

SOUTHEASTERN CONNECTICUT

TEN YEAR PLAN TO END HOMELESSNESS

# Next Stop, Home



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This plan is dedicated to the memory of Bill Walsh, Danny Worobel and all the others who have lost their lives to homelessness.

November 30, 2006

We are pleased to introduce the Ten Year Plan to End Homelessness for Southeastern Connecticut. We began by posing several questions, including, "What if we could end homelessness in southeastern Connecticut by 2016? What must we do to accomplish this goal?" That was the critical challenge we posed to the community. We believe that we have created a plan with a clear vision and achievable goals.

During the past six months, more than 100 people representing a wide variety of public institutions, private industry, agencies, service providers and homeless people offered guidance, input and insight into the development and production of this plan. Their names and affiliations are listed at the back of this plan, and to them we offer our most sincere thanks for their generous gifts of time, thought, and professional acumen.

Now we must commit ourselves to continuing our work together so we succeed in our vision to end homelessness. The model for taking care of our community must change—we are advocating for a change in the system.

Leaders in the private and public sectors must work collaboratively in the effort to address this crisis. Anything less is unacceptable. We will be there to support them through the transition, and we ask each of you to participate in developing solutions as well.

Finally, we promise to report back to you regularly on our challenges as well as our accomplishments.

We can end homelessness by 2016. Let us begin.

The Honorable Andrew Maynard  
Warden, Borough of Stonington  
Vice Chairman, SCCOG

Janet Dinkel Pearce  
President  
United Way of Southeastern CT

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# The Beginning: An Epilogue

Danny died today.

As I sit to add the final touches to this report, I am shaking inside. I just learned that Danny Worobel, among those that we interviewed and followed this summer as we researched this plan, was found dead in his tent this morning. It was below 35 degrees last night, and Danny died.

Danny was the living, and now the dying, example of why ending homelessness must be a priority for citizens of Southeastern Connecticut. He lived in the woods because he fell through the cracks. He lived in the woods because he was so hard to find.

This epilogue must be written before I tell the story. Danny died today. Alone in his tent. His intelligent face has been the picture in my mind as I have written this document. He has round glasses that are bent, a goatee, he likes to do the crossword puzzle when he can afford a paper. If things had been different for him, he would be one of those guys who you see at Barnes & Noble Café, drinking coffee and reading *The Economist* or some obscure British magazine. Tweed with patched elbows, that kind of guy. I've thought about him just about every night this fall, as I get cozy on my couch. I've thought about him and all of the rest like him sleeping in the woods of Southeastern Connecticut. Alone and cold in the woods.

This epilogue is a beginning. It is the beginning of a story about people who we need to remember as we sit warm in our homes, as we gather around our tables to form public policy around homelessness and housing, as we watch the campaign ads talking about taxes and the war, as we decide who to vote for. We cannot forget about Danny, who died today.

This epilogue is a beginning. There are fifty or more just like him right now, getting ready to retreat to the woods for the night. We know what to do. It is all here.

This planning process began with the death of Bill Walsh, out in the woods in April. It ends with the death of Danny today. Together, let us write a new beginning.

- Carol Walter, October 26, 2006



“I gave him my jacket.”

Larry Love, as he likes to be called, eating his lunch and recalling that chilly night in early April. “It got cold out that night. They closed the shelter and it got below 32 degrees. They had closed the shelter five nights before. Those guys were up there drinking, and I went up there and seen ‘em... Walsh said he was cold. So I took my jacket off and I gave him my jacket.”

“Was he drunk?”

Larry replies,

“He might not  
have been drunk,  
he may have  
been freezing.”



Like many of Southeastern Connecticut’s homeless, Bill Walsh went to sleep in the woods on April 5, 2006. He didn’t wake up. Instead, Larry, one of more than four dozen homeless men and women who make their home in the woods of New London, Waterford, Norwich, Preston and the rural communities of the region, recalls finding his friend much as he had left him: with the jacket draped over his shoulders, his blue eyes staring out to nowhere.

More than one-third of the homeless men and women interviewed in New London County during the summer of 2006 risk the same fate as Bill Walsh. The majority of those who experience long term homelessness make their homes in the woods during the spring, summer and into early December. For them, the crisp light of fall means the cold is coming and there is nowhere to go.

An August 2006 survey showed that more than half of the homeless men and women interviewed had slept outside the previous evening, representing 51 individuals without a home, or even a bed. Most of these individuals have no access to regular health care, relying on emergency rooms and hospitals to address their medical needs, if they address them at all. Several of them are veterans, having served in the military during the Vietnam or Gulf Wars. All of them have their own unique story to tell.

Larry is one of those individuals. Born and raised in Groton, he has wandered for more than five years, making his home in various campsites and clearings in the woods or under the bridge when the rain or snow falls. He is an alcoholic who is well known to city police, ambulance and emergency room personnel as well as homeless outreach workers. To many, he must look and sound just like the uncle or cousin who, despite being a terrifically nice man, warm and articulate, absolutely cannot stop drinking once he starts.

# Homelessness in Southeastern CT

We met Larry at 9:15 a.m. on a rainy Saturday in early June near the campsite he was sharing with a friend in Bates Woods on the Waterford-New London line. He was early, we were late. His friend Danny sat nearby on a stump-the surgically reconstructed ankle which he had broken a year before throbbing.

First stop, the bridge. It had been an unusually wet June, with torrential rains flooding Southeastern CT the night before. The bridge serves as a decent shelter from the drenching rain, and that was the first tent city Larry brought us to. Cutting through an abandoned rail yard, walking over an active railroad bridge, and through the woods we first encountered a lone ripped tent, bursting at the seams from top to bottom with clothing, canned food, and other junk. Pointing, Larry says:

“That’s just a storage tent.”

Finally we are under the bridge. Relatively dry, it looks much like the camp sites we loved as children when we took family vacations. There are four tents, one looks abandoned. Larry tells us he is not sure where the occupant is. A woman with serious mental health issues, maybe she’s in jail or the hospital, he says.

A man sits outside a tent sorting cans of vegetables from a bag; baked beans, chili. His name is Hollywood and as soon as we get a good look we understand. He is strikingly handsome. Kevin Costner handsome. On the boulder next to his tent he has spray-painted the words: “Work today, payed today.” Embarrassed, he apologizes for the misspelling. Of course it is p-a-i-d, he says.

We talk with Hollywood and another man, a veteran, who is looking for work so he can get an apartment. After some time we leave, and go to the next spot. And the next. By 11:00 a.m. Larry is drunk and it is starting to rain.

“Where do you want to be dropped off?” we ask.

We learn that the soup kitchen won’t open until noon, and the campsite is far, far away. We buy Danny a sandwich so he can eat at his campsite. The five mile walk from the soup kitchen would be too much on his wounded leg, especially on a damp day like this one. Larry asks to be dropped off by the soup kitchen, downtown. He gets out of the car and finds a doorway to stand in. A shopkeeper standing in front of his flower shop scowls at the car, scowls at Larry and closes the door which had been propped open. Larry, who had thoughtfully planned a tour of his world, who had made sure he was where he said he would be, early, and who made sure that people knew in advance that there would be visitors, is now a public nuisance. A legitimate threat to the vitality and future of downtown. No one is happy with this situation, not the shopkeeper, not the police, not the advocates for the homeless. In a reflective moment, not even Larry.



## Who Are The Homeless?

Larry is one of approximately 500 homeless people in Southeastern Connecticut, approximately one-third of whom are children. While he may seem a stereotypical homeless man, he is actually in the minority among homeless people. According to the National Alliance to End Homelessness, Larry is Chronically Homeless, a term used for those who have been homeless for a year or more, or have experienced more than four episodes of homelessness over a three year period. They are people with one or more disabling conditions such as alcoholism or substance use disorders, mental illness and/or HIV/AIDS. While nationally they represent only 10% of the homeless population they utilize 50% of the services available for the homeless. Not to mention the cost to communities in emergency health care, police, incarceration, mental health crisis, and other services disproportionately utilized by chronically homeless individuals.

In Southeastern Connecticut the chronically homeless make up between 35-40% of the homeless population, four times the national average. The cost to the community is four times greater than in so many other communities. For Larry, hospital documents show, more than \$50,000 worth of ambulance rides and emergency room visits in a one year period are paid for by the State of Connecticut as well as the hospital and ambulance companies themselves.

Seemingly hopeless, thousands of individuals just like Larry have become stable, healthy and productive members of Connecticut's communities as permanent supportive housing has become available.

Another group of homeless are the episodic homeless, a term which applies to those who are frequent users of shelter and other homeless services who are typically younger with a high frequency of substance use disorders, a lower frequency of mental illness, and a tendency to cycle back and forth from homelessness to employment and stability. They may be the future Larry's of the world, they may not, often depending upon their luck in accessing services such as employment assistance and substance abuse treatment. They too represent about 10% of the homeless population.

Finally there is the transitional homeless, representing 80% of those using homeless services nationally, over half in this region. The majority of these individuals and families just need access to affordable housing in order to regain stability and independence. They typically share a brief and isolated experience of homelessness often attributed to a one-time crisis such as a sudden loss of income or housing. Services such as one-time rental assistance, eviction mediation, and other interventions can often prevent transitional homeless from losing their housing in the first place.

In Southeastern Connecticut a lack of available housing stock amidst a growing middle to low income workforce makes finding and maintaining affordable housing increasingly difficult. An update to the 2002 study, "Housing a Region in Transition: An Analysis of Housing Needs in Southeastern Connecticut, 2000-2005" published by the Southeastern Connecticut Council of Governments, asserts that more units of rental housing need to be developed in the region in order to meet the estimated need by 2010. With rising sales prices, affordability will be a major barrier for the region overall, even if production needs are met.



## The Plan to End Homelessness

Not long after the tragic death of Bill Walsh, a group of government and elected officials, philanthropists, leaders from the faith community, hospital and health care officials, homeless service providers, housing developers, and a host of community members including homeless advocates and homeless people officially began meeting to examine the causes of homelessness in the region, define the problems which contribute to homelessness and to make recommendations to solve this social wrong.

More than 50 different community members worked together through the spring, summer and early fall of 2006 to create a comprehensive plan to end homelessness in Southeastern Connecticut. Their hard work culminated in the development of recommendations geared toward improving the lives of homeless citizens and, eventually, ending homelessness in Southeastern Connecticut. Their plan follows these central goals:

- ◆ Assure access to safe, decent, affordable housing with support services available if needed;
- ◆ Provide for seamless coordination of services, assuring that no door is the wrong door for those who are homeless or at risk of homelessness;
- ◆ Create partnerships with local institutions and facilities to support a zero tolerance policy for discharge into homelessness;
- ◆ Expand prevention services for those at risk of homelessness and assure rapid access to housing and support services for those who become homeless in the region;
- ◆ Increase access to income and/or employment services;
- ◆ Make sure that organizations and institutions who serve homeless individuals and families meet current and changing needs and prioritize the dignity and self-determination of those they serve;
- ◆ Adopt policies and practices in local government which reflect our shared commitment to ending homelessness;
- ◆ Work with local communities, including the faith community, to make sure that citizens of Southeastern Connecticut know of our efforts and have the opportunity to participate in our work.



## A Place to Call Home

“Having gotten my own place was a big step for me... When I was homeless I didn’t have a care in the world because I didn’t think there was anything to do but be homeless... That’s what I needed, not to be homeless and to start a life and to have other things that other people have, get my mind together, you know, start working, do the things that people do in society.”

“How often do you land in treatment now?”

Slightly angry, “I run groups now.”

And “Detox?”

Little smile, “None”

“How often do you get arrested now?”

Grinning, “No, none”

How often do you go to court, jail, hospitals?”

Laughing, “Nope, none.”



A recovering alcoholic, Basil recalls countless trips to the ER in his last years on the streets and more than a dozen arrests that he can remember. He lived like this for years, briefly living in an apartment here and there, with family members, in the shelter and on park benches. He tried treatment for his alcoholism 17 times. It never seemed to work.

Until finally it did. During a nine month stay at Lebanon Pines, a long term treatment center in the town of Lebanon, Basil was diagnosed with major depression and post traumatic stress disorder. Diagnosed, Basil was finally on the road to a recovery which he continues to enjoy today. Uninterrupted.

