

# Supportive Housing Providers Association

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## A Plan to Move Individuals with Mental Illness out of Nursing Homes and into the Community-based Option of Supportive Housing

### Executive Summary

The Supportive Housing Providers Association (SHPA) recommendations are summarized in this basic direction:

**Fully fund the cost of supportive housing—housing plus appropriate services—to accommodate all individuals with mental illness currently in nursing homes who are capable of living in the community and desiring to do so.**

These specific recommendations describe this direction:

- **Fund both services and rental subsidy.**
- For approximately one quarter to one third of the units, **access sources of capital funding for new supportive housing**, federal, state capital funding, city of Chicago, and other local funding to rehab or newly construct single site supportive housing, with not more than 16 units per site.
- Fund sufficient supportive housing units and create policy to **prevent additional individuals with mental illness from entering nursing homes.**
- **Fully fund a flexible mix of services**, including mental health, physical health, substance abuse treatment and management, supported employment, and everyday living skills. The mental health services should include a wide range of options, including ACT-like and CST-like options (with more flexibility than these models currently allow), as well as other flexible service options as dictated by the individual's needs and desires. The available options should also include the current DMH supported and supervised models. An important subset of these services will not be Medicaid billable.
- **Create a multi-year plan for moving individuals to the community, from IMDs first and then from regular nursing homes.** Involve state agency staff, residents, nursing home owners, and supportive housing providers (community mental health providers and providers of supportive housing to the general homeless population) in creating the plan. Make the plan one piece, not piecemeal. The plan must not include discharging individuals into homelessness.

### Begin by doing these basics:

- Keep the funding for existing supportive housing whole. Do not move backward by cutting services and forcing individuals now living in supportive housing to move into nursing homes!
- Fund services (\$3.6 million) for the 769 new units of supportive housing ready to open in FY 2011. This service funding will leverage over \$21 million worth of mostly federal funding for capital and rental subsidy. This additional funding is committed to these projects with the caveat that they will be matching this funding with funding for services.
- Fund the services for the 446 new units scheduled to open in FY 2012, now estimated at \$1.9 million.

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## **Initiate the plan:**

- Move 500 or more individuals from IMDs to the community in the first year.
- Use what has already learned from the Division of Mental Health (DMH) Money Follows the Person demonstration program and the DMH Permanent Supportive Housing Bridge Subsidy program. Also incorporate everything that is learned in the first year.
- Move 900 people a year for four years. Move at least 3,600 to 4,000 individuals to the community from IMDs and regular nursing homes. Then review what is left to be done.
- To fund this plan, it will be necessary to transfer resources from the IMDs to community-based solutions. Do so through carefully planned, well-thought out mechanisms.
- Make assessments based on clinical judgment, not rigid criteria. LOCUS should not be the only assessment tool used. A task force that includes providers should be convened to determine assessment tools and methodology.
- Create more ease in the way in which these services are billed. Per diem billing is preferred because it will allow providers more flexible service delivery to meet individual needs and will cut billing costs significantly.

**These recommendations will give many individuals with mental illness lives of dignity and purpose, will protect elderly individuals in nursing homes, and will save the state money.**

## **The Current Situation**

### **Context**

The Illinois issue of housing individuals with mental illness in nursing homes has a long history. In 1998, the Chicago Tribune featured a series of articles “Warehousing the Mentally Ill in Nursing Homes.” Some nursing homes sent “bed brokers” to homeless shelters looking for potential clients. Because Medicaid would support only homes where at least 50 percent of the patients were physically disabled, health problems were often invented for patients. One woman with a long history of mental illness received a diagnosis of “cranial dermatitis”— dandruff. In 1999 the U.S. Supreme Court decided the landmark decision of *Olmstead v. L.C. Ex Rel. Zimring*, giving rights to persons with disabilities (seniors, the physically disabled, the developmentally disabled, and persons with mental illness) to live in the least restrictive setting that is appropriate to their desires, needs, and capacity. This decision was based on the Americans with Disabilities Act of 1990 in which Congress identified the segregation of people

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with disabilities as a severe form of discrimination. The U.S. Supreme Court under the Olmstead Decision held that a state can meet its obligations if it has a “comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State’s endeavors to keep its institutions fully populated”. To date the State has not developed a comprehensive plan for implementing Olmstead.

