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: Residential Recovery Program

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:
Renewal Amount Requested: $27,115
Expansion Amount Requested: $18,885

Approximate number of people this program will serve: 80

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:
Neil M Rankin, IV 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: Residential Recovery Program

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
Emergency Shelter Operations		
Case Management	$27,115	18,885
Limited Support Services		
Maintenance		
Rent		
Security		
Supplies		
Utilities		
Other (specify)		
Subtotal	$27,1115	18,885
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**	**$18,885**

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	$11,500
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)

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 doctor. Within the first week, the health services navigator works with the patient to develop goals he/she hopes to accomplish during his/her stay. Immediate goals typically include doctor's 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 SOAR, 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.

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)

Without stable housing as a discharge option for homeless patients, they are three to four times more likely to die prematurely than their housed counterparts, the long-term effect of inpatient care plummets and hospitals accrue thousands of dollars in expenses that could otherwise have been avoided. Of the 221 people counted as homeless during Fredericksburg's 2019 point-in time count, 49% visited a hospital emergency room in a three-month period; 31% stayed inpatient in the last year; and 45% said the hospital emergency room was their first stop when they needed to see a doctor.

According to the National Health Care for the Homeless Council, National Alliance on Mental Illness and the Substance Abuse, Mental Health Services Administration, people experiencing homelessness have higher rates of serious mental illness (26% vs. 4.2% of the general population), substance abuse (38% alcohol; 26% other drugs vs. 6.3 % alcohol; 9.4% drug use among the general population) and chronic disease (80% vs. 45% of the general population). As a result, hospital stays among the homeless are twice as long as the national average and they are five times more likely to be readmitted within 30 days of discharge. The instability associated with lack of housing leaves the average U.S. homeless person with a life expectancy of 42-52, even though most Americans live to 78. As evidenced by the pattern of our CoC's prioritization list, the most vulnerable homeless in our community are generally sleeping in places not meant for human habitation. The eight beds available through the Residential Recovery Program at least offer some respite to these individuals when their complex medical and mental health conditions lead them to the hospital.

Renewal funding for the Residential Recovery program includes the existing share (.75 FTE) of the Health Care Navigator position, the primary case manager on site. It also seeks the remaining .25 FTE and benefits for the portion of this position's salary that is currently dependent on United Way funds, which are expected to decrease this coming year with the agency's new focus on ALICE. Without expansion, this position risks reduction to a part-time position 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. As part of the Micah team, staff at the respite house are frequently intervening regarding the health needs of those in our housing program and day center, which additionally pulls on their time.

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

	Renewal	Expansion
Households with Children	%	%
Households without Children	100%	100%
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 will 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)

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 non-VHSP funded first month's rent and deposit as resources allow. They may also be supported in identifying alternate arrangements, such as a treatment program, another shelter or the home of friends/family. This approach has made possible a 71% stabilization rate for those exiting the respite house. 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.

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 staff at respite. 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)

Although referrals to the residential recovery program must come 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.

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)

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. We are always looking for new ways to cut back on things that limit success of harder-to-serve individuals in our programs. This past year, we have gone through extensive coaching with our respite house on supportive care for those who may experience relapse or mental health crisis while in the program, including attempts to mediate rule violations vs. immediate discharge. Staff who have been unable to adapt to these expectations have resigned or been terminated. Several years ago, we also revised the rules to consolidate a long list of expectations into three areas—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.

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.**

The residential recovery program's unique nature positions it such that the highest needs and most vulnerable are 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.

In a recent situation, for example, a gentleman who was found to have repeated incidents of substance abuse, including bringing drugs on the property, was supported in accessing a detox facility where he tapered off methadone and began a new treatment regimen. He was supposed to transition to a 28-day-program, which fell through at the last minute due to the strength of methadone dose he was on. Respite advocated for the man through the entire process and brought him back to respite so that he could complete the rapid re-housing process.

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)

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.

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)	.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)	
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)

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. All staff are certified in CPR/First Aid, Therapeutic Options, Mental Health First Aid, Human Rights and Medication Management. The case management staff has

also recently certified in SOAR to increase access to disability application assistance. In addition, one case manager is currently pursuing a substance abuse counselor certificate. 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. 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.

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 56% 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)