REPORT ON HOMELESSNESS in Wareham

AND RECOMMENDATIONS TO PREVENT AND END HOMELESSNESS IN OUR COMMUNITY
Living Homeless

Eking out a life as a homeless resident in Wareham is a 24-hour a day job that requires intelligence, resourcefulness and most of all, luck.

It’s very hard work. And those forced to do it tell stories of physical and mental challenges that would be unimaginable to most of us. Often, one obstacle is overcome only to have another immediately assume its place. There’s mounds of confusing paperwork to be filled out often with no assistance. More paperwork that may get lost because addresses are non-existent or often change. And petty rules and regulations to overcome in programs that are meant to help.

First there is your actual living situation. In the winter, the Wareham Clergy Association provides Nights of Hospitality at alternating local churches, where residents can also get a hot meal. This is an unconditional offer of hospitality. The only rules are that you are not disruptive. It has been a godsend and literally a lifesaver for many unsheltered homeless residents in Wareham, whose number is close to that found in many large cities on the South Coast. In fact, this program has been severely taxed in recent years by the high numbers of people needing shelter.

The Nights of Hospitality end in March, and then, homeless residents often resort to camping in local woods. You need to make a campsite – which as one resident, Peter notes, requires lots of hard, manual labor. It has to be maintained, chores that again require physical labor and can take hours each day. If the site is discovered, then you have to immediately move, picking up all of your gear and equipment and hopefully finding a new site to set it all up.

When you move around each day, you need to carry a considerable amount of your belongings in heavy backpacks. You rely on the basic schedule of public transportation to take care of most of your needs so you have to literally plan every minute of your day. You might travel hours to make connections for a job interview, or assistance at a local service agency, only to have the appointment cancelled when you get there. And then you spend hours getting “home.” If bus service has ended, then you walk miles. Here in New England, you’re sometimes walking miles in snow or rain.

Potential jobs are limited by potential transportation. One local woman, who was able to land a part-time job for the first time in a long time, was thrilled to find that the bus took her near her job. But she has to rise early and leaves hours in advance so that she can be sure to work out the schedule. A 20 minute commute by car, takes almost three hours by public transportation.

Food is another issue, acquiring, transporting, cooking and most of all being able to afford it. There are dinners provided by local churches but sometimes there is no transportation to and from the sites. Local food pantries offer food supplies, but transportation is again an issue, and cooking often has to happen over an open fire. Some are able to acquire assistance like food stamps to use in local groceries, but one rule with food stamps is that they are able to only be used for uncooked items, so something like a hot rotisserie chicken, a good and nutritional choice if you’re living outdoors, can’t be on the menu. You can only buy an uncooked chicken, which is time-consuming and challenging to cook over an open fire.

It is one of the many impossible, and seemingly senseless situations that homeless residents often find themselves in. And, as one resident, Peter, notes, “it’s easy to get off the grid (of everyday living). But it’s incredibly hard to work to survive and get back on.”

“It’s using just about all of your energy overcoming obstacles,” says Brenda, a local resident who has been homeless since January. “Here’s one more hurdle to get over and we need to get ready for what might be coming next. That’s all you can do.”
### Table of Contents

I. Letter from Co-chairs ................................................................. 4

II. Executive Summary ................................................................. 5

III. Five Myths about Homelessness .............................................. 7

IV. Homelessness in Wareham .................................................... 11

V. Report on Homelessness in Wareham: Timeframe, Goals, and Year 1 Priorities ......................................................... 13

VI. Costs of Homelessness .......................................................... 15

VII. Summary of Goals, Action Steps and Benchmarks .................. 17

VIII. Implementation Strategy ...................................................... 24

IX. Appendices ............................................................................. 36
    A. Acknowledgements .............................................................. 37
    B. Memorandum of Agreement ................................................ 38
    C. Opening Doors –The Federal Plan to Prevent and End Homelessness ......................................................... 43
    D. the VA 5 Year Plan to Prevent and End Veteran’s Homelessness-6 Pillars ......................................................... 47
    E. Glossary of Terms ................................................................. 49

**Cover Photo:** Anne Marie Rita photographed by Jeannette Fuller

In remembrance of Anne Marie Rita and other homeless individuals who have struggled in our community.
John Cimmino’s story

John Cimmino, age 27, has a new life.

The clean-cut, pleasant young man is quick to point out that several years ago, his life was following a much darker path that lead him to estrangement from his family including a young son, life on the streets and face-to-face with a long prison term. His story is about how easy it is to make bad choices and where those choices can take you.

His story is also about the power of forgiveness and acceptance — for both yourself and your loved ones.

John grew up in Lawrence in a "loving, happy home," with his mom, dad and brothers.

He started using marijuana as a teen and that drug lead to others. He became much more focused on his next fix than his studies and he dropped out of high school.

“In the beginning, it was recreational drugs with friends but turned into something much more serious. I was the type of addict who didn’t like to go without. I did whatever I needed to do to get my next fix.” That included breaking and entering and burglaries and at his lowest point, John was facing over 70 charges in nine felony cases.

“There were many nights when I slept outside. I got to the point in my life where I had no hope. I had a son and he was totally out of my life. I didn’t want to die but I was in a really scary place.”

John spent time in the Middlesex House of Correction and then was offered a program through the courts that involved intensive and very structured rehabilitation. The first step was a treatment facility run by the Salvation Army in Worcester.

“I had been religious as a child and I re-established my religion. I found my faith again and I found my hope.”

The next step was a stint at Evergreen House in Wareham.

“I never considered that drug addiction is a disease and there is a way out. I had never had structure or rules. Evergreen House taught me how to build my recovery. I created my foundation there. They taught me practical things ... like how to cook. But they also taught me honesty and my spirituality blossomed. I learned things like gratitude and acceptance. I found my true self while I was there.”

“My time at Evergreen House taught me to do the next right thing no matter what.” Evergreen House encourages their residents to contribute to the community through work and volunteerism. John found work at local businesses, volunteered and began to take classes.

As he worked hard at his recovery and building a new life, his family was there with support and forgiveness. “For a long time, I thought I was a really bad person. But I am a good person who made some incredibly bad choices. I needed to forgive myself before I could expect anyone else to forgive me.”

“I have a life now that I never could have envisioned.”

His parents were there for him but most of all he had the love and support of his aunt and uncle, and their family, who live in Wareham. After Evergreen House he lived with them for a year and a half as he worked, went to school and continued to build his new life.

Today, John is a certified drug addiction counselor working at the Salvation Army treatment center where he first found help. He works at a large day program for over 115 men and women who are in treatment there. “I’m very proud of what I’ve been able to do and my family is very proud too.”

He has also earned joint custody of his son, age 9, and his face lights up when he talks about the time they spend together. “We love playing wiffleball, going to the movies ... even helping him do something as simple as look up his spelling words.”

“I have a life now that I never could have envisioned.”
I. Letter from Co-Chairs

An Open Letter to the Wareham Community:

When thinking about the problem of homelessness in Wareham, variations on two often-overused clichés come to mind.

The problem is right in front of us, yet we seem unable to see it.

A little change will make a world of difference.

But many probably stopped reading at “the problem of homelessness in Wareham.”


Except it’s not — because it’s an issue right here, in our community that prides itself on being the self-proclaimed Gateway to Cape Cod.

In January 2012, the annual count of homeless in Wareham rang in at 22 individuals. By comparison, nearby New Bedford counted 24 individuals. In fact, when you look at all of the potential sources of homeless individuals in Wareham, the count is estimated at 25 to 50, or more.

How can that be?

It’s a problem that has been right in front of us, growing slowly and steadily over the last several years.

Start by asking our local clergy and the staff and volunteers at Turning Point, who in 2006 took notice of the unexpected rise in homeless individuals when attempting to deliver holiday packages of warm clothing to encampments in town where the homeless were known to gather.

This was unacceptable, and our local clergy took on this issue. They created a program to offer shelter, called “Nights of Hospitality,” that moved from church to church to provide some needed relief for those willing to accept it.

But the numbers kept growing. And our clergy realized they could not do it alone.

Despite the efforts of many community organizations, services for the homeless in Wareham have been and continue to be stretched to capacity and are not coordinated.

Which brought us to the Wareham Leadership Council to End Homelessness — a group of non-profit, private and public sector individuals who felt that, collectively, we could find a way to put an end to homelessness in Wareham.

Our goal was simple: End homelessness now and for the future.

We were grateful to have significant assistance from Father Bill’s and Mainspring, who have worked to address homelessness in communities throughout Plymouth County. In addition to their experience and guidance, they helped connect us to others who have tackled this problem — on the Cape, on the South Shore and across Southern New England.

A lot of people worked very hard to think carefully, creatively and compassionately about how to end homelessness, putting aside their agendas and instead focusing on their ideals. Let’s help our fellow residents. Let’s eliminate homelessness here.

Now on to our second cliché — that a little change could make a world of difference.

During last year’s 91-day period, the Nights of Hospitality had 604 shelter guest visits for an average of 6.64 guests per night. If 13 of those guests, who were frequent visitors of the Nights of Hospitality, received permanent housing then the demand would be reduced to an average of about one visitor per night.

That’s where this Wareham Plan begins — suggesting a comprehensive and concrete plan to ensure that everyone in our town has a roof over their head.

This plan represents more than a year of work by dozens of people, many of whom are leaders in respected community organizations, private businesses and public service, working together to have a collective impact on this issue.

We hope this plan brings about more dialogue, involving more people in Wareham, to come together to help end homelessness in Wareham.

Let’s not only be the Gateway to the Cape. Let’s also be the Gateway to a Better Life.

Sincerely,

Linda Burke
Co-Chair
Vice President of Marketing & Communications
A.D. Makepeace Company

Jim Rattray
Co-Chair
Vice President of Marketing & Public Affairs
Southcoast Health System
II. Executive Summary

The Report on Homelessness in Wareham (the Wareham Report) is the culmination of over a year of collaborative work by individuals, agencies and institutions in Wareham who are concerned about the growing issue of homelessness in our town. The report has one simple and singular focus: all residents have a right to secure and stable housing and the coordinated support services that make it possible to maintain their housing. The implementation of the “housing first” philosophy has produced strong results in communities across the nation and is the guiding principle of both our short and long-term strategies in Wareham. The Wareham Report also emphasizes the need for solid goals and achievable benchmarks to measure progress in addressing homelessness and improving the lives of many of the town’s residents.

In creating the Wareham Report, the town joined a national movement to prevent and end homelessness. Since 2003, over 300 communities nationally, and many in Massachusetts have developed such plans. Massachusetts announced its initial plan to prevent and end homelessness in 2008. In 2009, VA Secretary Eric Shinseki called for a national commitment to prevent and end veteran’s homelessness in 5 years. In 2010, the federal government released the first ever comprehensive federal strategic plan to prevent and end homelessness, Opening Doors, committing to coordinating and targeting federal resources to achieve four goals: Finish the job of ending chronic homelessness in 5 years, prevent and end veterans homelessness in 5 years, prevent and end homelessness for families, youth and children in 10 years, and set a path to ending all types of homelessness. All have recognized the status quo was not working and a planful approach using evidence based and emerging best practices would be much more effective than the ad hoc, uncoordinated response many had been using. The Wareham Leadership Council used these federal, state, and community plans to inform its work.

Significant Problem

Homelessness in Wareham is a serious problem, with the numbers of chronically homeless individuals growing each year and stretching the town’s limited resources to the breaking point. Emergency shelter is available in Wareham during the colder months through the “Nights of Hospitality,” a coordinated effort by Wareham churches through the Wareham Area Clergy Association (WACA). However the numbers of homeless have increased each year and these temporary shelter services are stretched to capacity. In fact, in the most recent year’s count of unsheltered homeless individuals, the count in Wareham approached the nearby city of New Bedford, which has almost five times the population. Support services for homeless individuals in Wareham are limited and not coordinated, restricting access and curtailing their success.

Process

The Leadership Council recognized the need to consult experts from inside and outside of Wareham to inform the Wareham Report. As a result, the Leadership Council convened a Working Group charged with developing recommendations for goals and action steps/strategies.

The Working Group met on seven occasions from July through October 2012 with discussions focusing on four significant topics that are essential in addressing homelessness: Prevention, Intervention, Employment and Income and Housing. The last two meetings were used to review and discuss recommended goals and action steps.

The Working Group reviewed the local strengths and weaknesses of the current Wareham response to homelessness. It recognized there are both targeted and mainstream resources in Wareham and surrounding communities that could partner in the initiatives to prevent and end homelessness. It also recognized that community stakeholders (nonprofit agencies and organizations, town government, community institutions, the faith community, and the private sector) currently provided only an ad hoc response to adults who were chronically homeless or at high risk of homelessness. There was very limited infrastructure in the form of partnerships, collaborations and coordination...
of resources, to support the implementation of the Wareham Report. The Working Group noted that both the formation of the Leadership Council and The Working Group meetings actually served as an important first step in building such an infrastructure.

