2018 FRCoC Application for VHSP Funding
Outreach; Emergency Shelter Operations; Rapid Re-Housing; Targeted Prevention

Please complete a separate application form for each outreach, emergency shelter operations, rapid re-housing, and targeted prevention project.

Application Information

Type of Project (select one):
☐ Outreach
☐ X Emergency Shelter Operations
☐ Rapid Re-Housing
☐ Targeted Prevention

Type of Application (select one):
☐ Renewal (requesting level or reduced funding for existing project)
☐ X Renewal with Expansion (requesting increased funding for existing project)
☐ New (requesting funding for new project)

Note: While requests for renewal and expansion funding can be submitted on one form, the amounts will be ranked separately by the Funding & Performance Committee.

Applicant
Legal Name: Micah Ecumenical Ministries
Type of Applicant: ☐ X Non-Profit ☐ Housing Authority ☐ PDC ☐ Unit of Local Government
EIN/TIN: 20-4044884
Address: 1013 Princess Anne St.

Application Contact
Name: Meghann Cotter
Title: Executive Servant-Leader
Phone: 540-479-4116 x13
Email: Meghann@dolovewalk.net

Line-Item Budget

Please complete line-item budget below. Budget amounts should reflect the VHSP request only. Other funding sources will be included on the Spending Plan (required attachment).

> *Note: Renewal projects can apply for renewal HMIS and Administration amounts up to the grantee's total FY18 HMIS and Administration amounts regardless of 5% and 3% caps. HMIS and Administration amounts across all FY19 project applications shall not exceed total FY18 HMIS and Administration amounts.*

Expansion projects can apply for an HMIS expansion up to the amount where the combined renewal/expansion HMIS request is 5% of the combined renewal/expansion project subtotal and an Administration expansion up to the amount where the combined renewal/expansion Administration request is 3% of the combined renewal/expansion project subtotal.

New projects can apply for an HMIS amount up to 5% of the project subtotal and an Administration amount up to 3% of the project subtotal.

	Renewal Amount	New/Expansion Amount
Outreach		
Case Management		$27,040
Limited Support Services		
Other (specify)		
Subtotal		$27,040
HMIS (up to 5% of subtotal)		
Computer Costs		
Fees and Licenses		
HMIS Staffing		
Training		
Other (specify)		
Administration (up to 3% of subtotal)		
Administration		
Total		**$27,040**

	Renewal Amount	New/Expansion Amount
Emergency Shelter Operations		
Case Management	27,115	8935
Limited Support Services		
Maintenance		
Rent		
Security		
Supplies		
Utilities		
Other (specify)		
Subtotal	$27,115	$8935
HMIS (up to 5% of subtotal)		
Computer Costs		
Fees and Licenses		
HMIS Staffing		
Training		
Other (specify)		
Administration (up to 3% of subtotal)		
Administration		
Total	**$27,115**	**$8935**

	Renewal Amount	New/Expansion Amount

Rapid Re-Housing		
Housing Search & Placement	$46,000	$12,500
Housing Stabilization Case Management	$135,000	
Housing Stabilization Financial Assistance	$15,000	
Housing Stabilization Services		
Rent Arrears		
Rent Assistance	$87,510	
Service Location Costs		
Veteran Housing Stabilization Financial Assistance	$5000	
Veteran Rent Arrears		
Veteran Rent Assistance	$10000	
Subtotal	$298,510	$12,500
HMIS (up to 5% of subtotal)		
Computer Costs		
Fees and Licenses		
HMIS Staffing	$556	$2,560
Training		
Other (specify)		
Administration (up to 3% of subtotal)		
Administration		
Total	**$299,066**	**$15,060**

	Renewal Amount	**New/Expansion Amount**
Targeted Prevention		
Housing Search & Placement		
Housing Stabilization Case Management		
Housing Stabilization Financial Assistance		
Housing Stabilization Services		
Rent Arrears		
Rent Assistance		
Service Location Costs		
Subtotal		
HMIS (up to 5% of subtotal)		
Computer Costs		
Fees and Licenses		
HMIS Staffing		
Training		
Other (specify)		
Administration (up to 3% of subtotal)		
Administration		
Total		

Match

Please indicate sources of match. Match must equal 25% of requested amount and must be spent on eligible VHSP expenses, but does not need to be of the same VHSP Category as the request. Match must be from local or private sources. If the project is requesting partial or full waiver of the match requirement, please explain. (See Page 14 of the Virginia Homeless and Special Needs Housing Funding Guidelines for full explanation of the match requirement.)

