

CONTINUUM OF CARE

1. **Continuum of Care Accomplishments**

The Akron/Summit County Continuum of Care represents a broad collaborative effort of homeless service providers, supportive service providers, hospitals, The University of Akron, banks and foundations. Homeless providers are working together to further enhance a system providing emergency, transitional, and permanent shelter to homeless individuals, families, and special needs populations. The Continuum of Care system provides the homeless with not only shelter, but supportive services to equip them with the tools necessary to assist them in overcoming this difficult period in their lives. The Continuum of Care Committee has been meeting on a regular basis to further evaluate the needs in the community and to identify existing gaps.

The Akron/Barberton/Summit County accomplishments during this period include the development and implementation of several critical housing projects. These projects meet a need in the community, providing permanent supportive and transitional housing for the homeless. Agencies worked together to provide essential services to the homeless and those at risk of becoming homeless through the Continuum of Care approach. Through this process we have been able to coordinate and educate our members of all existing and new programs available within the community to meet the needs of the homeless.

Additional Continuum of Care accomplishment Include:

- Comprehensive gaps analysis
- Development of monitoring tool for renewals
- Collaboration for health care for additional resources to homeless

The Committee has made significant progress toward the development of a Homeless Management Information System (HMIS). The Continuum of Care Committee posted a request for proposal to select an agency to implement and operate the HMIS. Info Line was selected to be the lead agency of Summit County's HMIS. Info Line staff along with the HMIS committee examined various software solutions and selected Bowman's Service Point. This system will track the utilization of services to address homelessness. HMIS system will provide a mechanism to manage data, share information, and track the movement of homeless persons.

2. **Planning Process for Developing a Continuum of Care Strategy**

a. **Identify the lead entity for the Continuum of Care planning process**

The City of Akron is the lead entity for the Continuum of Care planning process. The size of the community enables substantial resources to be directed toward homeless needs. The Continuum of Care system can quickly respond to the needs of the homeless. The community is small enough so that development work can be readily initiated and accomplished and turf issues are kept at a minimum. The City of Akron has established a strong working relationship with homeless and supportive service providers. The City encourages providers to expand services in an effort to reach all homeless populations. The City administers the Community Development Block Grant Program, the HOME Program, and the Emergency Shelter Grant Program.

Each year the City sponsors an Annual Needs Meeting to identify the needs of the Community in preparation for the Consolidated Plan; homeless service providers and supportive service agencies are invited to the meeting. The meeting includes a special segment on the needs of the homeless population.

The following were identified by the Community as needs for the homeless population at the 2002 Needs Meeting held in August 2001.

- ◆ more funding needed to assist the homeless
- ◆ assistance needed for child care for women with children who are working and living in shelters
- ◆ chemical dependence programs and rehabilitation
- ◆ safety net for welfare recipients
- ◆ more efficiency apartments
- ◆ more homeless prevention programs
- ◆ expand utilization of Community Development Block Grant (CDBG) and HOME Investment Partnership (HOME) to include group homes and providers

The City of Akron is the recipient of Emergency Shelter Grant Program funds. The City sponsored a meeting for all shelter and homeless providers and solicited proposals from all interested parties for the use of these funds. The City supports activities such as rehabilitation, operating, and essential services for emergency shelters and transitional housing. The City of Akron incorporated a policy that all agencies seeking support and funding from the City for CDBG, HOME, and ESG funds must actively participate in the Continuum of Care process.

b. **Describe your Community's Continuum of Care planning process**

The Akron/Summit County Community has developed a Continuum of Care for the homeless. In an effort to be more inclusive of the planning process, the Committee annually examines membership and invites new organizations to join the Continuum of Care process.

The Continuum of Care Committee includes three subcommittees: The Core Subcommittee, the Supportive Services Subcommittee, and the Gaps & Priorities Subcommittee to implement the Continuum of Care Strategy. The subcommittees meet monthly to discuss the Continuum of Care Strategy and issues pertaining to the homeless. The Continuum of Care Community Committee meets quarterly (January, April, July, and October) to share information and update the other subcommittees on the progress of implementing the plan. All subcommittee members are invited to the quarterly meetings.

Over 100 individuals are involved in the Continuum of Care process. These individuals will continue to be involved in the development and evolution of the Continuum of Care process. Representatives of homeless housing providers, supportive service agencies and funding organizations are part of various councils, networks and committees in the community. These committees meet on a regular basis to discuss various homeless issues, policies, and other homeless related issues.

The Core Subcommittee, meeting on the fourth Wednesday of each month, was formed to assist in the development and implementation of the Continuum of Care strategy. The Core Subcommittee, composed of chairs of subcommittees and other interested members of the committee such as ACCESS and the Housing Network, serves as the monitor of the Continuum of Care process. The committee verifies that the goals and action steps of the Continuum of Care strategy are being met. This group provides overall direction and leadership. Speakers are invited to provide information and educate the committee of the latest programs and developments taking place throughout the community. Recommendations to improve the Continuum of Care process are discussed and recommended to the full membership.

The Gaps and Priorities Subcommittee is responsible for tracking gaps, prioritizing services and making recommendations regarding priorities to the full membership. The group is responsible for observing national and local trends, changes in the homeless environment that may impact the Continuum of Care Process and on-site monitoring visits. Foundations, lenders, The University of Akron, the Alcohol Drug Addiction and Mental Health Board, United Way, the City of Barberton, and the Summit County Department of Planning have been invited to participate on this subcommittee. This group meets on the fourth Thursday of each month.

The Supportive Services Subcommittee coordinates information regarding supportive services gaps. The group makes recommendations to strengthen relationships between housing and services. Agencies invited to participate on this subcommittee include housing and service providers representing various subpopulations listed in the Continuum of Care. This Subcommittee discusses the coordination of services, shares agency information, deals with problems regarding service delivery, works to develop a community wide plan, oversees the refinement of a vision/strategy focusing on the homeless, reviews components of the system currently in place, and is striving to develop a data gathering/tracking system. This group meets on the second Wednesday of each month.

The Gaps and Priorities Subcommittee formed a Review and Ranking Subcommittee made up of individuals who were involved in the Continuum of Care but are not individual project applicants. The Review and Ranking Subcommittee represents a range of governmental, housing and homeless advocacy groups, social service providers, and hospitals who participate in the Continuum of Care. The role of the Review and Ranking Subcommittee is to review the Continuum of Care Pre-Applications, determine if there is a need for each project and offer recommendations in improving the projects. The Subcommittee also reviews the final Continuum of Care project applications. After final review, applications are ranked and presented to the Continuum of Care Community Committee for final approval.

Each applicant agency individually presented their project to the Review and Ranking Subcommittee. This provided the subcommittee an opportunity to ask questions regarding the project and offer suggestions for improvement of the application.

The Review and Ranking Subcommittee developed a Review and Ranking Criteria Worksheet and a Review and Ranking Criteria Guide to assist in the review and ranking process and to ensure fairness.

The HMIS Subcommittee will meet monthly to develop program policies and standards, evaluation criteria, and reporting systems. The Subcommittee will be chaired by Info Line, Inc. and include key stakeholders of the Continuum of Care.

- c. List the dates and main topics of Continuum of Care planning meetings held since June 2001, which should demonstrate that these meetings (both plenary and committee) are: (1) regularly scheduled; (2) held year round; and (3) not solely focused on developing an application in response to the NOFA.

Committee	Topics	Dates	Future Dates
1. Continuum of Care Community Committee	<ul style="list-style-type: none"> - Subcommittee report - Continuum of Care Strategy - HMIS System 	July 17, 2001 October 16, 2001 January 15, 2002 April 16, 2002 June 11, 2002	Quarterly 3 rd Tuesday
2. Core Subcommittee	<ul style="list-style-type: none"> - Exploring HMIS Systems - Identifying Lead Agency - Reviewed Software Program - Visited and/or Contacted Other Communities - Continuum of Care Strategy 	June 27, 2001 July 25, 2001 August 27, 2001 September 26, 2001 October 17, 2001 November 26, 2001 January 22, 2002 February 27, 2002 March 27, 2002 April 11, 2002 April 26, 2002 May 9, 2002 May 22, 2002	Monthly 4 th Wednesday
3. Gaps and Priorities Subcommittee	<ul style="list-style-type: none"> - Reviewed Consolidated Plans from the City of Akron, City of Barberton, and Summit County - Point-in-Time-Count - Gaps Analysis - United Way Needs Assessment - ADM Housing Plan - Continuum of Care Strategy - Updated Continuum of Care Pre-application Form - Developed Agency On-site Monitoring Report 	June 21, 2001 July 19, 2001 August 23, 2001 September 27, 2001 October 12, 2001 November 15, 2001 January 17, 2002 February 21, 2002 March 21, 2002 April 25, 2002 May 16, 2002	Monthly 3 rd Thursday
4. Supportive Services Subcommittee	<ul style="list-style-type: none"> - Reviewed goals and action steps identified in Continuum of Care strategy - Update Resource Manual - Work with University to coordinate research efforts on the homeless - Information sharing - Continuum of Care Strategy - Increase and Broaden Participation on Committee 	June 13, 2001 July 11, 2001 August 7, 2001 September 12, 2001 October 10, 2001 November 14, 2001 December 12, 2001 January 19, 2002 February 13, 2002 March 13, 2002 April 10, 2002 May 1, 2002 May 8, 2002	Monthly 2 nd Wednesday
5. Review and Ranking Subcommittee	<ul style="list-style-type: none"> - Develop Review and Ranking Criteria - Application Presentation - Application Review 	April 8, 2002 May 20, 2002 May 29, 2002 June 6, 2002	April – June 2003

3. **Continuum of Care Goals and System Under Development**

a. **Our Community's Strategy for Ending Chronic Homelessness**

Summit County has taken on the initiative to end homelessness in ten years. The Continuum of Care sub-committees have focused on goals and activities that will move us closer to that goal. The following strategies have been initiated to assist us in this undertaking.

The Review and Ranking Committee has developed an evaluation tool to make sure that agencies that are seeking renewals meet their objectives, that their programs are meeting the needs of the homeless, that they are operating in a fiscally responsible manner, and continue to meet a critical need in the community.

The Core Committee has an initiative under way to obtain better representation from homeless and formerly homeless individuals to evaluate housing and services that are in place for the homeless. Plans are to arrange for focus groups to look further into the system of prevention, assessment, and the housing choices from the perspective of those who are using services. The goal of these focus groups will be to evaluate services, assess their accessibility, and to hear recommendations about ways to be more effective in delivering the most critical services.

The Core Committee has met with the Summit County Department of Planning and received a commitment for county involvement in the Continuum of Care planning process. It is also a goal to obtain more meaningful representation from the Department of Job and Family Services as a way to further assess and refine the connection of those mainstream resources to those who are both homeless and at-risk of homelessness. This County department processes State TANF, Medicaid, social service and job training funds. The committee is also attempting to get more buy-in from local businesses, having initiated contact with the Greater Akron Chamber, Rotary Club, and the Christian Businessmen's Association to educate them about the Continuum of Care in Summit County. The goal is to help businesses recognize the benefits of participation to the business community.

The Core Committee has initiated a plan to educate foundations about the Continuum of Care. The ultimate aim is to encourage the local foundations to make participation in the Continuum of Care a condition of funding for housing and supportive services that serve homeless persons. This will encourage agencies that are not dependent on HUD funding to participate in planning efforts through the Summit County Continuum of Care.

The Core Committee has focused on the issue of affordable housing in this community and has seen an increase in participation from Community Housing Development Organizations. Discussions about the potential loss of affordable, supportive housing due to expiring project-based Section 8 contracts is seen as critical to preventing future homelessness, and new development is seen as a way to keep our housing stock stable.

