Chattanooga Interagency Council on Homelessness (CICH)

Request for Proposals

Chronic Homeless Service Program

11/4/2019

I.   Introduction

Problem Statement
As of July 2019, the Chattanooga Regional Homeless Coalition (CRHC), Chattanooga's lead applicant for the Continuum of Care, estimated that there are a total of approximately 383 individuals and 61 families who are chronically homeless in the Chattanooga/Southeast TN Continuum of Care area. In the Fiscal Year 2019 Continuum of Care application, CRHC identified 473 Permanent Supportive Housing beds which are prioritized for individuals experiencing chronic homelessness. However, only an estimated 80 of these beds "rollover" and are available to new individuals experiencing chronic homelessness. The remaining 394 beds funded through our CoC funding are for chronically homeless individuals that have been housed in the past and still need ongoing permanent supportive housing. This means that approximately 303 chronically homeless individuals each year will not have access to permanent supportive housing in the Chattanooga area.

Opportunities for housing do exist through housing vouchers, but not all of these are able to be accessed because of a shortage of case management in Chattanooga. The Chattanooga Housing Authority has created a homeless preference set-aside of Housing Choice Vouchers available to chronically homeless individuals through CRHC's Coordinated Entry System, however, these vouchers are only able to be accessed if there is appropriate case management available for an individual.

The chronically homeless population in Chattanooga has been growing in recent years, and this may be due in part to this shortfall of permanent supportive housing. In 2016, the Chattanooga region's Point in Time (PIT) Count found 81 chronically homeless individuals and 5 chronically homeless families of 527 homeless individuals (16% of population) on a given night in Chattanooga. In 2017, the PIT count found 189 chronically homeless individuals and 3 chronically homeless families of 576 homeless individuals (33% of population). In 2018, the PIT Count found 310 chronically homeless individuals and 12 chronically homeless families of 623 homeless individuals (52% of population).

The member organizations of the Chattanooga Interagency Council on Homelessness (CICH) are interested in increasing the number of chronically homeless individuals and families who obtain and remain in permanent housing. With additional case management services, the Chattanooga Housing Authority anticipates that it would be able to issue approximately 150 additional housing choice vouchers each year for chronically homeless individuals and families. Currently, of those chronically homeless individuals who receive vouchers, a significant portion of them are unable to obtain permanent housing, as the requirements, time and paperwork necessary to navigate the housing system are often discouraging and overwhelming to individuals seeking housing. By providing Housing Navigator services to build connections with landlords and help chronically homeless secure housing, CICH anticipates that the Chattanooga community could connect significantly more individuals and families who receive vouchers to permanent housing each year.

Therefore, the member organizations of the Chattanooga Interagency Council on Homelessness (CICH) seek a qualified organization to create a new program that provides housing navigation and intensive case management services to help chronically homeless individuals successfully obtain available housing choice vouchers set aside by the Chattanooga Housing Authority and provide an appropriate level of supportive services to ensure individuals remain in permanent housing.

Background
The development of this program is a result of the December 2018 CICH Community Action Plan to address homelessness in Chattanooga and Hamilton County, Tennessee. This plan made numerous recommendations to improve the homeless service system locally, including hiring additional staff to assist chronically homeless individuals and families in finding housing and maintaining housing stability.

The Housing and Urban Development Agency (HUD) defines Chronic Homelessness as: "either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years (see appendix B)."

Individuals experiencing Chronic Homelessness require an intensive level of care to be successful in obtaining and maintaining housing. The intervention demonstrated to be the most effective is Permanent Supportive Housing, which includes 1) indefinite leasing or rental assistance and 2) supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability.

These supportive services include an assigned Case Manager. Broadly, Case Managers coordinate resources and services that will aid an individual or family. While a person is seeking housing, Case Managers connect the person to health, food, clothing and shelter services. Once the person is successfully housed, Case Managers provide support services for an extended period to ensure the individual or family exiting homelessness achieves housing stability. The general components of case management include intake, needs assessment, service planning, connecting to services, ongoing monitoring, and client advocacy.

Support services also include an assigned Housing Navigator. Broadly, Housing Navigators help individuals and families find housing options, submit relevant paperwork, and help them understand the resources available to them to understand the housing system and achieve housing stability. Housing Navigators also build relationships with property owners and landlords to help them understand the needs of the individuals being served.

