

Chronic Homeless Strategy Report

Recommendations on the Cowlitz Continuum of Care 10 Year Homeless Housing Plan

Submitted to Cowlitz-Wahkiakum Council of Governments

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Executive Summary

The Cowlitz Continuum of Care, in response to state legislation, initiated a planning process in 2005 to develop a 10 Year Homeless Housing Plan. The Cowlitz Homeless Housing Task Force was established to complete this work. During the initial phase of plan development the Task Force identified a significant gap in housing and services for chronic homeless. The most visible of the chronic homeless are in Longview who funded this Chronic Homeless Strategy through a CDBG Planning Grant. Over a three month period 40 different representatives of public and private organizations involved in health care, social services and housing collaborated in the development of this Chronic Homeless Strategy.

Good planning and prioritizing of limited resources is dependent upon accurate data and information to inform the decision-making process. The Homeless Housing Task Force acknowledged that the current process used in the Point in Time Count and a lack of a local Housing Management Information System is not providing an acceptable level of information. This strategy provides recommendations to improve the Point in Time Count. It also includes a project model that would provide a county-wide assessment and referral system that could also collect critical data regarding the needs and service gaps of the chronic homeless.

The Chronic Homeless Strategy provides recommendations that include both short term and long term actions. It identifies existing resources that could be re-positioned to improve access by the chronic homeless with existing housing and services. The strategy also explores various models of housing and services applicable to this community to better address the needs of the chronic homeless. The Housing Homeless Task Force has prioritized these projects, identifying projects for immediate action as well as projects/models that should be considered in the future by the Cowlitz Continuum of Care.

Finally, this strategy offers some general recommendations to move the Housing Homeless Plan forward, including the Chronic Homeless Strategy.

Point in Time Count

Cowlitz County has participated in the Balance of State Point in Time Count (PIT) for the past three years. Service and Housing Providers are concerned that the most recent PIT did not capture a good representation of the homeless and chronic homeless. The following are recommendations to continue to improve on this process acknowledging that in a PIT Count homeless not accessing services and in more remote areas of the county may be under-represented in the count.

Responsibility for the coordination of the PIT has been the function of the Senior Planner of the Cowlitz-Wahkiakum Council of Governments working with members of the Continuum of Care and Housing Homeless Work Groups. Communities that have had greater success in capturing the number, characteristics and needs of the homeless have acknowledged that it takes dedicated staff time to design, plan and implement a PIT Count. The Council of Governments has done a great job in analyzing and disseminating information garnered from the counts. The information from the count is used in planning the Cowlitz County Continuum of Care and 10 Year Plans to Reduce Homelessness. It may be worth considering hiring or contracting for some staff time for a 3 month period to guide the planning, recruitment of volunteers and agencies, develop and provide training for enumerators and interviewers and ensure that all information is correctly tallied. Improved responses to the PIT will better assist in planning, reporting, fund raising and increasing public awareness of the homeless and chronic homeless of this community.

There are three primary ways to focus the PIT Counts, each of which has been included to some degree in previous Cowlitz County PIT Counts;

- Shelter, Transitional Housing and Permanent Supportive Housing Count (including the county jail)
- Service Based Count
- Public Places Count

Shelter and Service Based Counts

There has been a good mix of non-shelter service sites including the jail, local hospital, food banks, health, mental health and dental clinics, DSHS and Social Security participating in the PIT. Shelter providers, transitional housing and permanent supportive housing have also participated. To improve the capturing of information of homeless, recruitment and use of volunteers to assist staff in the completion of surveys at various agencies would allow for more agencies to participate in the PIT that are supportive but simply have an already over-taxed staff.

The local schools should also be recruited to participate in the PIT. Local school districts have been sporadic in their participation in the PIT due to staffing limitations. A short-term goal could be to recruit volunteers in each school district, possibly through the local PTA's to assist with the count with some type of interview incentive for parents of homeless students, as well as homeless youth. In year's 3 through 5 the goals would be to meet with school district administrators and present information obtained from year 1 and 2 years PIT in their districts and engage in conversation about how best to support the school district's efforts in assisting homeless families with children and youth in their district. Years 7 through 10 goals could be participation of the school districts in the counts and sharing information with other providers about resources and services.

Public Places Count

Cowlitz County is a large, rural county and it would be nearly impossible to complete a county-wide count of homeless through every census tract. It is also to be acknowledged that many chronic homeless are “service resistant” and will be missed in the Shelter/Services Counts. It is recommended that a planning group that includes formerly homeless, homeless outreach workers and law enforcement identify locations throughout the county where homeless congregate. It is also key to identify what time of day or night is best to conduct a count for each of these locations. Parks, encampments, all-night laundries, abandoned buildings all are possible locations to be included in the Public Places Count.

Safety is always a concern. In some communities law enforcement officers are teamed with homeless outreach workers and/or volunteers to complete the Public Places Count. Informing/advertising of the count with homeless prior to the count will also be helpful. It may be better to do a count/observation the day of the PIT and provide homeless contacts a meal voucher or other type of incentive that can be “cashed in” the next day where a more in depth interview/survey will be completed.

The Department of Housing and Urban Development published a guide that provides good ideas and “best practices” in how to complete counts in public places and is recommended as a resource in expanding Cowlitz County’s count of homeless in public places.

A Guide to Counting Unsheltered Homeless People
Homeless Assistant Programs
Office Community Planning and Development
Department of Housing and Urban Development
October, 2004

Agency Re-Positioning

A mapping of current providers of low income housing services was completed as a part of the development of this strategy. The mapping of 32 different agencies is provided in Appendix B. The following are recommendations for organizational and resource re-positioning to better serve the chronic homeless of Cowlitz County:

- Increase the number of homeless individuals with mental illness who receive case management services and mental health services as a part of housing strategies for the chronic homeless. This will require broader participation/engagement of the local DSHS and RSN staff and resources.
- Increase the coordination of case management for people who are homeless and have a mental illness and history of substance abuse as part of housing strategies for the chronic homeless population. This will require broader sharing of information and case management responsibilities between substance abuse treatment providers, the RSN and DSHS.
- Identify an organization as lead agency, possibly Lower Columbia Community Action Council, to organize or facilitate the provision of multiple services at a single location using the one-stop model. The one-stop center would serve the general homeless population, as well as the chronic homeless population.
- Build on the participation of local law enforcement agencies and Department of Corrections to improve discharge/release planning that includes a housing component. This will require identification and/or development of housing that will be available to ex-offenders.
- Engage private landlords to improve access of current housing stock to chronic homeless to reduce the number of days in shelters and prevent loss of housing once in place. This will require resources for the following:
 - Landlord incentives (like damage securities) to mitigate higher risk tenants
 - Rental rehabilitation program that will improve housing quality for low income renters
 - Increase prevention assistance for single adults.
 - Provide 24/7 intervention assistance for landlord/tenant issues
- Increase the number of units that would be available to chronic homeless individuals with felony convictions through the development of units using funding sources that permit housing of individuals/families with felony convictions. These units could be owned and managed by the local Housing Authority's, nonprofit organizations and private landlords. There are several funding sources that do permit people with felony convictions to live in housing financed by that program, or could be allowed with the local administrating body permitting for housing of people with felonies including; McKinney-Vento Shelter Plus Care Supportive Housing, Community Development Block Grant, HOME program, Washington State Housing Trust Fund, Recording Fees Revenues 2060 and 2163.
- Establish the Continuum of Care Planning Group/Housing Homeless Planning Group as a forum for the regular sharing of information on housing and services for the chronic homeless population.