The Gaps & Priorities Committee has identified the need to strengthen the outreach component in this community, especially as it relates to persons who are chronic substance abusers. A discussion has been initiated with the Alcohol, Drug Addiction, and Mental Health Services Board, which is in charge of planning and funding mental health and substance abuse services in Summit County. It is hoped that this gap in service can be collaboratively addressed.

The Gaps & Priorities Committee has also looked at strengthening the Point in Time Count by recruiting volunteers from service agencies to accompany outreach workers as this count is conducted in the next year. Plans are also being made to involve law enforcement in outreach efforts and the point in time count. An outreach team in this community provides regular in-

service training to educate police about outreach efforts and to share information about ways to coordinate outreach efforts.

The Supportive Services will create an interdisciplinary team to problem solve difficult cases. The group has identified a need to facilitate community wide training for case managers to education them on programs available within the community.

The City of Akron has asked members of the Continuum of Care to list each agency's plans to address chronic homelessness so that efforts can be coordinated to maximize the efficient use of mainstream resources, and can be incorporated into the Continuum's goals and action steps.

The Continuum of Care has endorsed the development of housing modeled after Safe Havens, which targets the mentally ill homeless, and is intended to impact the chronic homeless persons with mental illness who are not receiving mental health services. One of these projects received funding in last year's Continuum of Care application, and another Safe Havens program is in this year's application.

Remaining Obstacles to Obtaining this Goal

The Continuum of Care has examined obstacles to achieving the goal of ending chronic homelessness, and has been attempting to put action steps in place to address these issues.

The Gaps & Priorities subcommittee has identified lack of outreach to the chronic substance abuser as an obstacle. To overcome this obstacle, a philosophical change will need to take place that will recognize the value of harm reduction versus the voluntary treatment philosophy. This change will be difficult in Akron, the birthplace of Alcoholics Anonymous. The State of Ohio Drug Alcohol and Drug Addiction Services does not fund activities that are meant to engage persons who are on the street who are resistive to treatment, so the outreach component needs to be funded locally. As a result, harm reduction activities are not provided in this community to work with persons who need alcohol or drug treatment, but are not willing to seek help voluntarily.

The inability of this community to effectively track the utilization of services to address homelessness is another obstacle. It is anticipated that the initiation of the HMIS will provide more clarity about services that are utilized and those that are not. The Continuum of Care Committees can then evaluate the reasons for under-utilization of some services, and initiate a plan to meet identified gaps.

Finally, the community has acknowledged that there is no systematic way to assess individuals and refer them for mainstream services, although each agency has procedures in place. The agencies rely on informal communication to avoid duplication of efforts, and see this as an area for further focus. It is anticipated that the HMIS will provide information that will help to determine where efforts are unnecessarily duplicated, and processes can be developed to systematically refer persons for services.

3. Your community's Continuum of Care goals and system under development.

The key to developing a successful Continuum of Care is to continually assess the existing system and identify shortcomings or gaps, then establish a set of goals and carry out a series of action steps intended to address these shortcomings or gaps. With this in mind, please provide the following:

- b. Describe your specific future-oriented goals, and specific action steps for each to be undertaken over the next 18 months in carrying out a strategy to end **chronic** homelessness in your community. Specify the entity that has the lead responsibility for success or failure in carrying out each step and provide specific target dates for completion. Be sure to include among your goals/action steps each of the plans for housing and services mentioned in section 3.d. Please use the following format: (Add to as needed for additional goals.)

Goal: End Chronic Homelessness ("What" are you trying to accomplish)	Action Steps ("How" are you to go about accomplishing it)	Responsible Person/Organization ("Who" is responsible for accomplishing it)	Target Dates (mo/yr it will be accomplished)
<p>Goal A: Develop a strategic plan to end chronic homelessness in Akron / Summit County</p>	<ol style="list-style-type: none"> Identify key stakeholders to lead the effort in developing a strategic plan. Identify and engage funders 	<p>Core Sub – Committee Core Sub – Committee</p>	<p>December, 2002 June, 2003</p>
<p>Goal B: Provide more effective case management to the chronically homeless</p>	<ol style="list-style-type: none"> Create interdisciplinary team to problem solve difficult cases Facilitate community wide training for case managers Facilitate community service coordination among homeless providers Investigate the feasibility of expanding case management services to underserved populations Conduct Community Education Seminars throughout the County to educate in dealing with chronically homeless population 	<p>Supportive Services Sub – Committee Supportive Services Sub – Committee Supportive Services Sub – Committee Supportive Services Sub – Committee Core Sub – Committee</p>	<p>December, 2003 March, 2003 Ongoing December, 2003 Ongoing</p>
<p>Goal C: Increase outreach and engagement services to the substance-abusing chronically homeless population.</p>	<ol style="list-style-type: none"> Identify agencies that are providing outreach services Facilitate collaboration between agencies that provide outreach to the chronically homeless Educate the community about alternative treatment models Investigate funding for outreach services to the substance abusing population Encourage appropriate agencies to apply for funding Work with Community Health Resources to develop medical services to homeless 	<p>Supportive Services Sub – Committee Supportive Services Sub – Committee Supportive Services Sub – Committee Supportive Services Sub – Committee Core Sub – Committee Core Sub – Committee</p>	<p>December, 2003 Ongoing Ongoing December, 2003 December, 2003 December, 2003</p>
<p>Goal D: Encourage the development of a system that helps to ensure monthly housing payments</p>	<ol style="list-style-type: none"> Conduct needs assessment of payeeship and ancillary services (i.e. consumer credit counseling, budgeting skills education, etc.) Identify providers of payeeship and ancillary services Encourage existing agencies who provide services to homeless population to 	<p>Supportive Services Sub – Committee Supportive Services Sub – Committee Supportive Services Sub – Committee</p>	<p>June, 2003 March, 2003 Ongoing</p>

	expand current services to underserved populations		
Goal E: Increase the supply of Permanent Supportive Housing for Chronically Homeless	<ol style="list-style-type: none"> 1. Evaluate the availability of Permanent Supportive Housing for chronically homeless population 2. Encourage the development of housing for persons with chronically mental health issue ineligible for rental housing due to rental history 3. Encourage the development of housing for persons with substance abuse issues 	Gaps and Analysis Sub – Committee Gaps and Analysis Sub – Committee Gaps and Analysis Sub – Committee	January, 2003 May, 2003 May, 2003

- c. In addition to the goals for ending chronic homelessness, please describe any other goals and specific action steps that your community has developed to address homelessness. Specify the entity that has lead responsibility for carrying out each step and specific target date for completion. Please use the following format.

Homeless Prevention

Goal: Other Homelessness	Action Steps	Responsible Person/Organization	Target Dates
Establish a prevention safety net that ensures that all agencies have Accurate knowledge of homeless prevention resources.	1. Participate in updating community resource manuals (Street Card, Project Rise, Housing Network). Identify all Information and Referral programs and provide them with updated information of where they can refer potential clients.	Supportive Services Sub – Committee	December, 2002
	2. Facilitate the coordination and collaboration of homeless programs and agencies providing homeless prevention services.	Supportive Services Sub – Committee	September, 2002
	3. Work to improve the link of the Department of Job and Family Services Prevention, Retention, and Contingency Program (and the subcontracting organizations) to homeless providers to prevent the reoccurrence of homelessness and improve system for accessing assistance for hard services (rent, utility, mortgage deposits).	Core Sub - Committee	Ongoing
	4. Work with The University of Akron to update their research study and evaluate the results for recidivism among the homeless population.	Supportive Services Sub – Committee	Completed
	5. Agencies will have access to HMIS.	HMIS Sub - Committee	August, 2003

Outreach

Goal: Other Homelessness	Action Steps	Responsible Person/Organization	Target Dates
Facilitate community service coordination among homeless providers.	1. Continue the development of a network among providers to discuss referrals and to meet the needs of the homeless.	Supportive Services Sub – Committee	Ongoing
	2. Conduct annual focus groups with homeless to identify gaps and barriers within the Community	Continuum of Care	September, 2002
	3. Create a Community education program related to homelessness.	Supportive Services Sub – Committee	Ongoing
	4. Collect and disseminate information to learn of emerging services in the community to address problems related to homelessness.	Supportive Services Sub – Committee	Ongoing
	5. The Housing Network will develop a Web page with a section devoted to the Continuum of Care.	Supportive Services Sub – Committee	Completed
	6. Collaborate with new resources that will provide medical services for the homeless.	Core Sub - Committee	Completed

	7. Assess and evaluate gaps in outreach efforts.	Supportive Services Sub – Committee	Ongoing
	8. Incorporate Best Practices in the Continuum of Care System and evaluate their applicability within Summit County.	Core Sub - Committee	

Emergency Shelter and Transitional Housing

Goal: Other Homelessness	Action Steps	Responsible Person/Organization	Target Dates
Emergency shelter and transitional housing systems will meet the changing needs of this community.	1. Establish networks and linkages between emergency shelters / transitional housing and supportive services agencies	Supportive Services Sub – Committee	March 2002
	2. Evaluate the availability of emergency shelters / transitional housing and determine need for additional shelters.	Gaps and Priorities Sub – Committee	December, 2001
	3. Develop a quality assurance plan to ensure the quality of facility and services located at emergency shelters and transitional housing.	Gaps and Priorities Sub – Committee	December, 2001
	4. Encourage the development of follow-up supportive services to the formerly homeless as clients leave the shelter.	Supportive Services Sub – Committee	December, 2002
	5. Incorporate Best Practices in the Continuum of Care System and evaluate their applicability within the community.	Core Sub - Committee	Ongoing
	6. Meet the needs of specialized subpopulations through the utilization of mainstream resources (ex. Child Care Now)	Supportive Services Sub – Committee	June, 2002
	7. Advocate for priority placement of homeless persons with the Akron Metropolitan Housing Authority. The Continuum of Care Committee will review and comment on AMHA's five-year plan.	Core Sub - Committee	Ongoing

Permanent Housing and Permanent Supportive Housing

Goal: Other Homelessness	Action Steps	Responsible Person/Organization	Target Dates
Retain the supply of existing permanent supportive housing units (Section 8) and negate the negative impact of the loss of existing permanent supportive housing units to meet community needs.	1. Work with Community Housing Development Organizations (CHDO's) and Community Development Corporations (CDC's) to identify development opportunities for low/moderate income housing.	Core Sub - Committee	Ongoing
	2. Share information about available funding opportunities for housing programs and services for the homeless.	Core Sub - Committee	Ongoing
	3. Investigate possible relationships between homeless providers, developers, and community stakeholders for the development of housing.	Core Sub - Committee	Ongoing
	4. Evaluate the availability of permanent housing and permanent supportive housing and determine need for additional housing.	Gaps and Priorities Sub – Committee	December, 2001
	5. Develop a quality assurance plan to ensure the quality of facility and services located at permanent supportive housing facilities.	Gaps and Priorities Sub – Committee	December, 2001
	6. Advocacy for continuation of Section 8 vouchers. Work to ensure no erosion of number of permanent supportive housing units.	Core Sub - Committee	Ongoing

	7. Incorporate Best Practices in the Continuum of Care System and evaluate their applicability within the community.	Core Sub - Committee	Ongoing
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Supportive Services

Goal: Other Homelessness	Action Steps	Responsible Person/Organization	Target Dates
Assure the availability and coordination of supportive services.	1. Evaluate the availability of supportive services, and identify gaps to determine the need for additional supportive services.	Supportive Services Sub – Committee	December, 2002
	2. Develop a quality assurance plan to ensure the quality of supportive services available in the community.	Gaps & Priorities Sub – Committee	December, 2002
	3. Incorporate Best Practices in the Continuum of Care System and evaluate their applicability within the community.	Core Sub - Committee	Ongoing

Homeless Management Information System (HMIS)

Goal: Other Homelessness	Action Steps	Responsible Person/Organization	Target Dates
The Continuum of Care Committee will have an HMIS system that will assist in tracking services for the homeless and chronically homeless.	1. Explore and evaluate other HMIS systems in the country.	HMIS Sub - Committee	Completed
	2. Identify and assess the changing needs of the Akron/Summit County Community and select an appropriate HMIS	HMIS Sub - Committee	Completed
	3. Analyze and make recommendations to Continuum of Care Committee based on the data collected, the utilization of existing services and facilities.	HMIS Sub - Committee	Completed
	4. Establish HMIS Advisory Committee	HMIS Sub - Committee	December, 2002
	5. Hire a Project Administrator	Info Line	July, 2003

- d. Using the format below, describe the fundamental service components of your Continuum of Care system currently in place, and any additional services being planned. Describe how homeless persons access or receive assistance under each component other than *Outreach*. **(Although you may require multiple pages to respond to this item, your response will count as only one page towards the 25-page limitation.)**

Fundamental Components in CoC System (Service Activity)

Component: Prevention

Services in place: Please arrange by category (e.g., rental/mortgage assistance), being sure to identify the service provider.