In addition to the lack of infrastructure, the Working Group identified the need for reliable data to better define the number, characteristics, and needs of the target populations, as well as current and potential resources that can be used to support implementation of the report recommendations. Baseline data was deemed critical as decisions are made about where to target resources and as benchmarks are identified to measure the Wareham Report’s impact.

Finally, preventing and ending homelessness among veterans deserves special mention. No woman or man who has taken the oath to serve in the military should be homeless or at risk of homelessness. The Veterans Administration has made preventing and ending veteran's homelessness one of its highest priorities and has targeted housing and support services to meet this goal. The Wareham Report will coordinate with the VA and state strategies regarding homeless veterans.

Finding a Solution
The Wareham Leadership Council on Homelessness (the Wareham Leadership Council) was formed in May 2012 by business, health, clergy, town, social services providers, and other institutional leadership in Wareham to develop a report on and recommendations to prevent and end homelessness. The initial impetus for forming this group was concern by local clergy that the problem of homelessness was approaching critical proportions, and that if not addressed, human tragedy was inevitable. The Leadership Council’s defined mission was to direct and oversee the development and implementation of the Wareham Report and to serve as the “voice of the community” in ensuring the report recommendations meet the town’s unique needs.

We Believe
The Leadership Council adopted the following guiding principles:

1. We believe every person should have a stable place to call home.
2. We believe every person has the capacity to move into and stabilize in an appropriate housing situation when provided with the necessary support services.
3. We believe the entire community is responsible for preventing and ending homelessness in Wareham.
4. We believe the best results will be achieved by engaging an inclusionary, multi-disciplinary community leadership team for development and implementation of the Wareham Report.
5. We believe a relentless focus on results will help ensure success in implementing the Wareham Report recommendations.
6. We believe resources must be targeted to evidence-based and emerging/promising practices.
7. We believe enhanced data capacity is necessary to help ensure resource investments are targeted and impactful.

After reviewing local data, the Leadership Council identified unaccompanied homeless and at risk adults, and unaccompanied youth as the target populations for the Wareham Report. The benchmark for completing the developing of the Report on Homelessness in Wareham was the end of 2013.
III. Five Myths about America’s Homeless

Five myths about America’s homeless
By Dennis Culhane
Sunday, July 11, 2010; B02

Last month, the Obama administration released a plan designed to end homelessness in 10 years. The goal reflects new optimism among academics and advocates that homelessness is not an intractable feature of urban life, as it has sometimes seemed, but a problem that can be solved. This belief is fueled by recent research debunking a number of long-standing myths about homelessness in America — and showing that many of our old policies were unwittingly making the problem worse.

1. Homelessness is usually a long-term condition.
To the contrary, the most common length of time that someone is homeless is one or two days, and half the people who enter the homeless shelter system will leave within 30 days, never to return.

Long-term homelessness is relatively rare. According to the Department of Housing and Urban Development, about 2 million people in the United States were homeless at some point in 2009 (meaning they stayed overnight in a shelter or in a place not meant for human habitation). But on any given day, only about 112,000 people fit the federal definition of “chronic homelessness,” which applies to those who have been continuously homeless for a year or more, or are experiencing at least their fourth episode of homelessness in three years.

Nearly all of the long-term homeless have tenuous family ties and some kind of disability, whether it is a drug or alcohol addiction, a mental illness, or a physical handicap. While they make up a small share of the homeless population, they are disproportionately costly to society: They consume nearly 60 percent of the resources spent on emergency and transitional shelter for adults, and they occupy hospitals and jails at high rates.

2. Most of the homeless have a severe mental illness.
Because the relatively small number of people living on the streets who suffer from paranoia, delusions and other mental disorders are very visible, they have come to stand for the entire homeless population — despite the fact that they are in the minority. As a result, many people falsely concluded that an increase in homelessness in the 1980s resulted from the deinstitutionalization of psychiatric care in the 1960s and 1970s.

In my own research, I have calculated that the rate of severe mental illness among the homeless (including families and children) is 13 to 15 percent. Among the much smaller group of single adults who are chronically homeless, however, the rate reaches 30 to 40 percent. For this population, mental illness is clearly a barrier to exiting homelessness.

But depending on a community’s resources, having a severe mental illness may, paradoxically, protect against homelessness. Poor people with severe psychiatric disabilities may have more means of support than other people in poverty because they are eligible for a modest federal disability income, Medicaid, and housing and support services designed specifically for them. Not so for the other childless singles — including ex-convicts, people with drug addictions and the able-bodied unemployed — who make up the majority of the nation’s homeless population.

3. Homeless people don’t work.
According to a 2002 national study by the Urban Institute, about 45 percent of homeless adults had worked in the past 30 days — only 14 percentage points lower than the employment rate for the general population last month. The number of working homeless would probably be even higher if “off the books” work was included. Whether
scavenging for scrap metal or staffing shelters, many homeless people adopt ingenious ways to subsist.

A recent job loss is the second most common reason people say they became homeless. In a study my colleagues and I are completing, we observe a steep drop in earned income in the year prior to the onset of homelessness. Interestingly, those people who return to work show a steep recovery in earned income three years after their initial homeless spell. Our preliminary data also suggest that about a third of the chronically homeless eventually end up working, thanks, quite likely, to substance-abuse recovery.

4. Shelters are a humane solution to homelessness.

When homelessness became a national epidemic in the 1980s, reformers responded with emergency shelters that were meant to be temporary havens. But as homelessness became more entrenched, so did shelters: Their capacity more than doubled by the late 1980s, then again a few years later and then again by 2000. Along the way, they became institutionalized way stations for lots of poor people with temporary housing crises, including those avoiding family conflicts, leaving prison or transitioning from substance-abuse treatment.

Large shelters are notoriously overcrowded and often unruly places where people experience the ritualized indignities of destitution: long lines for bedding or a squeeze of toothpaste; public showers; thieves; conflict. Many people have voted with their feet, and as a result, street homelessness persists.

Shelters may be the final safety net, but that net scrapes perilously close to the ground. To be in a shelter is to be homeless, and the more shelters we build, the more resources we divert from the only real solution to homelessness: permanent housing.

5. These poor you will always have with you.

Researchers and policymakers are newly optimistic about the prospect of ending homelessness. For two decades, the goal of our homeless programs was to first treat people for their myriad afflictions (substance abuse, say, or illness) and hope that this would lead them out of homelessness. Now, the attention has shifted to the endgame: Get people back into housing as quickly as possible, the new thinking goes, and the treatment for everything else can quickly follow – and with greater benefits.

People who haven’t had a private residence in years have succeeded in these new “housing first” programs, which place the homeless directly into their own housing units, bypassing shelters. Rent is subsidized and services are provided to help these tenants maintain their housing and be good neighbors.

According to HUD, the government has funded more than 70,000 such housing units since 2001. Meanwhile, the number of chronically homeless nationwide has decreased by a third since 2005, to 112,000.

The Obama administration’s new Homelessness Prevention and Rapid Re-Housing program takes a similar approach, giving people suffering temporary housing crises modest cash and service support, allowing them to avoid shelters or get out of them more quickly.

The cost of these programs is partly offset by reductions in expensive hospitalizations, arrests and shelter stays by the chronically homeless – to say nothing of the moral victory a society can claim in caring for its most vulnerable.

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Brenda’s story

Brenda, a soft-spoken woman in her forties is not a stranger to homelessness.

She grew up with a severely abusive father, and often ran away to escape the physical and emotional violence, staying here and there, crashing with family and friends. “I was often on the streets when I was young. ”

A hard life as a teen took its toll and Brenda has a chronic nerve condition that leaves her in constant pain and makes it difficult to do something as simple as bend her knees. She requires frequent treatment and like her partner, Peter, needs expensive medication each month. She has an especially hard time tolerating the cold.

She has lived all over Massachusetts, growing up in Springfield and Holyoke and most recently living in West Roxbury with a husband and son. She has no other family. She was introduced to Onset Village by her now ex-husband’s family who have a cottage there. She and her husband separated last year after 20 years of marriage. Her 14-year old son remains with his father.

“I do miss my son,” she says. Her ex-husband occasionally helps her with transportation and visits with her son. “For that”, she says, “I am grateful.” She met Peter, who lived down the street in Onset, last year, and they became close friends and began to live together. They worked briefly at a candy factory in Wareham, which closed, and mounting bills caused them to lose their apartment.

Today, they are a team in insuring each other’s survival as they cope with homelessness.

As both reflect on their situation, they are the victims of a long string of hard luck.

Like Peter, Brenda has been a hard worker all her life. “I have and can do just about anything … fast food, cleaning. I will do any job,” she says.

She and Peter spend most days following up on job leads and filling out and submitting applications.

In her competent and kind way, Brenda is resourceful and has found means not only to help herself, but also other homeless residents she has encountered in town. She documents and has become a font of knowledge about local resources and she assists others who need them …. how to get medical transportation through the Council on Aging, health insurance and food stamps, nutritional resources, how to apply for financial assistance.

This past winter, she befriended a long-time homeless resident in Wareham, Annemarie Rita, who tragically died in May when she was hit by a car trying to cross Cranberry Highway. She was able to coax Annemarie inside to overnight shelter in the Nights of Hospital for the first time in many years.

Her goals in life right now are quite simple. “What I want most is a job and a sense that I know where I can stay for at least awhile,” she says.

“I’m concerned about Peter. This has definitely taken a toll on him. We’re a team and we are the best thing that has happened to each other through all of this. It’s a very hard lifestyle. You have to plan your every move and one little thing can totally derail your day.”

“How do I get out? It’s very hard. But the first step is getting a job.”

She feels the judgement of other people. “Everywhere you go you feel like you’re being judged because you’re homeless. It’s very degrading. People refer to us as “that kind” of person. Well how am I a ‘kind’ (of person.) I’m a person and I deserve some dignity.”

Editor’s note: Peter and Brenda have moved in separate directions and are in separate housing situations.
IV. Homelessness in Wareham

Overview
Homelessness is difficult to measure completely and accurately. However, there is data for certain homeless subpopulations in Wareham and that data helps to estimate both the nature and extent of homelessness in our community.

Many chronically homeless individuals attend the Nights of Hospitality organized by the Clergy Association. The churches also host free meal programs or “soup kitchens” on virtually all days of the week. Some individuals attend Nights of Hospitality at some, but not all, of the participating churches. The same is true for the meals programs. So it is difficult to get an accurate measure of the homeless population unless we are able to integrate across all available sheltering and soup kitchen programs. There is currently no mechanism for that data collection in Wareham. Even if a perfect data collection process was available it would only accurately measure the homeless population that chooses to make itself known. There are homeless individuals in Wareham who choose to remain unknown, even to other homeless individuals.

The following is what we do know about homeless subpopulations in Wareham.

Unaccompanied homeless and chronically homeless men and women
The unaccompanied homeless/chronically homeless population in Wareham is estimated at 25 to 50 individuals.

An initial insight into the chronically homeless population of Wareham was obtained just after Christmas in 2006. At that time Turning Point, an organization that serves the homeless and near homeless in Wareham, attempted to deliver Christmas packages of warm clothing to encampments in town where homeless individuals were living. Turning Point volunteers were escorted by one of these individuals to approximately 25 campsites. The sites varied from somewhat protected encampments in the woods to completely unsheltered sleeping locations on open decks. At that time we could identify 25 chronically homeless individuals living outside. There is reason to believe that those individuals were the entire population known to our homeless guide.

Background
The Wareham Area Clergy Association (WACA) has operated a winter sheltering program since 2009. In the winter of 2011 – 2012 the churches averaged almost seven individuals per night. Over the course of 91 consecutive nights in five different churches, church volunteers developed a rapport with their homeless guests. In addition “triage professionals” from Father Bill’s and Mainspring made a special effort to reach out to Nights of Hospitality guests in an effort to assess opportunities to match those guests to available permanent housing programs. The following is a summary of some of the characteristics of the Nights of Hospitality guests during the 2011 – 2012 sheltering season.

• During the 91 day period there were 604 shelter guest visits for an average of 6.64 guests per night.

• There were six frequent guests (four men and two women) who spent 50 percent or more evenings in the shelter. They accounted for 54 percent of total shelter visits.
Based on the observations from 2006, insights from the Nights of Hospitality and point in time counts, and observations from various soup kitchens, the chronically homeless population in Wareham is estimated at 25 to 50 individuals.

- Seven additional guests (six men and one woman) were moderately frequent visitors, spending 20 to 40 percent of the season at the Nights of Hospitality. They accounted for over 28 percent of total shelter visits.

- The remaining 21 shelter guests (20 men and one woman) visited the Nights of Hospitality between one and 15 times accounting for the remaining 18 percent of shelter visits.

- If the thirteen guests that were frequent or moderately frequent visitors received permanent housing, the Nights of Hospitality would have experienced greatly reduced demand serving 21 people visiting a total of 105 times for an average of slightly more than 1 visitor per night.