Proposed Projects and Timelines

The Homeless Housing Task Force reviewed a number of models that the consultants identified as appropriate for this community given the characteristics and numbers of chronic homeless and the organizations skills and relationships and resources available. The project models are provided in Appendix A.

The following are projects that have been identified by the participants of the Chronic Homeless Strategy Work Group as projects that could benefit chronic homeless. The list has been prioritized by the interest shown by the Chronic Homeless Strategy Work Group. All of the proposed projects have support of the Work Group and endorse the inclusion of these projects in the implementation plan for county's Ten Year Plan to the Reduce Homelessness. The timeline offers recommended priority projects, lead agency and specific steps to be taken over the next two years to move the top four projects forward.

Projects listed below are numbered according to the priority assigned by the Task Force.

1. Resource Center for Homeless
2. Resource Guide for the Homeless
3. Transitional Housing for Chronic Homeless Women and Homeless Women with Children
4. Supportive Housing for Pregnant and Post Partum Women
5. Community Assessment and Referral System
6. Supporting Housing for Adults with Co-occurring Disorders
7. One Stop Intake and Referral Location
8. Resource Center with Housing for Chronic Homeless
9. Child Care Center for Homeless Families
10. Homeless Families rental assistance and case management services (WA. Families Fund)

Projects Timeline and Action Steps

Activity	Lead Agency(s)	Quarter 1 Year 1	Quarter 2 Year 1	Quarter 3 Year 1	Quarter 4 Year 1	Quarter 5 Year 2
Resource Center for the Homeless	CHOB LCMH	<ul style="list-style-type: none"> • Develop MOU • ID site • New Partners: Housing Authorities Family Health Veterans/VFW Salvation Army CAP Faith Community City and County • Initiate oversight committee • Staffing and Volunteer Plan • Set-up of site • Begin outreach <p style="text-align: center;">Benchmarks: Lease 4 sponsor organizations Operational 2 days/ 6 to 10 hrs</p>	<ul style="list-style-type: none"> • Increase Operational hours • Secure corporate donations • Create a fund raising committee • Expand outreach; develop flier • Complete 6 mo. Evaluation • Recruit additional agency partners <p style="text-align: center;">Benchmarks: 6 – 8 partner organizations with MOU's Operational 4 to 5 days per week</p>	<ul style="list-style-type: none"> • Develop and implement a schedule of activities/meals & services • Presentations & applications for funds with public funders • Assess the site for possible relocation options • Develop long-term staffing plan <p style="text-align: center;">Benchmarks: 6-8 organizations w/ annual commitment Oversight Committee fully operational</p>	<ul style="list-style-type: none"> • ID site for long term lease or purchase • Purchase equipment and furniture • Implement training program for staff and volunteers • Complete 1 yr evaluation • Public Funders applications 	
Resource Guide for Homeless	LCC CAP Pathways 2020 Ethnic Support Council Head Start	<ul style="list-style-type: none"> • CofC act as oversight committee • Decide which model to use • ID content, languages, distribution and updates • Recruit and formalize partners listed • ID sources for publication costs 	<ul style="list-style-type: none"> • Complete fund raising for 1st publication • Begin publishing “pocket card” information for distribution • Collect, organize and format info for handbook • Complete distribution plan 	<ul style="list-style-type: none"> • Apply/solicit additional funds • Final revision & printing of premier Edition • Begin distribution and outreach efforts 	<ul style="list-style-type: none"> • Update info • Expand distribution • Evaluate • Additional fund raising 	

Activity	Lead Agency(s)	Quarter 1 Year 1	Quarter 2 Year 1	Quarter 3 Year 1	Quarter 4 Year 1	Quarter 5 Year 2
Housing for Pregnant and Post Partum Women	<i>LHA DAPC</i>	<ul style="list-style-type: none"> • ID site and control • Apply for pre develop. Funds • Complete due diligence of site • ID development team • Apply to State Trust Fund 	<ul style="list-style-type: none"> • Begin site design • Development and Ops budgets • Begin public in put process • Apps for 2060 and 2163 funds 	<ul style="list-style-type: none"> • If awarded Trust fund – apply for Tax Credits • Complete site and building plans 	<ul style="list-style-type: none"> • If awarded tax credits – begin permitting and construction 	
Transitional Housing for Chronic Homeless Women and Homeless Women w/ children	<i>ESS</i>	<ul style="list-style-type: none"> • ID potential partners/housers and service providers • Better define concept • Document need Research models 	<ul style="list-style-type: none"> • Determine what Planning only grant app. to CTED /Kelso as sponsor or to the City of Longview 	<ul style="list-style-type: none"> • Complete application for POG 		<ul style="list-style-type: none"> • If awarded funds begin planning process

Objectives and Future Strategies for Assisting the Chronic Homeless Population

In addition to the models and projects identified above the following are other objectives and strategies that the Continuum of Care may want to consider as it modifies, adjusts and prioritizes funding priorities for the community.

Prevention

Objectives

- Increase placement rate of people released from institutions into housing
- Increase number of individuals/families facing eviction that retain their housing
- Increase number of homeless people referred to appropriate housing

Strategies

People with Felony Convictions, Release from Jail

- Substance abuse treatment for jail inmates
- Create a jail discharge plan
- Work to revise policies excluding households from affordable housing because of felony convictions including a review of policies that have been adopted locally for the administration of federal, state and local programs (McKinney, HOME, CDBG, 2060, 2163 and HTF) and explore increased flexibility in the Housing Choice Voucher Program. This would include a goal of differentiating between various types of felonies in the policies.
- Referral staff at jail to refer people being released to housing and services. Create a gatekeeper position at jail to link people released from jail to housing and services
- Discharge case management plans for people released from institutions

People with Co-Occurring Disorders and Chronic Substance Abusers

- Coordinate case management services with professionals trained to work with people who have a substance abuse history and/or mental illness to provide appropriate intervention with landlords (24/7 response)
- Eviction Prevention Program to work with landlords when tenant is hospitalized or in treatment for short periods of time
- Crisis beds for short term stays when an individual needs intense support for a short period of time before they can return home