When it was time to leave, discharge planners at the program found him housing through Reliance House, a local organization which provides comprehensive outreach, case management, and housing services for the region’s homeless. With a place of his own, his mental illness and substance use in check, and a comprehensive array of support services to depend upon if needed, Basil is stable and giving back. He works part time as a maintenance worker and facilitates recovery groups for others.

Today, Basil needs just a \$500 per month housing subsidy and about the same amount in supportive services. Compared to Larry, who has yet to realize Basil’s success, that is less than one fifth the cost of keeping him homeless and on the streets or in our emergency rooms and jails.

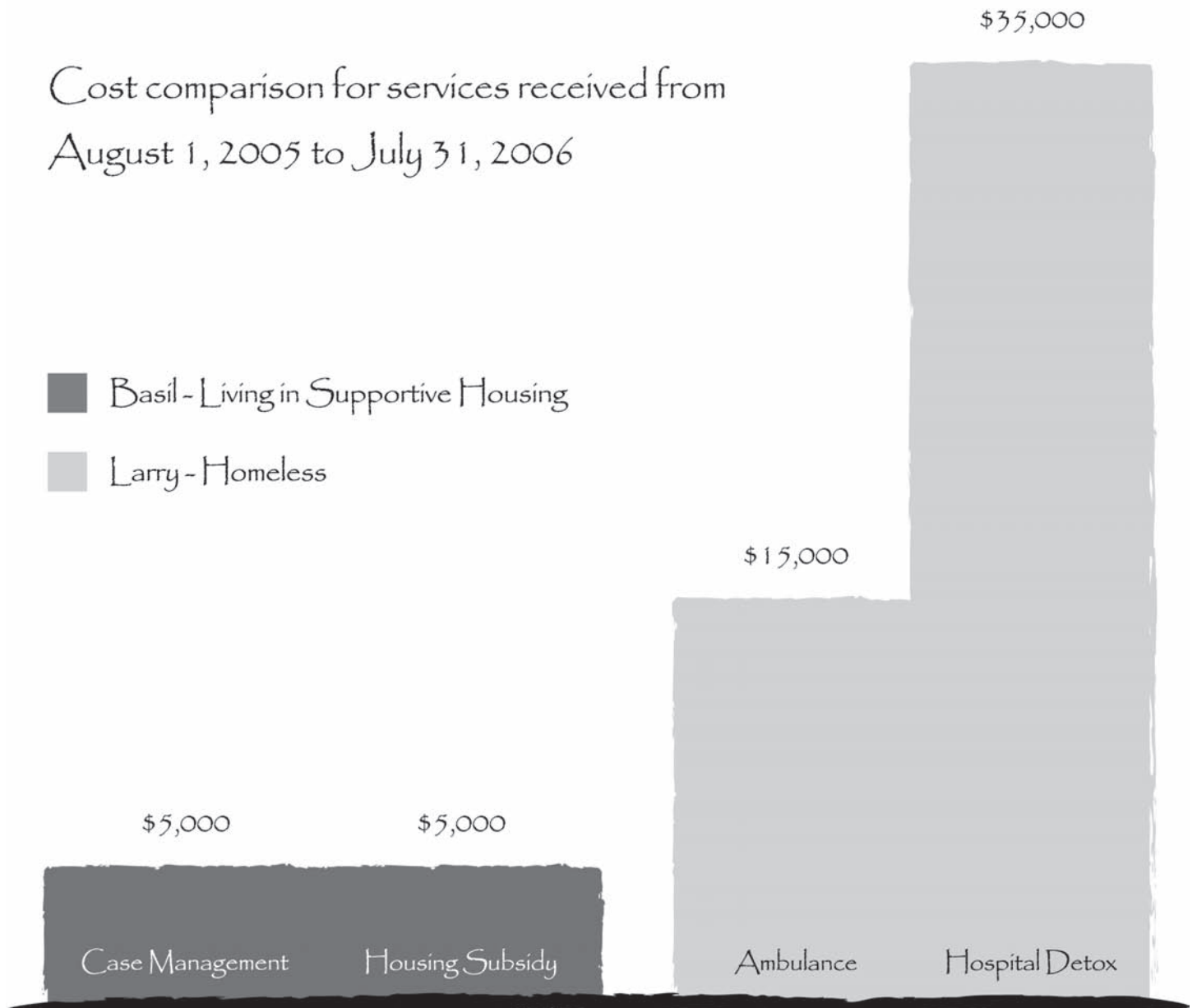
# Permanent Supportive Housing

Basil is the beneficiary of permanent supportive housing, considered by national experts to be the most efficient solution to long term homelessness and its devastating effect upon individuals, families and communities. Permanent supportive housing is typically created through mixed use development projects where renovation or new construction creates affordable units for homeless and non homeless individuals and families. Supportive services are readily available for all residents who choose to use them and are often provided on-site. Such programs stabilize neighborhoods by creating new, well managed housing and building affordable rental housing capacity in communities where it is desperately needed. In addition to this model, 'scattered site' subsidy programs allow homeless citizens to live in single apartments or houses of their choice throughout the community. Residents hold their own lease and have access to supportive services such as case management, mental health counseling, substance abuse services, and others.

The success of permanent supportive housing is well documented. Numerous studies have shown that it results in an increased level of stability among our most disabled homeless citizens. Those who cycled in and out of homelessness, prison, hospitals and institutions, like Larry and Basil, are now contributors to their families and communities.

Cost comparison for services received from August 1, 2005 to July 31, 2006

- Basil - Living in Supportive Housing
- Larry - Homeless



## Goals and Recommendations

Southeastern Connecticut's plan for addressing the housing needs of its homeless citizens will involve four core elements:

- Developing permanent supportive and affordable housing;
- Advancing a public policy agenda which minimizes the regulatory barriers to developing housing and prioritizes our shared goal of ending homelessness;
- Carrying a public information campaign regarding our plan to every town and city on the region;
- Assuring that agencies who provide services to homeless individuals and families prioritize the self-determination of their residents and have resources to continuously improve the quality of their programs.

### Goal:

All homeless individuals and families will have access to safe decent and affordable housing with support services available if needed.

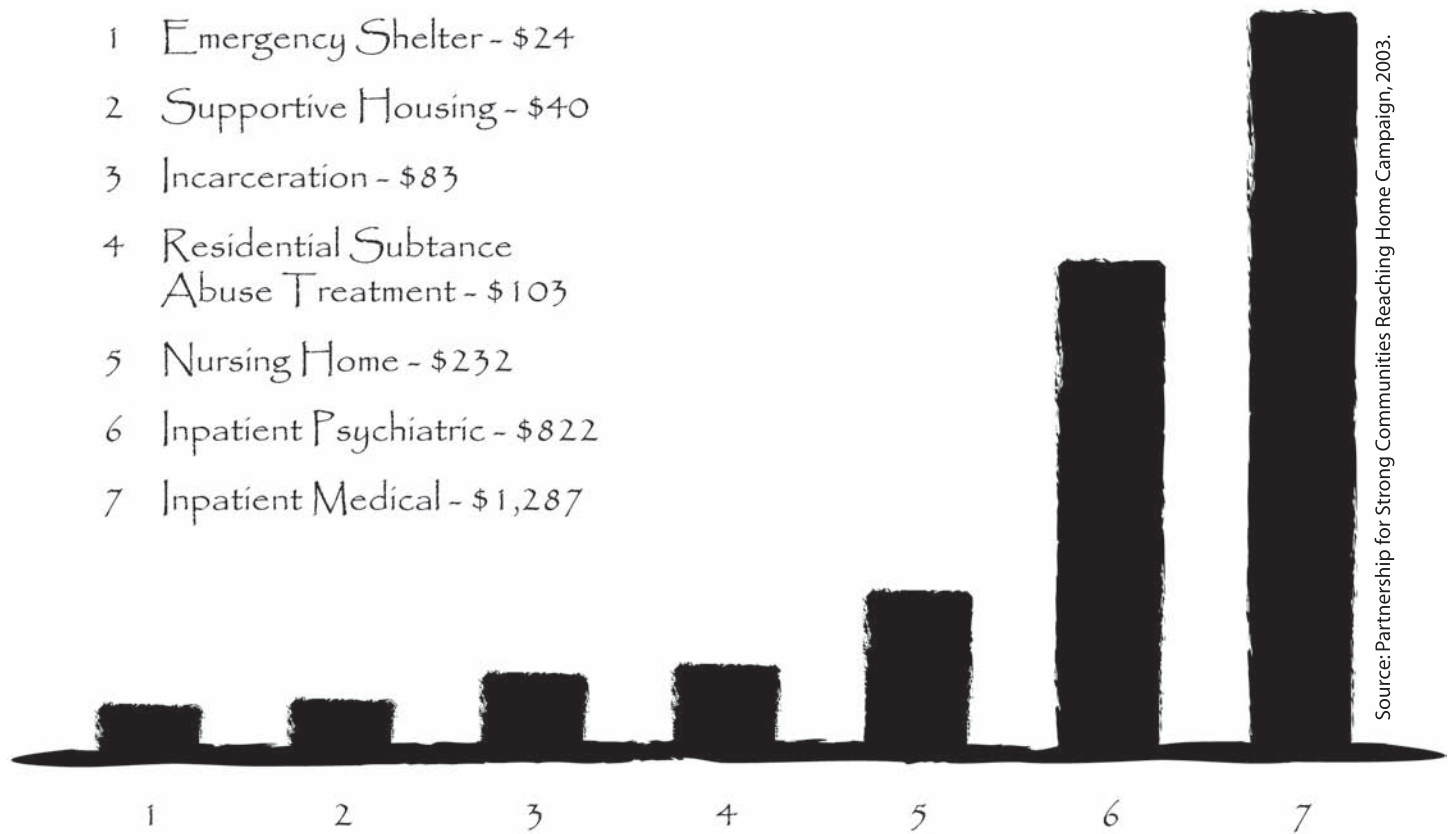
### Measures:

1. The average stay in area homeless shelters will be reduced to less than 30 days by 2012.
2. 90% of those leaving area transitional housing programs will move on to permanent housing.
3. The number of chronically homeless individuals and families will be reduced by 70% (from 148 to 48) by January 2010.

### Recommendations:

- Adopt recommendations of the statewide Reaching Home Campaign by creating 704 new units of permanent affordable and supportive housing over the next ten years:
  - Prioritize the addition of 148 units of permanent supportive housing over the next three years specifically for those who are currently experiencing chronic homelessness;
  - Develop 564 new units through a combination of new development and rehabilitation;
  - Utilize 140 total units through the use of existing housing.
- Expand the capacity of area non-profits to develop and operate supportive housing by encouraging formation of at least one development team annually to apply to the Corporation for Supportive Housing's One Step Beyond Training Institute, or other capacity building initiatives.
- Investigate formation of a non-profit housing development corporation or collaborative whose mission would focus on the creation of permanent supportive housing in the region.

# Cost per Day: Supportive Housing vs. Alternative Settings



- Identify traditional and non-traditional funding resources to support the development of permanent supportive housing in the region and disseminate information to potential developers, service providers and property managers. Examples of funding resources may include the Affordable Housing Trust Fund, resources for pre-development funding such as the Corporation for Supportive Housing, the Next Step Initiative, funds from the U.S. Department of Housing and Urban Development, tax credit deals, and others.
- Build on the successful collaboration between the Southeastern CT Mental Health Authority, Sound Community Services and the New London Housing Authority to add 20 units of supportive housing to those currently being utilized by formerly homeless individuals and families.
- Create initiatives similar to that of the New London Housing Authority in Groton, Norwich and other communities in the region.
- Identify area agencies that are willing to take on “master leases” and other models for supportive housing units developed through the use of existing housing, indemnifying private landlords who may be hesitant to lease units to individuals and families with poor rental histories or other barriers.
- In collaboration with the Regional Planning Agency, Southeastern CT Council of Governments, and the Southeastern CT Housing Alliance (SECHA), create an inventory of land and properties in the region suitable for housing development or rehabilitation.
- Increase housing production capacity by engaging for-profit housing developers in the attempt to end homelessness.
- Investigate new models to support homeless families in gaining access to permanent affordable housing including shallow subsidies (partial rental subsidies often for \$150 to \$200 month), transition in place models (transitional supportive housing programs where the tenant assumes the lease at the end of two years) and other alternative funding sources for housing subsidies.
- Prioritize funding for incentives to local landlords who make affordable units available to homeless such as small cash grants or loans for minor repairs.