How we compare

In an attempt to measure homelessness on a national basis a state-by-state point in time count is conducted each January and the results are reported through the Department of Housing and Urban Development to the United States Congress. Wareham has participated in the point in time count for the last two years.

- In January of 2011 Wareham reported a count of nine individuals that were sheltered on that evening in the Nights of Hospitality program.

- In January of 2012 Wareham’s reporting system was enhanced to capture both a sheltered and unsheltered “street count”. The unsheltered street count was provided by attempting to identify known homeless individuals and estimating that, if they were not at the Nights of Hospitality, they must be unsheltered and on the street that evening. Our 2012 point in time data was 10 individuals sheltered at the Nights of Hospitality, and 12 individuals unsheltered on Wareham streets, for a total of count of 22 individuals.

Homeless Families

Homeless Families are not specifically addressed in the Wareham Report. In Massachusetts, state law requires that any family that is homeless and meets specific guidelines have access to a support system which results in immediate sheltering. Based on this, the State Department of Housing and Community Development (DHCD) is responsible for sheltering/housing homeless families. If an emergency shelter opportunity for a family is not immediately available, the state houses homeless families in hotels and motels across the state. From time to time, Turning Point and other Wareham organizations are contacted by homeless families seeking shelter. Those families are always referred to the Massachusetts Department of Housing and Community Development. We typically lose track of the families at that point but we have every expectation that they receive emergency assistance immediately and are sheltered in out of area family shelters or hotels on a same-day basis.

Unaccompanied Youth

A count of unaccompanied youth was requested of the Wareham Public Schools in June of 2012. At that time Wareham high school reported 29 unaccompanied youths and the alternate school reported one. The Superintendent’s Office subsequently reported that during the course of a school year the homeless population among student’s ranges between 30 to 70 individuals. Strategies to deal with student homelessness include reconciliation with families, and failing that, a transitional arrangement with extended family or friends. Wareham Public Schools estimates that approximately six student apartments would be required to house homeless students that could not be accommodated in the preferred family or substitute family strategy.
V. Report on Homelessness in Wareham: Timeframe, Goals

Timeframe
The Wareham Report recommendations will focus on the five year period from 2014 to 2019.

Goals
The Wareham Report recommendations will have two primary goals:

• Move chronically, unaccompanied homeless adults and unaccompanied youth in Wareham into permanent housing as rapidly as possible with the wrap around services they need to stabilize in and maintain that housing
• Prevent unaccompanied adults and youth who are at high risk of homelessness from becoming homeless.

Achieving these outcomes is the sole measure of success. While specific initiatives are recommended for year one, building the infrastructure necessary to support ongoing implementation will also be of primary importance in the first year.

Year One Priorities

The Working Group has identified six immediate priority recommendations. While these priorities are embedded in the overall Wareham Report, with the exception of the recommendations concerning Youth, they also stand out in terms of their urgency and overall impact on the successful execution of the Wareham Report recommendations.

1. Housing
Implement strategies to access housing, housing subsidies, and wrap around services for the 12 most frequent utilizers of the Nights of Hospitality. The prioritized list for housing will be developed through Nights of Hospitality data.

Benchmark Year One: Move six frequent users of Nights of Hospitality into permanent housing with wrap around services they need to stabilize and maintain housing

Benchmark Year Two: Move six frequent users into permanent housing with wrap around services they need to stabilize and maintain housing

Key to the success of this two year housing goal is the development of a “landlord consortium”, made up of landlords, property managers, and realtors to help identify and access existing housing in Wareham.

2. Build Infrastructure for Implementation or the Wareham Report recommendations
Execute a Memorandum of Agreement (MOA) with Wareham area organizations and agencies, including appropriate town departments. The MOA will lead to enhanced coordination, collaboration and partnership to prevent and end homelessness in Wareham based on the goals and strategies outlined in the Wareham Report four key areas: Prevention, Intervention, Employment and Income, and Housing. The MOA will describe the resources and areas of expertise each agency can provide and the responsibilities each will commit to so the recommendations in the Wareham Report are effectively implemented.
### 3. Prioritize those targeted for permanent housing in year one and year two for intervention strategies

These will include outreach and engagement and strategies to help obtain qualifying benefits/entitlements, income supports and housing subsidies. This will help insure homeless residents have the resources to access and maintain permanent housing.

**Benchmark:** 75% of those prioritized for housing are approved for benefits/entitlements and income supports and qualified for housing subsidies by fourth quarter, 2013.

### 4. Prevention

Initiate effective homelessness prevention activities to help high risk, unaccompanied adults in Wareham avoid homelessness. This will include:

- Development of a targeted community resource guide identifying available resources for homeless and at risk unaccompanied adults.
- Implementation of early warning strategies to identify members of the community who are currently housed and at high risk of homelessness, including recognition of such issues as behavioral problems, rent arrearage, utility arrearage etc.
- Identification of resources/to increase the availability of emergency funds to prevent people who are housed and at high risk of falling into homelessness.
- Identification of intervention/case management resources to help stabilize the most complex cases of residents who are housed and most at risk of homelessness.

### 5. Employment

Establish an employer to employer outreach network led by private sector champions and enhance relationships with the Wareham Career Center and other agencies to help identify and access employment and training opportunities for unaccompanied homeless adults.

**Benchmark:** Through employer to employer network and the Career Center, three unaccompanied homeless adults in Wareham will be employed by the end of the second quarter, 2014 and 67 percent of these individuals will retain employment for six months.

### 6. Youth

Identify a subcommittee to develop goals and strategies within year one of implementation to address the issue of homeless and high risk unaccompanied youth in Wareham, including but not limited to:

- The extent of the problem
- Evidence based and promising best practices
- Existing and potential resources
- Lead agencies
- Goals and strategies

**Benchmark:** Unaccompanied Youth recommendations will be approved by the third quarter of 2014. The subcommittee to report progress quarterly to the Implementation Leadership Council beginning in fourth quarter, 2014.
VI. Costs of Homelessness

For many city officials, community leaders, and even direct service providers, it often seems that placing homeless people in shelters is the most inexpensive way to meet the basic needs of people experiencing homelessness; some may even believe that shelters are an ideal solution. Research, however, has shown something surprisingly different.

The cost of homelessness can be quite high. Hospitalization, medical treatment, incarceration, police intervention, and emergency shelter expenses can add up quickly, making homelessness surprisingly expensive for municipalities and taxpayers.

Hospitalization and Medical Treatment
People experiencing homelessness are more likely to access the most costly health care services. According to a report in the New England Journal of Medicine, homeless people spent an average of four days longer per hospital visit than comparable non-homeless people. This extra cost, approximately $2,414 per hospitalization, is attributable to homelessness. Homelessness both causes and results from serious health care issues, including addiction, psychological disorders, HIV/AIDS, and a host of other ailments that require long-term, consistent care. Homelessness inhibits this care, as housing instability often detracts from regular medical attention, access to treatment, and recuperation. This inability to treat medical problems can aggravate these problems, making them both more dangerous and more costly.

Prisons and Jails
People who are homeless spend more time in jail or prison, which is tremendously costly to the state and locality. Often, time served is a result of laws specifically targeting the homeless population, including regulations against loitering, sleeping in cars, and begging. A typical cost of a prison bed in a state or federal prison is $20,000 per year.

Emergency Shelter
Emergency shelter is a costly alternative to permanent housing. While it is sometimes necessary for short-term crises, too often it serves as long-term housing. The cost of an emergency shelter bed funded by HUD’s Emergency Shelter Grants program is approximately $8,067 more than the average annual cost of a federal housing subsidy (Section 8 Housing Certificate).

— From the National Alliance to End Homelessness website

Local costs of homelessness
Just as the national data demonstrates, in Wareham homeless women and men incur significant costs to the system. Homeless individuals often rely on hospital Emergency Departments for their health care, which is episodic and much more costly than coordinated care in a primary health care system. The Tobey site of Southcoast Hospitals reports that the Emergency Department frequently sees homeless individuals who rely on the hospital for care and sometimes shelter. During 2012, 36 individuals, who reported they were homeless, visited the Emergency Department. Each averaged three visits at a cost of over $2,500 per visit. The total for all of the visits exceeded over $314,000. One individual had over nine visits at a cost of over $91,000. Although hospital staff is usually able to obtain health insurance for these individuals, their tenuous living situation makes it almost impossible to arrange for coordinated, primary health
care. This results instead in costly, episodic care which does not promote good health for the individual.

**Home and Healthy for Good-A Massachusetts Model**

As a result of mounting evidence from around the country that Housing First is a cost-effective model that decreases chronic homelessness, the Massachusetts Legislature passed line item 4406-3010 in the FY07 state budget to fund a statewide pilot Housing First program for chronically homeless individuals. Called *Home & Healthy for Good,* (HHG) it serves chronically homeless adults and is operated by the Massachusetts Housing and Shelter Alliance. HHG is an outcome-based model, and the program’s success is measured in a variety of ways. MHSA evaluates HHG by examining tenants’ self-reported quality of life, destination status and public service usage, as well as through cost savings analysis.

Since HHG’s foundation in 2006, 632 chronically homeless adults (79% men and 21% women), including 119 veterans, have been placed into permanent housing with supportive services, which have been provided by 14 service agencies across the Commonwealth. Their average length of homelessness prior to moving to permanent housing of these individuals is over 5 years. Of those placed, 28 percent resided on the streets or in places not meant for human habitation and 72 percent resided in emergency shelters prior to obtaining housing. Of the HHG tenants, 51 percent have a medical disability, 67 percent have a mental disability, 23 percent have a self-reported substance abuse disorder, and 47 percent are dual-diagnosed, meaning they deal with multiple disabilities.

**Results**

Of the 632 people who have enrolled in HHG over the past 6 years, 73 percent of the total HHG population is either housed through HHG or resides in another type of permanent housing. An additional 3 percent of the population transitioned from HHG to long-term treatment care and 5 percent of all tenants housed over six years died while in housing, many from chronic health conditions. Remarkably, only 16 individuals – 3 percent of HHG participants – are known to have recidivated to homelessness after obtaining permanent housing. The three charts included here from the December 2012 HHG report to the legislature demonstrate the impact of a housing first strategy.
Successfully addressing homelessness involves a comprehensive and collaborative approach. The Wareham Report recommendations reflect both local and regional input from many who are invested in both improving the lives of the homeless and improving the quality of life in our community. It reflects a thorough examination of topics communities across the country have demonstrated as essential to effectively impact homelessness.

A. Housing

The ultimate solution to homelessness is appropriate housing opportunities, both for those who are at high risk of homelessness and those who are currently homeless. Over the last decade research and data tell us that rapid movement of homeless men and women into permanent housing, with the wrap around services they need to stabilize and maintain their tenancies, is the best way to reduce and end homelessness. Very low threshold housing, or housing first, has demonstrated even the longest term, vulnerable and disabled homeless individuals can successfully maintain their housing if they have the necessary wrap around services. In fact, most communities across the United States have adopted this evidence based best practice strategy as the centerpiece of their community plans to prevent and end homelessness.

Identifying and accessing existing rental housing is the quickest and most cost-effective housing strategy. In addition, there usually needs to be a housing production strategy since the volume or type of housing needed may not currently be available. A housing strategy may include accessing both scattered site and congregate housing options. Many homeless individuals are disabled and require housing subsidies to ensure stable, long term tenancies. Even those who are employed may not have sufficient income to pay market rate rents, and therefore, may need housing subsidies. Many will need short or long term support (wrap around services) to stabilize and maintain tenancies.

While planning and implementing a community housing strategy for unaccompanied adults and youth may seem complicated and daunting, research on outcomes of such strategy demonstrate it is well worth the effort.

“Most research shows that more than 80 percent of chronically homeless individuals that move into permanent housing with the wrap around services they need are able to stabilize and maintain their tenancies.”

A community plan that links an intervention strategy with a low threshold permanent supportive housing strategy is much more cost effective than unplanned, ad hoc responses. There is a direct correlation between permanent housing and reduced use of community resources such as emergency rooms and emergency medical services, police, acute mental health and substance abuse treatment, etc. There is also a reduction in complaints from community businesses and the general public. The quality of life for all members of the community, housed and homeless alike is improved.
B. Intervention

Intervention activities, including outreach and engagement are generally the first steps in helping unaccompanied homeless adults get on a trajectory out of homelessness. There are a number of community institutions, agencies, and organizations that provide “front door” opportunities to engage and reach homeless adults. They include but are not limited to Hospitals and Community Health Centers, Emergency Medical Services, Police Departments, Churches and Faith-Based Groups, Mental Health and Substance Abuse Agencies, Meals Programs, Schools, Courts, Government Officials and other community-based organizations.

However, these institutions and agencies often do not coordinate services or even know what the other may be able to provide. The result is often a fragmented, ad hoc response which typically does not work well for those experiencing homelessness.