The development of this program is aligned with the principles and core components of Housing First in Permanent Supported Housing programs as outlined by HUD. Please see Appendix X for more information.
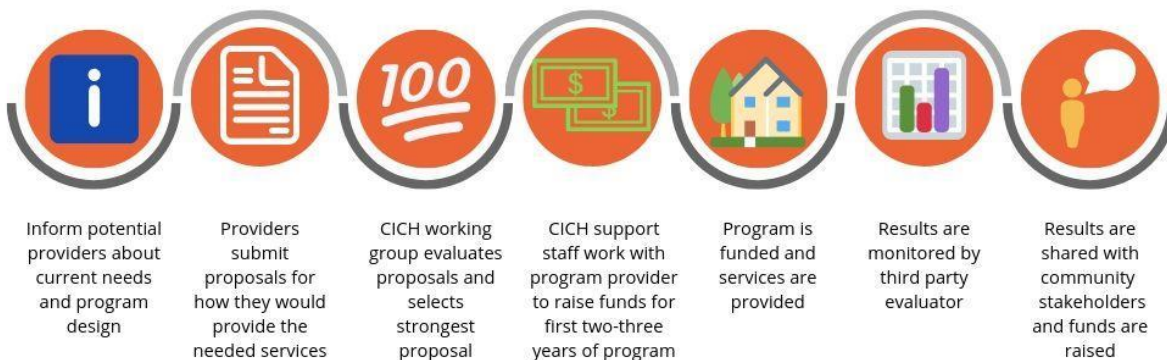
Program Development

Unlike other program development processes where funding is raised and then a provider is selected, CICH seeks to identify the strongest community organizations to partner with and then assist that organization with raising funding for the program. While a selected organization is not responsible for funding at the time of selection, the selection comes with a guarantee of support from CICH to assist in fundraising efforts.

By submitting a proposal, a community partner is stating their approach to delivering services described in this RFP, outlining a successful program that can reduce chronic homelessness in our community, while providing a valuable return on investment for health care, and philanthropic entities that can potentially invest in the program. Specifically, CICH members of the group tasked with developing this RFP will be points of contact for the selected agency will be Sam Wolfe - Homeless Program Coordinator - City of Chattanooga.

Chattanooga Interagency Council on Homelessness

Chronic Homelessness Service Expansion
Program Development Process

| Inform potential providers about current needs and program design | Providers submit proposals for how they would provide the needed services | CICH working group evaluates proposals and selects strongest proposal | CICH support staff work with program provider to raise funds for first two-three years of program | Program is funded and services are provided | Results are monitored by third party evaluator | Results are shared with community stakeholders and funds are raised |

1. CICH working group members will host an informational session with providers to present their vision for expanding services to house and stabilize people experiencing chronic homelessness.

2. Service Providers prepare a proposal for how they would implement the program.

3. CICH working group members evaluate proposals and select the strongest proposal to move forward with the program provider.

4. CICH support staff work alongside program providers to assist in raising funds for the first 2 to 3 years of program operating expenses and secure commitments for community resources.

5. Program implementation begins.

6. A third party evaluator performs quarterly program assessments and submits reports to CICH working group members and program funders.

7. CICH members and community stakeholders work to improve and enhance the program, and CICH support staff work to raise additional funds for the future operation of the program.

RFP Contact and Timeline

With the release of this RFP, all questions, and requests for information or clarification must be submitted in writing via application portal at connect.chattanooga.gov/cich, Answers will be responded to in the order in which they are received. All questions and answers will be published on the application portal at connect.chattanooga.gov/cich.

Any communication concerning this RFP must be conducted exclusively with Sam Wolfe - the staff person assigned to this working group until the evaluation and award process has been completed. No other employee, consultant, or contractor of any of the CICH member organizations is empowered to speak for CICH with respect to this RFP. Failure to follow this procedure will be negatively viewed in the selection process.

The website for this RFP and related documents is the Chattanooga Interagency Council on Homelessness website: connect.chattanooga.gov/cich.

The table below shows the preliminary RFP Schedule. Dates are subject to change. Any changes will be posted in an addendum that can be found on the RFP website.