The Akron/Summit County/Barberton community has in place a Continuum of Care that addresses the immediate needs of families and individuals at risk of becoming homeless. The Continuum of Care Committee and the Housing Network developed a Resource Manual. The Manual was disseminated to all agencies who have contact with homeless and at-risk individuals to identify all social service and housing programs available in the community and the specific qualifications for each program. Community organizations have developed other resource manuals to assist individuals and families in locating appropriate services. Street Cards, or “quick guides” that explain available services to people on the street, have been made available at local agencies and libraries.

Additional homeless prevention services are available as follows:

Rental/Mortgage Assistance

Adult Emergency Assistance Benefits	Dept. of Job and Family Services
AIDS Holistic Services Program	Fair Housing Contact Service
Akron/Summit Community Action Agency	FEMA – Hunger Shelter Program
Area Agency on Aging	Good Neighbors
Area Churches	Mature Services
Barberton Area Community Ministries	Open M
Battered Women’s Shelter	Red Cross
Catholic Social Services	The Salvation Army
Community AIDS Network	Twinsburg Community Center
Community Support Services (CSS)	Veteran’s Service Commission

Utility/Food Assistance

AIDS Holistic Services Program	East Akron Community House
Akron Pregnancy Services	FEMA – Hunger Shelter Program
Akron/Summit Community Action Agency	Good Neighbors
Area churches pantry program	Haven of Rest
Barberton Area Community Ministries	Open M
Battered Women’s Shelter	Red Cross
Catholic Social Services	Summit County Children Services
Community AIDS Network	Twinsburg Community Center
Dept. of Job and Family Services	Veteran’s Service Commission

Case Management/Housing Placement

ACCESS, Inc.	H.M. Life Opportunity Services
AIDS Holistic Services Program	Harvest Home
Battered Women’s Shelter	Haven of Rest
Catholic Social Services	Legacy III, Inc.
Community AIDS Network	Summit County Board of Mental Retardation
Community Health Center	Summit County Children Services
Community Support Services	The Salvation Army
Family and Children First Cluster	Veteran’s Administration (Akron Clinic)
Goodwill Industries	Youth Empowerment Project

Legal Services/ Diversion

Battered Women's Shelter
Community Legal Aid
Crisis Intervention Team (CIT)
Drug Court
Family Violence Court

Felony Drug Court
Fair Housing Advocates Assn
Fair Housing Contact Service
Mental Health Court

Respite Services

Akron Area Agency on Aging
MR/DD

Safe Landing
Tarry House Respite

Services planned:

The Continuum of Care community will continue its efforts to connect potentially homeless families and individuals to appropriate programs and services. Efforts will be made to maintain and update Community Resource Manuals (Project Rise – providing educational and enrichment services to homeless children, Street Card, the Housing Network, etc.) on a regular basis.

The City of Akron Police Department, in partnership with the Alcohol, Drug Addiction, and Mental Health Services Board, has created a Crisis Intervention Team (CIT) modeled after a program in Memphis. The CIT unit works with mental health providers to sensitize the Akron Police to issues surrounding mental illness and homelessness. CIT officers complete an intensive week-long training session focusing on responding to mental illness and complex issues related to persons experiencing mental illness. Officers attempt to work with mentally ill persons and guide them toward treatment. This program will be offered to other police departments in Summit and surrounding counties on a semi-annual basis. The Community Support Services Outreach team plans to meet on a regular basis with other police departments in the County.

In addition, the CSS Outreach Team will conduct Community Education seminars throughout the County to raise awareness in dealing with the seriously mentally ill homeless population. Target audiences include community organizations such as businesses, churches, hotels, emergency rooms, libraries, and shelters.

How persons access/receive assistance:

Persons and families facing a potential homeless episode may contact any of the above agencies for financial assistance or referral to other agencies. Case managers from organizations involved in the Continuum of Care are a source for referrals. Persons may contact Info-Line, the local information and referral agency and a participant in the Continuum of Care, whose central purpose is to provide access to social services delivery system to people in need. Infoline maintains a computerized resource directory of over 1,000 agencies and services for the Summit County area. It is the sole source for comprehensive information and referral, senior information and referral in the County. Infoline works closely with housing and supportive service organizations throughout the county, including those agencies involved in the Continuum of Care, to ensure callers receive accurate, up-to-date information about the organizations which can meet their unique needs. Infoline, Inc. recently published the "Where to Turn Directory – A Directory of Health and Human Services for Akron, Summit County and the surrounding region". This directory identifies the 300 – 400 most commonly used agencies, programs and services in Summit County and is an excellent source for referrals.

Component: Outreach

Outreach in place: Please describe for each sub-population (i.e., veterans, seriously mentally ill, substance abuse, HIV/AIDS, domestic violence, youth) the outreach activities undertaken (e.g., street canvassing) and the name of the entity providing the specific outreach. Include in your description, those outreach activities that specifically target chronically homeless persons.

Veterans

The Akron/Summit County community has several organizations in place to address the specific needs of homeless veterans. All of the existing shelters and treatment facilities provide services to veterans. The

Health Care for Homeless Veterans Outreach program, operated by the Veterans Administration Clinic,

provides outreach services in community locations to engage the homeless mentally ill and substance abuse Veterans population who require specialized treatment services. The services provided include intake, assessment, determination of eligibility, case management, connection with other VA and community programs, and psychiatric and medical evaluation and treatment.

Seriously Mentally Ill

Community Support Services has a Homeless Outreach team that engages “hard to reach” and chronically homeless populations on the streets. This population primarily includes the seriously mentally ill, and those dually-diagnosed with severe mental illness and substance abuse. The team attempts to secure the trust of the homeless and eventually connect them with programs and services of the mental health system. The Outreach program has a drop-in center where persons can use a telephone, take a shower, do their laundry, and receive information about resources to get them back on their feet. The Outreach Team works closely with mental health agencies that provide counseling and crisis services. The Outreach Team receives referrals from shelter providers and collaborates with both the Salvation Army and the Veteran’s Administration’s Outreach programs to ensure that efforts are coordinated and duplication is at a minimum.

Substance Abuse

The Alcohol, Drug and Mental Health Board (ADM Board) is the local agency responsible for planning and funding alcohol and other drug addiction services. The ADM Board contracts with organizations such as the Community Health Center (formerly the Community Drug Board) to provide treatment and supportive services targeting the special needs populations and the underserved. Community Health Center’s case managers work closely with over 21 social service agencies such as Oriana House and Interval Brotherhood Homes to provide services to the homeless. Outreach efforts are made to all local in-patient treatment providers in Summit County as well as other local shelters and housing providers. Case managers make referrals to outpatient programs such as Edwin Shaw and Akron Urban Minority Alcoholism Drug Abuse Outreach Program (UMADAOP).

The Program of Assertive Community Treatment (PACT) is a community treatment program that targets the most severely disabled substance abusing mentally ill patient group (SAMI). The PACT team follows a multidisciplinary team approach with an emphasis on community outreach. The PACT is a collaborative effort between the Community Health Center and Community Support Services with a homeless outreach component.

The Drop In Center of Oriana House serves as a temporary safe haven for those found on the streets in a state of acute intoxication, and is utilized as an alternative to jail. Clients are given a clean place to sober up, shower, and are given a meal. They are offered the opportunity to enter into a publicly funded, three-day detox program at the same facility (if they meet certain criteria).

HIV/AIDS

Community AIDS Network (C.A.N.) offers outreach through community education for the special needs of the HIV+ homeless population. HIV+ persons seeking housing related services gain access into the system primarily when in crisis. CAN works closely with AIDS Holistic Services Program to identify those in the HIV+ population in need of housing. The Akron/Summit County community and C.A.N. have made concerted efforts to secure housing for homeless persons and those threatened with homelessness. The Outreach Coordinator assists individuals in assessing housing needs and makes referrals and placement accordingly. CAN and AIDS Holistic Services Program are integral members of the HIV Interdisciplinary Team. This team is composed of professionals from mental health, substance abuse, and other agencies. The team develops wrap around services to address the needs of the most chronically impacted in the HIV+ population. The HIV/AIDS Interdisciplinary Team meets monthly to assure the provision of continual services by maximizing cooperation and linkages between existing services. The Akron/Summit County community and CAN have made concerted efforts to secure housing for homeless persons and resources for those threatened with homelessness in the HIV+ population.

Domestic Violence

The Outreach program of the Battered Women’s Shelter routinely provides speakers and brochures to area churches, schools, hospitals, law enforcement agencies, social service agencies, and government offices to educate on its services. The Shelter also educates at health fairs and other community forums and through

Regularly scheduled public services announcements. Additionally, clients are made aware of the shelter services when they call the crisis line or participate in other BWS programming such as court advocacy, early intervention groups, support groups or One Safe Night. This year a billboard was rented for five months and signs were placed on the entire fleet of Metro buses.

Youth

The Children Services Board, mental health institutions and the courts refer youth to a wide variety of residential centers that provide treatment (e.g. Safe Landing).

An Outreach Coordinator from Safe Landing visits area schools, churches, and service clubs informing youths of the services offered by the agency. In many instances, youths are referred by area agencies but the shelter does accept walk-ins.

YEP (Youth Empowerment Project) assists in empowering youths, ages 11-24, by increasing opportunities to participate in the community and to help improve the quality of life for youth who are homeless, previously homeless, or at-risk for being homeless.

The Community Health Center provides outreach services to schools located in Akron, Barberton, Cuyahoga Falls and Woodridge Schools. In addition, the CHC provides outreach and prevention services, including housing counseling and assistance, to residents of four public housing developments.

Chronically Homeless

The Homeless Outreach team provides regular street outreach to the hard-core street homeless. This team works to establish a connection based on trust with these individuals by utilizing rapport-building interventions such as leaving bus tickets, coupons for free fast food, blankets, gloves, and hats. Homeless persons who may have a mental illness are invited to their Drop-in center where they can make phone calls, do their laundry, or clean up. Outreach staff are available to assist in accessing resources, and treatment is offered to those who will accept it. Many of the homeless persons the Outreach team meets who are not eligible for services are referred to appropriate agencies to address their particular needs. In addition, some of these hard-core street homeless assist in outreach efforts by referring persons who may need mental health treatment, or telling outreach workers where to find them.