People with Mental Illness

- Wrap around assistance for mental health clients-first/last months rent and deposit, household items, medication until medical coupons go into effect
- Homeless outreach program (PATH through Regional Support Network) tied into Homeless Resource Center and/or One Stop Center
- Discharge case management plans

Outreach/Access/Public Awareness

- Community-wide assessment and referral system
- One stop case management system for homeless individuals/families
- Resource Guide targeted to homelessness and the housing and services available
- Build and improve upon PIT count and public education regarding the needs of the community's homeless

Maintaining Housing

- Referrals to a Rental Housing Mediation (Dispute Resolution Center) to work out potential evictions/work with landlords to develop payment arrangements that will allow for continued housing
- Work to revise policies for a specified percentage of units owned by the housing authorities, non-profits and private landlords that exclude households from affordable housing because of credit history providing incentives for those willing to relax their policies and house a higher risk tenant
- Develop a community Protective Payee Program that will address recent changes in state and federal regulations
- Eviction Prevention Program to assist in retaining housing units when short-term (3 to 6 weeks) hospitalization is required for mentally ill and for those completing treatment for alcohol/drug abuse that may require multiple re-entries' before maintaining sobriety.

Income

(Note income includes strategies that reduce the cost of meeting basic needs to the individual)

Objectives

- Increase utilization of benefit programs that households/individuals qualify for
- Increase employment rate and earned income amount for homeless households/individuals

Strategies

Benefit Programs

- Allow for easier access to applications process by siting benefits staff at Homeless Resource Center, One Stop Center & Health Clinic
- Ensure that SSI and medical benefits suspended during jail are reinstated
- Regular meetings of providers to increase staff knowledge of benefit programs and requirements, access, etc.

Reducing Costs of Meeting Basic Needs for the Homeless Person/Family

- Identify funding sources for transportation assistance including Supportive Housing, 2163, FEMA, ESG, and donations to provide gas vouchers, bus tokens;
- Education /training in car maintenance and repairs
- Make available low cost cars and financing for those who do not qualify for car loans
- Increase availability of public and private transportation through;
 - Volunteer Drivers with insurance and gas provided
 - Expanded hours and routes for those organizations that have vans/buses
 - Pursue USDA funding for a bus in rural areas
- Food-network of food banks, meal sites and bag lunches to ensure food is available daily
- Licensed childcare that will accept state payments
- Clothing and personal hygiene products-network of thrift stores and clothing banks are available daily and blankets, shoes and coats for winter months

Employment

- Create a labor-ready program through the Homeless Resource Center
- Bilingual job readiness program
- Develop jobs with public agencies, non-profits private employers through Work Source DVR
- Job apprenticeship program for chronically homeless population including enrollment in L&I and other apprenticeship programs that may be more informal
- Computer skills training

Financial Management

- Include budgeting/financial literacy counseling in voucher and emergency assistance programs
- Increase utilization of budgeting/financial literacy education and other life skills classes into community college or other established education opportunities

Health

Objectives

- Provide a range of healthcare choices for the homeless from preventative to routine to emergency health care.
- Increase the number of homeless individuals receiving treatment services addressing financial accessibility, physical accessibility and types of treatment that are accessible.

Strategies

Treatment Services

- Provide respite care beds for individuals with mental illness and/or homeless with physical illness or conditions requiring medical treatment through the purchase of beds/care from local nursing and assisted care facilities as needed
- Provide sub-acute detoxification/sobering, sleep off center
- Increase the range of healthcare with the use of local funds to subsidize payments to local clinics/hospitals that provide preventative and routine health care to the homeless
- Provide on-demand mental health crisis intervention

Healthcare Access

- Ensure that homeless individuals/families are enrolled in healthcare for which they are entitled
- Health screening for chronic homeless provided through Resource Center for the Homeless, One-Stop Center and/or mobile Health Van

Housing

Objective

Provide a higher quality service to people who are homeless and make better use of the limited resources available.

Strategies

Housing Access

- Develop a Community Assessment and Referral System that reduces the number of times an individual has to provide the same information to receive some type of assistance, assess the need of a homeless individual more quickly, make appropriate referrals, provide immediate assistance and make the experience of receiving the service more “user friendly” by creating a written/electronic record of the individual and what referrals are made and what assistance is provided.
- Develop a One Stop Center that would provide multiple services to the homeless in one location that will break down some of the barriers for the homeless needing to access multiple services and allow staff to coordinate services between providers and move beyond the provision of emergency services.

Housing Programs/Units

- Provide incentives to landlords to maintain housing as affordable to homeless (higher risk tenants). The assistance could include: rental assistance, loans/grants for maintenance or rehabilitation, supportive services for residents who need assistance to live independently, quick response to landlords and tenants when a problem arises, payment of higher deposits and paying holding costs to keep units available for tenants receiving short term health/treatment care.
- Develop supportive housing units for chronic homeless women and women with children, pregnant and post partum women, homeless adults with co-occurring disorders and homeless families and individuals.

Moving the Housing Homeless Plan and Chronic Homeless Strategy Forward

The following are general recommendations to ensure that the planning effort that Cowlitz County has engaged in results in projects moving forward and homelessness is reduced throughout the county.

Resource Staging

- When all strategies are completed it is recommended that priorities for local funding and implementation be agreed to by Continuum of Care and Housing Homeless Task Force through a formal adoption of the plan with a record of who participated in the development of the plan and those that support the plan.
- Forward the plan to local funding agencies, highlighting the relevant portions of the plan for that funding source.
- Regular meetings to share updates pertaining to specific activities of the plan with a letter of support and/or letters of commitment of supportive services or other collaborative efforts. As noted above, the Task Force would send a letter of support identifying the project as a priority in the plan and the list of organizations that agreed to the plan.

Plan Implementation

- Commitment of the agencies/organizations identified as lead for plan activities to carry-out planned activities through Memorandums of Agreement, Memorandums of Understanding or in some cases a contract.
- Create and fund a Homeless Housing Coordinator who would staff the following functions:
 - Oversee and coordinate implementation of Housing Homeless Plan
 - Coordinate project/program funding in concert with the Continuum of Care
 - Manage the 2060 and 2163 funding process for the County
 - Coordinate the Point In Time Count
 - Maintain the data bases for the Resource Guide for the Homeless and Community Referral System
 - Develop a community education program/campaign regarding the homeless and near-homeless of Cowlitz County

Project/Programs updates

- Identify a process for updating community partners as to the status of projects, evaluation of Housing Homeless Plan and corrective actions as new data, identified gaps, changing resources and opportunities are identified.