	DATE
RFP Released	November 4th, 2019
Deadline for questions or requests for clarifications (submit via email to Sam Wolfe)	November 12th, 2019, 11:59 PM

Response to final questions posted	November 14th, 2019
Deadline for submitting RFP proposal	December 4th, 2019 11:59 PM
Vendor selected	December 9th, 2019

B. Desired Outcomes and Scope of Work for Chronic Service Program

1. **Goals and Desired Outcomes**

The Chattanooga Interagency Council on Homelessness seeks case management and housing navigator services that are aligned with the following goals:
- **Housing**: Assisting chronically homeless individuals and families in accessing adequate, affordable housing;
- **Efficiency**: Optimizing service delivery to ensure the time from identification to housing placement is as short as possible;
- **Communication:** Regularly engaging program participants in person before and after they are placed into housing;
- **Stability**: Minimizing the number of individuals that re-enter homelessness through intensive case management and proper support

Aligned with these goals, through these services the Chattanooga Interagency Council on Homelessness is striving to advance the following short- and long-term outcomes. Agencies should strive to meet and track the specified outcomes below. *Data and reporting requirements of these Outcomes and Agency/Program Outputs are specified further below in the "Data and Reporting" section of this RFP.*

Short Term Outcomes - 6 months to 1 year
- Average 12 housing placements per month after 6 months of rendering of service
- Maintain an average time of housing placement rate of 90 days from the first date of contact
- 90% of clients are still in housing after 6 months from housing date

Long term Outcomes - 1 to 2 years or more
- Reduce total chronic population by 50% from current measurements (goal is 191 total chronically homeless individuals and 30 chronically homeless families)
- 80% of clients maintain housing after 2 years from housing date

- Increase the number of partners accepting referrals from case managers for services for chronic persons in programs
- Help facilitate the development of long term supportive housing for individuals with persistent mental health issues in coordination with state partners and other stakeholders

2. Service Entry and Caseload requirements

The lead agency will be required to adhere to strict entry and caseload requirements, due to the structure of prioritization of services present at the Continuum of Care level and the need to serve the most vulnerable chronic persons first.

a) Entry requirements

Persons served through the program will come exclusively through the Coordinated Entry System (CES) administered by our Continuum of Care's lead applicant, the Chattanooga Regional Homeless Coalition. Persons referred will first be assessed by street outreach workers, emergency shelters, healthcare for the homeless centers, and day shelters from within Hamilton County. Referrals and ongoing services will not be denied under any circumstances other than by review of the Governance Council of the Chattanooga Regional Homeless Coalition as per their CES operating guidelines. Chronic homeless status will be verified using HMIS records or other systems with documentation as to the length of time homeless. After being assessed and verified as chronically homeless, individuals or families will be referred to your organization by the Chattanooga Regional Homeless Coalition's Coordinated Entry Specialist to receive a housing choice voucher and admission into your program.

Program partners will be expected to familiarize themselves with the Coordinated Entry process, if not already receiving referrals, and receive training in the process from the Chattanooga Regional Homeless Coalition.

Staff will work with existing outreach services to locate individuals referred to the program. Examples of such programs are but are not limited to, Homeless Healthcare's Outreach program, the PATH program, City of Chattanooga's Homeless Service Program. Efforts will need to be made to engage with individuals wherever they are to be found.

b) Caseload requirements

It is of the utmost importance when working with individuals suffering from chronic homelessness for support staff to be available in a dynamic manner as needed. As such, the caseload of supportive staff needs to be manageable so that staff does not become overburdened. For case managers, that number should never exceed 30.

3. Services Requested: Case Management

People experiencing chronic homelessness live through a series of daily crises involving their health, safety, shelter, finances, relationships, and overall well-being. This type of daily life can cause prolonged time without housing or shelter, new barriers to housing, and limited time and agency to resolve their homelessness and find housing resources and support. Case managers serve as a chronically homeless person's first line of support to become and remain healthy, safe, happy, and financially stable.

Case managers should start with a comprehensive needs assessment of the person experiencing chronic homelessness that is completed upon program intake. The assessment will serve as a baseline to track program outcomes of various interventions implemented by the Case Managers. The purpose of this assessment is to:

    a. Track outcomes for those served through the development of surveys containing life stability scores;
    b. Inform program process improvement;
    c. Provide community data as to the barriers/needs of those experiencing chronic homelessness.