Type	Source	VHSP Category	Amount
Choose an item. CASH	Mary Washington Hospital	Choose an item. Emergency Shelter Operations	$93,926
Choose an item.		Choose an item.	
Choose an item.		Choose an item.	

Narrative Responses

Provide a description that addresses the entire scope of the proposed project. (Character Limit: 3,000)

The Residential Recovery Program is an eight-bed shelter that serves homeless exiting the hospital in need of temporary or terminal care. The facility, located at 1512 Princess Anne Street in Fredericksburg, offers 24-hour supervision, round-the clock referral capability, nutritious meals, dedicated care coordination, transportation and a health care hub for the homeless. Entering patients must be homeless, have an identified medical or mental health need and be referred by a physician. Referrals include basic demographics, doctor's orders for medications, discharge instructions and a prescribed amount of time the physician believes the patient needs to stay. Upon arrival, staff assesses patient needs, begins enrollment with a primary care provider (i.e. Moss Clinic, Fredericksburg Christian or the Community Health Clinic) and obtains initial prescriptions. Medication is managed by staff during the person's time in the program. Each person receives initial length of stay based on recommendation of discharging agency. Within the first week, the health services navigator works with the patient to develop goals he/she hopes to accomplish during his/her stay. Goals typically include compliance with appointments, enrollment with RACSB, substance abuse treatment, and applying for charity care and other benefits. Most enrollment applications are completed on site. Potential disability cases are proactively supported in applying for social security through an expedited process available to homeless individuals. Patients identified with mental health issues are connected with an internal PATH (Partners Assisting in Transitions from Homelessness) outreach worker who streamlines their entry into the Rappahannock Community Services Board (RACSB). Through Micah's Hospitality Center, participants may access a community-based eligibility worker who helps with food stamp and Medicaid applications. A Veteran's Administration representative comes once a week to connect eligible people to housing vouchers, assistance programs and medical benefits. DMV has also started visiting the center each month, and a volunteer is available each week to help clients access free phones. Because program stays average 30-45 days at the most, the discharge process starts at intake, when housing barriers are assessed and clients are asked to begin thinking about where they will go when they leave. The most support is available to people identified as chronically homeless or highly vulnerable, who are prioritized through a community process, then assigned for housing location, financial support and case management through the

local rapid-rehousing or permanent supportive housing programs. Those with higher chance of self resolving (i.e. fewer barriers, less disability, have income) are helped with housing search, identifying a roommate, if necessary, and may be supported with first month's rent and deposit. They may also be supported identifying alternate arrangements, such as a treatment program, shelter or the home of friends/family. Regardless of where a person is discharged, they remain connected to the agency's larger network of services when they leave.

If renewal funding is being requested, explain how the project continues to meet a community need. If new/expansion funding is being requested, explain how the additional funds will increase system capacity and justify the community need for additional capacity. (Character Limit: 3,000)

Renewal funding for the Residential Recovery program includes the existing share (.75 FTE) of the Health Services Navigator position, the primary case manager on site. It also seeks the remaining .25 FTE for the portion of this position's salary that is currently dependent on "found" money (i.e. fundraising, grant writing etc.). Expansion of this funding would offer more security to this as a full-time position. Reliance on finding new resources for the balance of this job, puts the position at risk of reduction or elimination. It is important for the residential recovery program to maintain two professional staff at all times due to the high needs of those being referred to the program. In addition, having two people allows flexibility in transporting guests to appointments and assisting them with necessary tasks in the community. As a program licensed through the state Department of Behavioral Health and Developmental Services, credentialed staff must be available 24-hours a day, 7 days a week.