Outreach planned:

Veterans

The HealthCare for Homeless Veterans Program (Akron VA Clinic) will continue to provide outreach services to the chronically homeless veteran by partnership with community agencies to identify and refer veterans in need and by expanding outreach efforts to all communities in Summit County.

Seriously Mentally Ill

The Homeless Outreach team is increasing its contacts with churches and social service agencies in an effort to increase referrals from the community. They continue to partner with Community Policing units throughout the county to reach street dwellers. They will participate in ride-alongs with law enforcement officers in an effort to locate those homeless living in unsafe environments. The team is expanding its outreach area to include Twinsburg and other outlying areas.

The Homeless Outreach Team plans to expand its community education program on homelessness and mental illness to possible referral sources. They will participate in a "Train the Trained" seminar to improve outreach and engagement skills to the chronically homeless population. The team will offer to provide similar training to other outreach workers in the community.

The Substance Abuse/Mentally Ill Program of Assertive Community Treatment (SAMI PACT) team will continue to provide outreach to the dually-diagnosed chronically homeless population. They are planning to increase the number served from 50 to 65.

Substance Abuse

In the fall of 2002, the Community Health Center in collaboration with Planned Parenthood and the Akron Community Health Resources, a federally funded health center under the Bureau of Primary Health Care, will begin to visit homeless emergency shelters, 3/4 way homes, and transitional and permanent housing programs on a rotating basis. This team approach will assist the homeless with health and substance abuse issues as well as provide referrals to outside agencies. The CHC hopes to add dental services to the homeless under this program by the spring of 2003.

The CHC is in the process of applying to SAMSHA for enhancement funds to provide comprehensive mental health and substance abuse services to the homeless dually diagnosed residing in permanent housing. A significant portion of these funds will be set aside for street outreach.

HIV/AIDS

Community AIDS Network will continue its existing outreach efforts with shelters, hospitals, and AIDS Holistic Services Program to find housing placement for the HIV/AIDS population. Community AIDS Network works with many agencies to meet the changing needs of this population. Outreach efforts will focus on the needs of the more difficult HIV/AIDS population. The chronically homeless among the HIV/AIDS population have multiple problems that include alcohol and drug abuse, mental illness and other mental health issues, developmental disabilities, poverty, and chronic health problems. Clients seeking services are in varying stages of chemical dependency recovery. They pose a particular challenge in finding housing and maintaining permanent independent housing in that their periods of relapse often jeopardize their housing due to nonpayment of rent or being disruptive to other tenants. Community AIDS Network will continue work with this subpopulation to provide them with a stable supportive housing environment to encourage emotional healing and a healthy lifestyle.

Domestic Violence

In addition to the traditional methods of outreach, this year the Battered Women’s Shelter (BWS) has planned extra activities in honor of its 25th anniversary. In April and October BWS will be mailing special informational newsletters to a database of almost 9,000 persons. In September, BWS is planning a multi-disciplinary 2-day training in conjunction with the Summit County Domestic Violence Coalition. Sgt. Mike Coker, a nationally recognized speaker on domestic violence, will speak to 150 participants including law enforcement officers, prosecutors, judges, medical professionals, educators and social service providers. BWS services will be outlined to Sgt. Coker’s presentation. This training is very important to the agency as criminal justice personnel tend to respond more positively to a message from “one of their own”. This will result in increased referral and ultimately broader access to BWS services.

Youth

Continuation of existing services. Future outreach efforts will include an on-the-street outreach worker.

Chronically Homeless

North Coast Community Homes has received funding for an eight unit single bedroom permanent housing program for persons who are homeless with a mental illness who have been either reluctant or unable to live in other housing in the community. Some of this is due to their resistance to treatment, while other issues also include criminal records, behavior problems, or substance abuse. Modeled after the Safe Havens concept, this program will provide a secure setting for these individuals to live while attempting to gradually engage them in services.

In addition, this application is seeking funding for a second Safe Havens Program, a permanent housing program that will complement the above-mentioned housing program by providing increased capacity for housing persons with mental health issues that are not eligible for other community housing programs. The Outreach team has found that the provision of a tangible resource such as housing is a vital engagement tool.

The Continuum of Care Committee has initiated a dialogue with the Alcohol, Drug Addiction, and Mental Health Services Board, which plans for and contracts for the provision of mental health and substance abuse services about the issues involved in engaging the chronic homeless person with substance abuse issues. Since there are no programs that provide street outreach to individuals with substance abuse treatment, the Continuum of Care plans to advocate for a plan to address this population as planning for services occurs by the Board.

Component: Assessment

Services in place: Please describe the assessment process you currently have in place.

Assessment of the needs of homeless persons occurs at the individual shelters, in the streets, and where homeless are known to gather. Due to the specialization of services, clients, and agency missions, each shelter controls their own intake process. The staff of existing shelters are adept at assessing the immediate needs of the homeless person(s). They are skilled in evaluating the needs of the homeless for longer-term services such as employment training, education, substance abuse issues and mental illness. The community has a well-developed system for assessing the mental health and substance abuse needs of homeless persons coordinating with agencies for mental health and substance abuse services.

<u>Agency</u>	<u>Subpopulation</u>	<u>Assessment Services</u>
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Infoline, Inc.	All	Lead agency – HMIS - Information and Referral Network
Community Support Services	Chronically Mentally Ill	Substance abuse, housing, vocational, income, mental health
Community Health Center	Substance Abuse	Health screens, HIV/AIDS, HCV testing
Portage Path Behavioral Health	Chronically Mentally Ill	Crisis & Mental Health Assessment screening for hospitalization
City of Akron Health Department	All	HIV, health, TB screening
Summit County Department of Job and Family Services	All	Assesses for income means and vocational readiness
Akron Metropolitan Housing Authority	All	Housing eligibility
Veteran's Administration (Akron Clinic – HealthCare for Homeless Veterans	Veteran's	Mental health, substance abuse, PTSD, medical, housing needs
Community AIDS Network	HIV/AIDS	Housing needs, HIV Screen, income support
Salvation Army	All	Substance abuse, Housing and vocational
Summit County Children Services Board	Youths	Independent living skills. Education and training
Edwin Shaw Hospital for Rehabilitation	All, Substance Abuse	Substance abuse, vocational
Community Health Center	Substance Abuse	Substance abuse, mental health
Oriana Detox	Substance Abuse	Substance abuse
AIDS Holistic Services Program	HIV/AIDS	Case management, healthcare

Services planned:

The Community is moving toward standardized assessment with the Homeless Management Information System (HMIS). HMIS will allow the community to better assess the utilization of services within the community and to determine gaps in housing and services.

The United Way, with guidance from a wide range of local service providers and agencies, including Continuum of Care agencies, is currently undertaking a community needs assessment and implementation strategy for the County. The United Way is an active participant in the Continuum of Care. Local service providers will be consulted to understand their current activities and to record what they see as the main challenges facing the community. A survey of the local assets will to be undertaken with the gaps in service provision clearly identified. The assessment will provide a better understanding of needs of this community including the needs of the homelessness and what can be done about it.

The Alcohol, Drug Addiction and Mental Health Services Board is conducting a community-wide needs assessment process to provide a snapshot of the strengths and the areas needing improvement for our mentally ill and substance abuse sub-populations. The information collected during the needs assessment process will allow the ADM Board to determine gaps in existing services and direct resources toward those gaps in services

How homeless persons access/receive assistance:

Assessment is the first order of business when utilizing services. The willingness of the homeless individual to utilize these services or the availability of these service slots in the community is not subject to the control of the provider. The Community Support Services Homeless Outreach team is in the street on a regular basis attempting to reach the on-the-street homeless. Several brochures are available at local service agencies and libraries guiding potential homeless to appropriate homeless providers. Info-line, the local telephone information and referral service, refers homeless individuals to appropriate shelters, e.g. battered women at the Battered Women's Shelter, men at the Haven of Rest. All shelters accept walk-ins pending assessment. Other methods of access include referrals from other agencies, churches, and law enforcement agencies.

Shelters use agencies in the community who specialize in treating various disabilities (mental health, substance abuse, child services) to provide more in-depth assessment through formal and informal referral relationships.

AIDS Holistic Services Program has received a Title III Ryan White Grant to develop a system to provide primary health care to persons with HIV/AIDS in an eight county area that includes Summit County. Many people with HIV/AIDS experience homelessness at some point in time. As part of this health care system, barriers to health care and maintenance including homelessness will be assessed.

Component: Supportive Services

Services in place: Please describe how each of the following services are provided in your community (as applicable): case management, life skills, alcohol and drug abuse treatment, mental health treatment, AIDS-related treatment, education, employment assistance, child care, transportation, and other.

Case Management

The case managers at the individual shelters and agencies serving the homeless population provide case management services. Case management services include referrals to other community agencies for identified services and the coordination and follow-up of the various services each client receives. Case managers work with the clients to help them meet their identified goals. In many cases, services may be fragmented in many areas and case managers provide a critical function to monitor a person's needs and assure that appropriate agencies get involved. Case management services can include: information and referral, transportation, case planning, progress review and transition services after the client leaves the shelter. The following agencies provide case management services in our community.

ACCESS, Inc. (all)	H.M. Life Opportunity Services (all)
Battered Women's Shelter (battered women)	Oriana House (substance abuse)
Community AIDS Network (HIV/AIDS)	Summit County Children Services Board (Youth)
Community Health Center (substance abuse)	The Salvation Army (all)
Community Support Services (mentally ill)	Veteran's Administration (Akron Clinic) (Veterans)
Haven of Rest (all)	

Life Skills Training

Life skills' training is provided to clients by individual agencies and shelters. Life skills training can be provided on an individual client basis and also in group settings. Life skills training includes instruction and practice in the following areas: budgeting, money management, obtaining affordable housing, obtaining employment, maintaining employment, job interviews, resumes and applications, child care, housekeeping and community resources. The following agencies provide life skills training in our community.

ACCESS, Inc. (all)	Haven of Rest (all)
Battered Women's Shelter (battered women)	H.M. Life Opportunity Services (all)
Community AIDS Network (HIV/AIDS)	Legacy III (substance abuse)
Community Health Center (substance abuse)	Summit County Children Services Board (Youth)
Community Support Services (mentally ill)	

Alcohol and Drug Abuse Treatment

Through collaboration and partnerships with diverse organizations, the community works together to provide programs and resources to individuals seeking to overcome alcohol and drug abuse issues. These organizations have the means to encourage healthful choices and informed decisions based on systematic, ongoing evaluations. Community efforts are derived from the shared focus of a determined, passionate and empowered community.

Akron Health Department	Interval Brotherhood Home
Akron Urban Minority Alcoholism Drug Abuse Outreach Program	New Start Ministries
Barberton Rescue Mission	Oriana House
Community Health Center	St. Thomas Hospital - Ignatia Hall
Community Support Services	The Salvation Army
Edwin Shaw Hospital	Urban Ounce of Prevention
First Step	Veterans Administration (Akron VA Clinic)

Mental Health Treatment

Mental health counselors assist homeless individuals with severe mental illness to obtain the services they need. Most persons with severe mental illness need medical care, social services, and assistance from a variety of agencies, including those dealing with housing, Social Security, vocational rehabilitation, and

mental health. Case management and outreach services are frequently provided by teams that may include people who are recovering from a mental illness who function as peer counselors, case management aides, or outreach workers.

