest needs (e.g. persons identified using Vulnerability Surveys), or convert transitional units to safe havens or permanent supportive housing

---

3. **Stakeholders in the Crisis Response System**

- 2-1-1
- Consumers of Services
- Homeless Outreach Teams
- Homeless Prevention & Rapid Re-Housing Programs
- Hospitals—Emergency Departments
- Landlords
- Legal Services & Housing Mediation Programs
- Local Plans to End Homelessness
- Police Departments
- Shelters (includes DV) & Drop-in Centers
- Soup Kitchens
- Transitional Housing Programs
- Town Social Service Directors
# Sector Snapshot: Health

## 1. Follow the Money

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Primary &amp; Behavioral Health Programs &amp; Services</th>
<th>Community Based Services</th>
<th>Medical Care Coverage</th>
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<td><strong>FEDERAL</strong></td>
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<tr>
<td>ARRA Medical Assistance Payments</td>
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<td>HHS CDC</td>
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<td>HHS HIV/AIDS</td>
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<td>HHS HIV Formula Grants</td>
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<td>HHS Medical Assistance Payments (MAP)-Federal Share</td>
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<td>HHS Money Follows the Person</td>
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<td>HHS SAMHSA Cooperative Agreements to Benefit Homeless Individuals</td>
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<td>HHS Protection &amp; Advocacy</td>
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<tr>
<td>VA Healthcare</td>
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<td><strong>TBD</strong></td>
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<tr>
<td><strong>STATE</strong></td>
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<tr>
<td>DPH AIDS Services</td>
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<td>DSS RAP (for MFP)</td>
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<tr>
<td><strong>TOTAL Federal &amp; State</strong></td>
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<td><strong>$1,293,800</strong></td>
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<td><strong>LOCAL Health Departments</strong></td>
<td><strong>Total Budget</strong></td>
<td><strong>% General Fund (Local Revenue)</strong></td>
<td><strong>% Other Sources (Federal, State, Private Grants)</strong></td>
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<tr>
<td>Hartford Department of Health &amp; Human Services</td>
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<td>44%</td>
<td>56%</td>
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<tr>
<td>New Haven Health Department</td>
<td>$15,661,479</td>
<td>22%</td>
<td>78%</td>
</tr>
</tbody>
</table>

Notes: **Medicaid spending includes former SAGA program participants.

## 2. Best Practices—Improving Health Outcomes for Homeless Individuals & Families

1. **Housing Assistance and “Housing First”**—to prevent homelessness; rapidly return people who become homeless to housing; and minimize barriers to housing access such as pre-conditions on housing readiness
a. identify the most vulnerable living on the streets and connect them to housing as quickly as possible; use data-driven targeting strategies where effective (i.e. Vulnerability Index community surveys linked with priority access to housing, health and other services)

b. target housing supports and other resources as needed to individuals/families identified as frequent users of health, homeless and other public/institutions systems

c. rapid placement of homeless persons into permanent housing using financial assistance and housing stabilization supports (length of time based on needs of each individual/family)

2. Integrated Systems & Services—to improve access to and effective use of programs and services

a. improve discharge planning from institutional care such as hospitals, nursing homes and criminal justice facilities to reduce re-admission and achieve better outcomes; establish statewide Pre-Release Agreement between Department of Correction and Social Security Administration;

b. strengthen collaboration with mainstream programs to ensure access to appropriate programs, and continuity of support; establish public sector policies that encourage cross-sector partnerships with mainstream systems (e.g. partnerships with local public housing authorities and community health centers; between community health centers and emergency shelters/transitional housing programs)

c. engage collaborations across health-homeless-housing sectors to strengthen program coordination and improve targeting of resources, including Patient Centered Medical Homes—to prevent homelessness (or returns to homelessness) and maximize timely access to and effective use of healthcare services

3. Access to & Effective Use of Mainstream Resources—improve access by simplifying requirements for access and receipt of services

a. maximize access to appropriate benefit and entitlement programs including SSI/SSDI, Medicaid, and Food Stamps; expand use of strategies such as SOAR (SSI/SSDI Outreach, Access and Recovery) to expedite access to federal benefit programs

b. implement integrated care delivery models that are responsive to the needs of low-income, chronically ill patients including the integration and co-location of behavioral health and primary care

c. focus on cultural competency to ensure effective services for identified cultural groups (e.g. non-English speaking clients)

d. eliminate programmatic requirements that act as barriers for vulnerable populations, including sobriety requirements, mandated service requirements (e.g. staff availability via expanded or adjusted program service hours)