### Goal:

Local government policies and practices will reflect the region's commitment to ending homelessness. Southeastern Connecticut will be an active participant in state and national efforts to effect change in support of our goals.

### Measure:

1. The Southeastern Connecticut Council of Governments (SCCOG) will adopt the ten year plan and assist with its implementation.

### Recommendations:

- Work with the SCCOG to gain the support of every town and city in the region to contribute to the shared goal of ending homelessness.
- Where new housing production is prevalent, encourage those communities to adopt 80/20 standards which assure that market rate development includes a 20% set aside for affordable housing. In addition, support the establishment of a per unit buy out clause on affordable housing development as utilized elsewhere in Connecticut cities to allow the establishment of local affordable housing trust funds.
- Work with towns in the region to assure that supportive housing is included as an ongoing strategy for meeting their 10% affordable housing development requirements and/or other community development initiatives.
- Through SCCOG and the Regional Planning Authority, identify adjustments to current zoning regulations across the region, including density restrictions, to support the development of permanent supportive housing. Look to municipalities around the state, such as Stamford and New Haven, for initiatives that can be replicated in Southeastern Connecticut.
- Work with the Statewide Reaching Home Campaign, Housing Production sub-committee to identify ways to speed production of supportive housing in the region and to create incentives for involvement by for-profit developers in order to increase local capacity.
- Collaborate with and support SECHA efforts to preserve and develop quality affordable housing in the region.
- Expand availability of security deposit assistance to homeless families and individuals who have located housing but cannot afford to pay a security deposit. Investigate the use of non-traditional funding resources for such assistance including the establishment of a loan pool supplemented by donations and housing court related fines.
- Advocate for the Department of Mental Health and Addiction Services to examine and include best practices in provision of treatment and substance abuse services to those who are actively using or prone to relapse.
- Advocate for the expansion of residential treatment opportunities for those struggling with addictions.



## Goal:

Individuals and groups throughout Southeastern Connecticut will know about the Ten Year Plan and understand how they can help to end homelessness.

## Measures:

1. By January 2007, at least one civic and one faith organization from each town will be represented on a public information planning committee promoting the Ten Year Plan.
2. By 2008, public information efforts will reach each town in the region, educating community members regarding homelessness in Southeastern Connecticut and what they can do to help end it.

## Recommendations:

- Work through the SCCOG, United Way of Southeastern Connecticut and community leadership to launch a public education campaign throughout the region with the goal of addressing the stigma associated with supportive housing and gaining widespread support for the region's efforts to end homelessness.
- Work specifically with the faith community to advocate in support of efforts to contribute as above, particularly in suburban towns.
- Increase public awareness at every opportunity by publicizing progress toward our goals through press releases, radio interviews, and public service announcements.
- Provide information and training to local landlords on the benefits of working with providers in housing homeless and formerly homeless individuals and families. Information and training include:
  - Information on local and state incentive programs;
  - Tax abatements and how to access them;
  - How supportive housing works;
  - Services and interventions for tenants;
  - Success of scattered site supportive housing.

### Goal:

Programs and organizations who serve homeless individuals and families will provide high quality services that meet the current and changing needs of the population and are accountable to the clients who depend upon their services, prioritizing their dignity and self-determination.

### Measures:

1. By 2008, 100% of area shelters, transitional and permanent housing programs will adhere to shared principles and standards of service.
2. By 2009, 80% of residents surveyed report that area shelter, transitional and permanent housing programs are operating within defined principles.
3. By 2008, area providers have access to no less than three training opportunities annually to assist managers and staff in adhering to defined community standards and principles.

### Actions:

- Articulate shared principles which define community standards for new and existing supportive housing programs, both scattered site and project based, to assure leasing and production of units which are appropriate to the needs of homeless tenants in the region.
- Identify effective service models for agencies providing services to residents in permanent supportive housing including ACT models (Assertive Community Treatment), inebriate housing, and other successful models from around the country.
- Provide specific training for case managers serving residents of permanent supportive housing in engagement strategies for service resistant residents.
- Define minimum standards for resident information and education in permanent supportive housing which includes education on tenant rights and responsibilities.
- Support Connecticut Coalition for Addiction Recovery's attempts to set standards for community recovery residences such as sober houses.
- Create an annual award which recognizes programs for excellence.
- Examine ways to ensure that both existing and proposed homeless services programs, including shelter, transitional and permanent supportive housing, provide quality services and work toward the ultimate goal of ending homelessness. Guide and support agencies in efforts to continuously review and revise programming for the benefit of homeless individuals and families.



## Spotlight Program: Coleman Street Partnership

A successful collaboration between the New London Housing Authority, Sound Community Services (SCS) and the Southeastern Connecticut Mental Health Authority (SMHA) has led to the placement of more than 60 individuals served by SMHA in housing authority units throughout New London, many of whom have experienced long term homelessness. Of particular note is the 202 Coleman Street high rise where more than 20 residents receive services through SMHA and on-site SCS staff. Since March 2005 the three agencies have worked together to provide the following services to residents of 202 Coleman Street:

- ◆ Twenty efficiency apartments set aside for formerly homeless clients of SMHA;
- ◆ Clinical and Case Management services provided to those residents by SMHA and SCS;
- ◆ On-site staffing provided from 7 a.m. to 10 p.m. by SCS for response to immediate issues and liaison with NLHA staff;
- ◆ Property management provided by NLHA;
- ◆ On-site activities for ALL residents provided by SCS. Activities, which are geared to integrate the supportive housing and elderly residents of the building include movie nights, grocery shopping trips, games, community meal nights, and holiday celebrations;
- ◆ On-site case management is provided for both the target population (supportive housing) and elderly residents including assistance in linking to benefits as well as connecting to a variety of behavioral health services;
- ◆ Transportation assistance is available for all residents to medical appointments, neighborhood alliance meetings or the nearest senior center.



“I had no help.”

Erica, now sitting in her two bedroom apartment, piled from floor to ceiling with furniture and boxes still waiting to be unpacked, describes her tortured days on the streets, separated from her children who she had voluntarily handed over to the Department of Children and Families:

“The most exciting part was finding someone who had money that I could jump in the car with and they’d get a hotel room and I’d be off the street for the night. The worst part was living out on the street in the winter time. I remember it being so cold that I couldn’t feel my hands. I would cry and my tears would just freeze. It was so cold. I had to bury what little belongings I had in a snow bank behind an abandoned building.”

We sit down for lunch and everyone eats but her, she is too busy feeding her 14 month old, Romeo, who sits in his high chair laughing and kicking his feet. Her four-year-old is enjoying his pizza and chatting for a moment, then frowning at his mom as she instructs him to eat his lunch and allow us to talk. It is the life of a young single mother and Erica is grateful for every moment.

After undergoing treatment for substance abuse, Erica was able to find a long term program for pregnant women where she gave birth to her youngest son. Soon she was approved for a housing subsidy through PILOTS, a state funded permanent supportive housing program administered in this case by a non-profit agency called The Connection. Reunited with her older son she was discharged from the program and stayed with friends until her apartment became available.

She has so many plans, but her ultimate goal is to no longer rely on assistance. “My son is going to school in three weeks. What I want to do is go to school part time myself and then possibly try to work.”

## Building the Safety Net

Permanent Supportive Housing has helped Erica to get back on her feet and reunite with her family. But this is not the end of the story. In order to assure that Erica and her family do not become homeless again, she will need a lot of help: childcare, transportation, assistance with education, job skills, only to name a few. She is fortunate to have the support of her case manager who will help her connect with the services she needs.

For those who live on the margins, a well coordinated and easily accessible system of support services is essential. Residents of family transitional housing interviewed during the summer of 2006 were quick to point out that such services are desperately lacking. The concerns which they identified almost unanimously were a lack of daycare, transportation assistance and cash assistance. Where services are provided, the residents report it is through a frayed service network which is difficult to navigate. It is a safety net full of holes and when families like Erica’s fall through they are forced to repeat the tragedy of homelessness again and again.



## No Wrong Door

From a disabled single man living in the woods of Waterford, or a single parent living just one paycheck away from homelessness, coordinated and robust service systems can prevent homelessness, help those who do become homeless get quickly back on their feet, or patiently engage those distrustful of services due to mental illness or simply too many years alone in the woods.

Building on existing services and partnerships, the Southeastern Connecticut Ten Year Plan to End Homelessness includes initiatives in three key areas:

- Expanding on existing collaborations to provide a “no wrong door” approach to providing services;
- Assuring rapid access to services for those who become homeless;
- Preventing homelessness before it happens.