Following an assessment, the case manager should work to ensure individuals in the program have appropriate shelter and safety while they seek permanent housing. To accomplish this, the service provider must educate themselves on local shelter options and build relationships with those that offer those services locally such as the Chattanooga Rescue Mission and Chattanooga Community Kitchen.

Next, case managers will work collaboratively with their clients to build service plans that start and maintain their stability. Using the initial assessment as a baseline, case managers will work daily on the following activities:

    a. Develops, implements, monitors and documents a written, individualized, and coordinated case management service plan.
    b. Builds relationships with other service provider agencies and community resources that can help their clients achieve their goals.
    c. Assists in applications for social security, disability, TANF, and other public benefit programs, if needed.
    d. Assists in the management of household finances, if needed.
    e. Assists in seeking employment and finding employment resources for clients that are able to work.
    f. Ensures safety for the clients they serve.
    g. Promotes the integration of behavioral change principles and science.
    h. Uses a collaborative, client-centric partnership approach.
    i. Facilitates self-care and self-determination through the tenets of shared decision making, advocacy, and education, whenever possible.
    j. Assists the client and their support system to address issues related to the implementation of the service plan.

Case managers should maintain constant contact with their clients, striving to know where they are and how to reach them at all times. At a minimum, the case manager should meet at least once per week in-person with the client at a place of his or her choosing. This could be their home, a safe public space, or an agency where they get assistance. Ideally, case managers are communicating with their clients 3-5 times per week to help them in following their service plan, securing resources, and completing the action items they need to find and maintain housing.

Case managers should have knowledge and experience working with people with disabilities including mental illness, physical and mental disabilities, and substance abuse. A background working in a mental health agency, substance abuse agency, or working with people with developmental or physical disabilities is preferred.

4. Services Requested: Housing Navigation

People experiencing chronic homelessness have a large number of barriers to rental housing that increase the difficulty of their ability to find an appropriate rental. Barriers include a criminal record, lack of income, past debt, history of evictions, or substance abuse and mental health issues that create a stigma for landlords. Housing Navigators help assist people experiencing chronic homelessness eliminate or work around these barriers to help them qualify for rental units they otherwise would not qualify for. The result is a faster, easier, and more dignified process for the individual experiencing homelessness to find a unit, sign their lease, and move in.

The Housing Navigator works closely with case managers in providing comprehensive care and support to the individuals they serve in common. Housing Navigators have knowledge of public and private housing units available in the community through networking and relationships with landlords, property managers, and housing agencies. They use knowledge of processes around renting such as public housing authority applications, appeals, and paperwork, and landlord and property management rental applications, background checks, credit checks, and other policies to assist their clients through complications and red tape they may experience. Finally, the Housing Navigator uses their working knowledge of housing discrimination laws, landlord and tenant responsibilities, housing rights, and immigration law to advocate for their clients and protect them from discrimination based on their disability, race, gender, or status.

In addition to activities to build this knowledge and experience, the housing navigator is responsible for the following day to day activities:
   a. Assists clients in their search for housing, filling out rental applications, interpreting leases, and understanding tenant rights and responsibilities.
   b. Network and collaborates with area Housing Resources and maintains a presence at all meetings.
   c. Maintain a relationship with existing property managers/owners and establishes new relationships.
   d. Establishes, updates, maintains and communicates a list of available housing opportunities.
   e. Serves as a mediator between clients and landlords to address barriers to housing.

    f. Coordinates with landlords to schedule property visits and drive individuals and families to housing appointments, if necessary.

    g. Advocates and works on behalf of their clients to navigate rental policies and procedures and expedite these processes.

5. How we collaborate and track success

A. Data Elements and Systems

Service provider will be required to enter relevant client information in the CRHC's HMIS database software called "Service Point" such as

1. Demographics and basic identifying information
2. Program entry/exit
3. Completed coordinated assessments

This information helps our local Continuum of Care track its overall performance in reductions in homelessness.

In addition to entering basic information into HMIS, the Service Provider will be expected to enter information daily into a data system of the service provider's choosing that captures a variety of information which can be helpful in increasing performance and allowing for collaboration between staff.