Please indicate the breakdown of household types targeted by this project:

	Renewal	New/Expansion
Households with Children	%	%
Households without Children	100%	100%
Total	**100%**	**100%**

Certify that the project will adhere to the *FRCoC Coordinated Entry Policies & Procedures,* including the following requirements of the document:

☐ X Follow the Housing First model

☐ X Participate in the FRCoC Coordinated Entry Process and/or the Victim Service Coordinated Entry Process (including coordinated assessment for shelter/prevention and prioritization for rapid re-housing)

☐ X Adhere to established project standards (including *FRCoC Rapid Re-Housing Policies & Procedures*)

☐ X Collect data through HMIS or a comparable database

What percentage of households will be served through the Victim Service Coordinated Entry Process (including coordinated assessment for shelter/prevention and prioritization for rapid re-housing)?

	Renewal	New/Expansion
Households Served through Victim Service Coordinated Entry Process	0%	0%

What systems are in place to ensure that households experiencing homelessness are moved quickly to permanent housing and remain stably housed? (Character Limit: 3,000)

Because program stays average 30-45 days at the most, the discharge process starts at intake, when housing barriers are assessed and clients are asked to begin thinking about where they will go when they leave. The most support is available to people identified as chronically homeless or highly vulnerable, who are prioritized through a community process, then assigned for housing location, financial support and case management through the local rapid-rehousing or permanent supportive housing programs. Those with higher chance of self resolving (i.e. fewer barriers, less disability, have income) are helped with housing search, identifying a roommate, if necessary, and may be supported with first month's rent and deposit. They may also be supported identifying alternate arrangements, such as a treatment program, another shelter or the home of friends/family. Regardless of where a person is discharged, they remain connected to the agency's larger network of services when they leave. Many do circle back at various stages of life to problem solve or access support that will keep them housed.

Describe specifically how participants will be assisted both to increase their employment and/or income and to maximize their ability to live independently. (RRH/Prevention Only, Character Limit: 3,000)

Micah operates a holistic income development program, called Step Forward, alongside each of its programs. Step Forward supports those staying at respite, in Micah's housing program or accessing street outreach in overcoming barriers to employment and accessing public benefits that provide a sustainable income. The program offers both technical support and intensive case management. A job help center operated by Rappahannock Goodwill is available next door to the Micah Hospitality Center for anyone in the community who needs a job, including those whose lack of employment has caused them to need homeless assistance from Micah's other programs. Those identified with significant barriers may access one-on-one assistance, up to and including placement in the mainstream market, job coaching and application for public benefits. At the basic level, staff supports guests by answering questions, making general service referrals, offering job leads, helping on the computer and even supporting them to complete their own applications for public entitlements, such as disability or veteran's benefits. People qualify for more comprehensive services when they are assessed to have more significant needs. At this level, staff reviews a participant's interests, skills and abilities related to obtaining and maintaining an income and work with them to identify the best path to achieving it. Once a plan is in place, staff directly connects the participant to related supports, such as helping them register for GED or higher education, engaging in trial work experiences, placing them in a job with a partner employer, coordinating transportation to and from work, or hand-carrying a disability application through the social security system. Once employed, program staff supports both employer and employee for 90 to 180 days to make the sure the hire is sustainable. If public benefits are obtained, staff will work with the participant to access incentives, such as ticket-to-work or the agency on aging job program, which can then supplement their fixed income. Step Forward is managed by a full-time income navigator, who supports the development of individual income plans and administers the SSI/SSDI application process for eligible

participants. She supports Goodwill in operating the on-site job help center and supervises a full-time employment specialist. The employment specialist is a Goodwill employee who handles much of the technical support, soft skills training and supportive employment activities. Step Forward staff also work alongside other program managers who provide trial work opportunities in the day center, furniture bank and the newly launched cafe. The cafe not only provides opportunities for all people to share a common table and pay what they can, the kitchen is a job-training program for those seeking to work in food service. The program is funded entirely by local resources.