3. Stakeholders in Systems Providing Health Services for Homeless Individuals & Families

- 2-1-1
- Advocates & Health Practitioners
- Benefits/Entitlement specialists
- Community Action Agencies
- Consumers of Services
- Detox Programs
- Food & Nutrition Programs—including soup kitchens, food pantries, WIC programs
- Health Centers & Wellness Programs—Community Health Centers, FQHC’s
- Home Care Agencies
- Homeless Shelters, Homeless Outreach Staff
- Hospitals—including emergency departments, inpatient units, discharge planners
- Institutional Settings—including correctional facilities, nursing homes
- Local Health Departments
- Local Plans to End Homelessness and Continuums of Care
- Needle Exchange Programs (Bridgeport, Danbury, Hartford, New Haven)
- Outpatient Health and Mental Health Clinics
- Public Housing Authorities & Resident Service Coordinators
- Veterans Administration Health Centers
- Visiting Nurses Association
## Opening Doors-CT
### Sector Snapshot: Families, Youth & Children

### 1. Follow the Money

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Housing</th>
<th>Income Support</th>
<th>Support Services</th>
<th>Child Care &amp; Early Childhood Education</th>
<th>Employment Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FEDERAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARRA CCDBG</td>
<td></td>
<td>$13,685,624</td>
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<tr>
<td>DOE McKinney Vento Education for Homeless Children</td>
<td></td>
<td>$765,000</td>
<td></td>
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<tr>
<td>DOE Rehabilitation Services Administration</td>
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<td></td>
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<tr>
<td>DOE WIA</td>
<td></td>
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<tr>
<td>DOL Job Corps</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>HHS CCDBG/TANF (Care4Kids)</td>
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<tr>
<td>HHS Chafee Foster Care Independence; and Education &amp; Training</td>
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<td>HHS CSBG</td>
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<tr>
<td>HHS SSBG</td>
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<td>HHS TANF (Jobs First) (DSS, DOL)</td>
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<td>$17,557,963</td>
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<td>HUD Section 8</td>
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<tr>
<td>HUD FUP</td>
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<td>VA SSVF</td>
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<td>$61,458,323</td>
<td>$194,059,252</td>
<td>$74,826,088</td>
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Notes: ARRA=American Recovery & Reinvestment Act; CCDBG=Child Care & Development Block Grant; CSBG=Community Services Block Grant; FUP=Family Unification Program; RAP=Rental Assistance Program; SSBG=Social Services Block Grant; SSVF=Supportive Services for Veteran Families; TANF=Temporary Assistance for Needy Families; WIA=Workforce Investment Act

### 2. Best Practices—Re-Aligned Systems for Better Outcomes

1. **Housing Assistance and “Housing First”—** to prevent homelessness; rapidly return people who become homeless to housing; link appropriate services with affordable housing to meet the needs of the family or youth/young adult and/or to ensure family preservation; target transitional housing resources to youth

   a. **identify the most vulnerable as quickly as possible**—use ‘early warning’ strategies to learn from educators, courts, child welfare agencies, community action programs, and others on the front lines; target street outreach resources to identify disengaged/disconnected youth
b. **target housing supports and other resources as needed** using financial assistance and housing stabilization supports tied to the needs of the individual/household; long-term rent subsidies targeted to appropriate households; direct permanent supportive housing resources to the subset of homeless/vulnerable families that are identified to be most in need

c. **rapid placement of homeless families and youth into permanent housing** using financial assistance and housing stabilization supports (length of time based on needs of each family)

d. **identify families and youth at greatest risk** through data and research-based targeting for prevention and rapid re-housing