Key data elements for daily performance and workflow tracking that service provider is expected to track for each client include but should not be limited to:

1. HMIS ID #
2. Client contact information
3. Client location(s)
4. Log of notes of interactions staff has had with each individual
5. Scores on coordinated assessments
6. Last date contacted
7. Sheltered status
8. Chronic homelessness verification status
9. Status of client reaching program milestones including dates client achieved these milestones such as:
    a. Identified
    b. Completed assessment - intake into the coordinated entry system
    c. Entry into program
    d. Referral to external support services
    e. Intakes into external support services
    f. Voucher, rental assistance applications submitted
    g. Voucher, rental assistance received
    h. Housing unit found and applied for
    i. Housing inspection complete
    j. Successfully housed
    k. Missing or inactive (if applicable)

    l. Declining services (if applicable)
    m. Does not fit program eligibility (if applicable)
    n. Eviction or re-entry into homelessness (if applicable)
  10. Names and contact information for other case managers or support service staff working with the client
  11. Interactions with the criminal justice system (arrests, charges, jail bookings, days in jail)

B. Reporting Requirements and Key Performance Indicators

Service provider is expected to work with Chattanooga Interagency Council on Homelessness
members and program funders to establish a dashboard that tracks key performance indicators of the program such as:

1. Total number of clients housed this week, month, year
2. Total % of clients housed after 3 months, 6 months, 9 months, 1 year, 2 years +
3. Average time from identification or initial assessment and housed
4. Average time from referral to program intake
5. % of clients who have been contacted this week
6. % of clients who are inactive, missing, or declining services
7. % of clients needing additional support services
8. % of clients " " who are successfully referred to support services
9. % of clients moving status
10. Ability to filter this data by race, gender, age, and household status

Service provider is expected to report these performance metrics to funders at least monthly and if possible establish a real-time connection for monitoring this data on a weekly basis.

D. Proposal Format

Your proposal should include the following sections: (1) introduction, (2) your approach to the project, (3) your background, qualifications, and team, and (4) your organization's financial health (5) your proposed program operating budget for one year. Please be straightforward and concise in your proposal.

1. Introduction

On the cover page, please provide **your principal contact information, including name, address, telephone number, email address, and website (if applicable).**

On the first page, please provide a letter issued by an Officer of the proposing business entity that introduces your organization and summarizes your qualifications for why you would be a good partner with CICH for this program.

2. **Approach to Scope of Work**

In this section of your response, you will share how your approach meets the needs outlined in the Scope of Work section.

Please describe your overall vision for how your organization would advance the outcomes and scope of work outlined in Section B.

Please also describe in detail how your organization would fulfill each of the components of the Chronic Housing Program services, as outlined in Section B.
- Program entry and caseload requirements
- Case Management including assessment, referral, emergency shelter for clients, and service planning and general case management support once clients are housed.
- Housing Navigation including landlord outreach and recruitment
- Data entry, reporting, and tracking performance
    - State the data system(s) does your organization uses.
    - State what your organization does with data collected.
    - State how often your organization looks at reports and measurements.
    - State how you use data to improve performance within your organization

3. **Background, Qualifications, and Team**

Please describe your organization's history, knowledge, and experience in serving and housing those experiencing homelessness, and particularly those who are chronically homeless.

Please also describe your organization's history, knowledge, and experience with wrap-around services that serve the homeless population.

Please describe the cultural competency of your organization and explain your experience in working with people of all races, ethnicities, ages, education levels, income levels, and cultures.

Describe the team that would work on this project. Include a list of key team members, including those responsible for managing payroll, benefits, accounting, and financials.

Please provide bios, resumes or whatever you think best highlights the strength of
The experience and competency of the team that would be working on this project. Please describe how the team would
be structured, including defined roles and responsibilities and the use of subcontractors, consultants, or partners.

4. **Organization and Financial Health**

Please describe the mission and vision of your organization.

Please describe the quantifiable outcomes your organization has been able to deliver in the past year, 3 years, and 5 years. Please include the outcomes achieved and any indicators tracked towards this outcome.

Please share the structure of your Board of Directors, including the names of board members.

Please explain your approach to involving service recipients in the governance and decision making of the organization.

Please share your organization's most recent annual budget

Please state the total amount of revenue your organization collected from private donations in your most recent annual budget.

Please state the total amount of grants received. Please include the amount of each grant, the funder, and a 2-3 sentence of the purpose of the grant.