To mitigate this, it is recommended the community develop a well coordinated, integrated front door response. Once someone experiencing homelessness steps through this front door at any of the participating agencies an agreed upon set of interventions or protocols are initiated. This replaces the ad hoc, fragmented response with an integrated, coordinated, effective response that will move the individual onto the trajectory out of homelessness.

The implication of this is that no one agency, organization, or institution would work alone, or would feel it is working in isolation. The shift is to a community-wide response that accesses all appropriate community resources. The Intervention segment of the Wareham Report establishes how the Wareham Front Door Intervention Initiative will be formed and effectively implemented.

C. Employment and Income

In order for homeless women and men to access and stabilize in permanent housing, they need financial resources. For some, this will come from employment. For some it will be a combination of employment and public resources/entitlements. For others who are disabled and unable to work, income will have to come from public resources. For all, an important first step is a comprehensive assessment, part of which would help determine potential for employment. Those who are determined to have current/future capacity for employment need a specific set of resources that will put them on a trajectory to find and maintain a job and permanent housing. Those determined not to be employable need specific resources that will help them access appropriate public resources that will provide the income and other supports necessary to move to permanent housing. For some, their plan will involve both.

D. Prevention

Preventing people from falling into homelessness should have equal priority with moving people out of homelessness. Key to prevention is identifying those most at risk of homelessness. There are certain subpopulations that tend to be high risk including youth aging out of foster care, women and men being discharged from jails and prison, and individuals who suffer from mental health issues and substance abuse.

For those who are housed, there may be early warning signs that someone is at risk of homelessness. Given the limited resources available, at what point should they be utilized. Mainstream resources and mainstream organizations should provide the lead when a community looks to prevent homelessness.

Who will be responsible

The Wareham Report to Prevent and End Homelessness is the work of a very broad coalition of local and regional leaders from health and human services, faith communities, business and government who have experience and expertise in enacting positive change in our community. They will continue, through both a Leadership Council and formalized collaborative groups, to oversee completion of key goals and benchmarks in the report.
**Housing Goals, Benchmarks and Strategies**

**Housing Goal**
Unaccompanied homeless adults are able to access appropriate housing that is affordable and access the wrap around services they may need to stabilize in and maintain their housing.

**Overall Benchmarks**
Thirty unaccompanied homeless adults move into permanent housing with appropriate wrap around services in the next five years:

- **Benchmark Year One**: Move six frequent users of Nights of Hospitality into permanent housing with wrap around services they need to stabilize and maintain housing.

- **Benchmark Year Two**: Move six frequent users of Nights of Hospitality into permanent housing with wrap around services they need to stabilize and maintain housing.

**Housing Strategies**

1. **Expand opportunities to access existing rental units**
   - Build landlord/property management/realtor consortium to increase access to rental units and identify ways landlords will be more willing to open units to this population. The role of the consortium will include:
     - Identifying funds to repair damaged properties
     - Identifying community contacts to help mediate problems
     - Accessing housing rehabilitation resources to help bring vacant/foreclosed units online
     - Building and accessing a housing data base to track and access available rental housing
     - Establishing a partnership with appropriate agencies to access housing subsidies, including HUD VASH vouchers

2. **Expand opportunities to help drive development of and access to units in new housing projects**
   - Participate in and partner with local and regional affordable housing planning initiatives
   - Develop collaborations with non-profit housing development agencies to identify possible new project opportunities for unaccompanied adults
   - Engage Town Government departments, CEDA, and the Wareham Housing Authority, to determine available resources for new housing opportunities
   - Establish a partnership with appropriate agencies to access housing subsidies, including HUD VASH vouchers

3. **Identify, through the Wareham Front Door Intervention Initiative, partners/resources for housing stabilization and support (wrap around services)**

4. **Secure private/public housing supports/subsidies to meet housing goals**
INTERVENTION

Intervention Goals, Benchmarks and Strategies

INTERVENTION GOAL
Through a Memorandum of Agreement (MOA) the community develops a well coordinated, integrated Wareham Front Door Intervention Initiative

OVERALL BENCHMARKS
Of those applying for benefits, the number approved for benefits within a specified length of time (to be determined)

INTERVENTION STRATEGIES
1. Execute a Memorandum of Agreement (MOA) that establishes the Wareham Front Door Intervention Initiative. This “front door” intervention strategy with community institutions, agencies, and organizations will provide opportunities to begin intervention activities with unaccompanied adults. It will include agreements to integrate medical and behavioral health resources, including resources for management of complex cases

2. Prioritize opportunities to co-locate front door resources, as appropriate, to help provide “one stop shopping” experience for unaccompanied homeless adults

3. Establish a range of emergency housing options for those that fall into homelessness/are currently homeless until permanent housing is accessed

4. Identify an appropriate universal assessment/screening tool and utilize across all agencies, organizations, and institutions that are part of the MOA

5. Identify a lead agency/host that can help enhance the community’s capacity to gather/collate data and use aggregate data to inform decision making about resource needs and resource allocation

6. Identify gaps in resources and partnerships/collaborations and implement strategies to access those resources for the Wareham community

EMPLOYMENT

Employment and Income Goals, Benchmarks and Strategies

EMPLOYMENT AND INCOME GOALS
Establish a network of community resources, both public and private, that will assess unaccompanied homeless women and men to determine their employability and create a plan of action that will lead to employment

Establish a network of federal, state, and local community resources, both public and private, for disabled unaccompanied homeless adults that will lead to successful application for public supports/entitlements in a timely manner

OVERALL BENCHMARKS
For those assessed as employable:
• 67 percent access permanent housing within 6 months of employment

For those that are disabled:
• Ten assessed and a plan of action implemented
  80 percent of disabled homeless unaccompanied with an action plan receive benefits/entitlements
• 67% of those that receive benefits/entitlements access permanent housing

EMPLOYMENT AND INCOME STRATEGIES
1. Build an employer to employer network, led by private sector employer “champions”

2. Enhance homeless provider/other community based organizations linkages with the Wareham Career Center, including expanding access to bridging programs that get very low wage and unemployed people into skills training

3. Establish a network of federal, state and local community resources, both public and private, for disabled homeless adults that will connect these individuals to appropriate public supports and entitlements

4. Identify opportunities to help establish and enhance support services for child care, basic skills literacy and transportation for unaccompanied homeless adults
**PREVENTION**

**Prevention Goals, Benchmarks and Strategies**

**PREVENTION GOAL**
Initiate effective homelessness prevention activities to help high risk unaccompanied adults in Wareham avoid homelessness

**OVERALL BENCHMARKS (YEAR 1)**
There is currently no good baseline data regarding the current use of, need for, and resource gaps for prevention. During year one of implementation, there will be an emphasis on identifying baseline data to more effectively develop and refine benchmarks. Baseline data may include:

- Number of individuals served
- Number of those successfully referred to other services, as needed to support ongoing housing stability
- Number of those that retain housing six months after receiving funds/services

**PREVENTION STRATEGIES**

1. Develop a targeted, comprehensive community resource guide/yellow pages identifying available resources for homeless and at risk unaccompanied adults and educate the Wareham community regarding its availability and how to use it. Have it both in print and web formats. Update annually.

2. Implement early warning strategies to identify members of the community who are currently housed and at high risk of homelessness, including on such issues as behavioral problems, rent arrearage, utility arrearage. Use year one to identify baseline data.

3. Identify and increase resources for emergency funds to assist people who are housed and at high risk of falling into homelessness. Use year one to identify baseline data.

4. Identify intervention/case management resources to help stabilize the most complex cases/those housed and most at risk of homelessness. Use year one to identify baseline data.

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**VETERANS**

**Homeless Veterans Goals, Benchmarks and Strategies**

**VETERANS GOALS**
Homeless veterans (women and men that have served in the military) living in Wareham are identified and permanently housed. At risk veterans are prevented from falling into homelessness

**BENCHMARK**
All chronically homeless veterans in Wareham are permanently housed by the end of 2015

**VETERAN STRATEGIES**

1. Expand partnerships with the VA, Massachusetts Department of Veteran’s Services, and others to build the community’s capacity to serve its chronically homeless veterans in Wareham

2. Align Wareham’s planning to prevent and end veterans’ homelessness with the VA five year plan and the Massachusetts Plan to Prevent and End Homelessness among Veterans
Susan’s story

Susan (not her real name) is a relative veteran of homelessness, living two years in the Wareham woods. A lifelong resident, she recently was able to find her first job in several years, was able to find a room with a friend, and is determined not to go back to life on the outside. A mom with four kids who are now grown with families, Susan had lived in Onset for fifty years. She earned a living cleaning hotels and motels. She lost that job, existed on $90 a week in unemployment and eventually became homeless.

For over a year she lived homeless with her fiancé who is now in prison. This winter she was forced to survive alone and she realized that she hated this life. “I was alone and I was afraid.”

Susan acknowledges that she has grappled with alcoholism and when she first became homeless, that is what she did most days. “It’s a very depressing place to be. My first year outside I was very sick. I had pneumonia, bronchitis, a broken finger. I slept in the rain and sometimes slept inside of old shacks. Winter is brutal. It’s a constant fight to survive. How will you find blankets? How will you find food?”

One night this year she was at the Nights of Hospitality at the Church of the Nazarene and she realized that her life needed to change and she stopped drinking. She tells the story of seeing a shooting star as she was standing outside the church and marked that as a turning point. “I put the bottle down and I started praying.”

“I call this church (Church of the Nazarene) my home and the people who come here are my family. When I first walked through those doors (into the Nights of Hospitality at local churches) I was scared to death. I had never done anything like that in my life. But everyone made me feel comfortable. This year I was asked to make others feel comfortable. Show them around and help them understand the rules. I was happy to do that.

Someone did it for me.” She also notes that the organization Turning Point, which is housed at the church, has been an invaluable help to her.

Susan now has a job that she travels miles to on the bus every day .... arriving an hour early. It’s the most important thing in her life. It’s just part time right now but she is hoping for more hours and trying to find a second job. She is trying to save and get on her feet. Her main focus is on getting housing for herself. Right now she is cobbling shelter together – staying with different friends. She is interested in perhaps finding a roommate but she emphasizes it has to be someone who is focused and trying to work hard like she is now doing. “I know I have to do the work,” she acknowledges.

“I want a place where I can have privacy and find sanity. I want to have my own bureau and stop living out of a bag. A bathroom where I can take out my toothpaste and toothbrush and actually put them away. These are the things I miss most.”
Intervention Goal

Develop a well coordinated, integrated front door response that creates an agreed upon set of actions leading to permanent housing.
VIII. Implementation

Collective Impact

“Large-scale social change requires broad cross-sector coordination, yet the social sector remains focused on the isolated intervention of individual organizations.”
– Stanford Social Innovation Review

When the Wareham Leadership Council and members of the Working Group first convened in 2012, the problem of homelessness in Wareham seemed enormous and complex and the task of making a positive impact seemed daunting. Many of the organizations involved had already been working hard to improve the lives of homeless residents in our community. But they had been working alone for the most part, as previously described. And most felt frustrated that despite their best efforts, the problem only seemed to be growing.

The simple process of sitting around a table on a regular basis, and discussing the issue of homelessness in a proscribed and focused way, helped the group realize that each member could benefit greatly from the expertise and support of the other. We understand that collectively, we can begin to address and solve this community issue. In fact, the coalition building that occurred has already made a good start.

The notion of collective impact has other common principles, including a shared agenda and measurement systems, mutually reinforcing activities, continuous communication and backbone support organizations. When you review the Wareham Report, you see these are the tenets that form our framework — and create a blueprint that we expect will transform collective ideas and values into a shared success.

• We have a broad and growing group of agencies and institutions who are committed to improving how we serve homeless residents in our community. This group will formalize our collaboration with a Memorandum of Agreement in the fourth quarter of 2013.

• Together, we have developed a shared strategy that focuses on creating housing and needed wrap-around services in our community. We have attached concrete but achievable goals and benchmarks that will be coordinated by lead partners in our coalition and monitored by our Leadership Council.

• We have created a network for improved communication among all who serve the homeless in our community and continue to add both government, non-profit and private sector partners who will expand our expertise and capacity for innovation.

Our Report on Homelessness in Wareham is not a document meant to outline a problem and then be placed in a file. Instead, it is a strategy built for action that is coordinated, purposeful and designed to have a very positive impact on the Wareham community.
## Housing Goal

Unaccompanied homeless adults are able to access appropriate and affordable permanent housing

### Recommendations for Action

<table>
<thead>
<tr>
<th>Number of homeless individuals moved into permanent housing</th>
</tr>
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</table>

### Measure

- **1.** Expand opportunities to access existing rental units.
  - Build a landlord/property management/realtor consortium to increase access to rental units
  - Identify ways that landlords will be more willing to open units to this population.

  *For example, creating a housing rehabilitation fund and building partnerships with housing rehabilitation resources to repair tenant damages to rental units*

- **2.** Develop a housing production plan to help insure unaccompanied homeless adults have access to housing in new housing projects.