2. **Integrated Systems**—to better align and link disconnected agencies, programs & systems
   a. **establish unified intake/assessment** across agencies and within regions; create a common ‘housing outcome’ for all sectors serving vulnerable families, youth and children, collect this data and link with local plans to end homelessness
   b. **utilize existing interagency collaborations to strengthen program coordination and improve targeting of resources**—request these councils and advisory bodies create a standing agenda item for “housing stability/status”
   c. **strengthen planning for transitions from institutional care** such as foster care and criminal justice (or juvenile justice) facilities;
   d. **strengthen collaboration with mainstream programs** to ensure access to appropriate programs, and continuity of support; establish public sector policies that encourage cross-sector partnerships with mainstream systems (e.g. partnerships with local public housing authorities and family service providers)

3. **Access to & Effective Use of Mainstream Resources**—improve access by simplifying requirements for access and receipt of services
   a. **ensure youth and families** of all configurations access needed programs in a timely way; ensure that youth are connected to case management, SSI, Food Stamps and Medicaid
   b. **focus on cultural competency** to ensure effective services for identified cultural groups (e.g. non-English speaking clients; LGBTQ youth); use peers and mentors (e.g. supportive adults for youth)
   c. **eliminate programmatic requirements** that act as barriers for vulnerable populations, including sobriety requirements, mandated service requirements
   d. **strengthen links with schools** to more effectively identify homeless children and at-risk families; create stronger ties between school homeless liaisons and crisis response systems

4. **Data & Demonstrations**
   a. Prioritize research to inform practice about the most effective combinations of housing plus services with optimal timeframes

3. **Stakeholders in Systems for Vulnerable Families & Youth**
   - 2-1-1
   - Advocates
   - Consumers of Services
   - Child Care Providers, Early Childhood Educators & After-School Programs
   - Community Action Agencies
   - Child Welfare, Courts & Juvenile Justice staff/programs
   - CTWorks Employment Centers (One Stop Centers)
   - Family & Children Agencies
   - Food & Nutrition Programs
   - Health Centers & Wellness Programs—Community Health Centers, FQHC’s
   - Landlords
   - Local School District Personnel—including Homeless Liaisons, School Social Workers
   - Local Plans to End Homelessness and Continuums of Care
   - Public Housing Authorities & Resident Service Coordinators
   - United Way
Opening Doors-CT
**Sector Snapshot: Criminal Justice**

1. **Follow the Money**

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Residential Treatment, Transitional Housing &amp; Supportive Housing</th>
<th>Community Based Treatment &amp; Services</th>
<th>Health Services to Persons Under DOC Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEDERAL</td>
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<td></td>
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<tr>
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<td>STATE</td>
<td></td>
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<tr>
<td>DMHAS FUSE (Services)</td>
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<tr>
<td>DMHAS &amp; DSS FUSE (RAPs)</td>
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<tr>
<td>DMHAS Jail Diversion</td>
<td>$4,426,568</td>
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</tr>
<tr>
<td>DMHAS Discharge &amp; Diversion Services</td>
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<tr>
<td>DMHAS SA Residential Services</td>
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</tr>
<tr>
<td>DOC Health &amp; Addiction Services</td>
<td>$300,000</td>
<td>$98,624,298</td>
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<tr>
<td>DOC Community Support Services</td>
<td>$31,000,000</td>
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<tr>
<td>JUD CSSD Adult Program Services</td>
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<tr>
<td>TOTAL</td>
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<td>$59,558,215</td>
<td>$98,624,298</td>
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</tbody>
</table>

2. **Best Practices—Breaking the Cycle of Incarceration & Homelessness**

1. Provide a continuum of community-based housing options linked w/appropriate employment, treatment and social supports—prepare for reentry as early as possible as key to preventing homelessness and reducing recidivism
   a. ensure that discharge planning includes specific preparation around housing and other basic needs
   b. minimize barriers to housing access such as broad restrictions based on past arrests/incarceration
   c. coordinate the efforts of corrections system staff and other government agencies in concert with community based organizations to ensure effective transitions
   d. identify the most effective housing plus service models to meet the needs of specific groups—such as ‘frequent users’—target resources effectively to substantively prevent homelessness and incarceration, and to reduce recidivism