The Summit County Adult Mental Health Admissions unit provides a single point of entry into all publicly funded mental health treatment. The intake worker assigns the client to either Portage Path Behavioral Health or Community Support Services, depending on the level of severity of the illness. Portage Path Behavioral Health provides counseling and psychiatric services to those with acute and less severe disorders. Community Support Services serves those who are disabled by their mental illness. Supportive services are provided in community settings by community living specialists. The community living specialist is a service broker, coordinator, monitor and planner of services who offers practical help, builds community support, and provides active outreach, advocacy and crisis assistance to the individual served. The Blick Clinic provides case management, day treatment, and psychiatric treatment to adults dually diagnosed with mental retardation and mental illness. The Veterans Administration Community Based Outpatient Clinic is located in the city of Akron. Eligible veterans may receive comprehensive medical and mental health treatment.

Blick Clinic
Community Health Center
Community Support Services

Portage Path Behavioral Health
Veterans Administration (Akron VA Clinic)

Housing Placement

Housing Placement for the homeless and chronically homeless occurs via area social service agencies based on the individual or family's need; for example a homeless or chronically homeless person with a mental health diagnosis would work with a Community Support Services community living specialist to locate housing. Other agencies that provide this service include but are not limited to:

ACCESS, Inc.
Catholic Social Services
Community AIDS Network
Community Health Center

Community Support Services
Haven of Rest
H.M. Life Opportunity Services
Oriana House

AIDS – Related Treatment

While the death rate decreased in the late 90's, the need for specialized services continues to increase. This is due to the fact that persons infected with HIV/AIDS are living longer with the disease and the number of new infections is increasing. Support services are primarily available through the Community AIDS Network. Services may include counseling, assistance with applications for financial assistance and other benefit programs, advocacy, transportation, and referral to other services such as psychotherapy, Medical services, job training, and alcohol/drug rehab programs.

AIDS Holistic Program
Area Hospitals
City of Akron Health Department

Community AIDS Network
Community Health Center

Child Care

The child care needs of families who come to shelters are addressed routinely. Child care specialists on staff have the responsibility of planning to meet the needs of the children and document progress to insure that the children are given professional and thorough care. While mothers have primary responsibility for their children, shelters such as the Battered Women's Shelter assist through day care and case management.

ACCESS, Inc.
Battered Women's Shelter
Community Health Center
East Akron Community House

H.M. Life Opportunity Services
Summit County Children Services Board
YMCA

Education

Area shelter providers work with agencies such as Project Rise to remove barriers to the educational process during a homeless episode for children and youth. Efforts are made to provide educational support through tutorial services, facilitation of school enrollment, assistance with transportation to school and raising awareness about the special needs of homeless children and youths.

Employment Assistance

Case managers work with area agencies to provide vocational training, education and job placement services to the homeless population. Job training agencies such as the Akron Urban League have built linkages with potential employers in areas of job growth to provide training and placement assistance. Clients receive counseling, classroom and literacy training and business apparel from local back-to-work clothes closets.

Akron Urban League
Bureau of Vocational Rehabilitation
Catholic Commission

Community Support Services
Community Health Center
East Akron Community House

Transportation

Transportation for the homeless and chronically homeless population is facilitated by community agencies. Case managers may transport via their own vehicle or an agency vehicle. Bus passes are given to the chronically homeless and homeless so that the Metro bus system may be utilized. Agencies that provide transportation services include but are not limited to:

ACCESS, Inc.
Battered Women's Shelter
Community Health Center
Catholic Social Services

Community Support Services
H.M. Life Opportunity Services
Legacy III

Services planned:

The Community continues to encourage the further development and coordination of all supportive services available to the homeless. Through ongoing community meetings with groups such as the Homeless Agency Network and Emergency Assistance Task Force, efforts will be made to ensure that agencies are aware of all of the supportive services that are available to the homeless population. HMIS will also provide a better picture of utilization patterns.

Tuff Stuff is a network of over 40 representatives from area shelters, health care agencies, social service, and housing services meeting monthly to address problem cases that test the limits of existing services. At these meetings, gaps or shortages in existing services are directly addressed by area representatives to meet the health and shelter needs of individuals in need of assistance. Though this group does not directly focus on the provision of services for the homeless, these meetings help prevent homelessness by identifying needs and formulating effective solutions.

The Homeless Agency Network is essentially a case management meeting of homeless service providers. This group meets monthly to discuss the needs of the homeless and how needs can be met through inter-agency connections. Presentations by service providers are used to identify gaps in existing service and identify solutions through increased linkages between service providers, an essential element of the Continuum of Care process.

A Mental Health Court was created this year and will be expanded. The Court was created to divert mentally ill misdemeanants who have been arrested from jail to treatment and intensive case management. The Drug Court provides chemically dependent misdemeanants with immediate chemical dependency treatment, intensive case management, graduated rewards and sanctions, and overall supervision to break chemical dependency and reduce criminal recidivism. This year Summit County has added a Felony Drug Court to provide similar services to felony offenders. Clients receive a suspended sentence and dismissal of charges conditioned upon successful program completion.

The Akron Community Health Resource Center is working with the community to develop a system to provide medical services to the homeless.

The Continuum of Care Committee has initiated a dialogue with the Alcohol, Drug Addiction, and Mental Health Services Board, which plans for and contracts for the provision of mental health and substance abuse services about the issues involved in engaging the chronic homeless person with substance abuse

issues. Since there are no programs that provide street outreach to individuals with substance abuse treatment, the Continuum of Care plans to advocate for a plan to address this population as planning for services occurs by the Board.

How homeless persons access/receive assistance:

The Homeless Outreach team provides regular street outreach to the chronic street homeless. This team works to establish a connection based on trust with these individuals by utilizing rapport-building interventions such as leaving bus tickets, coupons for free fast food, blankets, gloves, and hats. Homeless persons who may have a mental illness are invited to their Drop-in center where they can make phone calls, do their laundry, or clean up. Outreach staff are available to assist in accessing resources, and treatment is offered to those who will accept it. Many of the homeless persons who are not severely mentally ill are referred to appropriate agencies to address their particular needs. In addition, some of these chronic street homeless assist in outreach efforts by referring persons who may need mental health treatment, or telling outreach workers where to find them.

The homeless and potentially homeless access supportive services through referrals from agencies, Infoline, Inc., churches and other community oriented organizations. Local shelters and service providers operate an informal network in order to suggest referrals when space in a particular shelter is unavailable. Area shelters train their staff in available community services in order to make appropriate referrals for the residents to meet their needs and guide them to those services. As indicated earlier, agencies are members of various committees, councils, and task forces. At these meetings, information is shared to enable providers to learn of other services, solve particular problems, and make appropriate referrals.

e. Using the format below, describe the fundamental housing components of your Continuum of Care system currently in place, and any additional housing being planned. Describe how homeless persons access or receive assistance. Also, enter the inventory of CoC residential resources targeted to homeless individuals and families with children.

1. Provide the point in time inventory date used to complete the chart: **August 27, 2001**
2. In a separate narrative, provide your definition of (1) emergency shelter, (2) transitional housing and (3) permanent supportive housing. **(Although you may require multiple pages to respond to this item, your response will count as only one page towards the 25-page limitation.)**

Fundamental Components in CoC System (Housing Activity)			
Component: Emergency Shelter			
Provider Name	Facility Name	Bed Capacity	
		Individuals	Persons in Families with Children
EX: Homeless Help, Inc.	Second Chance Shelter		15
Haven of Rest Ministries	Haven of Rest	100	0
Haven of Rest Ministries	Harvest Home	20	32
ACCESS	Access	10	20
Battered Women's Shelter	Crisis Center	10	12
Battered Women's Shelter	Step II	11	37
Salvation Army	Salvation Army	5	16
Shelter Care	Safe Landing	24	0
Portage Path Behavioral Health	Crisis Stabilization Unit	4	0
Tarry House	Tarry House Respite	12	0
Subtotal		196	117
<p><u>Housing planned:</u></p> <p>Although there are no immediate plans for the construction or development of new emergency shelters, the Akron/Summit County community recognizes the need for such shelters. Community consensus indicates that community efforts should continue to focus on the development of transitional and permanent supportive housing in addition to supportive services rather than emergency shelters. The Continuum of Care Community has supported and will continue to support the expansion of existing emergency shelters if occupancy rates warrant expansion. To date, existing emergency shelters have not indicated plans for expansion.</p> <p>The City of Akron continues to support the rehabilitation of emergency shelters through the Emergency Shelter Grant Program.</p>			
<p><u>How homeless persons access/receive assistance:</u></p> <p>Homeless persons and individuals access the system from a number of different sources:</p> <ul style="list-style-type: none"> • Referrals – usually from social services agencies in the community or Info-Line, an information and referral service, shelter providers, churches and law enforcement • Outreach – CSS and the VA have outreach workers who are out in the streets attempting to gain the trust of the homeless and place them in appropriate shelters • Self Referrals – homeless may enter shelters on their own initiative 			
Component: Transitional Housing			
Provider Name	Facility Name	Individuals	Persons in Families with Children
Haven of Rest Ministries	Haven of Rest	23	0
ACCESS, Inc.	Step II	8	0
Legacy III, Inc.	Emerging Women	4	0
H.M. Life Opportunity Services			82*

Battered Women's Shelter	Step III	0	42
Genesaret		6	0
Summit County Children's Services Board	Transition to Independence	0	15
Tarry House	Tarry House	16	0
Shelter Care		9	
Community Support Services	Kibler Hall	14	0
Community Support Services	Edgerton Home	11	0
Community Support Services	Maggie Carol Smith Home	13	0
Community Health Center	Sherman and Burton Street	8	0
Salvation Army		57	0
Community AIDS Network	Micah House	5	0
Community Support Services	RAMAR (Rocco Antenucci Memorial Adult Residential)	14	0
Community Health Center		30	0
Alpha One		12	0
Oriana House	SHARP Program	8	0
Community Support Services (CSS)	HAP Consumer Based Housing Project	100	
Community Health Center	Peachtree Estates		8*
VSORP House		14	0
	Subtotal	352	148

Housing planned:

The need for additional transitional housing units, specifically transitional housing targeting a specific sub-population, is an ongoing priority for suburban communities in the County. The City's Annual Needs meeting identified the need for more transitional housing for individuals and single parent families with children exiting substance abuse programs. These findings are documented in the City's Consolidated Plan. Community efforts will continue to focus on developing transitional housing for families and individuals.

The Community Health Center has recently opened a transitional housing program for women and men in substance abuse recovery. This will add four scattered site units in the community serving individuals with substance abuse issues. Legacy III is in the process of starting their Women's Empowerment program. This is a transitional housing program designed to meet the special needs of homeless women who are in early recovery from chronic substance abuse. Transition to Independence, a program providing transitional housing for youths previously emancipated from the Summit County Children Services Foster Care System who have become homeless, will start in the Fall of 2002.

The proposed HOPE II program is a two-year transitional housing program for six homeless families in substance abuse treatment and/or recovery. Supportive services coordinated around the transitional housing include daily supervisory visits, primary health care, case management, welfare to work, vocational rehabilitation and job placement and the continuation of a drug treatment plan.

H.M. Life Opportunity Services (HMLoS) completed a transitional housing expansion project in October 2001. The project includes 10 additional units of transitional housing for homeless, single-parent families in Northfield Center Township, an underserved area of Northern Summit County, Ohio.

How homeless persons access/receive assistance:

Homeless individuals and families access transitional housing by referral from emergency shelters and community outreach efforts. Inpatient treatment facilities for mental health and substance abusers also refer clients to transitional or permanent supportive housing.