Appendix A

Models and Implementation Strategies

Chronic Homeless Model and Implementation Strategy Homeless Resource Center

Model Description:

Purpose

To provide a safe place for people who are homeless, provide basic survival services and reduce a public nuisance.

Types of Centers

Resource Centers are generally open 365 days a year with operating hours of 6 to 12 hours per day. Some Resource centers are available to any homeless person while others are age and/or gender specific. A Resource Center for homeless persons is first and foremost a place of hospitality. It is a welcoming place that provides generous treatment to guests and strangers alike. It is also a place of safety where people can begin to identify their hurts, hopes and hurdles. Hospitality begins with outreach workers extending invitation to those that are homeless and on the streets of the local community to come to the Resource Center.

Resource Centers are a key to providing basic survival services that meet immediate needs.

Basic services include; telephones and voicemail, a mailing address, storage, personal hygiene and laundry facilities, a hot meal and snacks, a community living room, and a library with computer access.

For some patrons of the Resource Center the basic services will be the only level of service requested or sought after, for others it is a way to begin developing trust that can move into assessment, goal setting and referrals to substance abuse treatment and/or health care, legal services, completing applications for benefits and housing, job training and placement. In some Resource Centers these services are on-site. Often times a One Stop Center is housed next door to a Homeless Resource Center. Resource Centers can also be a Day Labor Pool where folks can be hired for short-term jobs.

Benefits

Providing a place where people can address their basic needs and be treated with respect can often-times be the start of a new beginning for the homeless. A place to shower, wash clothes, pick up mail and voice mail, read a paper and have a cup of coffee are all access points with staff who believe that each homeless person possesses strengths that are key to ending their homelessness. A Resource Center can also reduce the number of homeless simply hanging out on the streets and be a place where behaviors are monitored.

What is currently available?

The services now in place through Lower Columbia Mental Health, the homeless outreach of the PATH program, protective payee, case management services, treatment referrals and benefits applications from a variety of service providers could be linked with on-site information and referral staff of the Resource Center.

What are the gaps?

A physical space of hospitality that can deliver the basic survival services with few barriers of access to patrons. Minimal staffing would require 1 to 2 trained Intake Workers per shift that could be augmented with volunteers.

OBJECTIVE

The Resource center would provide a safe place for people who are homeless, particularly homeless individuals who are living on the streets, camping out or living in vehicles, to go for a few hours each Resource. While at the center, individuals could receive emergency assistance as well as use hygiene facilities.

ACTIVITY

Establish a Resource center for the chronic homeless population (center would be open to all homeless individuals) that is open for 6-12 daytime hours each day, year around. The center could include:

- an area with tables, chairs, sofas and telephone, computer, television or radio
- hygiene area with restrooms, showers, laundry
- distribution of “brown bag” food and beverages, or offer a hot meal.
- staff or volunteers that could provide information about shelter or housing, distribution of emergency financial assistance and assistance with applications for public benefits

The Resource center could be co-located with a one-stop center, shelter or rental housing.

WHO IS RESPONSIBLE

- A lead agency would need to be identified to own/lease the facility and provide staffing for the center, possibly the same lead agency as the one-stop center, particularly if the centers are co-located.
- If shelter or housing is included with the Resource center, a nonprofit organization or the Longview Housing Authority could own and/or manage the housing.
- Service providers (e.g. outreach, counseling, treatment, emergency assistance) would agree to provide information to the Resource center staff, and materials for distribution at the center on the availability of services/housing, eligibility criteria and process for application, and if possible, agree to offer services on-site on a regular basis.

STRATEGIES

Housing

- Housing and shelter providers would agree to provide information on the availability of shelter beds or rental housing units, eligibility requirements and the application process with the Resource center staff, and update the information on a routine basis.
- Shelter or rental housing for the chronic homeless individuals provided at the same location as the Resource center.

Health

- Substance abuse treatment, mental health and medical providers would provide information on the availability of services; eligibility requirements and the application process with the Resource center staff, and update the information on a routine basis. Providers would commit to a schedule of on-site hours at the center per month to provide information and services.

Income

- Outreach staff responsible for assisting individuals with applications for benefits would commit to a schedule of on-site hours at the center per month to assist individuals with applications, and to answer questions about benefit programs.
- Providers of GED, job readiness or employment placement programs would commit to a schedule of on-site hours per month to assist individuals with education and employment.
- The Resource center can serve as a location to receive temporary labor assignments.

Prevention

- Provider of emergency assistance would commit to a schedule of on-site hours at the center per month to assist individuals with rent, deposits, food, transportation or other expenses.
- Resource center provides a place where homeless individuals who are temporarily staying with friends or relatives can go each day, providing respite for those who take in the homeless on a temporary basis.

Planning and administration

Identification of site for use as a Resource center.

Project planning, budget development, securing financial resources and purchasing/leasing a facility.

Development of a business plan for the center, (or center and housing) to operate.

OUTCOMES/IMPLEMENTATION STEPS

See the Projects Timeline Adopted by the Homeless Housing Task Force

RESOURCE OPTIONS

The financing needs and funding to be determined as part of the development budget and business planning process. Possible funding sources could include: rent/usage fees paid by each participating service provider, Recording fee revenues (2163), McKinney Supportive Housing Program, and private foundations, grants and donations.

Chronic Homeless Model and Implementation Strategy

Housing Placement Process

Model Description:

Purpose

To provide a higher quality service to people who are homeless and make better use of the limited resources available by assessing the need of a homeless individual or family more quickly by:

- making appropriate housing referrals
- providing immediate assistance to prevent homelessness or address an emergency need
- making the experience of obtaining housing more “user friendly”.

Housing Placement Process

Typically a housing placement process has 2 components, an interview with individual or adults in a household to understand their housing needs, and creating a written/electronic record of the individual/household. The goal of many housing placement systems is to reduce the number of times an individual(s) has to provide the same information to receive housing (and other services), and to use the information that is collected to provide housing referrals that are appropriate for the individual/households and menu of services that the individual can choose from to meet other needs (e.g. obtaining benefits, medical care, employment assistance, etc.)

Coordination with Service Delivery

Some communities have integrated the housing placement process with one stop centers, a service delivery site or shelter to increase the likelihood that the individual will actually receive the services that will help them successfully maintain a stable housing situation after the initial placement.

Benefits

Communities that have a housing placement process that involves sharing information (with the individual’s permission) between service providers report a significant increase in the number of people who maintain stable housing situations for a longer term (6 months+). Clients who have participated in a housing placement process of this type report increased satisfaction with the “in-take” or “assessment” process, being treated with more respect and that the housing and services they are referred to better match their needs. Housing providers also report a decreased cost in the housing application process when they can share information.

Housing placement information systems result in benefits in addition to housing stability; often the individual/household is referred to services that result increased or more stable source of income, lower cost healthcare and resources for maintaining their housing if they experience a financial crisis in the future.