2. Prioritize Employment, Health & Education
   a. engage mainstream workforce system to fully integrate ex-offender population in State’s workforce development strategy
   b. initiate comprehensive vocational assessment approaches prior to discharge; link with community partners to assist with job search and placement
   c. centralize the coordination of treatment and health services between correctional and community settings
   d. improve the connection between returning youth and schools
3. **Systems Coordination w/Shared Goals**—to better align organizations and responsibilities, and to clarify accountability
   
   a. **strengthen planning for discharges from DOC facilities (including transitions from community based transitional programs);** planning should include identification of housing, employment and health services/supports
   
   b. **create a protocol to establish public benefit eligibility (State and Federal);** or reinstate prior to release, including statewide Pre-Release Agreement with Social Security Administration
   
   c. **strengthen state interagency coordination** to define roles and responsibilities of partner agencies and to establish protocols for accountability; this applies also to the multiple public agencies involved with juvenile offenders

4. **Engage the Community**—to be active partners in discharge planning and post-release reintegration
   
   a. **involve families in discharge planning;** involve supportive adults in transition planning and reintegration of juvenile offenders
   
   b. **strengthen capacity of community partners, including faith-based organizations, to effectively support returning offenders**
   
   c. **build on and link with Reentry Roundtables** to engage broad community constituencies in support of reintegrating offenders, including civic, business and faith community sectors

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3. **Stakeholders in the Criminal Justice & Reentry Systems**

- 2-1-1
- Basic Needs Resources—food, clothing, transportation
- Community Action Agencies
- Community Health Centers
- Community Reintegration Programs—AIC programs, halfway houses, transitional housing programs
- Crisis Intervention Teams
- Discharge Coordinators & Planners
- Education Resources—Adult Education, Community College
- Employers
- Employment Resources—One Stop Centers, Apprenticeship Programs, Other Employment Programs
- Ex-Offenders, Peers
- Faith Community Organizations
- Family Service Centers
- Homeless Outreach Teams
- Jail Diversion Staff
- Juvenile Justice & Youth Programs—including Schools and Child Guidance Clinics
- Landlords
- Legal Services Agencies
- Mental Health & Addictions Treatment Programs/Providers
- Nonprofit Providers
- Police & Prosecutors
- Probation & Parole Personnel
- Public Housing Authorities
- Reentry Roundtables (link to Reentry Roundtables Statewide Collaboration website: [www.ccsu.edu/page.cfm?p=8015](http://www.ccsu.edu/page.cfm?p=8015))
- Shelters & Drop-in Centers
- Supportive Housing Programs
Opening Doors-CT  
**Sector Snapshot: Housing**

1. **Follow the Money (Affordable/Supportive Housing Financing Programs)**

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Capital Financing</th>
<th>Operating/Rental Subsidies</th>
<th>Multi-Use (may include services)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FEDERAL</strong></td>
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<tr>
<td>Federal Home Loan Bank</td>
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<tr>
<td>Affordable Housing Program</td>
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<tr>
<td>HHS Money Follows the Person</td>
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<tr>
<td>HUD CDBG</td>
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<tr>
<td>HUD HOME</td>
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<td>$21,146,912</td>
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<tr>
<td>HUD HOPE VI/Choice Neighborhoods</td>
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<tr>
<td>HHS Money Follows the Person</td>
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<tr>
<td>HUD HOPWA</td>
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<td>$3,307,813</td>
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</tr>
<tr>
<td>HUD McKinney Vento</td>
<td></td>
<td>$29,738,654 (capital, operating &amp; services)</td>
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<tr>
<td>HUD Neighborhood Stabilization Program</td>
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</tr>
<tr>
<td>HUD Section 8 DSS</td>
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<td>$64,125,460</td>
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<tr>
<td>HUD Section 8 Local PHA's</td>
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<td>$385,225,800</td>
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<tr>
<td>HUD Section 8 VASH</td>
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<td>HUD Section 811</td>
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<td>LIHTC</td>
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<td>USDA Rural Development</td>
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<tr>
<td><strong>Sub-Total Federal</strong></td>
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<tr>
<td>Community Investment Act</td>
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<tr>
<td>DECDA Affordable Housing Program (Flex) (includes new allocation in FY12 budget)</td>
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<td>DECDA Pre-Development Loan</td>
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<td>DMHAS Supportive Housing</td>
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<tr>
<td>DSS Money Follows the Person</td>
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<td>HTCC (Housing Tax Credit Contribution Program)</td>
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<td>Housing Trust Fund (remaining)</td>
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<td><strong>Sub-Total State</strong></td>
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<td>$374,726,722</td>
<td>$484,994,681</td>
<td>$88,518,651</td>
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</tbody>
</table>