How will the project leverage mainstream resources? Provide project and community level examples. (Character Limit: 3,000)

All of Micah's programs are heavily-rooted in a wrap-around support system, which depends on co-locating key community services in the spaces most convenient and comfortable to those needing assistance. This means offering space for community services to be provided directly from the day center at 1013 Princess Anne St., encouraging home visits of any resource that is willing and encouraging direct connection within our shelters. Examples of how these mainstream resources have been incorporated into our daily operations include:

- RACSB's mental health outreach worker (PATH) who works full-time from the day center. They also provide partial funding for the Micah staff person who completes disability applications using the SOAR method.
- Our partnership with Rappahannock Goodwill Industries, which operates an on-site job help center and provides a full-time employment specialist to our team.
- Department of Social Services sends an eligibility worker three days each week to enroll people in food stamps and Medicaid
- The Veteran's Administration comes weekly to connect eligible veterans with homeless assistance and VA benefits.
- Moss Free Clinic maintains a partnership that allows our onsite volunteers to complete eligibility applications for clinic enrollment.
- Germanna's nursing students come with a local doctor twice a month to conduct wellness screenings in the Community Café.
- Virginia Cares offers ex-offender support from the café on a weekly basis.
- The Lion's club conducts monthly on site vision and hearing screenings.
- DMV brings a mobile van every other month to support people needing identification.

How will the project leverage partnerships within the homelessness response system to limit duplication? (Character Limit: 3,000)

Although referrals to the residential recovery program must come via a referral from a medical or mental health provider (state-licensing requirements), all those entering are screened by the community's coordinated assessment. This happens first with a conversation between program staff and the referring party to ensure no other options can be identified. It then happens more specifically when the person arrives, using the community's authorized screening tool. This ensures that the person is in fact homeless, has no other alternatives and that the respite program is the most appropriate fit for the person. The program also continues to offer other homeless service providers the opportunity to re-direct high barrier and vulnerable individuals

who end up in their shelters when they are ill-equipped to support them. Likewise, the program's limited beds and focus on high need individuals also means that those with less vulnerabilities and higher likelihood of self-resolving may be moved on to other community shelters if they cannot make other arrangements in a short timeframe.

How will this project ensure that it does not screen people out based on severity of needs and vulnerabilities (including having too little or little income; active or history of substance abuse; having a criminal record with exceptions for state-mandated restrictions; history of domestic violence)? (Character Limit: 3,000)

The residential recovery program's unique nature positions it such that the highest needs and most vulnerable should be the primary recipients of available beds. The only way into the program is through a medical or mental health provider at the hospital, jail or local clinic. Once people enter the program, they are further triaged based on VI-SPDAT score, community prioritization and identified needs. The higher the vulnerability and severity of needs, the more likely the program is to hang on to the person until housing and adequate support can be obtained. Income is often a primary need of those coming to the program. Substance usage while in the facility does not result in an automatic exit. Those struggling with addiction are often given multiple warnings and supports to address their usage, unless their behavior imminently interferes with the therapeutic needs of others in the house. Even then staff will go to great lengths to support the individual in circling back through the program days or weeks later. Additionally, the program receives a number of referrals from mental health staff at the jail and does not turn people away based on criminal history. The program does not maintain a do not admit list and often receives people multiple times as they move in and out of housing crisis. The primary reasons that anyone would be denied from the program are needs that require a higher level of care, such as skilled nursing, or lack of bed space. Even when bed space is not immediately available, staff will sometimes coordinate with the hospital to keep the person a few days longer or make other arrangements until a bed can open.

How will the project ensure that participants are not terminated from the project for the following reasons: failure to participate in supportive services; failure to make progress on a service plan; loss of income or failure to improve income; being a victim of domestic violence; any other activity not covered in a lease agreement typically found in the project's geographic area. (Character Limit: 3,000)

Micah understands that, in many cases, the services it provides are a last and only resort. Staff is, therefore, committed to trying all strategies possible before exiting people from a program. All of our supports are voluntary and people utilize the resources we make available to varying degrees. Some are successful at sustainability using a minimum number of supports. Others are significantly impacted by minimal engagement. Our philosophy tends to be offering as many different wrap-around supports as we can come up with and using various methods to engage the person. While the burden of engagement responsibility is on the case manager, the program participant may eventually face natural consequences if they do not participate in what is offered and have not been able to make progress with their own devices. Progress and success, however, are defined very loosely and on an individual basis. In the rare case of termination, we seek alternative arrangements that will reset the course and get them back on track toward sustainability. Although we may give someone a break from our programs for short periods, we do not maintain a permanent "do not admit" list and we often welcome people to return multiple

times during their journey back from brokenness. This can mean re-housing people multiple times or bringing them back into shelter, even after a negative exit.

