2020 FRCoC Cover Letter for VHSP Funding

A separate cover sheet is required for each project application.

Applicant
Legal Name: Micah Ecumenical Ministries
Type of Applicant (select one): ☒ Non-Profit ☐ Housing Authority ☐ PDC ☐ Unit of Local Government
EIN/TIN: 20-4044884
Address: PO Box 3277 Fredericksburg, VA 22402

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

Project Name: Street Outreach

Project Type (select one):
☐ Coordinated Assessment ☒ Outreach ☐ Emergency Shelter Operations
☐ Rapid Re-Housing ☐ Targeted Prevention ☐ Housing Location
☐ CoC Planning *(Only the CoC Lead Agency is eligible to apply for CoC Planning VHSP funding.)*

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

New Amount Request: $31,200
Renewal Amount Requested:
Expansion Amount Requested:

Approximate number of people this program will serve: 100 with targeted Street Case Management; 300 total outreached

The applicant organization's governing board discussed and/or approved this application for funding at a meeting held on _____ (date). If this application has not yet been discussed, it will be discussed at the next meeting of the governing board, which will be held on ___March 10, 2020_____ (date).

The applicant organization named above will act as the responsible fiscal agent for any funds received and will comply with applicable tax laws, regulations, and CoC policies. By signing this application, we agree that we have read and approve of the content of this application.

Board Chair:
Sheila Rankin, III Feb. 27, 2020
Signature **Date**

Executive Director:
_____ 2/27/20 _____
Signature **Date**

2020 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.

Project Name: Micah Street Outreach

Line-Item Budget

Please complete line-item budget below. Budget amounts should reflect the VHSP request only.

> *Note: Renewal projects can apply for renewal HMIS and Administration amounts up to the grantee's total FY20 HMIS and Administration amounts regardless of 5% and 3% caps. HMIS and Administration amounts across all of the CoC's FY21 project applications shall not exceed total allowable 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.*

	Renewal Amount	Expansion Amount
Outreach		
Case Management		$31,200
Limited Support Services		
Other (specify)		
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 used to meet the goals of VHSP, but does not need to be of the same VHSP Category as the request. Match must be from local or private sources, must be received and expended within the grant year, and may not be used to meet multiple match requirements. If the project is requesting partial or full waiver of the match

requirement, please explain. (See Pages 18-19 of the Virginia Homeless and Special Needs Housing Funding Guidelines 2020-2022 for full explanation of the match requirement.)

Type	Source	VHSP Category	Amount
Cash	Mary Washington Hospital	Emergency Shelter Operations	$7,800
Choose an item.		Choose an item.	
Choose an item.		Choose an item.	

Narrative Responses

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

Micah's street outreach program is a close compliment to its rapid re-housing program. Its 1.5 staff members, with support from a mental health outreach worker from RACSB, works alongside the rapid re-housing team and focuses on engaging and supporting the highest barrier, most vulnerable individuals on the street prior to their placement in permanent housing. Everyone who accesses Micah's Hospitality Center and identifies as living on the street is captured in an over-arching street outreach program. At this stage, the street outreach case manager, called the Hospitality Navigator and a support staff person (Intake manager) play a crucial advocacy role for vulnerable homeless individuals seeking access to the coordinated assessment and shelter system. Staff will also visit, upon request, those who are identified in the community as living in places not meant for human habitation but not frequenting the day center. These individuals are also looped into the street outreach process so that they can be prioritized for housing, Continued need of street outreach support is monitored through services at the center and contacts in the community. A list of individuals receiving street outreach, ranked by vulnerability data (VI-SPDAT, episodes, disability, time homeless, etc.) is then reviewed monthly for the more targeted street case management program. Once enrolled in the street case management program, participants show up on a community prioritization list, where they can be assigned for housing placement. The Hospitality Navigator works with around 25 to 35 people at a time. Generally, people enrolled in street case management have been outdoors or precariously housed for an extended amount of time and are considered highly vulnerable. Once enrolled, the Intake Manager completes documentation of chronic homelessness (if applicable) and begins to identify the best housing intervention. This could include referrals to prevention, connection with veterans programs or prioritization through the CoC's community rapid re-housing process. The Hospitality Navigator then begins to establish goals with individuals and connects them to the supports they will need to eventually sustain housing (i.e. income, health care, identification, etc). As necessary, she will transport them to appointments, set up needed services in the community or problem-solve various life issues. The Hospitality Navigator supports the housing team in their efforts to identify and secure sustainable housing, then turns over the case to a housing case manager once assigned through prioritization.