## **Existing Situation**

In March of 2009, an Associated Press analysis showed Illinois ranking the highest among the states in the number of mentally ill adults under age 65 living in nursing homes. In 2008, according to the Associated Press analysis, 12,736 individuals with mental illness under 65 lived in Illinois nursing homes. Of these individuals with mental illness living in nursing homes, 5,063 live in nursing homes designated by the federal government as Institutions for Mental Diseases (IMDs). In IMDs, 50% or more of the population are individuals with mental illness and no medical or physical condition that would require nursing facility level care. A list of IMDs supplied by the Illinois Department on Aging is attached (Attachment A). According to the Associated Press estimate, this leaves 7,673 individuals under 65 with mental illness living in regular nursing homes throughout the state. The total number of people living in nursing homes in Illinois is approximately 100,000<sup>1</sup>.

Community care funding in Illinois has shrunk while institutional funding has expanded. In 1994, Illinois was allocating 92 percent of its Medicaid long-term care funds to institutional care and only 8 percent to home and community-based services (HCBS). In 2001, the distribution of Medicaid funds had not changed significantly: 86 percent to institutional care and 14 percent to HCBS<sup>2</sup>. In the past 5 years, Illinois has increased spending for intermediate care for persons with mental illness while decreasing community alternatives to intermediate care. Provider organizations have been flat-funded for four years and budgets were once again cut in FY 2009. Adjusted for inflation, that means that already thin resources have actually shrunk by 15-20% over the past four years<sup>3</sup>.

## **Cost**

According to the Illinois Department on Aging, nursing homes in Illinois cost on average \$117 per diem. IMDs are costing the state approximately \$160 million annually with no Medicaid reimbursement. Also, we are now spending taxpayer money to defend against lawsuits about institutionalization.

## **The Response**

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<sup>1</sup> Illinois Department of Public Health Website

<sup>2</sup> U.S. Department of Health and Human Services, State Long-Term Care: Recent Developments and Policy Directions, Barbara Coleman, Wendy Fox-Grage and Donna Folkemer, National Conference of State Legislatures, July 2002.

<sup>3</sup> National Alliance on Mental Illness Website

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Access Living, the ACLU, and Equip for Equality filed three class action lawsuits charging Illinois with violating Olmstead:

1. ***Ligas v. Maram***, filed on behalf of 6,000 people with developmental disabilities who now live in large private facilities.
2. ***Bertrand v. Maram***, filed on behalf of 30,000 people with disabilities in nursing homes.
3. ***Williams v. Blagojevich (Quinn)***, filed on behalf of 5,000 people with mental illness living in IMDs.

The Chicago Tribune has published a recent series of articles exposing the problems of housing people with mental illness in nursing homes. The Chicago Reporter in a recent issue revealed the devastating conditions in nursing homes with predominately African American residents. Governor Quinn created the Nursing Home Safety Task Force which has held a series of public hearings and is due to report its recommendations to the Governor by the end of January 2010. A combined state Senate Public Health and Human Services Committees' Hearing was held on Nov. 5, 2009 regarding nursing home safety. The state is currently negotiating a settlement to the lawsuit filed on behalf of people living in IMDs.

## **The Community-Based Supportive Housing Continuum of Care Solution**

### **Introduction**

Supportive housing is the core of a community-based continuum of care solution for individuals with mental illness currently living in nursing homes. An estimated 75%-85% or more of the individuals with mental illness currently living in nursing homes can be successfully housed in community integrated supportive housing, thereby saving the state money, increasing the federal return, and improving the results for individuals with mental illness. Supportive housing has been proven to be effective for individuals with serious mental illness. Providing supportive services to people in housing is effective in achieving residential stability, improving mental health and recovery from substance abuse, and reducing the costs of homelessness to the community<sup>4</sup>. The recently completed Study of Supportive Housing in Illinois demonstrated the cost savings of supportive housing across five state funding systems<sup>5</sup> (Attachment B), and other studies nationally have shown similar cost savings<sup>6</sup>. The mental health services provided to individuals living in supportive housing are Medicaid billable. Supportive housing also leverages federal funding for operational subsidy and capital funding for new construction or rehabilitation.

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<sup>4</sup>Culhane et al., 2001; Lipton et al. , 2000; Tsemberis and Eisenberg, 2000; Rosenheck et al., 1998; Shern et al., 1997; Goldfinger and Schutt, 1996; Hurlburt et al., 1996.