2. **Best Practices—Maximize Housing Options, Preservation & Resident Supports**

1. **Providing rental assistance** (which covers the difference between 30-40% of the tenant’s income and the apartment rent) has been demonstrated in numerous studies to be one of the most effective means to ending and preventing homelessness. Successful practices include the provision of state rental assistance, maximizing the acquisition of new federal Section 8 resources as they become available, and using a portion of local HOME dollars for rental assistance.
2. **Expanding the supply of affordable rental homes** where they are most needed, **preserving existing affordable units.** In new and preserved developments, incentivize the inclusion of units affordable to households with incomes below 30% of area median income with rent and capital subsidies. Maximize the use of public sector housing dollars to leverage private sector resources, and provide deep affordability through the provision of project-based rental subsidies or using capital funds to capitalize project operating reserves.

3. **Establishing a clear statewide housing policy** that incorporates benchmarks for preventing and ending homelessness and that is used to align and target State housing resources that may be administered by multiple departments and agencies. Coordinate policy and resources through an interagency working group that has clear targets, executive leadership, and dedicated staff support.

4. **Target housing resources and other supports as needed** and tied to the needs of the individual/household; provide long-term rent subsidies targeted to appropriate households; direct permanent supportive housing to the subset of homeless/vulnerable individuals/families that are most in need.

5. **Reduce barriers to housing access, and improve long-term housing stability with appropriate and effective supports**
   a. utilize partnerships with community providers and mainstream programs to secure appropriate supports, including employment, healthcare and education
   b. establish linkages with community plan efforts related to preventing/ending homelessness

6. **Strengthen and expand housing industry capacity and infrastructure**
   a. operating support and working capital for high-functioning, proven nonprofit housing development organizations dedicated to the creation of housing that includes extremely low income households
   b. partnerships with public housing authorities to increase resources that target the lowest-income households and reduce barriers to housing access
   c. team building between housing and service organizations focused on the creation and operation of supportive and service-enriched housing options

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3. **Stakeholders in Housing Systems**

- 2-1-1
- Advocates, Tenants, Consumers and Peers
- Community Action Agencies
- Continuums of Care & Community Plans to End Homelessness
- Emergency Shelters & Transitional Housing Programs
- Employment Service Organizations and Regional Workforce Investment Boards—One Stop Centers, Apprenticeship Programs, Employers
- Fair Housing Centers
- Health Centers and Wellness Programs—Community Health Centers, FQHCs, Hospitals
- Housing Finance—banks/private lenders, CDFI’s, syndicators/investors, housing finance agencies (public)
- Housing Developers and Owners (including Landlords)
- Housing Management-Asset Management, Property Management
- Legal Assistance Organizations
- Local Government—including Mayor/Selectman, agencies that serve vulnerable populations and agencies that manage housing and community development resources
- Nonprofit Providers
- Philanthropy
- Public Housing Authorities
- Reentry Roundtables (link to Reentry Roundtables Statewide Collaboration website: www.ctreentry.info)
- Resident Councils
- Supportive Housing Program
Opening Doors-CT
Sector Snapshot: Community Planning & Sustainability

1a. Follow the Money

<table>
<thead>
<tr>
<th>Federal Funding Source</th>
<th>Local Allocations</th>
<th>State Allocations</th>
<th># Vouchers/Units (Where Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOL WIA</td>
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<td>$3,700,000</td>
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<tr>
<td>HUD CDBG</td>
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<td>$14,692,943</td>
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</tr>
<tr>
<td>HUD HOME</td>
<td>$7,804,075</td>
<td>$13,342,837</td>
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<tr>
<td>HUD ESG</td>
<td>$658,702</td>
<td>$1,165,370</td>
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</tr>
<tr>
<td>HUD McKinney Vento</td>
<td>$29,738,654</td>
<td>$1,165,370</td>
<td></td>
</tr>
<tr>
<td>HUD Section 8 Local PHAs</td>
<td>$385,225,800</td>
<td>$64,125,460</td>
<td>39,714</td>
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<tr>
<td>HUD Section 8 DSS</td>
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<td>6,481</td>
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<tr>
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1b. By the Numbers