Please state your vision for how you would approach balancing fundraising and grant applications for the purposes of this program with general fundraising for your organization.

Please also propose an approach to partnership with CICH for the purposes of raising funds for this program and what you envision your organization's role vs. CICH's role is in raising funds for this program.

5. Proposed Program Budget

Please include a proposed annual operating budget for this program including the estimates for the cost of your proposal to provide the services outlined in your approach to the scope of work. Please also include proposed revenue sources that you believe could feasibly fund this program from grants, billing, or private donations.

E. Submission Instructions

This section includes submission instructions and a submission checklist for your proposal.

Implied Requirements
All products and services not specifically mentioned in this RFP, but which are necessary to provide the functional capabilities described by the Proposer, shall be included in the Proposal.

Proposer-Supplied Materials

Any material submitted by a Proposer shall become the property of the Chattanooga Interagency Council on Homelessness unless otherwise requested in writing at the time of submission. **Any agency submitting a proposal should assume the information included in the proposal is subject to the Open Records / Freedom of Information Act.**

Incurring Costs

Neither the Chattanooga Interagency Council on Homelessness nor any of its member organizations shall be liable for any costs incurred by the proposer prior to the issuance of a contract purchase agreement and will not pay for the information solicited or obtained. Proposer shall not include or integrate any such expenses as part of its proposal.

Proposal Withdrawal Procedure

A Proposal may be withdrawn at any time until the date and time set above for the opening of proposals. Any proposal not so withdrawn shall, upon opening, constitute an irrevocable offer to provide the specifications set forth in the proposal, until the successful proposal(s) is/are accepted and an agreement has been executed.

1. Submission Instructions
   All proposals should be submitted in a PDF format specified in this document at
   http://connect.chattanooga.gov/cich/. Alternatively, the vendor can email
   proposals to the staff member coordinating this CICH Working Group, Sam Wolfe,
   at samwolfe@chattanooga.gov. Late or misdirected proposals shall be rejected.

2. Submission Checklist
   ❏ Cover page including principal contact information
   ❏ Signed Cover Letter
   ❏ Approach to Scope of Work Response
   ❏ Background, Qualifications, and Team Response
   ❏ Organization and Financial Health Response
   ❏ Copy of your organization's most recent annual budget
   ❏ List of Board of Directors members
   ❏ Proposed program budget
   ❏ Copy of filing of your organization with the Secretary of State

E. Proposal Evaluation Criteria and Method

Selection of Finalist(s)

After review of the proposals by the Evaluation Committee and formal presentations (if any), the CICH will vote on whether or not to pursue a partnership with the organization who submitted the highest-scoring proposal.

The selection of Proposers for formal presentations (if any) and for contract negotiations will be evaluated based on an objective evaluation of the criteria listed above.

Formal Presentations

In the event that a Proposer cannot be selected solely on the Proposals submitted, the Committee may invite up to three (3) qualified organizations for formal presentations. The Committee reserves the right, however, to invite more or fewer than this number, if the quality of the proposals so merits.

The Evaluation Committee may revise the initial scores based upon additional information and clarification received in this phase. If your organization is invited to give a presentation, the offered dates may not be flexible.

A presentation may not be required, and therefore, complete information must be submitted within the proposal.

All proposals submitted in response to this RFP will be evaluated by an Evaluation Committee in accordance with the criteria described below. Total scores will be tabulated, and the organization that best meets the criteria will be recommended to the full CICH for final approval.

A committee consisting of CICH members will receive all proposals submitted. Each proposal will be awarded a maximum of 100 points based on the evaluation criteria listed below.

The specific categorical criteria that will be applied to the proposal information, in order to assist the Evaluation Committee in selecting the most qualified proposer(s) for the contract, are as follows:

- **40 points: Competence/Approach to Scope of Work**
- **30 points: Qualifications and Team Experience**
- **30 points: Organizational Health**

The selection of proposals for formal presentations (if any) will be evaluated based on an objective evaluation of the criteria listed above.