  *Affordable housing development plans include representatives of the Wareham Report implementation team. Wareham Report housing strategies are included in planning documents*

- **3.** Provide necessary wrap around services for those unaccompanied homeless adults moving into permanent housing.

  *The memorandum of Agreement among and between the members of the Wareham Front Door Initiative documents wrap around services to be provided and agencies/organizations responsible for delivering those services*

- **4.** Secure private/public housing subsidies necessary

  *Subsidies accessed*
and access the wrap around services they may need to stabilize in and maintain their housing

**Benchmarks**

30 unaccompanied homeless adults move into permanent housing with appropriate wrap around services in the next 5 years:

**Measure Year 1:** Move 6 frequent users of Nights of Hospitality into permanent housing with wrap around services they need to stabilize and maintain housing

**Measure Year 2:** Move 6 frequent users of Nights of Hospitality into permanent housing with wrap around services they need to stabilize and maintain housing

75% of overall housing goal met through existing housing in first 2 years of implementation

A plan of action is in place that identifies strategies to engage and retain landlords, property managers, and realtors that is developed through consortium meetings. 10 unaccompanied homeless adults in Wareham access appropriate newly developed housing over the next 5 years, including congregate and scattered site.

Achieve a housing stability of 80% after one year of housing

30 subsidies awarded over next 5 years

**Lead Agency**

**Working Committee**

**Stakeholders**

CEDA

Cape Cod Canal Region Chamber of Commerce

Father Bill's and Mainspring

Wareham Housing Authority

South Shore Housing
### Intervention Goal

Develop a well coordinated, integrated front door response that creates an agreed upon set of action trajectory to permanent housing

<table>
<thead>
<tr>
<th>Recommendations for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Execute a Memorandum of Agreement (MOA) with Wareham area organizations and agencies, including appropriate town departments. MOA to establish roles and responsibilities for implementation of the Wareham Front Door Intervention Initiative.</td>
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<tr>
<td>2. Prioritize opportunities to co-locate front door resources, as appropriate, to help provide “one stop shopping” experience for unaccompanied homeless adults.</td>
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<tr>
<td>3. Establish a range of emergency housing options for those that fall into homelessness/are currently homeless until permanent housing is accessed.</td>
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<tr>
<td>4. Integrate medical and behavioral health resources, including resources for management of complex cases.</td>
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<tr>
<td>5. Identify an appropriate universal assessment/screening tool and utilize across all agencies, organizations and institutions that are part of the MOA.</td>
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<tr>
<td>6. Identify a lead agency/host that can help enhance the community’s capacity to gather/collate data and use aggregate data to inform decision making about resource needs and resource allocation.</td>
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<tr>
<td>7. Identify gaps in resources and partnerships/collaborations and implement strategies to access those resources for the Wareham community.</td>
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<tr>
<td>Measure</td>
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<tr>
<td>------------------------------------------------------------------------</td>
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<tr>
<td>1. Eligible individuals approved for Mass Health</td>
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<td>2. Eligible individuals approved for Food Stamps</td>
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<tr>
<td>3. Eligible individuals approved for income supports such as:</td>
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<tr>
<td>• Supplemental Social Security (SSI)</td>
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<td>• Social Security Disability Income (SSDI)</td>
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<tr>
<td>• VA benefits</td>
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<tr>
<td>4. Case management support provided, as appropriate</td>
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<tr>
<td>5. Establish baseline data to refine measures and results</td>
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<tr>
<td>MOA in place</td>
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<tr>
<td>Implementation Working Group identifies co-location opportunities</td>
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<tr>
<td>and creates plan to begin co-location activities</td>
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<tr>
<td>Emergency housing plan strategies recommendations developed by</td>
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<tr>
<td>Intervention Working Group</td>
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<tr>
<td>Strategies for integration included in MOA</td>
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<tr>
<td>Implementation Working Group approves screening tool</td>
</tr>
<tr>
<td>• Agency identified and incorporated into Implementation Working Group</td>
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<tr>
<td>• Key data needs and reporting needs identified</td>
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<tr>
<td>Implementation Leadership Council and Working Group identify and</td>
</tr>
<tr>
<td>outreach</td>
</tr>
</tbody>
</table>

**Lead Agencies**
- Southcoast Health System
- Bayview Associates

**Stakeholders**
- Eliot Community Human Services
- Evergreen House
- Wareham Area Clergy Association
- Turning Point
- Wareham District Court
- Wareham Police Department
- Father Bill’s and Mainspring
- MA Department of Mental Health
## Income and Employment Goals

1. **Establish a network of community resources, both public and private, that will assess unaccompanied homeless women and men to determine their employability and create a plan of action that will lead to employment.**

### Recommendations for Action

<table>
<thead>
<tr>
<th>1. Establish an employer to employer network led by private sector champions that will lead to enhanced employment and training opportunities for unaccompanied homeless adults.</th>
<th>Number of currently homeless unaccompanied adults employed over next five years</th>
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<tbody>
<tr>
<td>Percentage who maintain employment for 1 year</td>
<td></td>
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<tr>
<td>Percentage who access permanent housing within 6 months of employment</td>
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</tbody>
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<tr>
<th>2. Enhance homeless provider/other community based organizations linkages with the Wareham Career Center, including expanding access to bridging programs that get very low wage and unemployed people into skills training.</th>
<th>Number of disabled, unaccompanied homeless adults assessed for entitlements/benefits and action plan implemented</th>
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<tbody>
<tr>
<td>Percentage that are successful in accessing benefits/entitlements</td>
<td></td>
</tr>
<tr>
<td>Percentage moving into permanent housing within six months of accessing benefits/entitlements</td>
<td></td>
</tr>
</tbody>
</table>

| 3. Establish a network of federal, state, and local community resources, both public and private, for disabled homeless adults that will connect these individuals to appropriate public supports and entitlements. |

| 4. Identify opportunities to help establish and enhance support services for child care, basic skills literacy and transportation for unaccompanied homeless adults. |

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Note: The number in the image seems to be incorrect or not clearly associated with the text. The focus is on the structured format providing recommendations and measures for income and employment goals.
2. Establish a network of federal, state, and local community resources, both public and private, for disabled unaccompanied homeless adults that will lead to successful application for public supports/entitlements in a timely manner

**Benchmarks**

- Three employed per year
- 67% retain employment for six months
- 67% access permanent housing within six months
- 10 per year
- 80% receive benefits/entitlements
- 67% access permanent housing

**Lead Agencies**
- Work Inc.
- Bayview Associates

**Stakeholders**
- Wareham Career Center
- Cape Cod Canal Region Chamber of Commerce
- Father Bill’s and Mainspring
# Prevention Goal

**Initiate effective homelessness prevention activities to help high risk unaccompanied adults in Ware**

<table>
<thead>
<tr>
<th>Recommendations for Action</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Develop a targeted, comprehensive community resource guide/yellow pages identifying available resources for homeless and at risk unaccompanied adults and educate community re: its availability/how to use. Have print and web availability. Update annually.</td>
<td>Number of individuals served</td>
</tr>
<tr>
<td></td>
<td>Number of those successfully referred to other services, as needed to support ongoing housing stability</td>
</tr>
<tr>
<td></td>
<td>Number of those that retain housing 6 months after receiving funds/services</td>
</tr>
<tr>
<td>2. Implement early warning strategies to identify members of the community who are currently housed and at high risk of homelessness, including on such issues as behavioral problems, rent arrearage, utility arrearage.</td>
<td>• Date available</td>
</tr>
<tr>
<td></td>
<td>• Public communication strategy</td>
</tr>
<tr>
<td>3. Identify base line data re: current resources/resources gap for emergency funds to prevent people who are currently housed and at high risk falling into homelessness.</td>
<td>• Number of high risk unaccompanied adults identified as high risk of homelessness</td>
</tr>
<tr>
<td></td>
<td>• Percentage of those at risk who receive services who retain their housing</td>
</tr>
<tr>
<td>4. Identify intervention/case management resources to help stabilize the most complex cases/those housed and most at risk of homelessness.</td>
<td>• Current utilization and utilization categories</td>
</tr>
<tr>
<td></td>
<td>• Resources gap</td>
</tr>
<tr>
<td></td>
<td>• Number of requests for case management resource</td>
</tr>
<tr>
<td></td>
<td>• Number receiving case management that retain housing</td>
</tr>
</tbody>
</table>
### Benchmarks

Use year one to identify baseline data to establish benchmarks

**For year one:** 80% of those receiving 1 or more services retain their housing for 6 months

- Resource guide/yellow pages available in print by Second Quarter, 2014
- Annual updates completed

- Need baseline data to determine benchmarks — use year one to identify baseline
- 80% of those at risk who receive services retain their housing

Need baseline data to identify unmet need and resource gap — use year one to identify baseline

- Need baseline data to determine benchmark — use year one to identify baseline
- 80% receiving this service retain housing for six months

### Lead Agencies

- Turning Point
- Southcoast Health System

### Stakeholders

- Father Bill’s and Mainspring
- Community Resources Network
- Bayview Associates
- Gleason Family YMCA
Peter’s story

“I am the riches to rags story”

Peter, age 59, is a highly skilled and industrious worker. He has been a mechanic, carpenter, landscaper, even an engineer on a tugboat. At one time, he was the head of the services department at a Volvo dealership in Boston. He owned his own business installing and maintaining pool covers, renovated two houses, raised four kids and put them through college.

“I was able to provide for my family.”

He took over the pool business from another owner in 1995 and was successful. He enjoyed transforming his property in Plymouth from a small cottage to a large home with koi ponds and a waterfall. He bought himself a Harley Davidson and a new truck.

“I was living the good life and keeping all of those balls in the air.”

Things started to unravel in about 2008 with both his own health and the health of the economy. Pools are a luxury for most people so demand for the pool cover business took a dive. Peter had a heart attack and discovered he has serious cardiovascular disease that needed treatment that includes expensive medication.

“I had high bills and before you know it, you can’t stay up with it.” When you’re not making the money you have to start getting rid of things … motorcycle, truck. His wife left and then he lost the house. He had to liquidate his business, selling $16,000 worth of equipment for $1200. His precarious finances engendered a number of legal issues which he had no funds to resolve.

“What I had left was a small truck and about $9000 in savings. I thought I’d be okay. I had lots of skills and thought I could find a job.” He got an apartment in Onset. He met a woman, Brenda, who had been forced to leave her marriage and home and the two pooled their resources. Then he had a small stroke.

“You think that $9000 is a good cushion but it isn’t. It’s amazing how quickly it can disappear.”

The string of hard luck continued.

Peter and Brenda found some minimum wage work at a candy factory in Wareham which closed just a couple of months after they started. They had no health insurance and were paying around $800 a month for needed medication. They fell behind in their rent. And in January, they were evicted and became homeless.

“At first, we lived out of the truck. But then I had to take that off the road because I owed a mountain of excise tax and other bills. It’s all about the dollars.”

This winter’s Nights of Hospitality were literally a lifesaver. The couple found nightly shelter and learned of support services such as food stamps and bus passes. Most importantly, they discovered through assistance at Tobey Hospital that they were eligible for health insurance that covered their medications. Ironically, if they had been aware of that assistance before January they probably could have continued to afford the rent on their apartment.

Since the Nights of Hospitality ended in March, they have been living in a tent deep in the woods. They try to stay somewhat isolated and depend on each other. “There are a number of other homeless residents in the woods but we’re quiet and like to mind our own business.”

Peter is dressed in jeans and a t-shirt – one of three pairs that he owns and is able to launder just about once a month. He scratches a stubbly beard and continually pulls ticks off his body and lights them with a lighter. “You get so dirty out there constantly having to pick up sticks and rocks.”

“It’s easy to get off of the grid. But then it’s almost impossible to get back on. I have a job application in almost every place I can think of. But it’s hard to hunt for a job when you don’t know what your address will be from one week to the next. I have to think about and plan everything … what time will the bus take me to town hall to get food stamps, then to the grocery store and back to camp. What do I need to do to maintain the campsite. It’s a full-time job just trying to live.”

On their first night camping, which was late
On their first night camping, which was late March, the couple was too tired to set up the tent so they slept outside in their sleeping bags. The temperature dipped to 24 degrees and they awoke with frost-encrusted faces.

There are many other hardships. “It’s a rough life out here. We’re living with wild animals. It’s their home, not ours. And there are many nights we have woken up face to face with coyotes who are right outside of our tent.”

“People think that the cold is the roughest thing but the heat is a problem too. I have three heart stents and a short walk is a chore for me. To have to walk miles in the heat is almost impossible. It’s hard to get water to drink. We’re always carrying heavy backpacks with everything we might need for the day.”

Financial and legal tangles continue to grow. “It’s like picking apart a giant ball of threads. You start to unravel one and then another big knot blocks the way.” But right now, Peter can only focus on daily survival and taking the steps he needs to, as he calls it, “get back on the grid.”