<table>
<thead>
<tr>
<th>Federal Funding</th>
<th>Bridgeport</th>
<th>Hartford</th>
<th>New Haven</th>
<th>Norwich/New London</th>
<th>Waterbury</th>
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<td>$15,962,733</td>
<td>$6,321,368</td>
<td>$8,562,647</td>
</tr>
</tbody>
</table>

Local Plans to End Homelessness Goals (Selection)

Housing
- Create 1,261 units of affordable & supportive housing
- Create 2,133 units of supportive housing in the Capitol Region
- Create 392 units of supportive housing
- Create 704 units of affordable & supportive housing
- Create 250 units of permanent supportive housing

Employment/Income
- 200 people will be served by CTWorks and BRS; 25% will have successful exits from services
- Partner w/One Stop to implement a pilot project targeting employment services to homeless persons; improve needs assessment and align services/training to effectively deliver employment supports
- Create new partnerships to integrate a strong employment focus into all local efforts to serve the long-term homeless population. Secure additional state & federal resources to expand employment services, particularly in connection w/supportive housing.
- Establish partnerships between homeless services-workforce development-and mainstream service systems
- Reduce fragmentation of employment & income services, increase linkage among employment, training, service & education resources. Create a sustainable flexible assistance fund to provide short-term financial assistance for individuals and families at risk of becoming homeless

Note: **WIA funds reflect allocations for each of the corresponding regions.
2. **Best Practices—Local Leadership & Targeted Resources to Ensure Long-Term Impact**

1. **Establish and sustain active and engaged leadership at the local level**—for plan development and through ongoing implementation activities
   a. cultivate civic leadership early (and often); engage into key leadership role to spearhead plan implementation efforts
   b. ensure participation of broad and diverse stakeholders with meaningful roles and expectations
   c. develop an appropriate organizational structure tied to plan goals and objectives, with measurable benchmarks, and engage plan stakeholders to take an active part in committee activities

2. **Secure all resources needed to effectively implement the plan goals and objectives**—to fund the plan implementation goals and to sustain the planning implementation/oversight efforts
   a. identify and quantify ‘resource gaps’ and engage private sector partners—philanthropy, business, civic leadership—to define concrete investment opportunities, and leverage additional public sector resources
   b. identify all housing and community development partners, and collaborate on specific commitments of resources (leveraged and funded)
   c. engage mainstream workforce system and community colleges as key partners to increasing employment and income outcomes

3. **Provide oversight and accountability throughout the plan development and implementation**—to sustain engagement of plan partners, to support effective implementation of plan activities, and to monitor accomplishments related to plan and modify as needed
   a. collect accurate and reliable information on a regular basis as needed to monitor and measure plan accomplishments
   b. provide regular reports of plan accomplishments, and disseminate broadly to plan partners and broad community members
   c. monitor accomplishments relative to plan goals, and be prepared to modify as needed to ensure plan success and to sustain engagement and investment of plan stakeholders

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3. **Stakeholders in Community Planning & Sustainability**
   - Advocates, Consumers and Peers
   - Chambers of Commerce and Business Leaders
   - Community Action Agencies
   - Community Colleges
   - Continuums of Care
   - Employment Service Organizations and Regional Workforce Investment Boards—One Stop Centers, Apprenticeship Programs
   - Health Centers and Wellness Programs—Community Health Centers, FQHCs, Hospitals
   - HMIS Administrator(s)
   - Housing Developers and Owners (including Landlords)
   - Local Government—including Mayor/Selectman, agencies that serve vulnerable populations and agencies that manage housing and community development resources
   - Nonprofit Providers
   - Philanthropy—Community Foundations, United Way
   - Police, Prosecutors & Probation/Parole
   - Public Housing Authorities
   - Reentry Roundtables (link to Reentry Roundtables Statewide Collaboration website: [www.ctreentry.info/](http://www.ctreentry.info/))
   - Shelters and Drop-in Centers
   - Supportive Housing Programs