Component: *Permanent Supportive Housing*

Provider Name	Facility Name	Individuals	Persons in Families with Children
Community AIDS Network	Shelter Plus Care	15	0
CSS	Licensed Boarding Homes	103	0
CSS	Shelter Plus Care	40	5
CSS	Tenant Rehab Program	22	0

Community AIDS Network	Harmony Place	10	5
Oriana House	Midtown Apartments	91	0
North Coast Homes		54	6
Summit Terrace		20	0
VSORP House		7	0
	Subtotal	362	16

Housing planned:

Permanent Supportive Housing remains a high need in this community. The Community Health Center is in the process of finalizing plans for two permanent supportive housing projects. Peachtree Estates II will provide permanent supportive housing to 8 female-headed households with chemical dependency/mental illness and other disabilities (dually diagnosed). McTaggart Court I will provide 14 permanent housing units to individuals with chemical dependency/mental illness and/or other disabilities (dually diagnosed). In addition, the Community Health Center is preparing to break ground on Hudson Drive 1 and 2, permanent group homes for the homeless dually diagnosed who are not able to maintain complete independent living.

North Coast Community Homes has received funding for eight single bedroom units providing permanent housing for persons who are homeless with a mental illness who have been either reluctant or unable to live in other housing in the community. Some of this is due to their resistance to treatment, while other issues also include criminal records, behavior problems, or substance abuse. Modeled after the Safe Havens concept, this program will provide a secure setting for these individuals to live while attempting to gradually engage them in services. North Coast Community Homes is scheduled to begin construction on these permanent supportive housing units shortly.

In addition, this application is seeking funding for a second Safe Haven Program, a permanent housing program that will complement the permanent housing program by providing increased capacity for housing persons with mental health issues who are not eligible for other community housing programs. The Outreach team from Community Support Services has found that the provision of a tangible resource such as housing is a vital engagement.

Legacy III, Inc. is proposing a permanent supportive housing program with supportive services for single homeless women who are recovering from chronic substance abuse. The project will add 12 units of permanent supportive housing in the Community. Supportive services will include case management, relapse prevention, transportation, and assistance in securing employment.

McTaggart Court II, as proposed by the Community Health Center, is a 9-unit apartment complex designed to provide permanent supportive housing for nine homeless individuals with chemical dependency / mental illness and or other disabilities (dually diagnosed). Substance abuse treatment services will be provided to the residents while they reside in a safe and sober environment.

The Continuum of Care Committee will continue to monitor and encourage the enhancement of existing programs. The Committee recognizes the need for additional permanent supportive housing programs in the Community, especially with the proposed closing of Canal Park Tower, a building which receives Section 8 assistance on a yearly contract with HUD and may displace over 100 persons with chronic mental illness.

How homeless persons access/receive assistance:

Individuals access permanent housing or permanent supportive housing from either emergency shelters or transitional housing. Local supportive service agencies may refer clients directly from the streets to permanent housing. This type of referral depends on the individual and their willingness/readiness to enter permanent supportive housing and leave the streets.

Please note: HUD does not consider certain facilities to be emergency shelters or transitional housing facilities e.g., detox facilities, juvenile detention facilities, and halfway houses for parolees.

2. **Emergency Shelters**

Emergency shelters are temporary, short-term shelters available to lessen an immediate need. Stay at an emergency shelter may vary from one night to up to thirty days. While at the emergency shelter, a more comprehensive evaluation of the clients' needs is completed and supportive services are also available to the clients. Individuals are encouraged to seek employment and housing while at the shelter. After their stay at the emergency shelter, persons move to either transitional housing, permanent housing, permanent supportive housing or return to their previous residence, depending on their circumstances. Those seeking emergency shelter access the system through referrals, outreach efforts or walk-ins.

Transitional Housing

Transitional housing offers homeless individuals and families an option prior to moving into permanent housing. In many instances, families are not equipped financially or psychologically to move to permanent housing after a homeless episode. Individuals have other issues that need to be addressed before they are ready to live in a stable home situation. Transitional housing offers decent, long term, low cost housing while the clients are receiving supportive services, job training or an education. Transitional housing counselors offer one-on-one case management to address specific needs of the client. Childcare is often available to those clients receiving job training or attending classes at the university. Transitional shelters offer housing and supportive services for up to two years. After their stay at a transitional shelter, clients usually move to permanent supportive housing or permanent housing. Individuals access transitional housing through emergency shelter referrals and community outreach efforts.

Permanent Supportive Housing

Permanent Supportive Housing recognizes that certain individuals and families in the community are likely to need an ongoing level of support in order to maintain stable, functioning lives in the community. This need can be due to a physical, mental or emotional/chemical impairment. Without such support, those persons run the risk of becoming homeless and/or engaging in unhealthy behavior.

Clients access permanent supportive housing from either emergency shelters, transitional housing or other public facilities.

4. Homeless Management Information System (HMIS). (Your response to this item will not count towards your 25 page limitation.)

- a. Describe in a brief narrative your Continuum of Care (CoC) strategy to implement an HMIS and the progress you have made to date in obtaining the participation of homeless assistance providers.

The Continuum of Care Committee has been meeting over the past year to implement a HMIS system for Summit County. The City of Akron, on behalf of the Continuum of Care Committee, posted a request for proposals for implementing and operating the HMIS system. The successful record of Info Line, Inc. in implementing similar programs demonstrated that the organization would be able to implement and sustain the project. Info Line, Inc. will have the responsibility for purchasing and installing the network equipment and software; training all users; compiling aggregate outcome reports; maintaining disaster recovery plans; and ensuring that the project meets the needs of the County as well as those of the participating agencies.

The Continuum of Care Core Sub – Committee and Info Line, Inc. have researched efforts to determine the best means of employing the HMIS system. Members of the committee examined various software solutions and met with regional and state programs to explore their options. Because it meets HUD’s requirements and because it is used successfully throughout the country in similar communities, the committee selected Bowman’s ServicePoint as Summit County’s software of choice. InfoLine presented their initial plan on how to implement the HMIS to the Continuum of Care Community Committee at the June 11, 2002 meeting.

The first step of implementation will be the establishment of the Summit County HMIS Advisory Committee consisting of key stakeholders of the Continuum of Care, including representative of homeless service providers, funders, homeless advocacy groups, community legal aids, and MIS experts. The committee will develop recommendations for approval by the Continuum of Care Committee concerning:

- Program policies and standards
- Evaluation criteria
- Use of aggregate HMIS data

With monies designated for the HMIS system project, Info Line will purchase and install network and connectivity necessary for implementation. These systems will be thoroughly integrated into Info Line’s current Citrix-based network, including the installation of redundant servers to preserve the data if one server should fail; the installation of redundant internet access to allow always-on, remote access to the ServicePoint program; and the installation of redundant access protection to meet HIPPA requirements

- b. Please check one of the following which best reflects the status of your CoC in having a Continuum-wide HMIS (see Section P of the “Questions and Answers” supplement to the application before completing):

- The CoC has not yet considered implementing an HMIS.
 The CoC has been meeting and is considering implementing an HMIS.
 The CoC has decided to implement an HMIS and is selecting needed software and hardware.
 The CoC has implemented a Continuum-wide HMIS.
 The CoC has implemented, but is seeking to update or change its current HMIS.
 The CoC has implemented, but is seeking to expand the coverage of its current HMIS system.

- c. **If your CoC has already implemented or is seeking to update or expand its HMIS system**, identify in the table below how many of the Current Inventory Beds listed on your Gaps Analysis chart are included in the CoC’s HMIS:

	Current Inventory Beds in HMIS	
	Individuals	Families
Emergency Shelter	_____	_____
Transitional Housing	_____	_____
Permanent Supportive Housing	_____	_____

5. Gaps Analysis

- b. Using the format below, identify the data sources and methods (e.g., City Shelter Survey), the methods (e.g. mail survey) and counts used as the basis for filling out the columns in the gaps analysis chart. Indicate the specific **point in time** date of data collection (e.g., March 30, 2001) for both "street" (all places not meant for human habitation) and shelter/transitional/supportive housing counts. If street or shelter counts have been taken, **insert total number of persons** identified in the appropriate box.

Data Source	Method	Date of Data Collection	Street Count (number)	Shelter Count (number)
Point in Time Count	Mail Survey	August 27, 2001		1,032
Point in Time Count	Street enumeration (Community Support Services - Homeless Outreach Team)	August 27, 2001	83	
Point in Time Count	Follow-up calls (to verify existing capacities and occupants)	September 10-21, 2001		X

c. Data Sources and Methods

1. The Continuum of Care Gaps and Priorities met monthly throughout the year to assess existing conditions and the process for determining gaps in service. This committee oversees an annual point in time count that reflects existing conditions in shelters, assesses shelter capacities and assures an accurate and updated count of existing beds and units. In 2001, the Point in Time Count was undertaken two times, first on January 29 and again on August 27. Data was collected via a mail survey, followed up with phone calls to assure a total count of existing facilities in Summit County. A street count was also conducted. A separate mail-out was utilized to assess existing Supportive Service for the homeless in the County. The August count was undertaken to assure a 100% count for all shelters. It was determined by the Gaps Subcommittee that the combination of a Point in Time Count reflecting shelter populations, capacities and turnaways combined with a street count and supplemented by data collected on a monthly basis from individual shelters served as the most accurate method available to obtain an estimated count of the homeless population in the County. An Urban Institute publication, Practical Methods for Counting the Homeless: A Manual for State and Local Jurisdictions, was referenced to assist in the establishment of this process.
2. In order to estimate the number of homeless people living on the streets or other places not meant for human habitation, a street count was undertaken by Community Support Services of Summit County Outreach Program. The street count was undertaken on Sunday night, August 26, 2001, between 7:30 p.m. and 11:30 p.m. and from 5:30 a.m. to 9:00 a.m. on Monday, August 27. Four different teams canvassed separate portions of the County Sunday night and three teams were used Monday morning. Homeless contacts were interviewed to identify locations where homeless persons might be identified (i.e. vacant buildings, bridge underpasses, parks, etc.).
3. The Gaps Analysis chart is consistent with both the County Consolidated Plan and the City of Akron Consolidated Plan and is often referenced in other studies on homelessness in the community. Data collection on an individual shelter basis will continue to be collected monthly and aggregated annually. Point in Time Counts will be conducted at least bi-annually. Until a centralized database for homeless information is established, mail-out surveys will be used, but it is anticipated that as the Continuum process advances, processes for information sharing will become more advanced.

6. Priorities

- b. Describe the methods you use to determine whether projects up for renewal are: (1) performing satisfactorily; and (2) effectively addressing the need (s) for which they were designed.

The Continuum of Care Gaps and Priorities Sub-Committee is a consortium of government officials, community stakeholders, and representatives from nonprofit agencies. This sub-committee began to discuss the need to evaluate all programs funded under the Continuum of Care shortly after last year's application process. Members of the Committee have taken on the role of monitoring Continuum of Care Programs. The Committee acknowledges that programs that are under the Continuum of Care must be monitored on a regular basis to ensure that statutory and regulatory requirements are being met and that, where appropriate, information being submitted to HUD is correct and complete. The on-site monitoring visits help verify that the renewal programs are operating effectively and are still meeting a critical need in the community. The Continuum of Care Gaps and Priorities Sub-Committee made a decision to begin monitoring all projects up for renewal in the 2002 funding cycle, with the eventual goal to monitor and become familiar with all projects funded through this program. This was planned so that the local Continuum of Care would be in a stronger position to evaluate the array of community programs receiving funding under the Continuum of Care.

This Committee developed an Agency On-Site Monitoring Report, a monitoring instrument that defines a set of process evaluations - examining program requirements and outcome (or performance) evaluations - examining progress towards meeting goals and objectives identified in the original application for each program. The monitoring instrument examines four segments of the renewal program; (1) Program Performance (2) HUD Annual Performance Report (3) Financial Review and (4) Impact on the community if the program was not funded. Members of the committee scheduled on-site monitoring visits in May 2002.