His short term goals, besides finding a job, are to try to get to a doctor and schedule an important heart test that he needs.

Peter can’t imagine many more months of living in a tent with no address to call home. “I’m age 59 and I’m starting all over. It’s incredibly depressing. I lay in the tent and think, wow, what have I lost? People take a lot for granted and it’s the really simple things that I miss most … the smell of your own grass that you’ve just cut.”

“It all starts” he says, “with a room and a bed and some clean clothes.”

Editor’s note: Peter and Brenda have moved in separate directions and are in separate housing situations.
IX. Appendices

A. Acknowledgements ........................................................................ 37
B. Memorandum of Agreement ........................................................... 38
C. Opening Doors — The Federal Plan to Prevent and End Homelessness ......................................................................... 43
D. The Veteran’s Administration 5 Year Plan to Prevent and End Veteran’s Homelessness-6 Pillars ................................................... 47
E. Glossary of Terms .......................................................................... 49
A. Acknowledgements

We would like to extend our appreciation to the following individuals who brought their commitment, experienced, and intelligence to help craft the Report on Homelessness in Wareham

**Wareham Leadership Council on Homelessness**
Linda Burke, *AD Makepeace, Co-chair*
Jim Rattray, *Southcoast Health System*
Richard Stanley, *Wareham Police Department*
John Walcek, *Wareham Police Department*
Rose Berry, *Eastern Bank*
Mary Oliva, *Cape Cod Region Chamber of Commerce*
Stacy Coolidge, *TD Bank*
Brendan Ahearn, *TD Bank*
Tim Nelson, *Wareham Career Center*
Rev. David Shaw, *Emmanuel Church of Nazarene*
Dr. Barry Rabinovitch, *Town of Wareham School Department*
Tom Fitzpatrick, *Turning Point*
Representative Susan Gifford, *2nd Plymouth District*
Salvador Pina, *Wareham Community and Economic Development Authority*
Robert Louzan, *Wareham School Department*
Kerry Mello, *Southcoast Health System*

**Wareham Working Group on Homelessness**
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Kerry Mello, *Southcoast Health Systems, Co-Chair*
Linda Almeida, *Wareham District Court*
Harriet Beasley, *Office of the MA Commissioner of Probation*
Arthur Bence, *Bayview Associates*
Helen Casoli, *Women’s Aid of Wareham*
April Connelly, *Father Bill’s and MainSpring*
Tracy Cunningham, *Work, Inc.*
Kathy Facchini, *South Shore Housing*
Bruce Frazer, *MA State Department of Mental Health*
Corey Fuentes, *Evergreen House*
Sharon Furtado, *Southcoast Health System*
Peggy Hall, *Father Bill’s and MainSpring*
Karen Hamilton, *Wareham Community and Economic Development Authority*
Nancy Johnson, *Community Resources Network*
Cheryl Kennedy-Perez, *MA Bureau of Substance Abuse Services*
Paul Key, *Father Bill’s and MainSpring*
Lea McDonald, *Turning Point*
Tim Nelson, *Wareham Career Center*
Mary Oliva, *Cape Cod Chamber of Commerce*
Bob Powilatis
Suzanne Robbins, *Tobey Hospital Emergency Services*
Anthony Scarisciotti
Pam Sequeria, *Wareham Housing Authority*
Barbara Sullivan, *Wareham Boys and Girls Club*
Lt. John Walcek, *Wareham Police Department*
Joann Watson, *Gleason Family Y*
Colon Wright, *Wareham Area Clergy Association*

**Also to:**
Joe Finn, *President and Executive Director, Massachusetts Housing and Shelter Alliance*
Mary LeClair, *Hyannis, MA*
Estella Fritzinger, *Hyannis, MA*
B. Memorandum of Agreement

Memorandum of Agreement for Implementation of the Recommendations from The 2013 Report on Homelessness in Wareham

INTRODUCTION
The Wareham Leadership Council on Homelessness (Wareham Leadership Council) has led the development of recommendations to Prevent and End Homelessness in Wareham. The Wareham Leadership Council is responsible for providing oversight for implementation of the recommendations.

The Leadership Council recommendations identify a comprehensive set of Goals, Benchmarks and Actions to prevent and end homelessness among unaccompanied homeless adults and youth in Wareham. In order to successfully implement the organizations and agencies with the necessary expertise and resources to carry out the Action Steps and meet the Benchmarks have agreed to shift from an ad hoc response to a coordinated, integrated response. They believe this will allow the recommendations to be implemented in the most efficient and cost effective manner and will ensure the greatest opportunity for permanently housing homeless men and women and youth in Wareham.

This memorandum of Agreement (MOA) will serve as the organizing tool for this enhanced coordination and collaboration. It will outline:

1. The Wareham Recommendations Goals, Benchmarks, and Actions
2. The organizations in the community/area that have the expertise and resources to help execute the actions/strategies
3. The responsibilities each organization agrees to assume to help ensure the successful implementation of the recommendations
4. An agreement regarding research, data collection, reporting

The MOA will be signed by the Co-chairs of the Wareham Leadership Council and the designated representative of each of the agencies/organizations that will serve as Conveners for the four areas of focus in the recommendations in the Wareham Report as a pledge of good faith and mutual commitment. The role of the Conveners is to coordinate the engagement of appropriate partners to execute the priority activities to meet the benchmarks in the Wareham Report.

I. HOUSING: GOALS, BENCHMARKS AND ACTION STEPS

The following organizations agree to serve as the Conveners for the implementation of the Housing goals:

Working Committee Co-chairs

HOUSING GOAL
Unaccompanied homeless adults are able to access appropriate housing that is affordable and access the wrap around services they may need to stabilize in and maintain their housing. Thirty unaccompanied homeless adults will move into permanent housing with appropriate wrap around services in the next five years.

BENCHMARK YEAR ONE
Move six frequent users of the Nights of Hospitality into permanent housing with wrap around services they need to stabilize and maintain their housing.

BENCHMARK YEAR TWO
Move six frequent users of the Nights of Hospitality into permanent housing with wrap around services they need to stabilize and maintain housing.
ACTIONS AND BENCHMARKS

1. Expand opportunities to access existing rental units:
   • Build a landlord/property management/realtor consortium to increase access to rental units and identify ways landlords will be more willing to open units to this population. The role of the consortium will include identifying funds to repair damaged properties.
   • Identifying community contacts to help mediate housing related problems.
   • Access housing rehabilitation resources to help bring vacant/foreclosed units online.
   • Build a housing data base to track and access available rental housing.
   • Establishing a partnership with appropriate agencies to access housing subsidies, including HUD VASH vouchers.

BENCHMARK: Seventy five percent of the overall housing goal will be met through existing housing in the first two years of implementation.

2. Expand opportunities to help drive development of and access to units in new housing projects.
   • Participate in and partner with local and regional affordable housing planning initiatives.
   • Develop collaborations with non-profit housing development agencies to identify possible new project opportunities for unaccompanied homeless adults and youth.
   • Engage Town Government departments, CEDA, and the Wareham Housing Authority, to determine available resources for new housing production opportunities.
   • Establish a partnership with appropriate agencies to access housing subsidies, including HUD VASH vouchers.

BENCHMARK: Ten unaccompanied homeless adults and youth in Wareham will access appropriate, newly developed housing over the next five years, including congregate and scattered site housing.

3. Identify, through the Wareham Front Door Intervention Initiative, partners/resources for housing stabilization and support services (wrap around services).

BENCHMARK: 80% of those housed retain permanent housing for at least 6 months.

4. Secure private/public housing supports/subsidies to meet housing goals.

BENCHMARK: Thirty housing subsidies will be awarded over next five years to unaccompanied homeless adults and youth in Wareham.

II. INTERVENTION: GOALS, BENCHMARKS AND ACTION STEPS

The following organizations agree to serve as the Conveners for the implementation of the Intervention goals:

Southcoast Health System
Bayview Associates

INTERVENTION GOAL

Through the Memorandum of Agreement (MOA) the community develops a coordinated, integrated Wareham Front Door Intervention Initiative.

ACTIONS AND BENCHMARKS

1. Execute a Memorandum of Agreement (MOA) that establishes the Wareham Front Door Intervention Initiative. This “front door” intervention strategy with community institutions, agencies, and organizations will provide opportunities to begin intervention activities with unaccompanied adults. It will include agreements to integrate medical and behavioral health resources, including resources for management of complex cases.

BENCHMARK: MOA in place by 4th Quarter 2013.
2. Prioritize opportunities to co-locate front door resources, as appropriate, to help provide a “one stop shopping” experience for unaccompanied homeless adults.

**BENCHMARK:** Recommendations for initial co-location opportunities in place by 3rd Quarter 2014.

3. Establish a range of emergency housing options for those that fall into homelessness/are currently homeless until permanent housing is accessed.

**BENCHMARK:** Emergency housing strategy recommendations developed by 3rd Quarter 2014.

4. Identify an appropriate universal assessment/screening tool and utilize across all agencies, organizations, and institutions that are part of the MOA.

**BENCHMARK:** Use of assessment/screening tool in use by MOA signers by 3rd Quarter 2014.

5. Identify a lead agency/host that can help enhance the community’s capacity to gather/collate data and use aggregate data to inform decision making about resource needs and resource allocation.

**BENCHMARK:** Initial report prepared by lead agency/host by 1st Quarter 2014.

6. Identify gaps in resources and partnerships/collaborations and implement strategies to access those resources for the Wareham community.

**BENCHMARK:** Recommendations that identifies resource gaps and potential new resources to meet gap is completed by 4th Quarter 2014.

### III. **EMPLOYMENT AND INCOME GOALS**

The following organizations agree to serve as the **Conveners** for the implementation of the Employment and Income Goals:

**Work, Inc.**

**Bayview Associates**

**EMPLOYMENT AND INCOME GOALS**

- Establish a network of community resources, both public and private, that will assess unaccompanied homeless women and men to determine their employability and create a plan of action that will lead to employment.
- Establish a network of federal, state, and local community resources, both public and private, for disabled unaccompanied homeless adults that will lead to successful application for public supports/entitlements in a timely manner.

**BENCHMARKS**

*For those assessed as employable:*

- Employ three currently homeless unaccompanied adults per year for the next 5 years
- Demonstrate a 67 percent job stabilization rate at 6 months
- 67 percent access permanent housing within 6 months of employment

*For those that are disabled:*

- Ten assessed and a plan of action implemented
- 80 percent of disabled homeless adults with an action plan receive benefits/entitlements
  - 67% of those that receive benefits/entitlements access permanent housing

**ACTIONS AND BENCHMARKS**

1. Establish a network of community resources, both public and private, that will assess unaccompanied homeless women and men to determine their employability and create a plan of action that will lead to employment.

   - Network established and begins coordinated assessment to determine employability of those on community-wide list. 80% assessed by 4th Quarter 2013.
   - Employ three currently homeless unaccompanied adults per year for the next 5 years.
   - Demonstrate a 67 percent job stabilization rate at 6 months.
2. Establish an employer to employer network led by private sector champions that will lead to enhanced employment and training opportunities for unaccompanied homeless adults.

**BENCHMARK:** Employer to employer network holds first meeting by end of 1st Quarter 2014.

3. Enhance homeless provider/other community based organizations linkages with the Wareham Career Center, including expanding access to bridging programs that get very low wage and unemployed people into skills training.

**BENCHMARK:** Needs to be developed.

4. Establish a network of federal, state, and local community resources, both public and private, for disabled homeless adults that will connect these individuals to appropriate public supports and entitlements.

**BENCHMARKS**
1. Ten assessed and a plan of action implemented by end of 4th Quarter 2013.
2. 80% of disabled homeless adults with an action plan receive benefits/entitlements.
   - 67% of those that receive benefits/entitlements access permanent housing.

5. Identify opportunities to help establish and enhance support services for child care, basic skills literacy, and transportation for unaccompanied homeless adults.

**BENCHMARK:** Need to be developed.

### PREVENTION GOAL
Initiate effective homelessness prevention activities to help high risk unaccompanied adults in Wareham avoid homelessness.

**BENCHMARKS (YEAR 1):** Currently there is no good baseline data regarding the current use of, need for, and resource gaps for prevention. During year one of the plan implementation, there will be an emphasis on identifying baseline data to more effectively develop and refine benchmarks. Baseline data may include:
- Number of individuals served
- Number of those successfully referred to other services, as needed to support ongoing housing stability
- Number of those that retain housing six months after receiving funds/services

### ACTIONS AND BENCHMARKS
1. Develop a targeted, comprehensive community resource guide/yellow pages identifying available resources for homeless and at risk unaccompanied adults and educate the Wareham community regarding its availability and how to use it. Have it both in print and web formats. Update annually.

   **BENCHMARK:** Distribution/public information plan in place by 1st Quarter 2014. Resource guide distributed by 2nd Quarter 2014.