What is currently available?

Housing and service providers in the Longview area conduct various “in-take or assessment” processes for their clients and maintain databases about their clients and services. Some of these processes are very formal to determine eligibility for government funded substance abuse or mental health treatment services. Some organizations use processes that collect very little information about the client, and the relationship between the client and the organization is very short-term. There are a few memorandums of understanding or service agreements that provide for information sharing or a “coordinated in-take/assessment process” between organizations, or between programs within an organization.

What are the gaps?

To have a more coordinated housing placement system for homeless individuals/households in the Longview area, an information management tool for collecting, sharing and managing information on clients and services/housing would need to be established. The information management system would include:

- Multiple organizations willing to share client information, with the client's permission
- Agreement between the organization to use a common form, or to have 1 or 2 organizations conduct the initial interview and information collection with the client
- Willingness of the participating organizations to provide information about eligibility requirements for housing (and services) and the availability of the housing/services (e.g. is there a waiting list? Is there a deadline?) to the coordinating organization
- An organization that is willing to "manage/maintain" the system
- Training for staff on services provided by other organizations (e.g. eligibility requirements, application processes, etc.).

Housing Placement Implementation Strategy

OBJECTIVE

Reduce the number of chronic homeless through improved and expedited access to community low income housing, mainstream programs, health, dental and mental health care and other community supportive services.

ACTIVITY

Establish a community assessment tool for housing and service needs employed by a network of community agencies that is linked to a resource data base that identifies appropriate services for referral. The assessment tool needs to integrate into the Housing Management Information System so that information on the individuals receiving services and their service usage is computed. This will provide a tool for evaluating the effectiveness of referrals and services provided.

WHO IS RESPONSIBLE

Data to be publicly owned and maintained
Lower Columbia Community Action Council as lead

STRATEGIES

Housing, Health and Income

Network agencies would include public and non-profit providers that would use the common assessment tool when making and receiving referrals reducing the redundancy for the chronic homeless client.

Data base would be up-dated regularly allowing for improved communication of current available housing and services.

Access to information would be county-wide and would not be limited due to geographical location for intake and assessment.

Prevention

Referrals would be generated from a tiered data base that allows for a better match of client needs and level of services that will not only increase customer satisfaction but allow for an improved and appropriate utilization of limited resources.

It is anticipated that there will be increased access to services by chronic homeless as the intake process is more humane, responsive and does not require the homeless client to repeat information or to be referred to agencies not appropriate or equipped to address their needs.

Planning and administration

Increased formalization of working relationships and network of public and non-profit organizations through Memorandums of Agreement.

Through regular updates of services and housing units and analyzing where there are referral gaps or under/over utilization of services or housing units will allow for strategic community re-prioritizing of new services/projects and funding priorities.

OUTCOMES/IMPLEMENTATION STEPS

Year 1

Quarter 1

Program description developed
Assessment tools researched
CTED – possibilities of expanding balance of state HMIS
For local uses; Cowlitz as potential pilot

Quarter 2

Research of software; adaptations need for interface with HMIS?
Project staffing, equipment and budget developed

Quarter 3

Fund sources identified – applications prepared
Development of MOA's; legal review re. HIPPA and other confidentiality concerns

Quarter 4

fund solicitations continue

Year 2

Staff hired
Develop and implement staff training for network intake workers
Program up and running

RESOURCE OPTIONS

Local public funds

Private foundations and grants

CTED

Chronic Homeless Model and Implementation Strategy

Low Demand Housing

Model Description:

Purpose

Low demand housing acknowledges that the skills needed for survival on the streets differs greatly from those needed for retaining permanent housing. Chronic homeless are not solely homeless due to economic crisis or the crisis regarding a lack of affordable housing. Low demand housing provides housing first to chronic homeless with mental illness, a substance use disorder, or co-occurring disorders.

Types of Low Demand Housing

Low demand housing is flexible with no treatment participation demands or poor tenant history as a disqualifying factor. The key objective is to retain tenancy within the low demand housing that provides case management and on-site coordination of support services. Some low demand housing have the expectation that with permanent supportive housing the resident's alcohol/substance consumption will be reduced leading to improved health of the resident, less demand on health care and a reduction in public nuisances. The Lyon Building in Seattle is an example of permanent supportive housing for homeless adults with multiple disabilities whose primary goal to successfully maintain the housing for each of the 64 residents.

Some low demand housing provides comprehensive on-site services including mental health and chemical dependency treatment, health care, medication monitoring, community meals, payee and case management services. 1811 Eastlake Project in Seattle is an example of housing targeted towards chronic homeless women and men with chronic alcohol addiction

Other models have the expectation that although treatment participation is not required, that over time, in the context of a safer, permanent and supportive environment re-engagement with treatment services will occur with movement towards less supportive permanent housing. Often called Transitional Housing, those that are targeted towards the chronic homeless provide housing and supportive services are flexible, allowing for self-direction towards recovery and stabilization. Homeward Bound in Anchorage, Alaska is an example of this type of low demand housing.

A fourth model are those that are built around the values of living clean and sober lifestyles. Some, like Safe Haven of Chicago, are targeted to women and men who are homeless, others for those being paroled from the Department of Corrections or referred from Drug Court. Safe Havens provide professional staff to assist each resident in reaching their goals. Oxford House is a self-help model offering a group home for individuals in recovery from alcoholism and substance abuse. Oxford Houses are self-managed and self-supported.

Benefits

Through providing housing first, the lives of the residents are stabilized, reducing the residents' use of the community crisis response system, reducing public nuisances and encourages residents to reduce if not stop their alcohol/drug consumption and seek appropriate medical and mental health care.

What is currently available?

There are a number of treatment programs that provide a continuum of care as residents of low demand housing choose treatment including the Drug Abuse Prevention Center, Community Mental Health, Country Run, Community House on Broadway and SL Start.

Most of the current “low demand” housing options in the Longview area require residents to move after a certain length of time in housing with supportive services. All require sobriety as a prerequisite for housing.

What are the gaps?

Currently there is no low demand housing available for the chronic homeless of Cowlitz County who are not agreeable to mental health or substance abuse treatment. A physical space that would provide SRO’s to a designated number of tenants, community room space and on-site 24 hour staffing capacity would be needed to provide low demand, housing first to the chronic homeless of Cowlitz County. The most challenging aspect for this type of housing is the budget for services. To provide 24/7/365 housing means that it takes 4.2 FTE to fill 1 position.

Low Demand Implementation Strategy

No low demand implementation strategy was developed at this time. Two potential supportive housing projects are in the Projects Timeline Adopted by the Homeless Housing Task Force.