Minimum Requirements

All proposals should meet the following minimum requirements to be evaluated for this RFP;
A) Organization submitting the proposal should be an established 501(c) type organization as established by the IRS, a registered business or corporation with the TN Secretary of State, or a government agency;
B) Hiring or dedicating at least 5 full-time staff members solely dedicated to meeting the outcomes outlined above;
C) Providing office space, required supplies, and meeting space for dedicated staff to perform day to day work;
D) Managing accounting of finances allocated on the program's behalf;

E) Managing the payroll and benefits for any program dedicated staff; and

F) Have a mission statement that aligns with the mission of CICH - "to plan, coordinate, and accelerate efforts to reduce homelessness in Chattanooga"

Appendix A

The following are the current collaborative partners of CICH

- City of Chattanooga
- Moccasin Bend Mental Health Institute
- Chattanooga Regional Homeless Coalition
- Volunteer Behavioral Health Care System
- Metropolitan Ministries
- Abba's House
- Southeast Tennessee Human Resources Agency
- University of Tennessee Chattanooga
- Salvation Army
- CHI Memorial
- Chattanooga Police Department
- BlueCross BlueShield of Tennessee
- Parkridge Health System
- Partnership FCA
- Chattanooga Housing Authority
- CARTA
- Helen Ross McNabb
- Hamilton County Government
- United Way of Greater Chattanooga
- Homeless Healthcare Center
- UnitedHealth Group
- AIM Center
- Family Promise of Greater Chattanooga
- Maclellan Foundation
- Fortwood Neighborhood Association
- Room in the Inn
- Community Kitchen
- Welcome Home of Chattanooga
- River City Company
- St. Paul's Episcopal Church
- Erlanger Health System
- Creating Homes Initiative

Appendix B

- A "homeless individual with a disability," as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who: [An individual who can be diagnosed with one or more of the following conditions: substance use disorder, serious

mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability]

- ○ Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
- ○ Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months [one year] or on at least 4 separate occasions in the last 3 years,[where each homeless occasion was at least 15 days] as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

- An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facilities, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Appendix C

A. About Chronic Homeless Service Programs and Overview of Chronic Homeless Population in Chattanooga and Hamilton County

1. Chronic Homeless Service Programs

As communities across the country have seen, individuals experiencing Chronic Homelessness require an intensive level of care to be successful in obtaining and maintaining housing. The intervention demonstrated to be the most effective is Permanent Supportive Housing. Permanent supportive housing is permanent housing with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability. These supportive services come in the form of having an assigned case manager.

Case management can be defined in many ways, but according to the Case Management Society of America (CMSA), case management is "a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes." Case managers seek to coordinate resources and gain timely access to services that will aid an individual or family. The basic components of case management include intake, needs assessment, service planning, connecting to services, ongoing monitoring, and client advocacy.

Housing First as defined by HUD: "Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry. Housing First is premised on the following principles:

- Homelessness is first and foremost a housing crisis and can be addressed through the provision of safe and affordable housing.
- All people experiencing homelessness, regardless of their housing history and duration of homelessness, can achieve housing stability in permanent housing. Some may need very little support for a brief period of time, while others may need more intensive and long-term support.
- Everyone is "housing ready." Sobriety and compliance in treatment are not necessary to succeed in housing. Rather, homelessness programs and housing providers must be "consumer-ready."
- Many people experience improvements in quality of life, in the areas of health, mental health, substance use, and employment, as a result of achieving housing.
- People experiencing homelessness have the right to self-determination and should be treated with dignity and respect.
- The exact configuration of housing and services depends upon the needs and

preferences of the population.

2. Core Components of Housing First in Permanent Supportive Housing

The following are core components identified by HUD for Housing First in Permanent Supportive Housing programs:

a. Few to no programmatic prerequisites to permanent housing entry
People experiencing homelessness are offered permanent housing with no programmatic preconditions such as demonstration of sobriety, completion of alcohol or drug treatment, or agreeing to comply with a treatment regimen upon entry into the program. People are also not required to first enter a transitional housing program in order to enter permanent housing.

b. Low barrier admission policies
Permanent supportive housing admissions policies are designed to "screen-in" rather than screen-out applicants with the greatest barriers to housing, such as having no or very low income, poor rental history, and past evictions, or criminal histories. Housing programs may have tenant selection policies that prioritize people who have been homeless the longest or who have the highest service needs as evidenced by vulnerability assessments or the high utilization of crisis services.