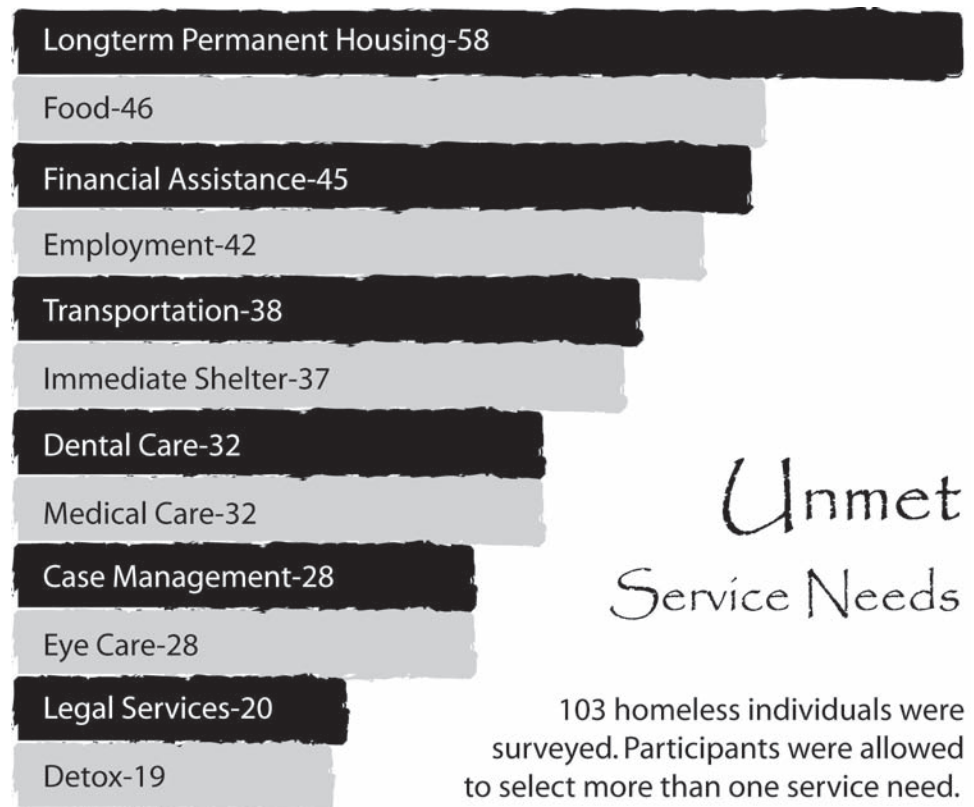
# Goals and Recommendations

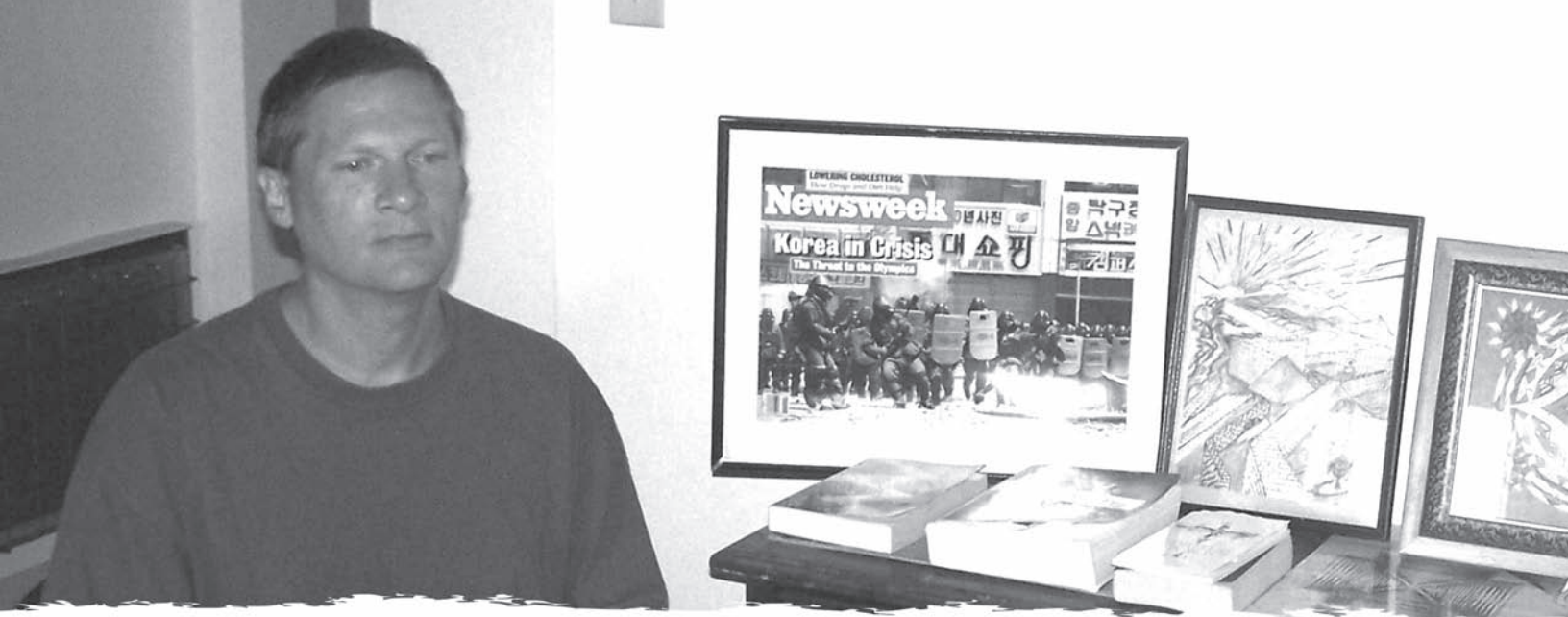
## Goal:

Southeastern Connecticut will assure seamless coordination of services for homeless individuals and families, assuring that no door is a wrong door for those who are homeless or at risk of homelessness.

## Measures:

1. At least 106 chronically homeless individuals in the region will be known to one of two community care teams by the end of 2007. By the end of 2008, at least 142 chronically homeless people will be known to one of the two teams, equal to the number of chronically homeless individuals identified through the Southeastern Connecticut Partnership to End Homelessness 2006 point-in-time census of the homeless.
2. Beginning in 2008, the number of chronically homeless individuals in the region (based upon the 2007 count) will decline by 10% per year.
3. 100% of all homeless service agencies and 98% of all other agencies and institutions as well as government agencies and departments who provide services to the homeless will be active members of one of two community care teams by July 2007.
4. A baseline database of consumer demographics, service needs and usage will be developed by January 2008, including development of systems to gather annual follow-up data in order to measure success and changing needs.





## Actions:

- Using the successful Norwich Community Care Team as a model, develop and implement two broader Community Care Team's for the Southern and Northern portions of the county, respectively, assuring that all towns in the region are connected to one of the two teams. The role of the Community Care Team is to assure comprehensive outreach, engagement and provision of services to homeless individuals and families, toward the goal of ending homelessness for all citizens in the region. Along with providing a hub for case conferencing and client level problem solving, the community care team can:
  - Coordinate cross-training of providers across all systems of care;
  - Disseminate important information and updates regarding services;
  - Minimize duplication of services by using a wraparound service approach;
  - Identify system wide barriers and problems.
- Develop and implement a regional Community Care Consortia including representation by key leaders of agencies and institutions associated with each Community Care Team. The role of the Community Care Consortium is to provide broad oversight and coordination of outreach, engagement and service systems, toward the goal of ensuring a seamless and well coordinated system of intervention and services for homeless and at risk individuals and families in the region. At a minimum, assure representation from the following community entities on the community care consortia:
  - City and Town Government
  - Community Care Teams
  - Southeastern Connecticut Partnership to End Homelessness
  - Hospitals and Healthcare
  - Police and Public Safety
  - Southeastern Connecticut Mental Health Authority
  - Substance Abuse Treatment Providers
  - Homeless Outreach
  - New London Grassroots Homeless Coalition
  - Adult Probation and Court Supportive Services
  - HIV/AIDS Services
  - Veterans Services
  - Thames Valley Council for Community Action
- Gather baseline data regarding service needs and usage, create process for annual data collection through consumer and provider focus groups and surveys to measure progress and effectiveness of wraparound services.

### Goal:

Those who become homeless in Southeastern Connecticut, regardless of the circumstances surrounding their homelessness, will have rapid access to the full array of housing and support services available in the region.

### Measures:

1. By the end of 2008, multidisciplinary outreach and engagement teams will be in place to provide active outreach to homeless individuals and families who sleep outside, in abandoned buildings or other places that are not fit for human habitation.
2. The number of “out of care” (as defined by the Community Care Teams) chronically homeless individuals and families will be reduced to below 5% by the end of 2010.

### Actions:

- Assure seamless engagement and service delivery, while saving lives, through the establishment of a year-round shelter and service facility targeting chronically homeless individuals.
- Establish specific strategies to identify and engage homeless youth (up to 25 with a focus on the 18-25 age group) by providing a summit on youth homelessness including representatives from school systems, youth services bureaus, law enforcement, local and state government, non-profit organizations serving youth and other stakeholders.
- Identify representatives to community care teams who work with homeless youth.
- Increase the capacity of homeless outreach and engagement programs to provide more active outreach to homeless individuals living outdoors in the New London area.
- Initiate a collaborative approach to outreach and engagement toward the goal of creating multidisciplinary homeless outreach teams throughout the region. Assure the inclusion of staff with specific expertise in substance abuse and harm reduction to such teams.
- Design and implement a seamless system for the integration of homeless outreach and delivery of health care services to homeless individuals and families including potential replication of the successful CHAMP (Community Health Access Management Program) pilot through Visiting Nurse Association of Southeastern Connecticut, Generations Health Center and Backus Hospital’s mobile medical van program.
- Expand hours at community meal sites by leveraging existing or expanded prevention and outreach programs to provide services on-site.

## Goal:

Those being discharged from institutions and facilities who are at risk of homelessness will be assisted by such institutions to access appropriate permanent housing.

## Measure:

1. By the end of 2008, 100% of the region's public and private institutions will be working with the Community Care Teams to create and revise discharge planning policies which detail comprehensive protocols to prevent discharge into homelessness.

## Recommendations:

- Engage institutions and facilities, both locally and around the state, to develop policies of zero tolerance for discharge into homelessness. Support local institutions in identifying red flags for risk of homelessness, identification of resources and adoption of discharge planning standards and protocols where appropriate.
- Facilitate the participation by all area treatment facilities, hospitals, correction or alternative incarceration facilities, and other institutions, in community care teams as well as the community care consortia.
- Work with the Coalition of Ten Year Plan Municipalities, the Governor's Interagency Council on Homelessness and Supportive Housing and the Connecticut Coalition to End Homelessness to establish a statewide discharge planning network including institutions, community residences such as sober houses, halfway houses and transitional housing facilities.
- Invite Adjutant General and other Base Commanders as well as state and federal veteran's organizations to work with community care consortia in order to create discharge plans for returning veterans from the Iraq and Afghanistan wars who are at risk of homelessness.
- Formalize link between community care teams/consortia, Department of Corrections, Adult Probation and Court Supportive Services by educating judicial and corrections personnel regarding homeless services and involving care teams in discharge planning.



### Goal:

Families and individuals who lose resources to secure their own housing will be able to utilize a variety of well publicized and accessible services and interventions to prevent homelessness.

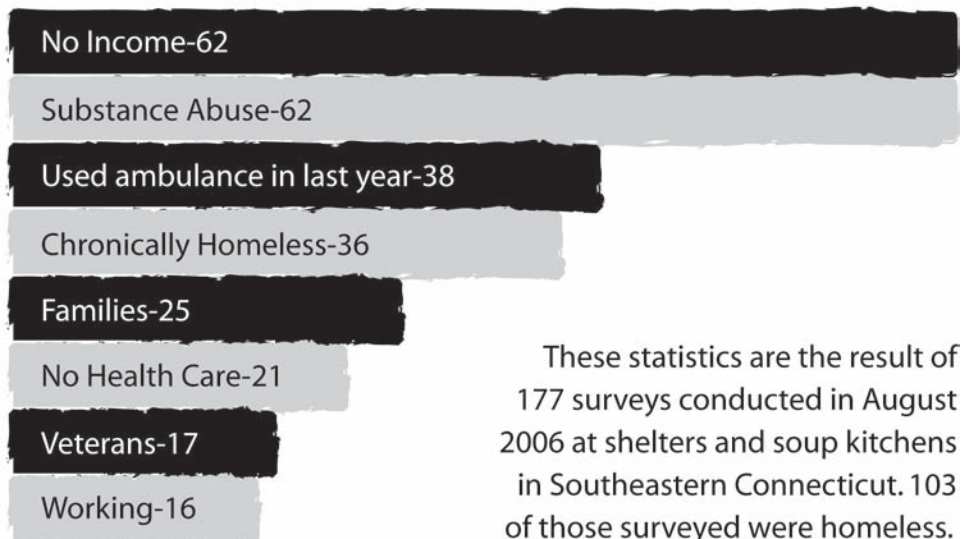
### Measures:

1. Individuals and service providers will have access to centralized information regarding prevention resources by the end of 2008.
2. Funding for prevention resources such as eviction prevention services, security deposit assistance and emergency subsidies will increase by an average of 10% each year beginning in January 2009.

### Recommendations:

- Increase funding for eviction prevention, security deposit assistance and emergency rental assistance funds which can help individuals and families maintain their housing.
- Provide education to property management groups and landlord associations regarding local resources to prevent homelessness.
- Expand the Partnership to End Homelessness website to include a section on prevention with information and links to appropriate services. Promote the website throughout the region as a resource for those who may come into contact with individuals and families at risk of homelessness.
- Expand outreach and follow-up services to homeless and formerly homeless families.
- Engage the Connecticut Office of Policy and Management to explore the possibility of utilizing funds through the recently awarded 'truancy grant' to assist with identification, outreach and engagement of homeless youth.

### Characteristics of Homelessness



These statistics are the result of 177 surveys conducted in August 2006 at shelters and soup kitchens in Southeastern Connecticut. 103 of those surveyed were homeless.



## Spotlight Program: Norwich Community Care Team

Established in 1998, the Norwich Community Care Team is a collaborative of municipal, non-profit and state health and human service agencies who have banded together explicitly for the purpose of finding long-term solutions to serving chronically homeless people. The target population, on whom the team focuses, is the hardest to serve, usually afflicted with severe and persistent substance abuse, mental health issues or both. Team participants are as diverse as the needs of the region's homeless. They include:

- ◆ City of Norwich Human Services
- ◆ Reliance House
- ◆ Eastern Region Service Center
- ◆ Eastern Region Mental Health Board
- ◆ Generations Health Clinic
- ◆ Southeastern CT Mental Health Authority
- ◆ Clergy Association
- ◆ St. Vincent de Paul's
- ◆ Norwich Police Department
- ◆ William Backus Hospital
- ◆ State of CT - Department of Social Services
- ◆ Social Security Administration
- ◆ Southeastern Council on Alcohol & Drug Dependency
- ◆ Martin House
- ◆ State of CT - Adult Probation
- ◆ American Ambulance
- ◆ Norwich Health Department



## Employment and Income

“I had a job at Lorelei’s. Lorelei’s restaurant on State Street...me and this other dude Carlos. I was there for a while. Saved up enough money to get an apartment. Then Lorelei’s closed down, so we lost our jobs. Now we couldn’t afford the apartment.”