Based on the on-site monitoring visits, renewal projects were ranked as Critical or Non-Critical performers in the community.

- A Critical performer is an agency that meets and exceeds all program goals identified in the application, has high capacity and fulfills a need in the community.
- A Non- Critical performer is an agency that fails to meet program goals identified in the application, has a difficult time filling beds and struggles to meet a need in the community. The Committee will evaluate the need for the programs offered, and if seen as a critical need, recommend funding for only one year (probationary status). Further funding would be contingent upon improved performance in the subsequent year.

The evaluation of renewals is considered an evolutionary process. Since this is the first year that this instrument was used, it will be modified each year to better measure critical elements of the programs that are evaluated in the future.

c. Describe how Each Project Will Fill a Gap in Community's Continuum of Care

All of the proposed projects will fill a need in the community.

Community Support Services – Safe Haven

This new project for the Supportive Housing Program will provide Safe Haven Permanent Supportive Housing. Community Support Services provides outreach to chronically homeless, mentally ill individuals. Lack of housing for this population is an obstacle to the success of these

efforts. The program will house 10 individuals in a SRO – type setting and will be staffed 24 hours a day, seven days a week. Each resident will have private sleeping quarters and will share cooking facilities. The individuals housed will be homeless, have a severe mental illness, and may be dually diagnosed with a substance abuse disorder. This project was ranked 1 by the Review and Ranking Subcommittee.

InfoLine, Inc. - HMIS

This new project for the Supportive Housing Program will assist in the development of the Homeless Management Information System (HMIS) in Akron/Barberton/Summit County. This system will allow for a delivery system to coordinate services among agencies. Agencies will have the capability to standardize and manage data and create and access reports. The HMIS project ranked 2.

H.M. Life Opportunity Services (Copley Road)

This Renewal Project for the Supportive Housing Program will allow for the continuation of this transitional housing program. This program will provide housing to 30 homeless, single parent families over a three-year period. The program will offer housing, case management, life skills training, children's programs and assistance with education and/or job skill training. Without this program, the community would experience a significant increase in need for this type of housing. This project ranked 3 in overall ranking.

Battered Women's Shelter (City)

This Renewal Project for the Supportive Housing Program will allow for the continuation of this transitional housing program for battered women and their children within the City of Akron. The program is a two year transitional housing program that provides the tools necessary for families to become self-sufficient. The project will assist up to eight families with financial assistance for up to 24 months to assist in establishing permanent housing while receiving ongoing life skills training. Without this project, the need for this type of housing would substantially increase. This project was ranked 4 by the Review and Ranking Sub-Committee.

Battered Women's Shelter (County)

This Renewal Project for the Supportive Housing Program will allow for the continuation of this transitional housing program for battered women and their children within Summit County. The program is a two year transitional housing program that provides the tools necessary for families to become self-sufficient. The project will assist up to eight families with financial assistance for up to 24 months to assist in establishing permanent housing while receiving ongoing life skills training. With out this project, the need for this type of housing would substantially increase. This project was ranked 5 by the Review and Ranking Sub-Committee.

ACCESS, INC. – Step II (High St)

This Renewal Project for the Supportive Housing Program will allow for the continuation of this transitional housing program. The program will provide transitional housing and supportive services to 21 single women over a three year period. The program addresses various subpopulations in the community including drug and/or alcohol addictions in the community. The project was ranked 6 by the Review and Ranking Sub-Committee.

Community Support Services – Assertive Community Treatment (ACT)

This Renewal Project for the Supportive Housing Program will allow for the continuation of this Supportive Services program. ACT assists individuals diagnosed with serious mental illness and concomitant chronic substance abuse with obtaining and maintaining housing while recovering from their co-occurring illness. Thirty-two individuals will be served over a three-year period. This project was ranked 7 by the Review and Ranking Sub-Committee.

Legacy III, Inc. – Brubaker Program

This new project for the Supportive Housing Program will provide Permanent Housing for chronically homeless women who are in early recovery from substance abuse. Participants will be provided with intensive case management and supportive services that will facilitate a lifestyle of recovery and self-sufficiency. Legacy III will also link the participants to other mainstream resources in the community. Twelve women will be served during the tenure of this grant. This project was ranked 8 by the Review and Ranking Sub – Committee.

Community Health Center – HOPE 2

This new project for the Supportive Housing Program will provide transitional housing to six families (either single or two parent) in substance abuse treatment and/or recovery. The program will serve 12 families over a three-year period. The Community Health Center will provide case management, counseling, life skills, family development, vocational and other training to assist families and allow them to become self-sufficient. This project was ranked 9 by the Review and Ranking Subcommittee.

Community Health Center – McTaggart Court 2

This new project for the Supportive Housing Program will provide Permanent Supportive Housing for homeless individuals with chemical dependency/ mental illness and/or other disabilities (dually diagnosed). McTaggart Court II will consist of nine one-bedroom apartments. All units will be one floor living and handicapped accessible. Approximately 14 individuals will be served over a three-year period. Residents at McTaggart II will receive substance abuse treatment services while they reside in a safe environment. This project was ranked 10 by the Review and Ranking Subcommittee.

d. Demonstrate how the Project Selection and Priority Placement was Conducted Fairly and Gave Equal consideration to Projects Sponsored by Nonprofit Organizations

In March, 2002, 35 homeless shelter providers and supportive service organizations in Akron/Summit County were sent invitations to participate in the application process and given a Continuum of Care Pre-Application. The pre-application was used to determine project eligibility, HUD thresholds and priority need in the community. The Review and Ranking Subcommittee determined that Renewal projects which continued to meet documented need and were fulfilling their program goals should receive priority over new projects or an expansion of an existing project.

This Subcommittee developed a Review and Ranking criteria scoring worksheet and a Review and Ranking Criteria Guide. All projects were given a score by the Review and Ranking Subcommittee according to the following criteria:

- is the application cost effective
- has the applicant met threshold criteria
- is the scope of the project appropriate
- is the application understandable, readable
- are program goals, objectives, and methods clear
- does the experience narrative demonstrate that the applicant is able to carry out the project
- Renewal performance evaluation –Critical performer, non-critical performer

In addition, Continuum of Care Criteria were also examined.

- what is the applicant organizations' level of involvement in the Continuum of Care process
- what type of housing will be provided. Additional points were awarded to permanent Supportive Housing Programs
- Supportive Services ranked for gaps analysis

The Review and Ranking Committee consists of a broad base representation from the community including government housing advocates, social service providers, and homeless shelter providers. This allows for an equal and unbiased review of the applications.

Applicants were given a copy of the Criteria in addition to a guide describing exactly what the reviewers are looking for. Each applicant presented their project to the Review and Ranking Committee and questions were addressed from both sides. Each individual project was then discussed by committee members to determine project activity and need. Points were assigned to each of the items listed above. Projects were ranked utilizing a ranking sheet. Further discussion followed and the projects were ranked according to priority identified by the Gaps Subcommittee and the Community Committee. Consensus among the group was used to determine final points.

The recommendations of the Review and Ranking Committee were forwarded to the Continuum of Care Community Committee for review and input prior to submission to the Department of Housing and Urban Development.

Continuum of Care: Project Priorities

(This entire chart will count as only one page towards the 25-page limitation)

Applicant	Project Sponsor and Project Name	Numeric Priority	*Requested Project Amount	Term of Project	Program (Check only one)				
					SHP new	SHP Renew	S+C new	S+C renew	SRO new
Example: ABC Nonprofit	ABC Nonprofit/Sarah's House	1	\$1,026,000	3 (yrs)	X				
Example: XYZ County	AJAY Nonprofit/BeeJee's Place	2	\$500,000	2 (yrs)	X				
Community Support Services	Safe Haven	1	\$531,047	3	X				
Info Line, Inc.	HMIS of Summit County	2	\$479,390	3	X				
H.M. Life Opportunity Services	Copley Road	3	\$309,644	3		X			
Battered Women's Shelter	Step III Transitional Living Program (City)	4	\$381,904	3		X			
Battered Women's Shelter	Step III Transitional Living Program (County)	5	\$422,206	3		X			
ACCESS, Inc.	Step II Transitional Housing Program	6	\$486,416	3		X			
Community Support Services	Assertive Community Treatment	7	\$150,462	3		X			
Legacy III, Inc.	Brubaker Program	8	\$399,825	3	X				
Community Drug Board (Community Health Center)	HOPE II	9	\$527,244.27	3	X				
Community Drug Board (Community Health Center)	Mc Taggart Court II	10	\$469,008.44	3	X				
		11							
		12							
Total Requested Amount:			\$4,157,146.71						

***The Requested Project Amount** must not exceed the amount entered in the project budget in Exhibits 2, 3, and 4. If the project budget exceeds the amount shown on the priority list, the project budget will be reduced to the amount shown on the priority list.

Please Note:

- (1) Place all Shelter Plus Care renewal projects as the last entries on the Chart.
- (2) For all Shelter Plus Care and SRO projects, please be advised that the actual FMRs used in calculating your grant will be those in effect at the time the grants are approved which may be higher than those found in the October 1, 2001 Federal Register.

Continuum of Care: Project Leveraging

(Complete only one chart for the entire Continuum of Care and insert in Exhibit 1. ***This entire chart will count as only one page towards the 25-page limitation***)

Project Priority Number	Name of	Type of Contribution	Source or Provider	*Value of Written Commitment
3	Example: Sarah's House	Child Care	Spotsville Co. Department of Social Services	\$10,000
1	Community Support Services – Safe Haven	Cash	Community Support Services	\$168,586
2	Info Line, Inc. – HMIS	Cash	City of Akron	\$60,000
2	Info Line, Inc. – HMIS	Cash	Summit County	\$60,000
3	Copley Facility	Facilities (Utilities, Repairs, etc.)	City of Akron, Emergency Shelter Grant	\$53,000
3	Copley Facility	Supportive Services, Rental Assistance	State of Ohio, Housing Trust Fund	\$105,000
3	Copley Facility	Supportive Services	State of Ohio, TANF	\$40,000
3	Copley Facility	Operating, Supportive Services	State of Ohio, Supportive Housing for the Homeless	\$73,300
3	Copley Facility	Youth Coordinator, Youth Programs	Akron Community Foundation	\$15,000
4	Step III Transitional Housing Program (Akron)	Unrestricted Cash	United Way of Summit County	\$13,880
5	Step III Transitional Housing Program Summit County (except Akron)	Unrestricted Cash	United Way of Summit County	\$17,410
6	ACCESS STEP II	Cash	DOD – SHH Program	\$20,000
6	ACCESS STEP II	Cash	ODOD – Ohio Housing Trust Fund	\$42,000
7	Assertive Community Treatment	Cash	ADM Levy – Community Supportive Services	\$102,846
8	The Brubaker Program	Cash Match	Legacy III	\$44,231
9	Project HOPE 2	Treatment Services	Community Health Center (CHC)	\$198,360
9	Project HOPE 2	Outreach-Women's Recovery	Community Health Center (CHC)	\$18,000
9	Project HOPE 2	Medical Services-Medical Department	Community Health Center (CHC)	\$28,000
9	Project HOPE 2	Early Start	Community Health Center (CHC)	\$22,000

10	McTaggart Court 2	Construction	Dept. of Housing and Urban Development (HUD)	\$784,246
10	McTaggart Court 2	Treatment Services	Community Health Center (CHC)	\$223,155
10	McTaggart Court 2	Outreach-Women's Recovery	Community Health Center (CHC)	\$18,000
10	McTaggart Court 2	Medical Services-Medical Department	Community Health Center (CHC)	\$41,400

****Please enter the value of the contribution for which you have a written commitment at time of application submission.***

- 7. b. Enrollment and Participation in Mainstream Programs.** Describe your Continuum of Care strategy currently in place to **systematically**:
- (1) identify homeless persons eligible for mainstream programs.
 - (2) help enroll them in the following programs for which they are eligible:
 - Medicaid
 - State Children's Health Insurance Program (SCHIP)
 - TANF
 - Food Stamps
 - SSI
 - Workforce Investment Act
 - Veterans Health Care
 - (3) ensure they receive assistance under **each** of the programs for which they are enrolled.