Because the street case management program sits at the center of Micah's wrap-around support system, program participants have instant access to a wide range of community resources. This includes a full-time PATH outreach worker, a full-time Goodwill employment specialist and a wide variety of rotating community partners (i.e. a DSS eligibility worker, veteran's

administration representative, DMV, etc) that operates from Micah's main office. The Hospitality Navigator generally walks program participants through the process of connecting to community resources either through a warm hand off or direct connection vs. handing out referral lists and phone numbers.

2. **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. Be sure to use data to support the demonstrated need.** (Character Limit: 3,000)

Although this is a position that currently exists, outreach money is a relatively new opportunity through VHSP. Having dedicated funding will allow this position to get away from a conglomeration of responsibilities, required by the multiple funding sources that currently support it, and have a more a focused approach. The resources currently funding the Hospitality Navigator position could be reallocated to make the intake manager full-time, if the requested VHSP outreach budget is funded. If the Hospitality Navigator can be relieved of the administrative responsibilities and many hours it takes to help vulnerable people navigate the CoC's coordinated assessment and shelter system, she can focus more directly on the housing-focused case management aspect of her job.

Particularly with the community's movement to a more centralized intake process, the success of those on the street in accessing needed services (i.e. shelter, prevention and housing) is depending on the available staffing to advocate and make connections. Those on the street, particularly those with high barriers, often struggle to access systems due to limited transportation, access to phones, being poor self-advocates and having little trust in people and systems. During the 2019-20 cold weather shelter, for example, it took a conglomeration of staff to keep up with who still needed to complete coordinated assessment, helping people call the number, completing online assessments with coordinated assessment could not be reached, advocating to reduce high numbers at the cold weather shelter by filling empty beds at other shelters in the community, tracking down people when a bed came available and coming up with new solutions when individuals failed out of shelter. Without additional resources for street outreach we will be unable to maintain this advocacy in the future. Data indicates that a lack of advocacy for this population will mean less connection with coordinated assessment, fewer shelter entries from those literally on the street and higher numbers living in places not meant for human habitation and at the cold weather shelter.

As a point in time example of the need, a 30-day monitoring of how those using the cold weather shelter this season were interacting with the homeless service system revealed:

• 10 people had entered shelter and remained at month's end
• 18 people remained on the shelter list waiting for a bed. Another four had screened, but were not yet eligible because they had already exceeded their 90 days for the year.
• 27 people had already been to shelter during the winter season, but exited and came back to the shelter (reasons range from unknown/disappeared to voluntarily leaving to rule violation/non-compliance to time expiration)
• 14 had not screened due to variation in shelter stay, disruption by jail or hospitalization, or lack of follow up on intake.

• 4 had previously screened, but were unavailable for the bed when offered
• 10 were ineligible
• 25 refused shelter
• 7 were unlikely to be screen or be viable in shelter
• 6 were diverted

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

	Renewal	Expansion
Households with Children	%	5%
Households without Children	%	95%
Total	**100%**	**100%**

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

☒ Follow the Housing First model

☒ 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)

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

☒ Collect data through HMIS or a comparable database

5. **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	Expansion
Households Served through Victim Service Coordinated Entry Process	0%	0%

6. **Describe in detail how your organization implements a Housing First approach. Include specific examples such as organizational or programmatic policies, procedures, guidelines, etc.** (Character Limit: 3,000)

Policies and procedures for all of our programs begin with the goal of transitioning people to permanent housing, regardless of their barriers, presumed sustainability or background. Upon assignment in the community prioritization process, Micah's housing team makes a referral to the housing locator who starts identifying units. While the locator works on finding housing, a Housing Stabilization Navigator begins housing-focused case management that continues after move in. This process starts with an assessment in eight areas—basic needs, community resources, physical health, mental health, barriers to housing stabilization, income, education and social support. Based on information gathered from this strength-based, trauma informed tool, navigators work with clients to identify the top areas that need to be addressed to support

successful transition into housing. Housing-focused goals generally include obtaining identification, identifying a path toward income (i.e. employment/disability), setting up public benefits and addressing identified medical or mental health needs, as prioritized by the client and often most relevant to making a case for disability. The process moves forward regardless of how high the barriers.