For so many of Southeastern Connecticut’s homeless, that is how it started. Living on the edge for most of his adult life, Danny is just another example of how tentative that edge really is. Now he is in an air conditioned conference room at the New London Community Meals program, grateful to have a break from the stifling heat if only for an hour.

His story is disturbing. After traveling with a carnival during the spring, summer and early fall of 2004, Danny returned to New London with no job and no housing. His only valuable possession was a \$200 tent, he found a spot near a homeless encampment in the woods near the Waterford New London line. One morning after a heavy snow fall, Danny was making his way out of the woods when he stepped in a hole and badly snapped his ankle.

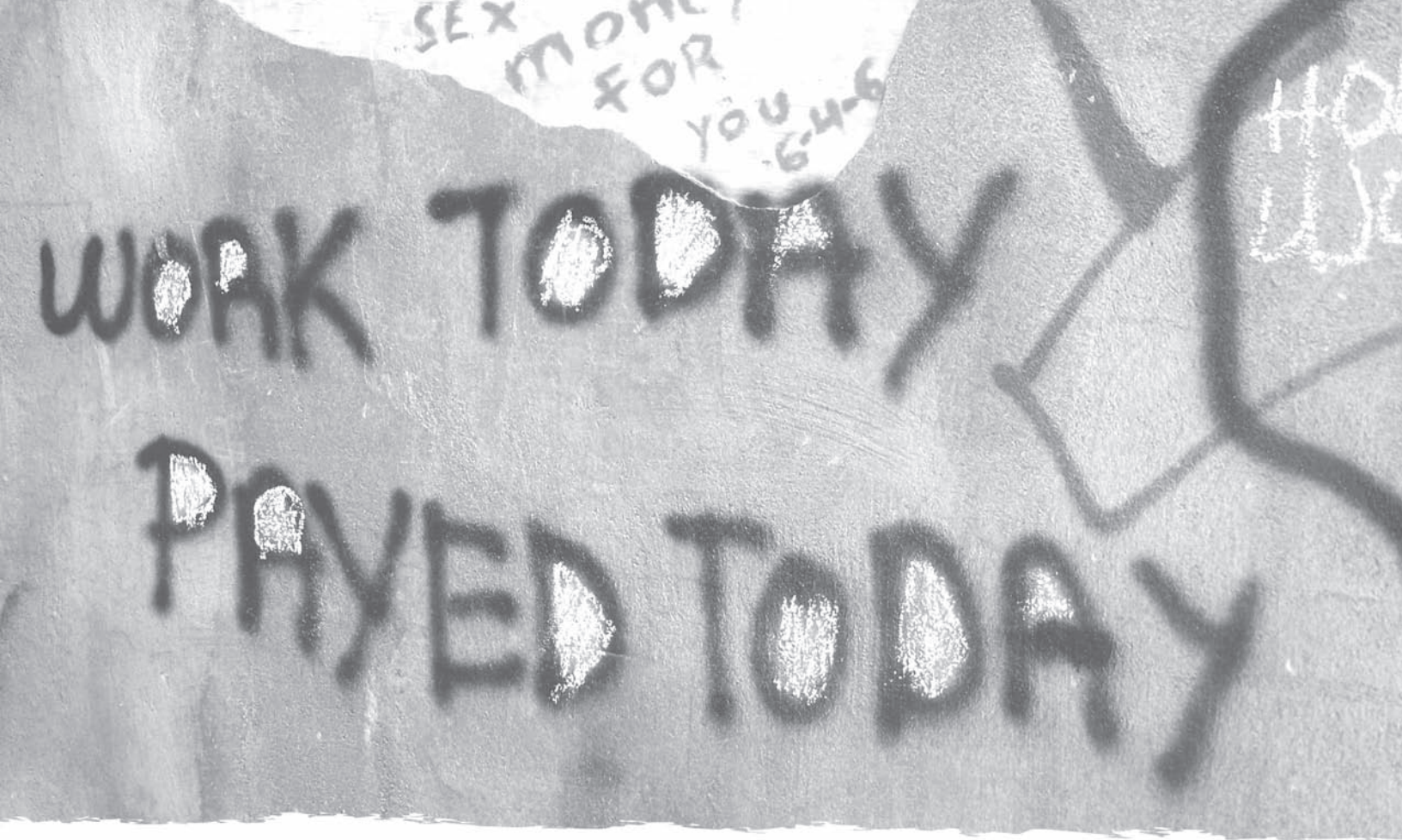
“I paddled my way  
[through the snow]  
backwards toward  
the road, yelling  
for help.”



After receiving treatment for a compound fracture of the ankle, he was released to the street with a cast up to his knee. In early July, x-rays showed that the injury had not healed properly and that Danny would require surgery to implant a metal rod in the ankle. After the surgery, the ankle became badly infected. He returned to the hospital. This time he stayed for nearly three months.

Since his last release from the hospital, Danny has spent the majority of the time living in his tent. He is unable to stand or walk for long periods of time, making it impossible to find work in the food service industry where he had been trained and worked most of his life. He has applied and been turned down for Social Security Disability three times.

At 48, Danny must learn a new trade and find a non-physical job which will pay enough to cover his basic living expenses. All of this from a tent in Bates Woods.



## Coming Soon: Project SOAR

Social Security Outreach, Access and Recovery Program

According to data from the Norwich Winter Shelter collected during the winter of 2005-2006, more than 40% of the homeless individuals who utilized their services reported that they have disabilities which could make them eligible for Social Security benefits. With the complication of co-occurring substance use disorders it is fair to assume that among Southeastern Connecticut's chronically homeless that number is much higher.

Like Danny, many of these individuals spend years applying for social security benefits only to be turned down again and again. The challenge of having no fixed address, the need for detailed information and follow-up, and the time limits imposed on application and response to inquiries by SSA make it very difficult for transient homeless individuals to be successful in securing benefits regardless of their eligibility. But a new initiative being launched in the region should soon change that: the Department of Mental Health and Addiction Services, the Department of Social Services and the Office of Workforce Competitiveness have chosen New London County as one of two pilot sites for Project SOAR, a comprehensive planning and training program to create systems change and collaboration regarding SSI/SSDI.

Beginning in early winter 2007, comprehensive training and technical assistance will be provided to case managers and social workers as well as clinical staff from the region's hospitals, health clinics, mental health agencies and homeless service providers through a curriculum called, "Stepping Stones to Recovery". The stated goal of the program is to, "increase the number of successful applications for SSI and SSDI for eligible people who are homeless, to facilitate their recovery and enable them to become successful, contributing members of their communities." The program guides staff through information gathering, developing a detailed medical summary report, working with clinicians to provide all needed information at the time of application, and providing follow up services to recipients so they may use their benefits as a stepping stone to employment, independence and self-determination.

## Goals and Recommendations

The barriers which homeless individuals and families face in finding and retaining employment or accessing entitlements are numerous. For example, when correspondence that requires follow up is lost in the system the result is too often frustration and failure.

Seemingly routine things such as lack of identification, access to hygiene supplies and showers, proper clothing, automobile maintenance and so much more seem simple to most but are often insurmountable problems to a homeless person with no resources.

The Employment and Income Committee of the Southeastern Connecticut Ten Year Plan to End Homelessness will work to improve access to employment and/or benefits by pursuing three strategies:

- Assure that homeless individuals and the staff who assist them have easy access to mainstream services that assist job seekers in finding competitive employment;
- Increase access and speed up application processes for disabled individuals applying for benefits through the Social Security Administration;
- Mitigate barriers which homelessness creates to finding and maintaining employment.

### Goal:

Build partnerships within the homeless services, workforce development, and mainstream service system.

### Measures:

1. Within three years, 100% of case managers working for homeless service providers will receive training in employment services.
2. Eighty consumers of homeless services will access employment services at the One Stop each year.

### Actions:

- Provide twice yearly DMHAS trainings to One Stop staff to improve services to clients who are mentally ill or substance abusers.
- Host summit twice annually employing One Stop partners and area non-profits for mutual education and networking.
- Train case managers and providers about the VITA (Volunteer Income Tax Assistance) program which will help clients take advantage of the earned income tax credit.
- Schedule the statewide Mobile One Stop to area locations frequented by people who are homeless once every six weeks.
- Build an active network of consistent contacts that meet monthly drawn from One Stop partners and area nonprofits.

## Goal:

Increase access to income and entitlements for homeless individuals who are disabled.

## Measures:

1. 100% of case managers will receive training from the Social Security Administration or the Connecticut Bureau of Rehabilitation Services in benefits eligibility and work incentives.
2. Successful Social Security application will increase to 50% in the first year.
3. 100% of consumers staying in winter shelters will receive information and access to benefits.

## Actions:

- Increase the capacity of non-profits to serve as representative payee for at least five individuals;
- Utilize Social Security Administration resources to provide regular trainings to update emergency shelter and homeless provider staff on eligibility and other Social Security issues.
- Implement “Project SOAR” (Social Security Outreach, Access and Recovery) through the two community care teams.
- Train 100% of case managers and others who assist with entitlement applications to increase successful Social Security applications.

## Goal:

Through advocacy and training, existing resources will be utilized to make sure daily impediments to employment are removed.

## Measures:

1. Fifteen employers each year will receive training concerning issues of substance abuse and mental illness in the workplace.
2. One hundred homeless individuals will receive services at each Project Homeless Connect service fair event.

## Actions:

- Using Employee Assistance Programs, small businesses and Chambers of Commerce, organize annual workshops to educate employers regarding substance abuse and mental illness in the workplace.
- Maximize the partnership between technical schools and the Workforce Investment Board for the maintenance of automobiles.
- Support current legislative efforts to change Department of Correction’s policy of destroying inmate documentation 30 days after incarceration, which currently makes reintegration much more difficult and time-consuming.
- Use Project Homeless Connect as a venue for eliminating the red tape slowing the process of obtaining identification.
- Work with Department of Labor to expand the types of apprenticeship possibilities, and with unions to increase the number of possibilities.
- Develop a resource guide for case managers describing locations of clothing rooms and hygiene resources.
- Coordinate Project Homeless Connect events twice annually employing members from each subcommittee and addressing the diverse geographic needs of the region.

# Glossary of Terms

## Section 1 - Housing

### **Reaching Home Campaign**

The statewide campaign to create 10,000 units of supportive housing, endorsed by Governor Rell and the Interagency Commission on Supportive Housing and Homelessness. Please see [www.ctpartnershiphousing.com](http://www.ctpartnershiphousing.com) for more information.

### **Next Step Initiative**

Governor Rell's funding initiative designed to add 500 units of supportive housing throughout the state over the next three years. Next Step will provide funding for supportive services, development and/or rental subsidies. It is designed to leverage additional development grants as well as federal funds.

### **Permanent Supportive Housing**

A cost-effective solution to long-term homelessness in which residential stability is combined with appropriate supportive services to meet residents' individual needs. Permanent supportive housing can come in a variety of forms. Some programs are "scattered site," meaning a client or agency leases apartments in the community, and the program subsidizes the rent. Others develop a dwelling or apartment building where supportive services are available on-site. Some programs require that clients utilize services as a condition for remaining in the program while others provide, but do not require, participation in services. For many, the need for services is reduced over time, as households gain stability.

### **Housing First**

Based upon the premise that homeless individuals and families are more likely to successfully utilize support and intervention relative to their disabilities and special needs when they are housed. There are numerous studies, which show that the Housing First approach saves money and resources as it decreases recidivism and increases stability and independence. Please see [www.beyondshelter.org](http://www.beyondshelter.org) for more information.

### **HMIS**

Homeless Management Information System, a community-wide database congressionally mandated for all programs funded through the Department of Housing and Urban Development (HUD) homeless assistance grants. The system collects demographic data on consumers as well as information on service needs and usage.

### **Continuum of Care/**

#### **Southeastern CT Partnership on Housing and Homelessness**

New London County's consortium of homeless service providers and stakeholders which is commonly referred to as The Southeastern CT Partnership on Housing and Homelessness. The Continuum of Care was established by HUD to oversee community planning around homelessness. Around the state and the nation, Continuum work together to define needs, plan strategies and prioritize funding for supportive housing services. The New London County Continuum of Care has applied for and won almost three million dollars in federal funds each year for homeless assistance programs.