<sup>5</sup> The Social Impact Research Center of Heartland Alliance, *Supportive Housing in Illinois: A Wise Investment*. 2009.

<sup>6</sup>Culhane et al., 2002; Houghton, 2001.

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## **Supportive Housing Defined**

Supportive housing is a combination of affordable, permanent rental housing and supportive services, appropriate to the needs and preferences of residents, either on-site or closely integrated with the housing. Typically the tenant pays no more than 30% of their income for rent. The supportive housing tenant has a standard lease or operates under a payee arrangement. Just like any other tenant there are no limits on length of stay as long as the supportive housing resident abides by the terms of the lease or agreement. The community-based mental health service provider works closely with the tenant and the landlord to insure lease compliance and to intercede as necessary. Through voluntary services tenants are supported in their efforts to recover, to achieve their individualized goals, and to maximize their ability to live independently. Many individuals are then able to move to other housing settings, if affordable housing is available. Services include mental health services, which will be described in detail below; medical and wellness services; substance use management, treatment and recovery; vocational and employment services; and coordinated support (case management).

## **Transition**

Since so little is known about the population of individuals with mental illness housed in IMDs and in nursing homes, the first year of transferring individuals from nursing homes to supportive housing should be considered a demonstration year. During this first year, one or several community mental health providers selected through an RFP process could move 500 individuals from one to three IMDs. What is learned from this demonstration year should then inform the plan for moving additional persons with mental illness, the mix of service levels needed, and the cost of these services. Experience gained from the Division of Mental Health's portion of the Money Follows the Person (MFP) demonstration, the Division of Mental Health (DMH) Permanent Supportive Housing Bridge Subsidy program, and other similar demonstration programs should be used as the base from which to begin this process.

The transition process will begin in the nursing home with assessments. Assessments should be robust, fast, and flexible. They should be based on clinical judgment, not rigid, standardized criteria. LOCUS, could be a tool used, but should not be the only assessment tool used. Risk to self and others should be assessed. Level of functioning is not the best predictor of the level of services needed. A task force that includes providers should be convened to determine assessment tools and methodology.

Enough assessments should be done annually to allow for the transfer of 900 individuals from nursing homes to community supportive housing settings per year for at least four years. Provided that adequate service funding is made available, providers could agree to take the individuals referred to them. Residents should have choice in the location to which they move. Clear rules with significant deterrents must be in place to prevent nursing homes from obstructing this assessment process. Individuals should be re-assessed at least annually. Collaboration between all agencies in a community or area to plan and implement this effort will make this workable. Agencies in mid-sized cities and more rural areas have strong motivation to serve individuals from their areas, to transfer them from nursing homes, and to keep them out of nursing homes.

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## **Supportive Housing and the Continuum of Care**

In this section the current supportive housing supply is described and other existing IDHS-service funded housing. These important resources, usually filled to capacity, keep many individuals from having to live in nursing homes. If services to these existing units are cut in this budget (FY 2010) or the next (FY 2011), individuals will be at great risk of regressing in their recovery and returning, at high cost to the state and to themselves, to state-operated mental health facilities, nursing homes, prisons, or homelessness. The supportive housing units currently in the pipeline will then be listed. Finally, we will outline the additional supportive housing units needed. Much of this is all ready part of the state's Comprehensive Housing Plan, described in the Supportive Housing Working Group Final Report (Attachment C) accepted by the Illinois Housing Task Force in August 2008.

## **Current Supportive Housing Supply**

There are approximately 7,500 existing units of supportive housing in Illinois. These units are in single site locations or are scatted site supportive housing located in market rate rental buildings. Of the scattered-site units, at least 375 units are part of the DMH Bridge Subsidy Permanent Supportive Housing program. Also, 43 of the scattered site units are from the DMH Money Follows the Person demonstration project. In addition, there are 3,911 units of supervised (staffed 24 hours and usually group homes) and supportive residential housing (staffed 12 hours and usually efficiency or one-bedroom apartments). These units are in single site locations with 16 or fewer units each.