(Although you may require multiple pages to respond to this item, your response will count as only one page towards the 25 page limitation.)

The efficient utilization and connection of clients to mainstream resources is the goal of all providers in the Akron/Summit County Continuum of Care. Existing mainstream resources, such as the ones listed below, provide medical care and food stamps to clients. The utilization of services, available through existing programs, allows local homeless providers to apply otherwise scarce resources to other critical needs of the homeless that are not otherwise covered by mainstream resources. Providers meet on a regular basis through groups such as Tuff Stuff to discuss problem cases that test the limits of existing services. These meetings assist in identifying needs and formulating effective services.

During intake all assessment, local homeless provider agency's case managers determine client eligibility for virtually programs available within the community. Case managers work closely with the client to link them to appropriate programs and services including mainstream resources. Case managers conduct a monthly review to ensure that clients maintain their enrollment in Medicaid. Agencies may contact Medifax to determine if people are enrolled in Medicaid. The implementation of the Homeless Management Information System will improve the coordination of services within the community.

Enrollment Process:

- 1) Intake and Assessment to determine client needs and eligibility for mainstream resources
- 2) Verification of enrollment in programs
- 3) If not enrolled, connect clients to mainstream resources
- 4) Assist in completing required applications
- 5) Educate local case managers of changing rules and regulations regarding eligibility for all mainstream programs
- 6) Coordinate with other community agencies on difficult cases to ensure all of the clients' needs are met.

The Continuum of Care will be expanded to develop a closer relationship with the Department of Job and Family Services. The enrollment process for mainstream resources will be evaluated and simplified. Eligibility determination will be improved to allow clients immediate benefits to programs. The community will examine the challenges that provider's face in connecting people who are homeless to mainstream programs, particularly the lack of mainstream resources available to the single homeless individual.

The Akron/Summit County Continuum of Care will advocate closer collaboration among mainstream programs to improve service delivery. Efforts will be made to determine how well our mainstream programs fit into the continuum of care concept for serving the homeless.

Program	Local Coordination Activities
Medicaid	<ul style="list-style-type: none"> • Guarantee that Continuum of Care – Supportive Housing program funds will not be used to pay for services that are eligible for Medicaid reimbursement • Coordinate with special needs populations served by the Ohio Department of Alcohol and Drug Services (ODADAS) and Ohio Department of Mental Health (ODMH) • It is a priority for case managers to assess client medical needs and if eligible connect them to the Medicaid program • Individual homeless service agency case managers will assist the homeless in completing Medicaid application • Monthly review to ensure that clients maintain enrollment in Medicaid • Coordinate with Medifax to determine if people are covered by Medicaid
State Children's Health Insurance Program (SCHIP)	<ul style="list-style-type: none"> • Advocate with agencies that serve children to educate the agencies about the CHIP program and encourage enrollment of children in the program • Individual homeless service agency case managers will work with clients and their children to determine the medical needs of children and connect them to

	<ul style="list-style-type: none"> State CHIP program Case managers will assist the homeless in completing the State CHIP application Work with area schools to distribute information and encourage enrollment of all eligible children
TANF	<ul style="list-style-type: none"> Ensure that the County Prevention, Retention, and Contingency (PRC) program for homeless prevention activities are publicized to agencies who benefit from program and have access to information It is a priority for case managers to evaluate the eligibility of clients to receive TANF funds Case managers will assist in enrolling all eligible clients to the program Case managers have applications on hand to provide assistance in completing a TANF application
Food Stamps	<ul style="list-style-type: none"> It is a priority for case managers to evaluate the eligibility of clients to receive Food Stamps Case managers will enroll all eligible clients in the Food Stamp program Case managers have applications on hand to provide assistance in completing required applications Advocate with County administrators to educate the homeless about the Food Stamp program
SSI	<ul style="list-style-type: none"> It is a priority for case managers to evaluate the eligibility of clients to receive SSI Case managers will enroll all eligible clients for SSI Case managers have applications on hand to provide assistance in completing required applications Advocate with County administrators to educate the homeless about the Food Stamp program and encourage enrollment in the program
Workforce Investment Act	<ul style="list-style-type: none"> The Continuum of Care will educate the Community about State advocacy groups which are monitoring the implementation of the W.I.A in order to assess the impact on homelessness The Case managers coordinate clients needs with all appropriate W.I.A programs available in the Community
Veterans Health Care	<ul style="list-style-type: none"> Veterans Clinic provides outreach services Case managers engage veterans Assess needs of chronically homeless veterans Case managers will connect homeless veterans to all eligible mainstream programs

7. c. Use of Mainstream Resources. Using the following format, describe how the identified mainstream resources are currently (within the past 2 years) being used to assist **homeless persons** (see definition of “homeless person” in Glossary). “Prevention” activities are *not* to be included. **(Please ensure that there is no overlap between the resource funds listed on your Project Leveraging Chart and the uses/projects described below.)**

Mainstream Resources	Use of Resource in CoC System (e.g., rehab of rental units, job training, etc.), for <u>homeless</u> persons	Specific Project Name	\$ Amount or number of units/beds provided within last <u>2</u> years specifically for the <u>homeless</u>
CDBG	<ul style="list-style-type: none"> Supportive services Sewer Tap In Fees Sewer Tap in Fees Sewer Tap In Fees 	<ul style="list-style-type: none"> HMIS Peachtree Estates Hudson Dr. 1 & 2 McTaggart Court 	<ul style="list-style-type: none"> \$50,000 \$34,983 \$34,322 \$48,000
HOME	<ul style="list-style-type: none"> Construction Costs Construction Costs 	<ul style="list-style-type: none"> Peachtree Estates Peachtree Estates II 	<ul style="list-style-type: none"> \$100,000 \$125,000
ESG	<ul style="list-style-type: none"> Operational expenses, essential services, rehabilitation and building maintenance for agencies providing shelter for the homeless 	<ul style="list-style-type: none"> ACCESS Salvation Army Safe Landings H.M. Life Opportunity Services Community AIDS Network Legacy III Community Health Center 	<ul style="list-style-type: none"> \$185,000 \$28,000 \$26,000 \$125,000 \$30,000 \$78,000 \$10,000

		<ul style="list-style-type: none"> Battered Women's Shelter Community Support Services 	<p>\$55,000</p> <p>\$23,000</p>
Housing Choice Vouchers (only if "priority" is given to homeless)	<ul style="list-style-type: none"> N/A 	N/A	N/A
Public Housing (only if units are dedicated to homeless)	<ul style="list-style-type: none"> Shelter Plus Care 		45
Mental Health Block Grant Total - \$167,628	<ul style="list-style-type: none"> Community residential Services (SRO rent subsidy) for severely and persistently mentally ill persons meeting the definition of homeless Residential component of services for severely emotionally disturbed children within homeless families 	<p>Community Support Services – Residential – Proprietary Homes</p> <p>Child Guidance Centers</p>	<p>About \$29,000 in rent subsidy</p> <p>\$1200</p>
Substance Abuse Block Grant	Medical treatment, counseling, support of methadone clinic, case management and long term residential treatment for substance abuse. Substance abuse treatment for the HIV population. Treatment services for special populations – persons of color, the elderly, children and those involved in the criminal justice system	<ul style="list-style-type: none"> Community Health Center. Oriana House Akron Health Dept A-UMADAOP Edwin Shaw Hospital Interval Brotherhood Home 	\$125,000
Title XX	Childcare services, mental health, operating costs	<ul style="list-style-type: none"> Community Support Services Summit County Dept. of Jobs and Family Services 	Unknown – current data unavailable
Federal Program Projects for Assistance in Transition from Homelessness (PATH)	Outreach services to identify individuals who are homeless and suffering from mental illness	Community Support Services Homeless Outreach Team	\$177,713
Welfare-to-Work	<ul style="list-style-type: none"> Case managers assess the client's need for education and/or employment training Clients are encouraged to enroll in education or training programs to promote career advancement and long-term self-sufficiency Supportive services and transitional housing are available to homeless clients for up to two years while they are enrolled in these programs 	Community Health Center – CSAT Grant	\$1,000,000
State			
<ul style="list-style-type: none"> State ESG Ohio Department of Alcohol and Drug Services (ODADAS) Ohio Housing Trust Fund 	<ul style="list-style-type: none"> Rehabilitation, operating, and supportive services Residential treatment and services for persons with substance abuse Operating and supportive services 	Community Health Center	<p>\$100,000</p> <p>\$149,500</p> <p>\$150,000</p> <p>\$143,941</p>
<ul style="list-style-type: none"> Medicaid Supportive Housing for the Homeless State Program Homeless 	<ul style="list-style-type: none"> Hospital care, primary care, substance abuse and mental health Rehabilitation, operating, and supportive services Rental Assistance 	<ul style="list-style-type: none"> ACCESS H.M. Life Opportunity Services Community Support Services Compre-hensive ACCESS H.M. Life Opportunity Services Community Health Center Community Support Services Dept. of Jobs and Family Services 	<p>Unknown – current data unavailable</p> <p>\$300,000</p> <p>100 units</p>

<ul style="list-style-type: none"> Assistance Program (HAP) Food Stamps 	<ul style="list-style-type: none"> Food Stamps 		75% of homeless population (estimate)
City/County Funded Programs <ul style="list-style-type: none"> Akron Child Guidance Center County HWAP Summit County Children Services Board Summit County Juvenile Court Summit County 	<ul style="list-style-type: none"> Operating and essential services Rehabilitation Operating, supportive services Youth Assessment Operating and supportive services 	<ul style="list-style-type: none"> Shelter Care Community Health Center Shelter Care Shelter Care Battered Women's Shelter 	<ul style="list-style-type: none"> \$275,000 \$2,613 \$255,000 \$53,655 \$187,000
Private <ul style="list-style-type: none"> Donations Catholic Charities United Way 	<ul style="list-style-type: none"> Operating Operating Operating, supportive services, and essential services 	<ul style="list-style-type: none"> Legacy III ACCESS Community Network ACCESS Legacy III ACCESS H.M. Life Opportunity 	<ul style="list-style-type: none"> \$42,470 \$32,000 \$201,800
Foundations (Identify by name) <ul style="list-style-type: none"> Sisler McFawn Foundation Omnova Foundation Akron Community Foundation Chase Manhattan Foundation Knight Foundation FirstEnergy McDonald's Bank One Knight Foundation Sisler Foundation Musson Foundation Ritchie Foundation Summit Count Housing Trust Fund GAR Foundation 	<ul style="list-style-type: none"> Operating Transportation Supportive services Operating Operating Construction Construction Construction Construction Construction Construction Construction Construction Construction 	<ul style="list-style-type: none"> ACCESS ACCESS ACCESS ACCESS ACCESS Community Health Center 	<ul style="list-style-type: none"> \$10,000 \$2,500 \$23,858 \$5,000 \$50,000 \$250 \$8,062 \$3,500 \$200,000 \$5,000 10,000 \$5,000 \$10,000 \$75,000