### **80/20 Plan**

Policies, adopted by municipalities, which combine rental units affordable to low income persons (at least 20% of total) with market rate apartments.

### **Harm Reduction**

According to the Harm Reduction Coalition, “harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use, to abstinence. Harm reduction strategies meet drug users “where they’re at,” addressing conditions of use along with the use itself. “In relation to supportive housing, services which use a harm reduction approach provide housing regardless of the clean/sobriety status of residents, basing successful tenancy solely on an individual’s compliance with the requirements of their lease agreement.

## *Section 2 - Safety Net*

### **Discharge Planning**

A significant percentage of homeless individuals report recent discharge from incarceration, hospitalization, residential health care, or treatment facilities. Successful discharge planning begins long before the end of someone’s stay in such an institution and includes connection to housing and supportive services to assist the person in gaining/maintaining stability. Integrated services both within and outside of institutions are necessary to assure effective discharge planning.

### **No Wrong Door**

Homeless individuals often cite a fragmented service system with poor communication between mainstream and non-profit providers as a major obstacle as they attempt to access needed services. “No wrong door” refers to an approach in which all caregivers share common information and tools, can break down unnecessary barriers and allow clients to gain access to all needed services regardless of whose door they come to first.

### **Wraparound Services**

If every door is the right door for a homeless or at-risk individual or family, services must be well integrated to avoid gaps and/or unnecessary duplication. A wraparound service model coordinates all caregiver services, often through a team case management or shared service plan system, bringing mainstream and non-profit providers together for case conferencing and problem solving.



### **Co-occurring disorders**

The presence of two or more disabling conditions such as mental illness, substance abuse, HIV/AIDS, and others.

### **Mainstream Services**

Refers to the government funded safety net including Workforce Investment Programs, Temporary Assistance to Needy Families, State Administered General Assistance, Medicaid, Social Security, Veterans Services, and other large government programs. Many cite an erosion of safety net services as a significant contributor to the dramatic increase in homelessness in recent years.

### **Service Plan**

Case managers in shelter, transitional, and supportive housing programs typically create a comprehensive service plan for clients including goals and objectives, which will assist them in addressing barriers and maintaining stability. A good service plan is comprehensive in that it includes an array of needs, multiple service providers, long-term and short-term goals, timelines, and specific expectations of both the client and caregivers.

### **Relapse Tolerant**

For those who struggle with substance use issues, relapse from abstinence to active use is often part of the recovery process. Even the most effective clinical programs admit that a majority of patients will relapse into active use at one time or another. Many of them also point out that the most effective way to promote long-term success for those individuals is to continue to work with them toward long-term recovery. Relapse tolerant programs are those that are willing to continue working with clients who relapse without interrupting residential stability.

## Section 3 - Employment & Income

### **Workforce Development System/CT Works**

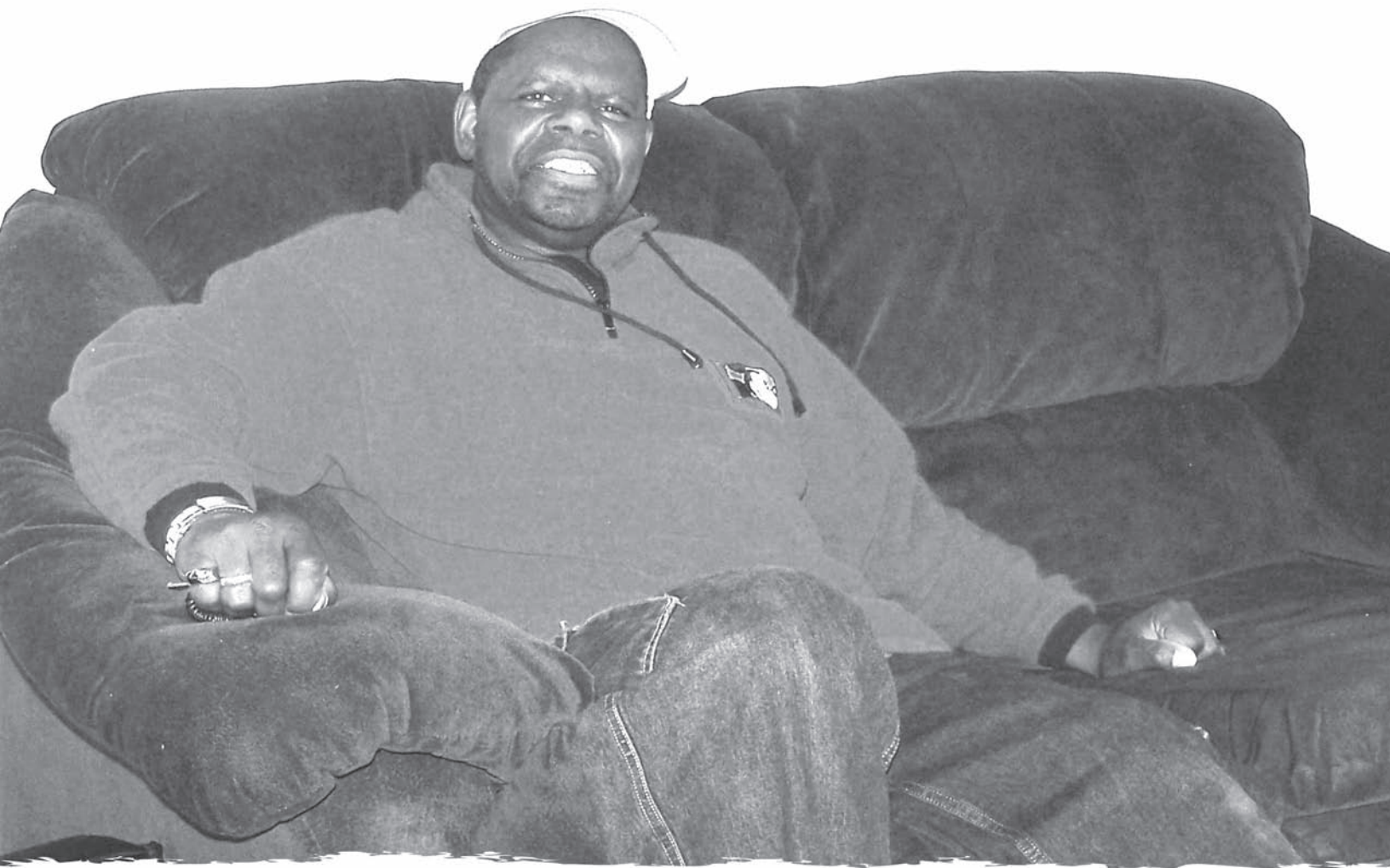
The area Workforce Investment Board leads coordination of the federally mandated Workforce Investment/Development system for the region, including funding operations at CT Works, a one stop career center linking employers and job seekers throughout the region. Other partners in the workforce development system include the Bureau of Rehabilitation Services; Veterans Administration; Connecticut Departments of Labor, of Social Services, and Mental Health and Addiction Services; community colleges; and others.

### **Vocational Rehabilitation System**

Referring to mainstream programs that provide assistance to disabled job seekers, the Connecticut “voc rehab” system is operated through the Bureau of Rehabilitation Services, a division of the Connecticut Department of Social Services. BRS provides assistance to people with disabilities through assessment and counseling, job placement and coaching, and support in job retention among other services. BRS also provides benefits counseling to assist job seekers in understanding the impact of employment on disability and medical benefits.

### **DMHAS Recovery Model**

The Connecticut Department of Mental Health and Addiction Services is currently training agencies throughout the state in this approach, which is based upon principles of holistic service provision and consumer choice.



### **Federal Bonding Program**

This program, operated through the U.S. Department of Labor, attempts to minimize the risk to employers who hire candidates who were recently incarcerated by insuring them against potential damages for up to \$50,000.

### **Universal Design**

Usually refers to engineering and architectural designs, which assure appropriate accommodations for people with physical disabilities. The Universal Design subcommittee of the Greater Bridgeport CT Works Disabilities Task Force is applying the principles of Universal Design to an assessment of services for people with mental illness, learning disabilities, HIV/AIDS, and substance abuse to assure accessibility.

### **Day Labor “Trap”**

Perhaps the most common employers of homeless adults are day labor and temporary staffing agencies. For many consumers who have sporadic work histories and limited skills, day labor seems their best or only alternative. Low wages and, in some companies, daily pay are often counterproductive for homeless individuals who need improved skills and a steady income in order to gain independence.

### **Transitional Employment**

Temporary labor can be an effective introduction to employment for someone who has been out of the workforce. Combined with job counseling, training, and other services, the temporary placement becomes a stepping stone to more stable employment for those who have been out of the workforce for a long period of time or for those who have never held a regular job. A transitional employment model provides consumers with supported work experience as part of the process of transitioning to the workforce.



## Coordination/Facilitation:

Carol Walter, Connecticut AIDS Resource Coalition  
Chris Kelly, Connecticut AIDS Resource Coalition

## Research:

Chris Kelly, Connecticut AIDS Resource Coalition  
Jeremy Walter, Community Volunteer

## Research Consultant:

Irene Glasser, Ph.D., Community Renewal Team, Inc.

## Copy Editing:

Tom Clark, New London Homeless Hospitality Center  
Janet Pearce, United Way of Southeastern Connecticut  
Will Steigerwald, Community Volunteer  
Beth Ann Stewart, Town of Southington  
Beverly Goulet, City of Norwich

## Photography:

Chris Kelly, Connecticut AIDS Resource Coalition

## Design and Layout:

Jennifer Chase, Connecticut AIDS Resource Coalition

## Written by:

Carol Walter, Connecticut AIDS Resource Coalition

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participated in this process, for their  
vital input and inspiring courage.

## Co-Chairs

The Honorable Andrew Maynard  
Janet Dinkle Pearce

Warden, Borough of Stonington, Vice Chairman, SCCOG  
President, United Way of Southeastern Connecticut

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Angela Arnold  
Barun K. Basu  
Margaret Beglinger  
The Rev. Michel Belt  
Chuck Bunnell  
Kevin Cavanagh  
Tom Clark  
Carol Croteau  
Deborah Donovan  
Alice Fitzpatrick  
Marcia Flowers  
Kathryn Forschler  
Beverly Goulet  
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The Rev. Sheldon Kelleher  
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David Pascua  
Katherine Reilly  
Mike Rosenkrantz  
Beth Ann Stewart  
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Community Volunteer  
New London Main Street/American Institute of Architects-CT  
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St. James Episcopal Church  
Chief of Staff, Mohegan Tribe  
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New London Homeless Hospitality Center  
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Southeastern Connecticut Enterprise Region  
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Eastern Pequot Tribal Council  
Covenant Shelter of New London, Inc.  
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Eastern Connecticut Chamber of Commerce  
Thames River Family Program  
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Lawrence and Memorial Hospital  
Alliance for Living, Inc.  
Stonington, Department of Human Services  
Mashantucket Pequot Tribal Council  
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Tom Hyland, Chair	Martin House/Thames River Family Program
Barun Basu	American Institute of Architects
Peter Battles	Eastern Connecticut Housing Opportunities
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Don Campbell	Niantic Community Church/Outreach Committee
Amy Chase	Women's Center of Southeast Connecticut
Tom Clark	New London Grassroots Homeless Coalition
Carol Croteau	Bethesda Community, Inc.
Barbara Dixon	City of New London
Kathryn Forschler	Covenant Shelter of New London, Inc.
Debra Gluszczyk	Habitat for Humanity
Jennifer Gross	Sound Community Services, Inc.
Stephanie Guess	Sound Community Services, Inc.
Andy Maynard	Warden, Borough of Stonington
Bud McAllister	P.E.A.C.E.
Sharon McCombs	United Way of Southeastern Connecticut
Peggy Morrison	United Cerebral Palsy of Eastern Connecticut
David Pascua	Southeast Connecticut Mental Health Authority
Sue Shantell	New London Housing Authority
Doug Stoehr	Habitat for Humanity of Southeastern CT, Inc.
Mike Van Vlaenderan	Reliance House, Inc.
Catherine Zeiner	Women's Center of Southeastern CT, Inc.