Most of these existing units are funded through two state budget line items: one called Supportive Housing Services in the IDHS general revenue budget at \$3.382.8 million and the other, Supportive MI Housing, in the Mental HealthTrust Fund for \$17.965 million. Both line items need to be protected from cuts in order to move forward, instead of backward, in transitioning individuals with mental illness from nursing homes. Some supportive housing is developed with HUD Homeless funding. The requirements of this funding allow an institutional stay of up to 90 days with a history of previous homelessness. Supportive housing with this type of funding is very valuable and able to keep individuals out of nursing homes that would otherwise end up there after hospital, jail, or prison stays, or in housing people who have been in nursing homes for three months or less.

## **Supportive Housing in the Pipeline**

There are 769 units ready to open in FY 2010 and FY 2011 with federal funding already committed for capital and rental subsidy, needing only \$3.6 million in state service funding to be operational. In addition to these units, DMH estimates that a total of 700 Bridge Subsidy units and 150 MFP units will open in FY 2010. In FY 2012, there are 476 units scheduled to open that have their federal funding lined up, needing only 1.9 million in state service funding. In addition, approximately 132 MFP units will open in FY 2011, 130 units in FY 2012 and 130 units in FY 2013.

## **Additional Supportive Housing Units Needed**

If the Associated Press is correct that 12,736 individuals with mental illness live in nursing homes in Illinois, and excluding the 2,572 units currently in the pipeline, an estimated 6,500 to

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8,500 more units of supportive housing are needed to house all the individuals with mental illness in nursing homes who could be successfully housed in supportive housing.

Approximately 15% to 25% of these units could be new construction or rehabilitation of single site projects with 16 or fewer apartment units each. The remaining units could be scattered site rental units located in existing market rate rental buildings.

Moreover, to keep nursing homes from filling up again with mentally ill individuals, additional supportive housing will need to be available. It is difficult to estimate the number of mentally ill individuals who currently enter nursing homes annually. However, it seems reasonable to estimate that at least 1,000 to 2,000 additional units will be needed to accommodate new people needing this affordable housing with support. Combining an estimated 10% annual turnover rate in existing supportive housing with these additional units, may be enough to alleviate the need for additional individuals with mental illness to be funneled into nursing homes.

HUD Housing Quality Standards are currently used to inspect units for the Bridge Subsidy program and the MFP demonstration. These standards seem reasonable, but inspections must be carried out in a timely fashion.

Some providers have found that, in addition to having their own apartments, some individuals may benefit from having a more supported situation, i.e., a group home, living with another person in an apartment, or other arrangement, when they are functioning poorly. Also, for some individuals it may be necessary to provide an initial more supported living environment, such as supervised or supported residential housing.

## **Services**

A flexible mix of services, including mental health, physical health, substance abuse treatment and management, supported employment, and everyday living skills should be fully funded and available to be used as needed and desired by each individual. The mental health services should include a wide range of options, including ACT-like and CST-like options (with more flexibility than these models currently allow), as well as other flexible service options as dictated by the individual's needs and desires. The available options should also include the current DMH supported and supervised models. An important subset of these services will not be Medicaid billable.

More will be known about the range of the level of services needed after the first demonstration year. It is important that the flexibility to work as needed with each individual be built into the service delivery system. Services should not be mandated at levels higher than necessary, nor should they be limited for individuals requiring very high intensity services.

Actual services provided could include, but not be limited to, the following:

- Assessment
- Transition planning and support
- Engagement, motivational interviewing, and retention
- Service planning for high risk behaviors
- Specialized training and support of jail/prison involved persons

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- Integrated dual disorders treatment
- Individualized placement and support (supported employment)
- Wellness management and recovery services
- Case management
- Crisis management
- Psychiatric services: prescribing and medication monitoring and support
- Social: recreation activities and development of natural sources for this
- Representative payee services
- Life skills training: money management, transportation, health care, personal hygiene, housekeeping, laundry, shopping, food preparation, and use of community services
- Apartment finding and landlord relationships

The connection to primary healthcare resources is of paramount importance. Partnerships with Federally Qualified Healthcare Centers, Rural Health Clinics, and hospitals should be strongly encouraged.

## **Funding Required for Supportive Housing**

Two or three types of funding are required for supportive housing (See Attachment D). Single site or scattered site supportive housing requires funding for operating or rental subsidy. Single site supportive housing, either newly constructed or rehabbed, requires operating or rental subsidy and it requires capital funding for acquisition, rehabilitation, and construction. All types of supportive housing require funding for services.