2. Implement early warning strategies to identify members of the community who are currently housed and at high risk of homelessness, including on such issues as behavioral problems, rent arrearage, utility arrearage. Use year one to identify baseline data.

   **BENCHMARK:** 80 percent of those at risk who receive services retain housing for 6 months.

3. Identify resources and increase resources for emergency funds to assist people who are housed and at high risk falling into homelessness. Use year one to identify baseline data.

   **BENCHMARK:** Identify existing funding for prevention activities and develop data about current needs/utilization to develop baseline information to identify possible prevention funding gap.
BENCHMARK: Identify unmet financial resource need.

4. Identify intervention/case management resources to help stabilize the most complex cases/those housed and most at risk of homelessness. Use year one to identify baseline data.

BENCHMARK: 80 percent of those at risk who receive services retain housing for 6 months.

5. Identify opportunities to help establish and enhance support services for child care, basic skills literacy, and transportation for unaccompanied homeless adults.

BENCHMARK: Need to be developed.

Convening Agencies’ Representatives Signatures:

Agency ________________________________ Date __________________
Representative Signature ________________________________

Agency ________________________________ Date __________________
Representative Signature ________________________________

Agency ________________________________ Date __________________
Representative Signature ________________________________

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Representative Signature ________________________________

Agency ________________________________ Date __________________
Representative Signature ________________________________

Revised 10/20/2013
C. Opening Doors — The Federal Plan to Prevent and End Homelessness

Federal Strategic Plan to Prevent and End Homelessness :: 2010

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

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

### THEME: INCREASE LEADERSHIP, COLLABORATION, AND CIVIC ENGAGEMENT

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>STRATEGIES</th>
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<tbody>
<tr>
<td>ONE</td>
<td>Provide and promote collaborative leadership at all levels of government and across all sectors to inspire and energize Americans to commit to preventing and ending homelessness</td>
</tr>
<tr>
<td></td>
<td>a. Educate the public on the scope, causes, and costs of homelessness, the Federal Strategic Plan to Prevent and End Homelessness, and the reasons for taking action.</td>
</tr>
<tr>
<td></td>
<td>b. Engage state, local, and tribal leaders in a renewed commitment to prevent and end homelessness in their communities.</td>
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<tr>
<td></td>
<td>c. Get states and localities to update and implement plans to end homelessness to reflect local conditions and the comprehensiveness of this Federal Plan, as well as to develop mechanisms for effective implementation.</td>
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<td></td>
<td>d. Involve citizens—including people with firsthand experience with homelessness—and the private sector—businesses, nonprofits, faith-based organizations, foundations, and volunteers—in efforts to prevent and end homelessness.</td>
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<tr>
<td></td>
<td>e. Test, model, and learn more about interagency collaboration.</td>
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<tr>
<td></td>
<td>f. Seek opportunities to reward communities that are collaborating to make significant progress preventing and ending homelessness.</td>
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<td>g. Review budget processes to determine avenues for recognizing savings across partners resulting from interventions to prevent and end homelessness.</td>
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<td></td>
<td>h. Seek opportunities for engaging Congressional committees collaboratively on issues related to preventing and ending homelessness.</td>
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### THEME: INCREASE ACCESS TO STABLE AND AFFORDABLE HOUSING

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>STRATEGIES</th>
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<tbody>
<tr>
<td>THREE</td>
<td>Provide affordable housing to people experiencing or most at risk of homelessness</td>
</tr>
<tr>
<td></td>
<td>a. Support rental housing subsidies through federal, state, local, and private resources to individuals and families experiencing or most at risk of homelessness. The rent subsidies should be structured so that households pay no more than 30 percent of their income for housing.</td>
</tr>
<tr>
<td></td>
<td>b. Expand the supply of affordable rental homes where they are most needed through federal, state, and local efforts. To provide affordable housing to people experiencing or most at risk of homelessness, rental subsidies should better target households earning significantly less than 30 percent of the Area Median Income so that residents pay no more than 30 percent of their income for housing. The supply will need to include units that are accessible to persons with mobility needs.</td>
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<tr>
<td></td>
<td>c. Improve access to federally-funded housing assistance by eliminating administrative barriers and encouraging prioritization of people experiencing or most at risk of homelessness.</td>
</tr>
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<td></td>
<td>d. Increase service-enriched housing by co-locating or connecting services with affordable housing.</td>
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</table>
### INCREASE ACCESS TO STABLE AND AFFORDABLE HOUSING (cont’d)

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>STRATEGIES</th>
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</thead>
<tbody>
<tr>
<td>FOUR</td>
<td>Provide permanent supportive housing to prevent and end chronic homelessness</td>
</tr>
<tr>
<td>a.</td>
<td>Improve access to and use of supportive housing by encouraging prioritization and targeting for people who need this level of support to prevent or escape homelessness.</td>
</tr>
<tr>
<td>b.</td>
<td>Create protocols and consider incentives to help people who have achieved stability in supportive housing—who no longer need and desire to live there—to move into affordable housing to free units for others who need it.</td>
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<tr>
<td>c.</td>
<td>Expand the supply of permanent supportive housing, in partnership with state and local governments and the private sector.</td>
</tr>
<tr>
<td>d.</td>
<td>Assess options for more coordinated, sustainable, dependable sources of supportive housing service funding. This should include consideration of incentives for local communities to develop supportive housing and how best to coordinate service funding with housing funding.</td>
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### THEME: INCREASE ECONOMIC SECURITY

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<tr>
<th>OBJECTIVE</th>
<th>STRATEGIES</th>
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</thead>
<tbody>
<tr>
<td>FIVE</td>
<td>Increase meaningful and sustainable employment for people experiencing or most at risk of homelessness</td>
</tr>
<tr>
<td>a.</td>
<td>Collaborate with economic recovery and jobs programs to ensure that job development and training strategies focus attention on people who are experiencing or most at risk of homelessness. Care, child support, domestic violence, criminal justice history, disabling conditions, and age appropriateness.</td>
</tr>
<tr>
<td>b.</td>
<td>Review federal program policies, procedures, and regulations to identify educational, administrative, or regulatory mechanisms that could be used to improve access to work support.</td>
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<tr>
<td>c.</td>
<td>Develop and disseminate best practices on helping people with histories of homelessness and barriers to employment enter the workforce, including strategies that take into consideration transportation, child care, child support, domestic violence, criminal justice history, disabling conditions, and age appropriateness.</td>
</tr>
<tr>
<td>d.</td>
<td>Improve coordination and integration of employment programs with homelessness assistance programs, victim assistance programs, and housing and permanent supportive housing programs.</td>
</tr>
<tr>
<td>e.</td>
<td>Increase opportunities for work and support recovery for Veterans with barriers to employment, especially Veterans returning from active duty, Veterans with disabilities, and Veterans in permanent supportive housing.</td>
</tr>
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### SIX Improve access to mainstream programs and services to reduce people’s financial vulnerability to homelessness

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>STRATEGIES</th>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>Document, disseminate, and promote the use of best practices in expedited access to income and work supports for people experiencing or at risk of homelessness. This includes improved outreach to homeless assistance providers and collaborations across government and with community nonprofits, online consolidated application processing, and electronic submission. Consider lessons learned from the SSI/SSDI Outreach, Access and Recovery Initiative (SOAR), and the Homeless Outreach and Projects and Evaluation Initiative (HOPE).</td>
</tr>
<tr>
<td>b.</td>
<td>Review federal program policies, procedures, and regulations to identify administrative or regulatory mechanisms that could be used to remove barriers and improve access to income supports.</td>
</tr>
<tr>
<td>c.</td>
<td>Enhance public information, targeted communications, and a national toll-free homeless call center to ensure that all Veterans and their families know they can obtain homelessness prevention assistance from the VA or other places in their community.</td>
</tr>
<tr>
<td>d.</td>
<td>Create clear pathways to greater financial independence. Collaborate to review program eligibility and termination criteria across the range of programs which people experiencing or at risk of homelessness may access. 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.</td>
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<tr>
<td>e.</td>
<td>Prepare for Medicaid expansion to effectively enroll people who experience or are most at risk of experiencing homelessness. This should include systems to reach out to, engage, and enroll newly eligible people in health care insurance benefits.</td>
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### THEME: IMPROVE HEALTH AND STABILITY

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<tr>
<th>OBJECTIVE</th>
<th>STRATEGIES</th>
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<tbody>
<tr>
<td>SEVEN</td>
<td>Integrate primary and behavioral health care services with homeless assistance programs and housing to reduce people’s vulnerability to and the impacts of homelessness</td>
</tr>
<tr>
<td>a.</td>
<td>Encourage partnerships between housing providers and health and behavioral health care providers to co-locate or coordinate health, behavioral health, safety, and wellness services with housing and create better resources for providers to connect patients to housing resources.</td>
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<tr>
<td>b.</td>
<td>Build upon successful service delivery models to provide services in the homes of people who have experienced homelessness including using Medicaid-funded Assertive Community Treatment teams for those with behavioral health needs.</td>
</tr>
<tr>
<td>c.</td>
<td>Seek opportunities to establish and evaluate the effectiveness of a “medical home” model to provide integrated care for medical and behavioral health, and to improve health and reduce health care costs in communities with the largest number of people experiencing homelessness.</td>
</tr>
<tr>
<td>d.</td>
<td>Seek opportunities to establish medical respite programs in communities with the largest number of people experiencing homelessness to allow hospitals to discharge people experiencing homelessness with complex health needs to medical respite programs that will help them transition to supportive housing.</td>
</tr>
<tr>
<td>e.</td>
<td>Increase availability of behavioral health services, including community mental health centers, to people experiencing or at risk of homelessness.</td>
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<tr>
<td>f.</td>
<td>Improve access to child and family services that improve early child development, educational stability, youth development, and quality of life for families—including expectant families, children, and youth experiencing or most at risk of homelessness.</td>
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### THEME: IMPROVE HEALTH AND STABILITY (cont’d)

<table>
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<tr>
<th>OBJECTIVE</th>
<th>STRATEGIES</th>
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|**EIGHT**<br>Advance health and housing stability for youth aging out of systems such as foster care and juvenile justice | a. Improve discharge planning from foster care and juvenile justice to connect youth to education, housing, health and behavioral health support, income supports, and health coverage prior to discharge.  

b. Review federal program policies, procedures, and regulations to identify administrative or regulatory mechanisms that could be used to remove barriers and improve access to stable health care, housing, and housing supports for youth.  

c. Promote targeted outreach strategies to identify youth experiencing homelessness who are most likely to end up in an emergency room, hospital, jail, or prison, and connect them to the housing and support they need. |
|**NINE**<br>Advance health and housing stability for people experiencing homelessness who have frequent contact with hospitals and criminal justice | a. Improve discharge planning from hospitals, VA medical centers, psychiatric facilities, jails, and prisons to connect people to housing, health and behavioral health support, income and work supports, and health coverage prior to discharge.  

b. Promote targeted outreach strategies to identify people experiencing homelessness who are most likely to end up in an emergency room, hospital, jail, or prison, and connect them to the housing and support they need.  

c. Increase the number of jail diversion courts at the state and local levels that are linked to housing and support, including those specifically for Veterans, those experiencing homelessness, or people with mental health issues or drug abuse problems.  

d. Reduce criminalization of homelessness by defining constructive approaches to street homelessness and considering incentives to urge cities to adopt these practices. |

### THEME: RETOOL THE HOMELESS CRISIS RESPONSE SYSTEM

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<tr>
<th>OBJECTIVE</th>
<th>STRATEGIES</th>
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|**TEN**<br>Transform homeless services to crisis response systems that prevent homelessness and rapidly return people who experience homelessness to stable housing | a. Develop and promote best practices for crisis response programs and increase their adoption by agencies receiving federal funds.  

b. Determine opportunities to utilize mainstream resources to provide housing stabilization assistance to clients who are homeless or at high risk of homelessness.  

c. Develop implementation strategies for the HEARTH Act—especially the new Emergency Solutions Grant—that sustain best practices learned from the Homelessness Prevention and Rapid Re-Housing Program and the Rapid Re-Housing Demonstration.  

d. Ensure continuity in the provision of homeless prevention and rapid re-housing services to families, youth, and individuals—including Veterans and their families—through HUD’s Homelessness Prevention and Rapid Re-Housing Program.  

e. Ensure that homelessness prevention and rapid re-housing strategies are coordinated with Education for Homeless Children and Youth, and incorporated within federal place-based strategies to improve neighborhoods and schools, including Promise Neighborhoods and Choice Neighborhoods. |
The Five Year Plan to End Homelessness Among Veterans: Actions for FY 2010
VA Five-Year Comprehensive Plan to Eliminate Homelessness Among Veterans

VA will expand existing programs and develop new initiatives to prevent Veterans from entering into homelessness and to treat those who are currently homeless.