Outcomes/Implementation Steps

Year 1	
Quarter 1	Program description developed as to who and number to be served Site selection criteria developed
Quarter 2	Site selection Development of preliminary financing strategy and project budgets
Quarter 3	Apply for predevelopment funding Obtain site control
Quarter 4	Preliminary Design Apply for funding
Year 2	
Quarter 1-4	Apply for funding
Year 3	
Quarter 1	All funding in place Complete design Obtain permits
Quarter 2	Begin construction
Quarters 3-4	Construction
Year 4	
Quarter 1	Construction complete Tenants move in

Resource Options

Project Sponsor	Local public funds	CTED
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Chronic Homeless Model and Implementation Strategy

One Stop Center

Model Description:

Purpose

To make it easier for people who are homeless to access services by offering multiple services at one location; and to break down some of the barriers to receiving services caused by services being offered at multiple sites.

Types of Centers

There are a variety of models for one-stop service centers for people who are homeless. Most of the one-stop centers started with a few services offered on-site, usually provided by 1 or 2 organizations at the location of one of service providers. Over time these centers have grown to offering a full range of services on-site and involve many providers. The one-stop center becomes more of a “mall of services” and the building may be owned/managed by another organization.

Another variation of the one-stop service center is service fairs or events at which multiple service providers have a table/booth with staff available to answer questions, provide referrals and process applications. The event may be held once or twice a year, or on a regular schedule (e.g. monthly, quarterly)

The one-stop center also provides referrals to services at other locations, and in some cases facilitate transportation to other service locations. Some one-stop centers are located adjacent to shelters, Resource centers or affordable housing sites to decrease transportation problems. One-stop service centers often include a housing placement process to facilitate referrals to housing and services.

Benefits

Communities that have one-stop centers report a significant increase in the number of homeless people who are able to find and stay in housing. Staff at one-stop service centers report an increase in the client’s ability to:

- access public benefit programs and placement in job readiness programs
- obtain medical and dental care
- maintain housing because they have a protective payee, receive case management, receive emergency assistance when needed or are receiving the treatment services they need

One-stop service center staff also reports that client’s are more likely to return for additional services at a center, because it is more convenient for them and increased coordination of services between providers, because staff at organizations interact formally and informally on a daily basis.

What is currently available?

Housing and service providers in the Longview area provide a range of case management, life skills training, employment assistance, medical care, shelter and rental housing. For example, a client could go to 4 organizations to receive assistance education, employment readiness and job placement or to 6 different locations to receive medical or dental care. Few of the services are located close to each other, and some are not located close to affordable housing options. There is a referral network among several housing and service providers in the Longview area, and there are formal service agreements between several organizations.

What are the gaps?

The Longview area has multiple service providers located at separate sites that serve the same population. Some of the service providers are not located close to other services providers or the affordable housing

options in the community. There isn't a location that has multiple service providers represented (either through staff or cross-training staff in other organizations) on an event or regular basis. Training for staff on services provided by other organizations (e.g. eligibility requirements, application processes, etc.) is not available on a routine basis. Staffs at organizations involved in the provider network are better informed as what other services are available in the community, and what the eligibility requirements for those services are. Community members outside of the referral network of services do not know what services and housing are available for homeless people.

One Stop Center Implementation Strategy

OBJECTIVE

Reduce the number of chronic homeless through improved and expedited access to community low income housing, mainstream programs, health, dental and mental health care and other community supportive services.

ACTIVITY

Establish central location(s) or "one-stop center" for the chronic homeless population to be able to access a variety of services and housing options. The services available on-site would likely include: referral to shelter or housing, assistance with applications for public benefits, and emergency assistance for food, clothing, medical and transportation.

WHO IS RESPONSIBLE

- Lower Columbia Community Action Council as lead for co-location of services, possibly in conjunction with housing that is owned/managed by another nonprofit organization or the Longview Housing Authority.
- Providers of outreach, counseling, treatment, emergency assistance, shelter and housing providing information on the availability of services/housing, eligibility criteria and process for application, and if possible, agreeing to offer services on-site on a regular basis.

STRATEGIES

Housing

Housing and shelter providers would agree to provide information on the availability of shelter beds or rental housing units, eligibility requirements and the application process with the "one-stop center" staff, and update the information on a routine basis.

Health

Substance abuse treatment, mental health and medical providers would provide information on the availability of services; eligibility requirements and the application process with the "one-stop center" staff, and update the information on a routine basis. Providers would commit to a schedule of on-site hours at the center per month to provide information and services.

Income

The RSN, DSHS or other agency staff responsible for assisting individuals with applications for benefits would commit to a schedule of on-site hours at the center per month to assist individuals with applications, and to answer questions about benefit programs.

Lower Columbia Community Action Council or other provider of GED, job readiness or employment placement programs would commit to a schedule of on-site hours per month to assist individuals with education and employment.

Prevention

Lower Columbia Community Action Council or other provider of emergency assistance would commit to a schedule of on-site hours at the center per month to assist individuals with rent, deposits, food, transportation or other expenses that will allow them to retain housing.

Planning and administration

Dedication of space within Lower Columbia Community Action Council’s office for use as a one-stop center, or establishment of a center at another site designated for that purpose. Agreements between Lower Columbia Community Action Council and other organizations regarding space and services at the one-stop center will need to be negotiated.

OUTCOMES/IMPLEMENTATION STEPS

Year 1

Quarter 1 Identification of one-stop center location within Lower Columbia Community Action Council offices (or other location) and allocation of LLCAC resources to start the center
Agreements with 2-3 providers for service commitments at the center
Initiate contacts with shelter and housing providers to establish interim referral system

Quarter 2 Establish one-stop center (likely with limited hours)
Market the availability of one-stop center
Agreements with 2-3 additional providers for service commitments at the center
Continue to make contact with housing providers to add to interim referral system

Quarter 3 Evaluate 6 months operation of limited one-stop service center and decide whether to expand the center at existing location (e.g. hours, days, types of services), or identify alternatives
Develop business plan for one-stop center, continued operation and funding
Continue/expand services at one-stop center

Quarter 4 Continue/expand services at one-stop center
Implement business plan (e.g. ongoing funding for the center, location decision, range of services provided)

Year 2 Continuation of center operations
Annual review of center operations regarding outcomes, financial health, location or service issues

RESOURCE OPTIONS

Lower Columbia Community Action Council initially. LCCAC may be the best long-term choice, but there should be a process for evaluating the program after a year of operation; is it being used, how often, by whom, what services have people requested that are not offered, what problems if any have resulted? Based on the evaluation of a year’s operations a decision would be made if the current site is adequate/optimum for what is used and needed, and if LCCAC wants/has the resources to continue and/or whether another agency is needed. The long term financing needs and funding to be determined as part of business planning process. Possible funding sources could include: rent/usage fees paid by each participating service provider, Recording fee revenues (2163), McKinney Supportive Housing Program, and private foundations, grants and donations.