## **Cost of Services**

The cost of the services will depend on the results of the demonstration year and on the mix of individuals living in IMDs and other nursing homes. Obviously, the greater the degree of acuity and risk the greater the cost. All estimates at cost come in substantially under IMD costs to the state. Much of service costs incurred, but not all, will be Medicaid billable. Services should be billable on a per diem basis rather than per hour, drastically reducing the cost and the risk incurred by providers to bill for services. Billing for services needs to be done in way that allows providers to do what it takes to succeed with each individual, to be flexible, and to be paid for non-Medicaid eligible services as well as Medicaid eligible services.

## **Cost of Rental/Operating Subsidy**

With DMH's Bridge Subsidy program, the average rent per unit per month has been \$719 for efficiency and one bedroom apartments. The average subsidy paid by the state has been \$580 per unit per month with the tenant paying \$120 per month out of their income. This is consistent with the estimates of the Illinois Housing Task Force Supportive Housing Working Group report, which estimates the rent of an efficiency apartment at a statewide average of \$600 per month and a one-bedroom apartment at \$900 per month.

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## Capital Costs

This same report estimates the capital costs for new construction and rehab at \$125,000 per efficiency unit. An estimated average cost of \$1,000 will be required to bring each scattered site rental unit up to inspection standards.

## Moving Costs

Moving costs for the MFP are \$2,000 per person, covering the cost a security deposit, utility connection, and household items.

## Funding Recommendations

- In order to go forward, and not backward, in the amount of supportive housing available for this transition, **keep current state funding for existing supportive housing services intact.**
- **Fund the \$3.6 million in service funding needed to bring 769 more supportive housing units on line in FY 2011.** Federal funding is already committed for capital and rental subsidy. (Attachment E)
- **Fund the \$1.9 million in service funding needed to bring 476 more supportive housing units on line in FY 2012.** Federal funding already committed for capital and rental subsidy. (Attachment F)
- **Apply for the same enhanced Medicaid reimbursement rate** that the MFP project is currently receiving for the whole of this project.
- **Use the current set aside in the state capital budget for affordable housing** toward capital costs for supportive housing construction.
- **Access federal sources for capital and subsidy**, including the 1,000 housing voucher set aside for individuals transitioning from institutions.
- **Ask for a special set aside at the federal level to fund this mass transition** of individuals from nursing homes to the community.

## Policy Recommendations

Policies will need to be formulated that prevent additional individuals with mental illness from being diverted to nursing homes. Adequate funding for community mental health services can prevent individuals from having to go to hospitals. Hospital social workers must be educated about alternative placements to nursing homes, e.g. supportive housing, as soon as these alternatives are available.

## Capacity Building for DMH and Community Mental Health Providers, Engaging and Training Providers

### Capacity Building for DMH

This complex undertaking with great potential to benefit Illinois citizens and save state money requires strong state leadership. DMH will need to be supported as it under takes this effort so that it can serve as the clinical, administrative, and fiscal authority for this project. Additional staff with appropriate background and concentration of authority will be required. It will not work to have this endeavor spread over several state departments. Assistance from a consultant will be helpful to initiate this program.

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## **Capacity Building for Providers**

Providers for this project should be selected based on a RFP process with providers competing on the basis of quality and added value rather than price. The state could spec and price the contract requirement and ask providers to offer their best proposal within the limits of the specifications and price. Providers should also be selected based on their capacity and expertise in the following areas, considering geographic coverage and cultural competency:

- Assessment of high risk consumers
- Engagement and retention expertise
- Expertise in motivational and state-wide interventions
- Service planning for high risk behaviors
- Assertive Community Treatment team-like services and higher intensity community support team services with focus on recovery and community integration
- Integrated dual disorders treatment
- Individual placement and support (Supported Employment)
- Wellness management and recovery services
- Psychiatric services including prescribing and medication monitoring and support
- Representative payee services
- Medical case management & supportive services (education, monitoring, etc)
- Apartment finding
- Transition planning & support
- Specialized training for support of jail/prison involved people
- Peer support & education
- Cognitive behavioral treatment
- 24 hours a day, 365 days year continuous operations
- Robust information management capacity
- Strong recovery orientation as measured by a standardized assessment
- Strong program evaluation and quality management processes

Providers selected should then participate in a series of training sessions and ongoing support mechanisms covering these same areas. A lead training group should be selected by the state through an RFP process and could include the Corporation for Supportive Housing, the University of Illinois at Chicago, providers, or other entities.