Prior to being identified for housing resources, Micah staff work with individuals at all levels to help identify housing solutions. Veterans are referred to VA representatives who come weekly to our office or the Volunteers of America (SSVF) program. People with HIV/AIDS access FAHASS program. People who teeter between sleeping in places not meant for habitation, hotels and the home of friends and family are guided through coordinated assessment for possible connection to prevention. When possible, we encourage and facilitate reunification with family, bus tickets to communities where other housing options exist, connection to treatment programs or other long-term residential options.

7. **Describe the systems in place to ensure that households experiencing homelessness are moved quickly to permanent housing and remain stably housed. Be sure to use data demonstrating the outcomes of these systems.** (Character Limit: 3,000)

Micah works with the community's prioritization process to identify those most vulnerable in our homeless system. Prioritization considers VI-SPDAT score, episodes, disability and consecutive time homeless. Using this methodology as a guide, households are assigned to the program at monthly meetings of system planning partners. They are then set up with a targeted case manager who begins working intensively on their housing stabilization. Once enrolled in the street case management program, the individual goes onto the community's prioritization list where they are ranked based on vulnerability. Once assigned, they are generally referred to the housing locator within a week's time and housing is identified as quickly as possible. Case managers begin wrap around support services as soon as the individual is assigned. Prior to housing, case management occurs wherever the client feels comfortable—on the street, in a coffee shop, our office or in the shelter they are staying. Once housed, case managers conduct home visits at a frequency deemed necessary by the client's needs and offer whatever support is necessary to connect program participants to the services that will help them remain stably housed.

8. **Describe the specific strategies used to assist participants with both increasing their employment and/or income and maximizing their ability to live independently. Be sure to include data demonstrating the outcomes of these strategies.** (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 in Micah's day center for anyone who needs a job. 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 benefits, such as disability or veteran's. 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 works with them to identify the best path to achieving it. Once a plan is in place, staff directly connects the participant to a newly launched "Bridge to Work" program. In this model, participants begin by volunteering in a structured setting. As they demonstrate they can be reliable and capable employees they are bridged to a paid internship with a local employer for 30-60 days. The goal, at the end of that time is that participants will be hired permanently by that employer. Once employed, program staff supports both employer and employee for 90 to 180 days to make the sure the hire is sustainable. While in the bridge program, participants attend a weekly empowerment group, case management meeting and evaluation with an Employment Specialist. Based on individual need, help is available for GED registration or higher education as well as coordinating transportation to and from work. Participants that are more disabled can also access assistance with a disability application through one of several SOAR trained case managers, including housing, respite and street outreach staff. 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. The program is funded entirely by local resources.

Last year, Micah's wrap around income development supports achieved the following outcomes:

- 19 people maintained employment for 90+ days
- 33 people hired/obtained employment
- 24 benefit approvals
- 36 people enrolled in certificate, degree, licensure, or work incentive program

9. **Describe how the project leverages mainstream resources to support clients as they prepare to move on from project involvement. 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 Hospitality Center.
• Virginia Cares offers ex-offender support 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.
• Probation and Parole makes on site visits to decrease violations for transportation and other social reasons,

10. **Describe how the project leverages partnerships within the homelessness response system to limit duplication.** (Character Limit: 3,000)

All those entering street case management are screened by the community's coordinated assessment. This may happen at the time of their first encounter with Micah, but at a minimum prior to their enrollment in street case management. Once in street case management, they are evaluated for vulnerability, chronic homelessness and other programs for which they may qualify. Cases are not assigned to the housing program until they have been discussed at the community prioritization meeting, which involves all other partners in the local system. It is determined at those meetings which agency is best suited to work with the individual and what supports will be needed.