- Increase the number and variety of housing options including permanent, transitional, contracted, community-operated, and VA-operated
- Provide more supportive services through partnerships to prevent homelessness, improve employability, and increase independent living for Veterans
- Improve access to VA and community based mental health, substance abuse, and support services

These program enhancements will provide housing, VA health care and benefits, gainful employment and residential stability to more than 500,000 Veterans

The provision of safe housing is fundamental. However, programming must include:

- Mental health stabilization
- Substance use disorder treatment services
- Enhancement of independent living skills
- Vocational and employment services
- Assistance with permanent housing searches and placement

VA’s Strategy to Eliminate Homelessness Among Veterans

VA’s philosophy of “no wrong door” means that all Veterans seeking to prevent or get out of homelessness must have easy access to programs and services. Any door a Veteran comes to – at a Medical Center, a Regional Office, or a Community Organization – must offer them assistance.

Built upon 6 strategic pillars:

- Outreach/Education,
- Treatment,
- Prevention,
- Housing/Supportive Services,
- Income/Employment/Benefits and
- Community Partnerships.
E. Glossary of Terms

**Affordable Housing:** Housing, either ownership or rental, for which a household will pay no more than 30 percent of its gross annual income.

**Assertive Community Treatment (ACT) teams:** Multidisciplinary teams that provide case management, crisis intervention, medication monitoring, social support, assistance with everyday living needs, access to medical care and employment assistance for people with mental illness.

**Case Management:** Overall coordination of an individual’s use of services, which may include medical and mental health services, substance use services, and vocational training and employment. Although the definition of case management varies with local requirements and staff roles, a case manager often assumes responsibilities for outreach, advocacy, and referral on behalf of individual clients.

**Chronic Homelessness:** Description of an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years, as defined by the U.S. Department of Housing and Urban Development (HUD).

**Community Development Block Grant (CDBG):** A flexible program that provides communities with resources to address a wide range of community development needs and provides annual grants on a formula basis to local government and states.

**Consolidated Plan:** A long-term housing and community development plan developed by state and local governments and approved by HUD. It contains information on homeless populations.

**Continuum of Care (CoC):** The Continuum of Care was established by HUD to oversee community planning around homelessness. Continua work together to define needs, plan strategies and prioritize funding for supportive housing services.

**Co-occurring Disorders:** The presence of two or more disabling conditions such as mental illness, substance abuse, HIV/AIDS and others.

**Crisis Response System:** In housing and homelessness, this generally refers to a network of programs including emergency homeless shelters, disaster relief, stimulus funded short term assistance and in some cases, transitional housing.

**Discharge Planning:** A significant percentage of homeless individuals report recent incarceration, hospitalization, residential health care, foster care or placement at treatment facilities. Discharge planning provides the consumer with a plan to live after a facility “discharge.” Successful discharge planning starts long before the end of an individual’s stay in such an institution and includes connection to housing and supportive services to gain and maintain stability. Integrated services both inside and outside institutions are necessary to assure effective discharge planning.

**Doubled up:** A situation when people join a family or friend’s household but are not on lease, mortgage, etc. and then are subsequently removed from this arrangement or lose it without legal filing and become homeless.

**Dually-diagnosed:** See Co-occurring Disorders.

**Engagement:** Efforts to develop a relationship between a service system’s staff members and clients. Such efforts are characterized by purposeful strategies and intentional interventions designed to connect the client with needed services and to maintain that connection.

**Harm Reduction:** A set of practical strategies that reduce the negative consequences associated with drug use, including safer use, managed use, and non-punitive abstinence. These strategies meet drug users “where they’re at,” addressing conditions and motivations of drug use along with the use itself. This approach fosters an environment where individuals can openly discuss substance use without fear of judgment or reprisal, and does not condone or condemn drug use.

**HEARTH:** Homelessness Emergency Assistance and Rapid Transition to Housing Act - The federal re-authorization of McKinney Vento, the 25 year old legislation funding homeless services and programs. HEARTH will make areas such as education and health care as it related to people experiencing homelessness and those at imminent risk.

**Homeless Outreach Team:** A service model that applies a multi-disciplinary Assertive Community Treatment team incorporating clinical, paraprofessional and peer staff. This team’s philosophy is to “meet people where they’re at” and to support them in a self-directed manner to reach stability, wellness and recovery. Services are made available according to the needs of the client and must include food, medications, clothing, peer support, clinical services, employment and housing.
Homeless Persons: Persons or families lacking a fixed regular and adequate nighttime residence and are residing in a place not meant for human habitation (e.g., on the streets) or in an emergency homeless shelter, or in transitional housing for the homeless, or are being evicted within a week from a private dwelling, or are being discharged within a week from an institution in which they have been a resident for more than 30 consecutive days, or are fleeing a domestic violence situation; in the case of children and youth, it also includes sharing the housing of other persons due to loss of housing, economic hardship or a similar reason or awaiting foster care placement.

Homeless Management Information System (HMIS): A community-wide database congressionally mandated for all programs funded through the Department of Housing and Urban Development (HUD) homeless assistance grants. The system collects demographic data on consumers as well as information on service needs and usage.

Housing for People with AIDS/HIV (HOPWA): HOPWA is a federally funded program to provide states and localities with resources for housing assistance and services for low-income persons living with HIV/AIDS and their families. The program provides formula-based grants to eligible metropolitan areas and States based on the number of reported cases of AIDS in the area.

Housing First: A model that moves homeless participants from the streets immediately into permanent housing with the provision of supportive treatment services to the extent of need.

Housing and Urban Development (HUD): Federal Agency whose mission is to increase homeownership, support community development and increase access to affordable housing free from discrimination.

HUD HRE: The Homelessness Resource Exchange is your online one-stop shop for information and resources on assisting people who are homeless or at risk of becoming homeless.

HUD VASH: Veterans Administration Supportive Housing program funded through HUD.

Literally Homeless: An individual, household or family who is living in emergency shelter, domestic violence shelter, transitional housing, or place not meant for human habitation such as a car, abandoned building or outdoors.

Master Leasing: A legal contract in which a third party (other than the actual tenant) enters into a lease agreement and is responsible for tenant selection and rental payments.

McKinney-Vento Homeless Assistance Act: This 1987 federal legislation established programs and funding to serve homeless people.

McKinney-Vento Liaison: School district staff who serve as point people to assure that federal law relating to the education of homeless children is followed in schools.

National Alliance to End Homelessness (NAEH): An organization that seeks to mobilize the non-profit, public and private sectors of society in an alliance to end homelessness.

NHCHC: The National Health Care for the Homeless (HCH) Council is a home for those who work to improve the health of homeless people and who seek housing, health care, and adequate incomes for everyone. In the National HCH Council, agencies and individuals, clinicians and advocates, homeless people and housed people come together for mutual support and learning opportunities, and to advance the cause of human rights. http://www.nhchc.org/

NLCHP: National Law Center on Homelessness and Poverty. The mission of NLCHP is to prevent and end homelessness by serving as the legal arm of the nationwide movement to end homelessness. http://www.nlchp.org/about_us.cfm

“No Wrong Door”: Homeless individuals often cite a fragmented service system with poor communication between mainstream and non-profit providers as a major obstacle as they attempt to access needed services. “No wrong door” refers to an approach in which caregivers share common information and tools that can break down unnecessary barriers and allow clients to gain access to all needed service regardless of whose door they come to first.

Opening Doors: The federal strategic plan to prevent and end homelessness approved in 2010.

Outreach: A process and set of activities aimed at identifying and engaging people to connect them with the services they need. In our context, outreach programs assist people living without permanent homes and connect them with a range of services.
**Prevention:** Assistance that is targeted to persons facing housing instability who are at risk of losing their housing and require at least temporary assistance to prevent this or to move to another home.

**Rapid Re-Housing:** Approach that focuses on moving individuals and families who are living in shelters as quickly as possible into appropriate housing using many of the same tools used by prevention strategies.

**Re-Entry Housing:** Transitional and supportive housing options for people coming out of prison and jail.

**Safety Net:** Services targeted to needs of at-risk individuals and families.

**Scattered-Site Housing:** Dwelling units in apartments or homes spread throughout a neighborhood or community that is designated for specific populations, usually accompanied by supportive services.

**Section 8:** Section 8 of the U.S. Housing and Community Development Act of 1974. Title 42, Chapter 8, Section 1437f. In the 1970s, when studies showed that the low income housing crisis was no longer substandard housing, but the high percentage of income spent on housing, Congress passed the Housing and Community Development Act of 1974, further amending the U.S. Housing Act of 1937 to create the Section 8 Program.

**Service Plans:** Case managers in shelter, transitional and supportive housing programs typically create a comprehensive service plan for clients including goals and objectives, which will assist them in addressing barriers and maintaining stability. A service plan should be comprehensive and include an array of needs, multiple service providers, short- and long-term goals, timelines and specific expectations of both the client and caregivers.

**Shelter Plus Care:** Funded under McKinney Vento Homeless Assistance Programs, Shelter Plus Care provides vouchers to units of State Government or Public Housing Authorities for permanent subsidies targeted to chronically homeless individuals and families. This program does not fund supportive services.

**Single Room Occupancy (SRO) Building:** A type of building that offers residents a single, furnished room, often with shared bathroom and kitchen facilities.

**Single-Site Housing:** A housing program wherein all living units are located in a single building or complex.

**Social Security Disability Insurance (SSDI):** Program that provides benefits to disabled or blind individuals who are insured by workers’ contributions to the Social Security trust fund.

**S.O.A.R.:** Social Security Outreach Access and Recovery Program.

**Social Services Block Grant (SSBG):** Social Services Block Grant (SSBG) funds are to enable each State to furnish social services best suited to meet the needs of the individuals residing within the State. Such services may be, but are not limited to: protective services for children or adults, special services to persons with disabilities, health-related services, foster care for children or adults, substance abuse, housing, transitional living, employment services or any other social services found necessary by the State for its population. Services funded by the SSBG are directed at one or more of five goals: achieving or maintaining economic self-support to prevent, reduce or eliminate dependency; achieving or maintaining self-sufficiency, including reduction or prevention of dependency; preventing or remedying neglect, abuse or exploitation of children and adults unable to protect their own interest, or preserving, rehabilitating or reuniting families; preventing or reducing inappropriate institutional care by providing for community-based care, home-based care or other forms of less intensive care; and/or securing referral or admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions.

**Stages of Change:** A model of understanding change in human behavior, especially as it relates to substance use. Related interventions are based upon the individual’s state of awareness and desire to change behavior at a given point in time. It includes five stages: pre-contemplation, contemplation, preparation, action, maintenance and relapse.

**Stakeholders:** Individuals who have a vested interest in the outcomes or the process of a particular endeavor.

**Supplemental Security Income Program (SSI):** Cash assistance payments to aged, blind and disabled people (including children under age 18) who have limited income and resources.
Supportive Housing: Supportive housing combines rental housing with individualized health, support and employment services. People living in supportive housing have their own apartments, enter into rental agreements and pay their own rent, just as in other rental housing. The difference is that they can access, at their option, support services – such as the help of a case manager, help in building independent living skills, and connections to community treatment and employment services – designed to address their individual needs.

Ten Year Plans to End Homelessness: These local and statewide campaigns in regions across the country seek to engage all sectors of society in a revitalized effort to confront and overcome homelessness in America. Each Ten Year Plan to End Homelessness provides solutions and options for communities committed to ending homelessness rather than just managing it.

Transitional Housing: Housing meant to help homeless people access permanent housing, usually within two years.

Under-Employed: Employed at a level not consistent with education or past work experience.

USICH: The mission of the United States Interagency Council on Homelessness is to “coordinate the Federal response to homelessness and to create a national partnership at every level of government and with the private sector to reduce and end homelessness in the nation while maximizing the effectiveness of the Federal Government in contributing to the end of homelessness.” They issued a strategic plan to end homelessness, Opening Doors, in 2010.

Vulnerability Index: According to Common Ground who is advancing this model across the country, the Vulnerability Index is a tool for identifying and prioritizing the street homeless population for housing according to the fragility of their health. It is a practical application of research into the causes of death of homeless individuals living on the street conducted by Boston’s Healthcare for the Homeless organization, led by Dr. Jim O’Connell. The Boston research identified the specific health conditions that cause homeless individuals to be most at risk for dying on the street.

Workforce Investment Act (WIA): The federal legislation which funds one-stop career centers and job training and search programs funded through local Workforce Development Boards.

Work Incentives: Special rules that make it possible for people with disabilities to work and continue to receive certain federal or state benefits. People receiving SSDI or SSI can work and still receive monthly payments and Medicare or Medicaid. Social Security calls these rules “work incentives.” HUD also encourages eligible tenants with disabilities living in HUD-assisted housing to work by disallowing earned income in calculating monthly rents for certain programs.

Wrap-around Services: A wraparound service model coordinates all caregiver services, often through a team case management or shared service plan system, bringing mainstream and non-profit providers together for case conferencing and problem solving.