## **Safety Planning**

Planning in this area should be based on the results of the demonstration year and other examples of providers working successfully with high risk populations. Attention should also be given to providers working well with landlords in housing high risk individuals. Each individual should have a risk assessment and mitigation plan in place.

## **Evaluation**

System outcomes could include: housing stability, ability to perform daily living tasks, increase in income, integration into the community, connection with family, and progress on other goals that individuals set for themselves. However, evaluation of performance should be primarily based on process measures (fidelity measures, assessment of recovery orientation, quality process, etc.), rather than outcomes to avoid the pull to serve those easiest to serve.

Attachment A  
Illinois Department of Healthcare and Family Services

IMD FACILITIES

FACILITY NAME	ADDRESS	BEDS
ABBOTT HOUSE	405 Central Avenue, Highland Park 60035	106
ALBANY CARE INC	901 Maple, Evanston 60202	417
BAYSIDE TERRACE	1100 South Lewis, Waukegan 60085	168
BELMONT NURSING HOME	1936 W. Belmont, Chicago 60657	61
BOURBONNAIS TERRACE	133 Mohawk Drive, Bourbonnais 60914	197
BRYN MAWR CARE INC	5547 N. Kenmore, Chicago 60640	174
CENTRAL PLAZA	321 N. Central, Chicago 60644	260
CLAYTON RESIDENTAL HOME	2026 N. Clark Street, Chicago 60614	247
COLUMBUS MANOR RES CARE HOME	5107 21 W. Jackson, Chicago 60644	189
DECATUR MANOR (FORMERLY PERSHING ESTATES)	1016 W. Pershing Road, Decatur 62526	147
GRASMERE PLACE	4621 N. Sheridan, Chicago 60640	216
GREENWOOD CARE	1406 N. Chicago, Evanston 60201	145
KANKAKEE TERRACE	100 Belle Aire, Bourbonnais 60914	146
LAKE PARK CENTER	919 Washington Park, Waukegan 60085	210
LYDIA HEALTHCARE	13901 S. Lydia, Robbins 60472	412
MARGARET MANOR	1121 N. Orleans, Chicago 60610	135
MARGARET MANOR NORTH	940 W. Cullom Avenue, Chicago 60613	99
MONROE PAVILION HEALTH CENTER	1400 W. Monroe, Chicago 60607	136
RAINBOW BEACH NUR CTR INC	7325 S. Exchange, Chicago 60649	211
SACRED HEART HOME	1550 S. Albany, Chicago 60623	172
SHARON HEALTH CARE WOODS INC	3223 W. Richwoods Blvd, Peoria 61604	152
SKOKIE MEADOWS NURSING CTR II	4600 Golf Road, Skokie 60076	111
SOMERSET PLACE	5009 N. Sheridan Road, Chicago 60640	450
THORNTON HEIGHTS TERRACE LTD	160 W. 10 <sup>th</sup> Street, Chicago Heights 60411	222
WILSON CARE INC	4544 N. Hazel, Chicago 60640	198
WINCREST NURSING CTR CORP	6326 N. Winthrop, Chicago 60660	82

Attachment A  
Illinois Department of Healthcare and Family Services

IMD FACILITIES

# SUPPORTIVE HOUSING IN ILLINOIS: A WISE INVESTMENT

The full report of **Supportive Housing in Illinois: A Wise Investment** is available at:

[www.heartlandalliance.org/research](http://www.heartlandalliance.org/research)

[www.supportivehousingproviders.org](http://www.supportivehousingproviders.org)

[www.csh.org](http://www.csh.org)

**S**upportive housing is permanent affordable housing coupled with supportive services that enables residents to achieve long-term housing stability. Residents include people who were homeless and those who have serious and persistent issues such as mental illness, chronic health problems, and substance use.

This analysis focused on 177 supportive housing residents in Illinois and the impact of supportive housing on their use of expensive, primarily publicly-funded services. Analysis compared the 2 years before they entered supportive housing with the 2 years after. Data were collected on these residents from Medicaid, mental health hospitals, substance use treatment, prisons, and various county jails and hospitals.