Describe how the project is meeting the requirement of reducing barriers to homeless services programs and the specific barriers that have been reduced. Additionally, describe in detail how the project will meet the Prohibition Against Involuntary Family Separation and Equal Access and Prohibited Inquiries requirements. (Character Limit: 3,000)

All of Micah's programs have been historically low barrier. For example, the program does not breathalyze, drug test or have other limitations that prevent people from entering. The program prefers higher barriers and more vulnerabilities. As part of the state's emergency shelter initiative last year, the main barrier identified was language when it came to program rules. As a result, we revised the rules to focus everything on respect, responsibility and safety. This has made it much easier for guests in the program to understand what is expected. Although the program does not serve families, it is prepared to address the Equal Access and Prohibited Inquiries Rule when it comes to transgender individuals who may require gender specific sleeping arrangements. This could include allowing the person to sleep in the bedroom of their identified gender or offering a neutral option with a room of their own. Unless the information is offered by the program participant, sexual orientation is not a question that is asked as part of the eligibility process for any of Micah's programs.

Provide the following data. These numbers will be used to calculate anticipated number of households served by the project.

	Renewal	New/Expansion
Number of FTE Case Managers Dedicated to Project (could be fraction)	.75	.25

Ideal Caseload for 1 FTE Case Manager	8
Average Length of Stay for Project Participants	30-45 days
Average Financial Assistance Cost per Household (RRH/Prevention Only)	n/a
Shelter Beds for Households without Children (Shelter Operations Only)	8
Shelter Beds for Households with Children (Shelter Operations Only)	0
Shelter Units for Households with Children (Shelter Operations Only)	0

Provide a description of project staff capacity to include experience and training. If any staff dedicated to the project are also dedicated to other projects, explain the breakdown of hours by project. (Character Limit: 3,000)

Staff at the residential recovery program includes a program manager, one full-time case manager and overnight and weekend staff. The program manager and case manager are qualified mental health professionals, as certified by the Virginia Department of Behavioral Health and Developmental Services. While they may support up to eight guests staying in the residential recovery home at a time, they are often troubleshooting issues with former guests who have moved on to other shelters or into permanent housing. The program manager, for example, currently supports up to 6 supportive housing clients living in Micah-owned units and on a case-by-case basis takes on rapid re-housing cases that have transitioned out of his program when the housing department is at capacity. As appropriate and

necessary, professional staff at the residential recovery program have made themselves available to other homeless service agencies to troubleshoot health-related issues of those staying in their programs. This is a capacity the program is willing to do more of, up to and including bringing that person into the respite house, if the comprehensive services are a better fit for that person's needs.

Provide evidence of organizational capacity to include governance, leadership, experience, and financial management. (Character Limit: 3,000)

Micah was founded in 2005 by a group of churches whose history with the homeless population extends back to the 1980s. It is governed by a twelve-member board of directors, comprised of appointees of each of the nine founding churches. It has a full-time staff of 15, four part-time and three seasonal for cold weather shelter purposes. Finances are managed by a fulltime bookkeeper/administrative position and supported by an Executive Director. Between these two positions, checks are cut on an at least weekly basis, remittances are submitted for grant reimbursement monthly and quarterly reports are complied as requested. Financial and risk management policies govern financial practices. Micah's housing program has existed in an official capacity since at least 2010. In that time, its targeted efforts for housing and supporting the most vulnerable has resulted in an 84% decline in community chronic homelessness.

Are there any unresolved monitoring or audit findings for any grants operated by the applicant or potential subrecipients? If yes, please explain. (Character Limit: 1,000)

☐ Yes ☐ X No

Attachments (each project)

-Housing First Checklist (Project Level section only)
-Project Policies & Procedures
-Project Job Descriptions (must be housing-focused)

Attachments (once per agency)

-Spending Plan
-Organizational Certifications and Assurances
-Board of Director Listing(s)
-Org Chart
-990 (if applicable)
-Profit and Loss Statement (prior year and most recent YTD)