Appendix B

Mapping of Cowlitz County Service and Housing Providers

1. CBS	Center for Behavioral Solutions
2. CCHD	Cowlitz County Health Department
3. CCCorr	Cowlitz County Corrections/Jail
4. CFHC	Cowlitz Family Health Center
5. CHOB	Community House on Broadway
6. CSAC	Cowlitz Substance Abuse Coalition
7. DOC	Department of Corrections
8. DSHS	Department of Social and Health Services
9. DVA	Department of Veterans Affairs
10. DAPC	Drug Abuse Prevention Center
11. ESS	Emergency Support Shelter
12. ESC	Ethnic Support Council
13. FFRC	Family Finance Resource Center
14. FHC	Family Health Center
15. FISH	FISH
16. Habitat	Habitat for Humanity
17. HS	Head Start/ECEAP
18. KaHA	Kalama Housing Authority
19. KHA	Kelso Housing Authority
20. LCCAC	Lower Columbic Community Action Council
21. LHA	Longview Housing Authority
22. LCMH	Lower Columbia Mental Health
23. LINK	LINK
24. PHealth	Peace Health
25. PHAs	Public Housing Authorities
26. RC	Red Cross
27. RPOA	Rental Property Association
28. RR	Residential Resources
29. SALY	Salvation Army
30. SLS	SL Start
31. STVD	Saint Vincent DePaul
32. VFW	Veterans and Ladies Auxiliary

**COWLITZ COUNTY HOMELESS AND CHRONIC HOMELESS
FAMILIES
CURRENT ORGANIZATIONAL ROLES AND AFFILIATIONS**

SERVICES

AGENCY	SERVICE AGREEMENTS	REFERRALS FROM	REFERRALS TO	SERVICES	PUBLIC \$
LCCAC	Habitat Saly CHOB STVD ESS	Saly CHOB Local churches	CHOB ESS Saly STVD Red Cross PHA's	Child care GED Food Bank Job placement Transport.	CSBG ESAP
CCHD		CHOB PHealth LCMH CBS	CHOB	HIV/Aids testing & case management STD's Needle Exchange Free Clinic Assist in benefits applications	DOH
FFRC	LHA		CHOB FISH LCCAC Saly	Financial Counseling	HUD
CFHC	DAPC LCMH DSHS	CHOB LCMH Free Clinic CCHD LCCAC DSHS ESS	CHOB LCMH CCHD LCCAC DSHS PHealth	Health and Dental Care	
ESS	ESC KHA LHA	Police CHOB CPS Service Agencies	CHOB LCCAC Saly	Food Case Management Rental Assistance Child care Meals	ESAP ESG
DAPC	Drug Court Hope Court LCMH CSAC	DOC ADATSA	CHOB Oxford House	Case Management Substance Abuse Treat. Child care GED	DASA Medicaid County
Woodland Community Center				Food Clothing Hispanic Outreach	

FAMILY SERVICES – CONT'D

AGENCY	SERVICE AGREEMENTS	REFERRALS FROM	REFERRALS TO	SERVICES	PUBLIC \$
LCMH	RSN FHC DAPC CBS SLS	Kelso VFW DOC CCCorr DSHS PHealth	LINK DSHS LCMH CHOB Saly CBS Goodwill STVD PHA's	PATH Mental Health Treat. Transportation Case Management Protective Payee Medications Life Skills	PATH RSN HUD
CHOB	LCCAC	LCCAC CFHC CCHD FFRC ESS	LCCAC CFHC ESS	Life Skills Protective Payee GED Meals Medical Clinic Clothing Case Management	ESG ESAP HOPWA
FISH				Emerg. Rental \$ Utilities Assistance Food Medication Dental Care	
SALY				Meals Food Baskets Clothing Rental Assistance Motel Vouchers	
Goodwill				Clothing GED's Job training	
Red Cross				Homeless Prevention	ESAP
DSHS		HUD LCCAC Local churches	LCCAC PHA's CHOB ESS FISH Landlords	Medical Assistance Alcohol and Substance Abuse Developmentally Disabled Mental Health Vocational Rehab	
HS	CPS LCMH Progress Cent. School Dist.	ESS CHOB Schools	PHA's ESS CCHD FHC	Food and Meals	

**COWLITZ COUNTY HOMELESS AND CHRONIC HOMELESS
FAMILIES
CURRENT ORGANIZATIONAL ROLES AND AFFILIATIONS**

SHELTERS

AGENCY	SERVICE AGREEMENTS	REFERRALS FROM	REFERRALS TO	SERVICES	PUBLIC \$
CHOB				5 /long term	
CHOB				25 beds	ESG, ESAP, 2060
CHOB				26 beds Overflow	
ESS				36 Beds • Domestic Violence	ESG, ESAP, 2060

**FAMILIES
TRANSITIONAL HOUSING**

AGENCY	SERVICE AGREEMENTS	REFERRALS FROM	REFERRALS TO	SERVICES	PUBLIC \$
LCCAC				15 units	
LHA	ESS	ESS		3 units • Domestic Violence	THOR
CHOB	Country Run			20 units	
DAPC		Courts Doctors Community		16 units • Post Partum Women	
KHA		ESS		15 units • Domestic Violence	HOME
LHA		ESS DAPC HOPE		19 units • Domestic Violence 6 units • Substance Abuse	HOME
Oxford House		DAPC		2 units (16 beds) • Substance Abuse	

**FAMILIES
PERMANENT HOUSING W/ DEEP SUBSIDY**

AGENCY	SERVICE AGREEMENTS	REFERRALS FROM	REFERRALS TO	SERVICES	PUBLIC \$
LCCAC				16 units	
Habitat				1- 2 units per yr	
LHA	CHOB ESS			1,040 vouchers: <ul style="list-style-type: none"> • Homeless Preference 25% monthly avail. Vouchers Elderly • 102 units Family • 37 units 	HUD USDA USDA
KHA				256 vouchers PH – 50 family PH – 50 elderly	HUD
Ka HA				27 vouchers 16 PH	HUD
Country Run				51 units	
20 th Dorothy	LCCAC			21 units	
La Casa Woodland	LHA/ Archdiocese HA			13 units <ul style="list-style-type: none"> • Farm Worker 	HUD
Ville San Martin	LHA/ Archdiocese HA			25 units <ul style="list-style-type: none"> • Farm Worker 	HUD