c. Rapid and streamlined entry into housing
Many people experiencing chronic homelessness may experience anxiety and uncertainty during a lengthy housing application and approval process. In order to ameliorate this, Housing First permanent supportive housing models make efforts to help people experiencing homelessness move into permanent housing as quickly as possible, streamlining application and approval processes, and reducing wait times.

d. Supportive services are voluntary, but can and should be used to persistently engage tenants to ensure housing stability
Supportive services are proactively offered to help tenants achieve and maintain housing stability, but tenants are not required to participate in services as a condition of tenancy. Techniques such as harm reduction and motivational interviewing may be useful. Harm reduction techniques can confront and mitigate the harms of drug and alcohol use through non-judgmental communication while motivational interviewing may be useful in helping households acquire and utilize new skills and information.

e. Tenants have full rights, responsibilities, and legal protections
The ultimate goal of the Housing First approach is to help people experiencing homelessness achieve long-term housing stability in permanent housing. Permanent housing is defined as housing where tenants have leases that confer the full rights, responsibilities, and legal protections under federal, state, and local housing laws. Tenants are educated about their lease terms, given access to legal assistance, and encouraged to exercise their full legal rights and responsibilities. Landlords and providers in Housing First models abide by their legally

defined roles and obligations. For instance, landlords and providers do not enter tenants' apartments without tenants' knowledge and permission except under legally-defined emergency circumstances. Many Housing First permanent supportive housing programs also have a tenant association or council to review program policies and provide feedback, and formal processes for tenants to submit suggestions or grievances.

f. Practices and policies to prevent lease violations and evictions

Housing First supportive housing programs should incorporate practices and policies that prevent lease violations and evictions among tenants. For instance, program policies consistent with a Housing First approach do not consider alcohol or drug use in and of itself to be lease violations, unless such use results in disturbances to neighbors or is associated with illegal activity (e.g. selling illegal substances.) Housing First models may also have policies that give tenants some flexibility and recourse in the rent payment, which in many subsidized housing programs is 30% of the participant's income. For example, rather than moving towards eviction proceedings due to missed rent payments, programs may allow tenants to enter into payment installment plans for rent arrearages, or offer money management assistance to tenants.

g. Intensive case management

Case managers are the point person in building stability for those experiencing homelessness. They are the person that the individual can go to when there is need; they are the problem solvers. Intensive Case Management (ICM) is individually based and generally targeted to those with the greatest needs. Those experiencing Chronic Homelessness will fit into this category due to the barriers they face. ICMs are strengths-based and empower consumers to fully participate in all service decisions. These strengths-based models operationalize recovery principles while simultaneously helping people reclaim, recover, and transform their lives through the identification and sustaining of a range of resources for thriving in the community.

h. Outreach

While external outreach efforts will help provide information as to the location of chronically homeless households, there must be efforts on the part of the Chronic Service Program to go out and engage with the people they will serve. For service to effectively be rendered, service providers cannot simply sit in an office and wait for the participant to come to them. As such, the expectation will be for service providers to send staff into the field to locate clients when appropriate.

i. Housing Navigation

Housing navigators differ from case managers in that their focus is singular: get the individual they are assisting into housing. This is accomplished by building relationships with property owners and landlords willing to rent to individuals being served. With the ever-shrinking affordable housing market, the need for Housing Navigators grows every day. The work to find suitable units is not easy, and if there are not people specifically dedicated to finding them they will not be found in suitable quantity.

B. Overview of Chronic Homeless Population in Chattanooga and Hamilton County

Measuring the chronic homeless population comes with inherent challenges. Many people experiencing chronic homelessness are less likely to present at resource centers for services and fluctuate between systems. As such, the estimates for how many people there are in Hamilton County experiencing chronic homelessness should be seen are an estimate. The Chattanooga Regional Homeless Coalition measured 383 Chronically Homeless individuals and 61 Chronic Families that have been assessed within the last year from July of 2019. While the local Continuum of care has numerous permanent supportive housing units in place, their units remain nearly full.

One aspect that separates the chronic homeless population for the general homeless population is the individual possessing a disabling condition. The condition itself can be verified by HUD standards only needs to be self-reported by the individual at the time of assessment. Disabilities are listed in the following non-exhaustive examples:

- Severe and persistent mental health issues
- Substance abuse disorders
- Physical health condition that impacts one's ability to work or live independently