## Safety Net Committee

Beverly Goulet, Co-Chair	Norwich Human Services
Beth-Ann Stewart, Co-Chair	Stonington Human Services
Greg Allard	American Ambulance
Kathy W. Allen	Thames River Family Program
Angela Arnold	Community Volunteer
Cecilia Baldwin	Connecticut AIDS Resource Coalition
Lloyd Barber	SCADD
Lacey Bartlett	Stonington Human Services
Pat Bazinet	Thames Valley Council for Community Action
Margaret Beglinger	Reliance House
Kevin Cavanagh	New London City Council
Alyse Chin	Southeastern Mental Health Authority
Tom Clark	New London Grassroots Homeless Coalition
Erik Clevenger	Reliance House, Inc.
Cheryle Colonna	Southeastern Mental Health Authority
Nancy Cowser	Thames Valley Council for Community Action
Nora Curioso	St. Francis House
Virginia De Bosse	Southeastern Mental Health Authority
Pat Dixon	Norwich Human Services
Carrie Dyer	Reliance House, Inc.

Bill Edwards  
Sean Feeney  
Mike Giconi  
Lee-Ann Gomes  
Jonathan Jacaruso  
Rhonda Kincaid  
Cheryl Kramer  
Marek Kukulka  
Norma Lacasse  
Dr. Donna LaPaglia  
Sylvia Laudette  
Mary Lenzi  
Captain Annette Lock  
Maggie Marley  
Patrick R. McCormack  
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Kate Nichols  
Ida Parker  
David Pascua  
Janet Pearce  
Jacqueline Pelphrey  
Susan Radway  
Brett Rayford  
Spring Raymond  
Kathy Reilly  
Marina Santiago  
Peter Schultheis  
Karen Snyder  
Don Staub  
Jim Tackett  
Kimberly Turner-Haugabook  
Vevalee Valentin  
Hon. Harry Watson  
David Yovaisis

New London Police Department  
St. Vincent de Paul Place  
Alliance for Living  
Norwich Human Services  
Connecticut Department of Children and Families  
Connecticut Department of Mental Health and Addiction Services  
United Cerebral Palsy of Eastern Connecticut  
Catholic Charities, Diocese of Norwich  
Norwich Adult Probation  
Stonington Institute  
Catholic Charities  
Visiting Nurse Association of Southeastern Connecticut  
The Salvation Army  
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Uncas Health District  
Sound Community Services, Inc.  
Lawrence & Memorial Hospital  
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YMCA  
Thames Valley Council for Community Action-Shelter  
Southeastern Mental Health Authority  
United Way of Southeastern Connecticut  
Alliance For Living  
Waterford Youth Services Bureau  
Connecticut Department of Children and Families  
Bethsaida Community  
Lawrence & Memorial Hospital  
United Community & Family Services-Norwich  
Norwich Youth & Family Services  
Connecticut Department of Children and Families  
Veterans Center  
Connecticut Veterans Administration  
Connecticut Citizens for Addiction Recovery  
United Community & Family Services  
Mayor, Town of Groton  
Thames Valley Council for Community Action

## Employment & Income Committee

Paul Bushey  
Joanne Charles  
Amy Chase  
Jessica Corneau  
Kate Foley  
Lorna Josph  
Carole Labelle  
Bud McAllister  
Tracy Morton-Morales  
Christine Paquette  
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U.S. Social Security Administration  
Connecticut Legal Services  
Women's Center of Southeastern CT, Inc.  
Connecticut Bureau of Rehabilitation Services  
Connecticut Bureau of Rehabilitation Services  
Office of Workforce Competitiveness  
Eastern Connecticut Workforce Investment Board  
P.E.A.C.E.  
Covenant Shelter of New London, Inc.  
Connecticut Department of Labor  
Alliance for Living  
Alliance for Living

# Initial Action Plan - Housing

**Activity:** Create 49 units of permanent supportive housing for chronically homeless citizens in Southeastern, CT.

Action	Convener	Begin	End
Create chart of current projects in pipeline.	Tom Hyland David Pasqua	2/07	3/07
Apply for funding under 2007 HUD SuperNofa for approximately five to ten new units through the Supportive Housing Program.	Partnership to End Homelessness	4/07	N/A
Assure at least one application through the Next Step Initiative for either development or subsidies that would create 30-35 new units in the region.	Partnership to End Homelessness	As posted in RFP	N/A

**Activity:** Expand the capacity of area non-profits to develop and operate supportive housing by encouraging formation of at least one development team annually to apply to the Corporation for Supportive Housing's *One Step Beyond* Training Institute, or other capacity building initiatives.

Action	Convener	Begin	End
Gain commitments from members for at least one team.	Carol Croteau	Apply in 1/07	
Convene discussion between Sound Community Services & Reliance House in regard to developing another team and apply.	Stephanie Guess Mike Van	Apply in 1/07	
Each Fall the Southeastern CT Partnership to End Homelessness will identify at least one development team.	Partnership co-chairs	Ongoing	

**Activity:** Build on successful collaboration between the Southeastern CT Mental Health Authority, Sound Community Services and the New London Housing Authority to add twenty units of supportive housing to those currently being utilized by formerly homeless individuals and families

Action	Convener	Begin	End
Southeastern CT Mental Health and Sound Community Services to work with New London Housing Authority to secure 10 or more family units and obtain funding for rehabilitation.	Stephanie Guess & David Pasqua	1/07	12/07

**Activity:** Investigate formation of non-profit housing development corporation of collaborative who's mission would focus on the creation of permanent support housing in the region

Action	Convener	Begin	End
Begin discussions with area non-profit developers and other interested non-profits to discuss supportive housing.	Barun Basu & Carol Croteau	1/07	N/A
Conveners contact Corporation for Supportive Housing, Connecticut Housing Coalition, Partnership for Strong Communities, and Local Initiatives Support Collaborative for technical assistance.	Barun Basu & Carol Croteau	3/07	N/A

**Activity:** Advocate for the expansion of residential treatment opportunities for those struggling with addictions

Action	Convener	Begin	End
Reactivate Housing Options Committee.	Cheryl Colanni	1/07	ongoing

**Activity:** Work with the Southeastern CT Council of Governments (COG) to gain the support of every town and city in the region to contribute the shared goal of ending homeless.

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Present plan to Executive Committee of COG.	Andy Maynard	11/06	N/A
Gain support of full COG via Executive Committee.	Andy Maynard	1/07	N/A
Educate COG of opportunities for involvement.	Andy Maynard	1/07	N/A

**Activity:** Work through the COG, United Way of Southeastern CT and community leadership to launch a public education campaign throughout the region with the goal of addressing the stigma associated with supportive housing and gaining widespread support for the regions efforts to end homelessness.

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Meeting convened by United Way including COG rep, Jennifer Gross, CCAR, Partnership to end Homelessness rep. to develop public education campaign strategy.	Andy Maynard United Way ED	1/07	ongoing

**Activity:** Work specifically with the faith community to advocate in support of COG's efforts to contribute as above, particularly in suburban towns.

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Faith Community meet with United Action, Community Education Subcommittee of SMHA Advisory Board and Faith in Action to advocate with suburban faith communities to promote/educate around supportive housing in suburban communities.	Don Campbell Jennifer Gross	1/07	ongoing

**Activity:** Articulate shared principles which define community standards for new and existing supportive housing programs, both scattered site and project based, to assure leasing and production of units which are appropriate to the needs of homeless tenants in the region.

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Create subcommittee from Partnership to create principles of community standards.	CARC & Partnership to End Homelessness	6/07	9/07
CARC will receive and tweak report from Partnership.	CARC & Partnership to End Homelessness	10/07	10/07

## Initial Action Plan - Safety Net

**Activity:** Expand the Partnership to End Homelessness Web Site to include a section on prevention with information and links to appropriate services. Promote the web site throughout the region as a resource for those who may come into contact with individuals and families at risk of homelessness.

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Create consolidated list of prevention providers and resources.	Community Care Team Chairs	7/07	8/07
Solicit links from agencies identified above.	Tom Hyland Beverly Goulet	8/07	10/07
Add information to web site (pehsect.org) and continue to update with pertinent information.	Carrie Dyer	10/07	ongoing

**Activity:** Facilitate the participation by all area treatment facilities, hospitals, correction or alternative incarceration facilities, and other institutions in community care teams as well as the community care consortia

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Meet with institutional representatives and staff to educate regarding plan, care team structure and solicit commitment for participation.	Beverly Goulet, Beth Ann Stewart	4/07	6/07

Identify representatives from each institution and invite to Community Care Team and/or Consortia meeting.	Beverly Goulet, Beth Ann Stewart	6/07	ongoing
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**Activity:** Expand hours at community meal sites by leveraging existing or expanded prevention and outreach programs to provide services on site.

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Create sub-committee of Southeastern CT Partnership to End Homelessness and invite soup kitchen directors to join.	Tom Hyland Beverly Goulet	4/07	3/08
Identify current and potential staffing and volunteer resources which may be leveraged.	Sub-committee	same	same
Gain commitments from existing resources and create potential expanded schedule.	same	same	same
Identify gaps in schedule.	same	same	same
Identify and obtain additional funding to expand hours.	same	same	same

**Activity:** Increase the capacity of homeless outreach and engagement programs to provide more active outreach to homeless individuals living outdoors in the New London area

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Identify present initiatives in homeless outreach including hospitals, police, health departments, veterans programs.	Erik Clevenger, Debra Morgan	7/07	10/07
Expand list of potential participants who may leverage staff hours or resources for collaborative outreach model.	same	same	same
Examine outreach models from New Haven and Hartford and request technical assistance in replicating model.	same	10/07	12/07
Create schedule for collaborative outreach and identify gaps.	same	10/07	12/07
Identify potential funding resources to support expanded outreach.	same	12/07	12/07

**Activity:** Assure seamless engagement and service delivery, while saving lives, through the establishment of a year-round shelter and service facility targeting chronically homeless individuals.

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Complete joint planning process between New London and Norwich Hospitality Centers to investigate solutions to regional needs.	Tom Clark Lee-Ann Gomes	11/06	ongoing
Gain resources to expand months of service in existing shelters.	Tom Clark Lee-Ann Gomes	1/07	3/07
Support ongoing efforts of year round emergency shelter initiatives until first 148 units of housing for chronically homeless are available.	Community Care Teams & Community Organizations	ongoing	ongoing

**Activity:** Gather baseline data regarding service needs and usage, create process for annual data collection through consumer and provider focus groups and surveys to measure progress and effectiveness of wraparound services.

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Create and administer baseline survey based upon outcome measures detailed in plan.	Gaps & Needs Committee	Spring 2007	
Expand Homeless Management Information System to include outcome data and for regional usage.	Spring Raymond	ongoing	ongoing

**Activity:** Using the successful Norwich Community Care Team as a model, develop and implement two broader Community Care Teams for the Southern and Northern portions of the county, respectively, assuring that all towns in the region are connected to one of

the two teams. The role of the Community Care Team is to assure comprehensive outreach, engagement and provision of services to homeless individuals and families, toward the goal of ending homelessness for all citizens in the region. Along with providing a hub for case conferencing and client level problem solving, the community care team can:

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Invite key members of New London community to attend Norwich Community Care Team in order to observe Process.	Lee Ann Gomes	<b>completed</b>	
Expand Norwich Community Care Team to include towns in the northern portion of the county.	Lee Ann Gomes	4/07	7/07
Identify and contact potential participants for a Southern County team (potentially in concert with activity concerning institutional leaders).	Kathy Reilly, Mary Lenzini, Beth Ann Steward	4/07	5/07
Convene group and provide training regarding plan and group activities, leveraging leadership from Norwich team to provide initial technical assistance regarding group process.	same	5/07	N/A
Begin regular meetings.	same	6/07	ongoing

## Initial Action Plan – Employment & Income

**Activity:** Schedule the statewide Mobile One Stop to area locations frequented by people who are homeless once every six weeks.

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Mobile One Stop is going to New London Community meal site, once every 6 weeks and is scheduled from 10am to 2pm (hrs may change) Had 15 people at first visit.	Chris Kelly & DOL Regional manager	10/06	Pilot 1 year
Expansion to Norwich, St. Vincent de Paul soup kitchen and shelter sites.	Chris Kelly & DOL Regional manager	12/06	

**Activity:** Implement “Project SOAR” (Social Security Outreach, Access and Recovery) through the two community care teams. Train 100% of case managers and others who assist with entitlement applications to increase successful Social Security applications.