**FAMILIES
PERMANENT SUPPORTIVE HOUSING**

AGENCY	SERVICE AGREEMENTS	REFERRALS FROM	REFERRALS TO	SERVICES	PUBLIC \$
N/A					

**COWLITZ COUNTY HOMELESS AND CHRONIC HOMELESS
INDIVIDUALS
CURRENT ORGANIZATIONAL ROLES AND AFFILIATIONS**

SERVICES

AGENCY	SERVICE AGREEMENTS	REFERRALS FROM	REFERRALS TO	SERVICES	PUBLIC \$
CCHD	CHOB LHA	CHOB PHealth LCMH CBS	CHOB	HIV/Aids testing & case management STD's Needle Exchange Free Clinic Assist in benefits applications	DOH
LCCAC	Saly CHOB SVDP ESS	Saly CHOB	CHOB	Case Management Job Training Transportation Food Bank	ESAP
CFHC	DAPC LCMH DSHS	CHOB LCMH DAPC ESS CCHD LLCAC DSHS Free Clinic	CHOB LCMH DAPC ESS Free Clinic PHealth CCHD LCAC DSHS Fish	Health and Dental Care	
ESS	ESC LHA KHA	Police CHOB CPS Service Agencies	CHOB LCCAC Saly	ER financial /rental assistance Case management Food Meals	ESAP ESG
SL START				CMI case management Life Skills	
LCMH	RSN FHC DAPC CBS SLS	Kelso VFW DOC CCCorr DSHS PHealth	DSHS LCMH HA's CHOB Saly CBS Good Will STVDP	PATH CMI treatment Transportation Case Management Protective Payee Medications Life Skills	HUD RSN Path
Saly				Meals Food Baskets Clothing Rental/Motel Assist.	ESAP

AGENCY	SERVICE AGREEMENTS	REFERRALS FROM	REFERRALS TO	SERVICES	PUBLIC \$
CHOB	CCHD LCCAC	CCHD LCCAC CFHC ESS DAPC	CCHD LCCAC CFHC ESS	Life Skills Protective Payee Education Meals Clothing Case Management Medical Clinic	ESAP
Goodwill				Clothing Job Training GED's Ex-Offender Program	
Red Cross				Homeless Prevention	ESAP
DOC	RSN Goodwill	Prisons Offender self report	CHON DSHS Hotels/motels	Case Management (court-ordered_	
VFW	CC Veteran Relief fund VA	Veteran organizations	CHOB VA transition WA. Dept. of Veteran Affairs	Rental assist. Case management Substance Abuse treatment Transportation	
DAPC	Drug Court LCMH Family Health CSAC	DOC ADASTA	CHOB Oxford House	Substance abuse treatment Case Management GED	DASA Medicaid County
RR	DD DCFS	DDD DCFS	DDD DCFS	Case Management Meals Health Care	DDD DCFS

**COWLITZ COUNTY HOMELESS AND CHRONIC HOMELESS
INDIVIDUALS
CURRENT ORGANIZATIONAL ROLES AND AFFILIATIONS**

SHELTERS

AGENCY	SERVICE AGREEMENTS	REFERRALS FROM	REFERRALS TO	SERVICES	PUBLIC \$
CHOB		LCCAC		80 beds	ESG ESAP 2060
LCMH				5 crisis/respice beds	CDBG
ESS					ESG ESAP 2060

**INDIVIDUALS
TRANSITIONAL HOUSING**

AGENCY	SERVICE AGREEMENTS	REFERRALS FROM	REFERRALS TO	SERVICES	PUBLIC \$
DAPC				40 units	ADATSA Trust Fund
PHealth CMI		RSN		12 units	RSN
Country Run				20 units	
LCCAC				1 unit (2 bedrooms)	
LHA	Drug Court			6 vouchers	HOME
LHA	CCHD			2 units HIV/AIDS	HOPWA
LHA	ESS			19 units • Domestic Violence	HOME

**INDIVIDUALS
PERMANENT HOUSING (DEEP SUBSIDY)**

AGENCY	SERVICE AGREEMENTS	REFERRALS FROM	REFERRALS TO	SERVICES	PUBLIC \$
LHA				5 units • Homeless elderly	Set Asides
Westgate				100 units • Elderly/disabled	HUD
Parkland Terrace				51 units • Elderly/disabled	HUD
Fremont Village				28 units • Elderly/disabled	HUD
Crescent Terrace				15 units • CMI	HUD
Tartan House				26 units • Elderly/disabled	HUD
LHA	CHOB ESS			1,040 vouchers: • Homeless Preference 25% monthly avail. Vouchers Elderly 102 units	HUD USDA
KHA				256 vouchers PH – 50 elderly	HUD

Ka HA				27 vouchers 16 PH	HUD
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**INDIVIDUALS
PERMANENT SUPPORTIVE HOUSING**

AGENCY	SERVICE AGREEMENTS	REFERRALS FROM	REFERRALS TO	SERVICES	PUBLIC \$
KHA	SL Start			21 units • Chinook/CMI	HUD
LHA	SL Start			3 units • Harmony House/CMI	HUD
Oxford House				24 beds • Group Home Substance Recovery	

Appendix C

Homeless Housing Task Force Chronic Strategy Sessions Attendees

Name	Organization Representing
Alex Perez	Longview Police Dept.
Angie Klein	Emergency Support Shelter
Billie Rantala	Cowlitz Family Health Center
Bob Gaston	FISH
	Veterans of Foreign Wars/Homeless
Bob Johnston	Vets
Chris Pegg	Longview Housing Authority
Chuck Tilton	Father's House
Dennis Meyers	Lower Columbia Mental Health Center
Derreta Winsor	Volunteer
Gus Nolte	Drug Abuse Prevention Center
Helen Reid	Veterans of Foreign Wars
Jack Keolker	Kelso Citizen
James H. Conrod	Faith Community
James LeFever	Drug Abuse Prevention Center
Janet Burnap	Rental Association – Cowlitz County
Joseph Manchester	Citizen/Formerly Homeless
Julie Hourcle	City of Longview
Karen North	Cowlitz County Health Department
Kathleen A. Johnson	Cowlitz County Commissioner
Kathleen Griffin	Woodland. Services Center/Schools
Lesa Ware	Cowlitz County Heath & Human Services/RSN
Leslie Jatchob	Community House on Broadway
Maria Lillard	Citizen/Formerly Homeless
Marin Fox-Hight	Cowlitz County Dept. of Corrections
Martin Franke	State Department of Corrections
Mary Jane Melink	Longview City Council
Mindy Hegstad-Hulsizer	Cowlitz County Health & Human Services/RSN
Richard Kirk	Community House on Broadway
Roger Simpson	Social and Health Services
Shawn Huntley	ADC Pathways to Employment
Sheila Girt	Lower Columbia Community Action Council
Sheila Soto	Rental Association – Cowlitz County
Sheri Monge	Woodland Community Service Center
Sherrie Tinoco	Emergency Support Shelter
Todd Broderius	Emergency Dept/ St. John Medical Center
Wayne Cain	Department of Corrections
	Cowlitz-Wahkiakum Council of
Melissa Taylor	Governments