11. **Describe if/how the project identifies harder-to-serve individuals/households, including sex offenders, large families, persons who are medically fragile, persons identifying as LGBTQ+, unaccompanied youth, households with accessibility concerns (including language and mobility), and households with limited or no personal phone or internet access.** (Character Limit: 3,000)

The more barriers a person faces, the more likely Micah's program is to take them on. Vulnerability and time homeless, for example, is actually a pre-qualifier for who is identified for street case management. Once people enter Micah's street case management program, they are triaged based on VI-SPDAT score, community prioritization and identified needs. This can mean coordination with veteran specific programs or problem solve so that a person may relocate or be reunited with family and friends who will take them in. The higher the vulnerability and severity of needs, the more likely the person is to be assigned to a housing case manager. Income, substance usage and mental health are often primary challenges of those being housed by Micah. How and when these issues are addressed is a voluntary part of the program. However, the effects of unaddressed substance abuse, mental health or income deficits can have natural consequences if they result in tenancy issues such as unpaid rent, property damage or neighborhood disturbances. To the extent they are willing, those struggling with addiction and mental health are often given great support in problem solving and connecting to resources before natural consequences occur. Even then, staff will go to great lengths to support the individual in avoiding eviction, making other arrangements, or being re-housed again if

necessary. Micah's programs often come in and out of people's lives as they face cycles of housing crisis. People remain open to Micah's services no matter how well they do in any of our programs or how many times they cycle through.

12. **Describe efforts made by the project to serve those individuals/households identified as being harder-to-serve (as defined in Question 11), including strategies employed, staff training, and/or partnerships with other organizations, either within or outside of the homelessness response system.**

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 "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.

13. **Does either the organization as a whole or this project have any rules or requirements for assistance that could act as a barrier to services (i.e. birth certificate or photo ID, residency requirement, service participation requirement, etc.)? Please list each requirement, describe the purpose of the requirement(s), and describe the efforts the organization makes to assist households in need of services that do not or cannot meet the requirement(s).** (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. 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 arrangements. This could include allowing the person to consider a housing match with a person of their preferred gender. 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.

14. **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)		.65 FTE

Ideal Caseload for 1 FTE Case Manager	25-35
Average Length of Stay for Project Participants	90-120 days
Average Financial Assistance Cost per Household (RRH/Prevention Only)	
Shelter Beds for Households without Children (Shelter Operations Only)	
Shelter Beds for Households with Children (Shelter Operations Only)	
Shelter Units for Households with Children (Shelter Operations Only)	

15. **Provide a description of project staff capacity to include experience and training. Include a list of the applicable certificates of training for direct program staff. If any staff dedicated to the project are also dedicated to other projects, explain the breakdown of hours by project. If any portion of the funding request is to pay for a new staff position, how will the agency ensure position is filled in a timely manner?** (Character Limit: 3,000)

The Hospitality Navigator has a bachelor's degree and many years experience in non-profit social services. She is supervised by Micah's Community Care Leader who also manages Respite and the cold weather shelter. As her work with those on the street is not as intense as housing case management, she is able to manage about 25 to 35 people at a time. As situations change frequently in her role and the goal is handing those in street case management off to housing as quickly as possible, she is typically able to exit people within 90 days. Funding from the street outreach portion of the grant will allow this position to be dedicated to the relational side of street case management and increase the hours of her support staff (intake manager), which will free her of administrative aspects of street outreach and dedicate staffing to helping our most vulnerable homeless navigate the CoC system.

16. **Provide evidence of organizational capacity to administer the requested funding and implement VHSP-funded activities, to include governance, leadership, experience, and financial management. Will project activities be ready to begin on July 1, 2020?** (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.

17. **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 ☒ No

Attachments (each project)

Project Policies and Procedures
Project Job Descriptions (must be housing-focused)
MOU(s) (if applicable)
For DV Renewal Projects ONLY: FRCoC Data Sheet (template provided)

Attachments (once per agency)

Board of Director Listing
Organizational Chart
990 (if applicable)
Profit and Loss Statement (prior year and most recent YTD)
Spending Plan (template provided, please submit in Excel format)
Organizational Certification and Assurances (template provided)