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
First training mid- January 2007 in New London. Site yet to be determined. Training will be presented by Cecilia Baldwin and Ron Krom.	Lee-Ann Gomes	1/07	12/07
Additional sessions planned for 2007.			

**Activity:** Build an active network of consistent contacts that meet monthly drawn from One Stop partners and area non-profits.

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Identify attendees for network from One Stop partners and frontline case managers for mutual education and network (those working with those who are homeless: employment, housing, medical, benefits etc).	Nancy Cowser TVCCA	1/07	2/07
Have kick-off meeting to set foundation of bi-monthly meetings (have good food and water!).	Nancy Cowser	Spring 2007	

**Activity:** Utilize Social Security to provide regular trainings to emergency shelter and homeless provider staff

<b>Action</b>	<b>Convener</b>	<b>Begin</b>	<b>End</b>
Hold training workshop on SSI/SSA issues for providers & clients.	SSA Paul Bushey	ASAP	ongoing
Be available to meet informally with groups to set up procedures for filing for SSD/SSI benefits.	SSA	ASAP	ongoing



# CoC Planning Process Organizations Chart

	Specific Names of All CoC Organizations	Geographic Area Represented	Subpopulations Represented, if any* (no more than 2)	
<b>PUBLIC SECTOR</b>	<b>STATE GOVERNMENT AGENCIES</b>			
	Department of Mental Health and Addiction Services Department of Social Services Department of Children and Families Department of Corrections CT Judicial Branch Bureau of Rehabilitative Services SMHA	NL County NL County NL County NL County NL County NL County NL County	SMI  Y  SMI SMI	SA    SA SA
	<b>LOCAL GOVERNMENT AGENCIES</b>			
	Groton Human Services Montville Social Services NL Department of Health and Social Services New London Office of Dev. And Planning Norwich Office of Dev. And Planning Norwich Human Services Stonington Department of Health & Services Council of Governments Senator Edith Prague Representative Diana Urban Congressman Simmon's Office-Jane Dauphinais Representative Jack Malone Representative James Spallone Representative Kevin Ryan Representative Lenny Winkler Representative Linda Orange Representative Steven Mikutel Senator Andrea Stillman Senator Catherine Cook Senator Eileen Daily Representative Melissa Olson Representative Lenny Winkler Representative Ed Jutila Representative Tom Reynolds Representative Betsy Ritter Representative Ernest Hewitt Representative Edward Moukawsher	Groton Montville New London New London Norwich Norwich Stonington Stonington NL County Norwich Stonington NL County Norwich  Montville Groton  Waterford Groton Lyme Norwich Groton East Lyme Ledyard Waterford New London Groton		
	<b>PUBLIC HOUSING AGENCIES</b>			
	New London Public Housing Authority Norwich Public Housing Authority	New London Norwich		
	<b>SCHOOL SYSTEMS / UNIVERSITIES</b>			
	Three Rivers Community College Norwich Public School System New London Board of Education	NL County Norwich New London		
	<b>LAW ENFORCEMENT / CORRECTIONS</b>			
	New London Police Department Norwich Police Department	New London Norwich		
	<b>LOCAL WORKFORCE INVESTMENT ACT (WIA) BOARDS</b>			
	Eastern CT Workforce Investment Board	All Eastern CT		
	<b>OTHER</b>			

\*Subpopulations Key: Seriously Mentally Ill (SMI), Substance Abuse (SA), Veterans (VET), CoC-D HIV/AIDS (HIV), Domestic Violence (DV), and Youth (Y).

<b>PRIVATE SECTOR</b>	<b>NON-PROFIT ORGANIZATIONS</b>			
	Alliance for Living	NL County	HIV/AIDS	
	Bethsaida Community	Norwich	SMI	SA
	Care Plus	NL County	SMI	SA
	Covenant Shelter	New London		
	Disabilities Network of Eastern CT	NL County	SMI	SA
	Eastern Region Mental Health Board	NL County	SMI	SA
	Eastern Region Service Center	NL County	SMI	SA
	Sound Community Services	New London	SMI	SA
	InfoLine	NL County		
	Latinos Unidos Siempre	NL County	SMI	
	MALTA	NL County		
	Martin House	NL County	SMI	SA
	Mothers' Retreat	Groton	SA	
	Mystic Area Shelter and Hospitality	NL County		
	New London Community Meal Center	NL County		
	New London Homeless Coalition	NL County	SMI	SA
	Reliance House	NL County	SMI	SA
	SCADD	NL County	Y	
	Thames River Community Service	NL County		
	Thames Valley Council for Comm. Action	NL County		
	Veterans' Center	Norwich	Veterans	
	WARM Shelter	NL County		
	Women's Center of SE CT	Norwich	DV	
	<b>FAITH-BASED ORGANIZATIONS</b>			
	All Souls Unitarian Congregation	New London		
	Catholic Charities	NL County		
	Central Baptist Church	Norwich		
Christ Episcopal Church	Norwich			
Diocese of Norwich	Norwich			
Lee Memorial Church	Norwich			
Mount Moriah Church	New London			
New London Clergy Association	New London			
Park Congregational	Norwich			
Salvation Army	NL County			
Shiloh Baptist Development Corporation	New London			
St. Vincent DePaul Society	Norwich			
St. Francis House	New London			
St. James Episcopal Church	New London			
Unitarian Universalist Church	Norwich			
<b>FUNDERS / ADVOCACY GROUPS</b>				
Partnership for Strong Communities	STATEWIDE			
United Way of SE CT	NL COUNTY			
CT Coalition to End Homelessness	STATEWIDE			
Corporation for Supportive Housing	STATEWIDE			
CT AIDS Resource Coalition	STATEWIDE			
<b>BUSINESSES (BANKS, DEVELOPERS, ETC.)</b>				
Northeast Utilities	NL County			
Shop Rite	NL County			
Stop & Shop	NL County			
Mashantucket Pequot Tribal Nation	Ledyard			
Mohegan Tribal Nation	Montville			
Big Y World Class Market	NL County			
<b>HOSPITALS/ MEDICAL REPRESENTATIVES</b>				
Lawrence & Memorial Hospitals	New London			
Backus Hospital	Norwich			
Generations	Norwich			
<b>HOMELESS PERSONS</b>				
Anonymous Person #1	Norwich			
Anonymous Person #2	Norwich			
<b>OTHER</b>				
<b>Housing Developers:</b>				
Corporation for Supportive Housing	NL County			
Corporation for Independent Living	NL County			
Eastern CT Housing Opportunities	NL County			
Center for Urban Development	NL County			
Habitat for Humanity	NL County			
<b>Media:</b>				
New London Day	NL County			
Norwich Bulletin	NL County			
Shoreline Publishing	NL County			

Source: 2006 SuperNofa, U.S. Department of Housing & Urban Development, Southeastern Connecticut Response, Exhibit 1

# CoC Services Inventory Chart

(1)  <b>Provider Organizations</b>	(2) <b>Prevention</b>					(3) <b>Outreach</b>			(4) <b>Supportive Services</b>									
	Mortgage Assistance	Rental Assistance	Utilities Assistance	Counseling/Advocacy	Legal Assistance	Street Outreach	Mobile Clinic	Law Enforcement	Case Management	Life Skills	Alcohol & Drug Abuse	Mental Health Counseling	Healthcare	HIV/AIDS	Education	Employment	Child Care	Transportation
Alliance for Living		X				X			X			X		X				X
Catholic Charities		X							X			X						
MSS Housing Office Eviction and Mediation Program (Sound, SMHA, Reliance House)		X							X						X			
Norwich Human Services		X				X									X	X		
Thames Valley Council for Community Action		X							X							X	X	
Katie Blair House		X																
Thames River Family Program		X							X	X							X	
Veteran's Center		X				X						X				X		
Dime Bank and Liberty Bank	X																	
Infoline/211		X																
Generations Mobile Van							X											
Reliance House						X			X	X						X		
SMHA Programs						X				X	X	X						
New London Homeless Coalition						X												
Police Departments						X												
Centro de la Comunidad									X									
Eastern Regional Service Center									X									
LUS									X									
Martin House									X						X			
Women's Center									X	X		X			X		X	
Backus and L&M Hospitals										X	X	X						
Care Plus										X								
Noank Baptist Group Homes										X								
Pennobscot Place										X								
Visiting Nurse Associations										X								
Connection											X							
Stonington Institute											X							
DCF															X			
LEARN															X			

# CoC Services Inventory Chart

(1)  <b>Provider Organizations</b>	(2) <b>Prevention</b>				(3) <b>Outreach</b>			(4) <b>Supportive Services</b>										
	Mortgage Assistance	Rental Assistance	Utilities Assistance	Counseling/Advocacy	Legal Assistance	Street Outreach	Mobile Clinic	Law Enforcement	Case Management	Life Skills	Alcohol & Drug Abuse	Mental Health Counseling	Healthcare	HIV/AIDS	Education	Employment	Child Care	Transportation
Madonna Place															X			
Norwich and New London Adult Ed															X			X
Uncas Health District															X			
Department of Labor																X		
Bureau of Rehab Services																X		
Southeastern Employment Network																X		
Labor Ready																X		
Opportunities Industrialization Center																X		
Child and Family Agency																	X	
Department of Social Services																	X	
Southeastern Area Transit																		X
Alternative to Incarceration Program																		
Churches																		
Good Will																		
Salvation Army																		
SCADD									X		X							
Sound Community Services										X	X	X				X		
Community Enterprises																X		

Source: 2006 SuperNofa, U.S. Department of Housing & Urban Development, Southeastern Connecticut Response, Exhibit 1

# CoC Housing Inventory Charts

<b>Emergency Shelter: Inventory Chart</b>							
Provider Name	Facility Name	Year-Round			Total Year-Round Beds	Other Beds	
		Family Units	Family Beds	Individ. Beds		Seasonal	Overflow & Voucher
City of Norwich	YMCA			2	2		
Covenant Shelter	Covenant Shelter		18	17	35		
MASH Charities	MASH Shelter	5	30		30		
Reliance House	OHP Shelter			8	8		
TVCCA	TVCCA Shelter		45		45		
Waterford Country	Youth Shelter			20	20		
Women's Center of	Genesis House		13	2	15		
Norwich CCT	Hospitality Center					18	8
New London Coalition	Emergency Winter					45	
<b>Totals:</b>		5	106	49	155	63	8

<b>Transitional Housing: Inventory Chart</b>							
Provider Name	Facility Name	Year-Round			Total Year-Round Beds	Other Beds	
		Family Units	Family Beds	Individ. Beds			
Bethsaida Community	Katie Blair House			8			
Reliance House	TLC			14	14		
TRCS	TRFP	24	72		72		
WCSECT	Phoenix House	7	27	2	29		
<b>Totals:</b>		31	99	24	123		

<b>Permanent Supportive Housing: Inventory Chart</b>							
Provider Name	Facility Name	Year-Round			Total Year-Round Beds	Other Beds	
		Family Units	Family Beds	Individ./CH Beds			
Alliance for Living	AFL SHP	2	6	4/1	10		
DMHAS (SMHA)	NL PILOTS (TRA)	12	26	28/28	54		
TVCCA	HCN	25	87	25/10	112		
Bethsaida Community	Flora O'Neil Apts.	2	4	4/2	8		
NL Housing Authority	Housing Authority			5/5	5		

<b>Inventory Under Development</b>						
Provider Name	Facility Name	Year-Round			Total Year-Round Beds	Anticipated Occupancy Date
		Family Units	Family Beds	Individ./CH Beds		
Sound Comm. Services	PILOTS Program			13/8	13	6/1/2006
Reliance House	Reliance			9/5	9	6/1/2006
Sound Comm. Services	PILOTS Program			10/5	10	6/1/2006
Alliance for Living	AFL SHP			4/4	4	7/1/2007
City of Norwich	Norwich Social Services			16/16	16	7/1/2007

Source: 2006 SuperNofa, U.S. Department of Housing & Urban Development, Southeastern Connecticut Response, Exhibit 1

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SOUTHEASTERN CONNECTICUT  
TEN YEAR PLAN TO END HOMELESSNESS