## Key Findings

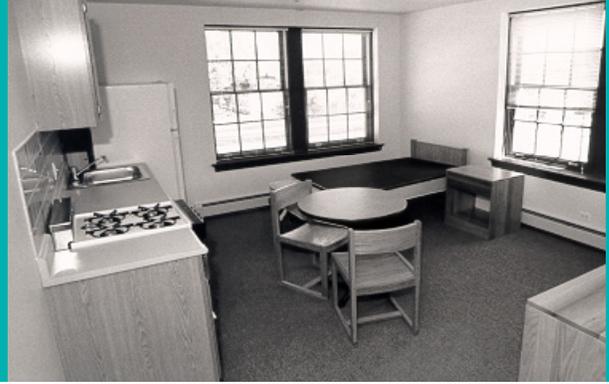
- There were cost savings in every system studied from pre- to post-supportive housing. There was a 39% reduction in the total cost of services from pre- to post-supportive housing with an overall savings of \$854,477. This was an average savings of \$4,828 per resident for the 2-year time period or \$2,414 per resident, per year.
- Once in supportive housing, residents who had previously lived in more restrictive settings (i.e., nursing homes, mental health hospitals, and prisons) were unlikely to return.
- Residents shifted the type and volume of services they used—from a high reliance on expensive Inpatient/Acute services before supportive housing to less expensive Outpatient/Preventive services after supportive housing.
- Residents reported an increased quality of life after entry into supportive housing. Not only did their housing stabilize, but their health improved, and they experienced less stress.

The cost savings from supportive housing is likely to be much higher than reported here. A number of costs were infeasible to include or beyond the scope of this analysis, including the homeless system and related costs, substance use treatment costs, social costs, and many others. Also, cost savings likely continued in the years following this study time frame.

In sum, supportive housing reduced the volume of publicly-funded services residents used, changed the type of services used, and resulted in a significant cost savings over time.



# SUPPORTIVE HOUSING IN ILLINOIS: A WISE INVESTMENT



## Methodology

The purpose of this study was to investigate how permanent supportive housing impacts residents' reliance on primarily publicly-funded services. The key research questions are:

1. Does living in supportive housing change the **volume** of publicly-funded services residents use?
2. Does living in supportive housing change the **type** of publicly-funded services residents use?
3. Does living in supportive housing decrease the **cumulative cost** of services residents use?

The study was structured as a repeated measures panel design, using a 4-year time period for each resident. The data were divided into pre- and post-time periods, each time period being 2 years. The analysis compared the volume, type, and cost of services each resident used in the 2 years before supportive housing to the 2 years after they entered supportive housing.

Recruitment for the study ran from February to September 2006. To get a cross-section of the typical composition of Illinois supportive housing residents at a given time, all residents in the supportive housing projects at the time of recruitment were eligible for the study, regardless of how long they lived there or their reasons for living there. Researchers obtained consent and release of information forms to access data from state agencies, local hospitals, and jails. Data requests were sent to the entities in Table 1 for the time period of July 1, 1999 to June 30, 2006 for information on use of listed services:

**Table 1: Service-Type Categories for Each System**

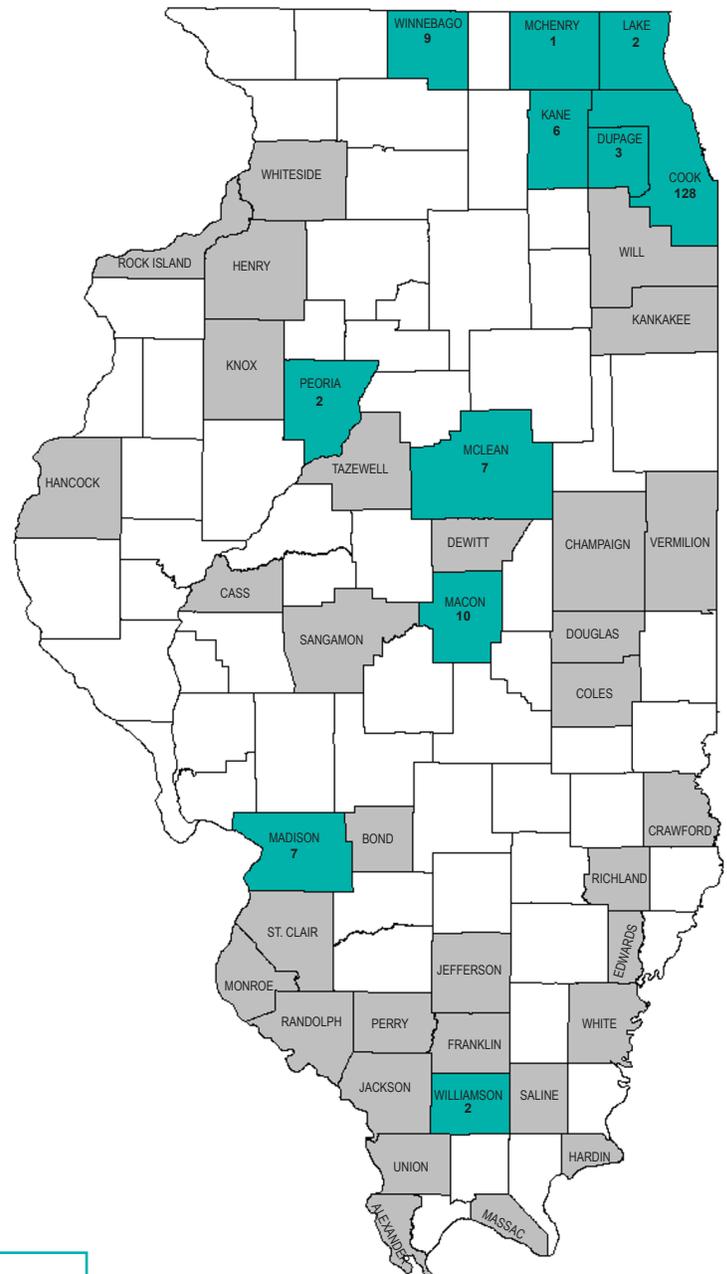
	Inpatient/Acute Services	Outpatient/Preventive Services	Incarceration
Medicaid-Funded Services (DHFS)	Inpatient medical care	Pharmacy	
		Home health & medical equipment	
	Inpatient psychiatric care	Outpatient medical care	
	Nursing homes	Outpatient psychiatric care	
	Ambulance	Physician care	
		Care by other providers	
	Dental care		
Uncompensated Hospital Services (Local Hospitals)	Inpatient medical care	Outpatient medical care	
	Inpatient psychiatric care	Outpatient psychiatric care	
	Emergency room	Outpatient care: Type unknown	
Substance Use Treatment Services (DASA)	Residential rehabilitation	Outpatient treatment	
	Halfway house		
	Recovery home	Case management	
	Detoxification	Toxicology	
State Mental Hospital (DMH)	Inpatient mental hospital		
State Prison (IDOC)			State prison
County Jails			County jails



## Background on Study Participants

177 residents in the study had complete data for their 2 pre-supportive housing years and 2 post-supportive housing years. In order to look comprehensively at the effects of supportive housing over a 2-year time frame, this report focuses on this 177 sample, which had the following characteristics:

- They had been in supportive housing for an average of 38 months. Time in supportive housing ranged from 21 months to 63 months.
- They had an average age at time of the study enrollment of 43, ranging from 18 to 68 years of age.
- Over half (52%) were male and 48% were female.
- In terms of race/ethnicity, 69% were African American, 26% White, 4% Latino, and 0.6% other.
- Six percent identified themselves as veterans.
- In the week prior to entry into supportive housing, 39% lived in a homeless shelter or transitional housing, 15.8% were living doubled up with family or friends, almost 10% were unsheltered, and 9% were in some type of facility (nursing home, jail, treatment center, etc.).
- They were from 26 supportive housing projects in 11 counties in Illinois.



-  Counties with supportive housing projects
-  Counties with supportive housing projects participating in the study and number of residents enrolled in the study

## SUPPORTIVE HOUSING IN ILLINOIS: A WISE INVESTMENT

### Results: System-Specific Service Analysis



## Medicaid-Reimbursed Service Use (Illinois Department of Health and Family Services)

Medicaid is a state-administered health insurance program that is available only to people with limited income who meet certain eligibility requirements.

### Does living in supportive housing change the volume of Medicaid services residents use?

While there was a slight increase in the volume of Medicaid services used from pre- to post-supportive housing, there was a shift in type of services used from more expensive, intensive services to less expensive, preventive services.

- Medicaid-reimbursed **inpatient psychiatric care** users decreased almost 20% and use decreased over 66% from pre- to post-supportive housing.
- **Nursing home** use decreased 97%.
- As expected, use of health stabilizing services increased, such as **pharmacy, home health care, and dental care**.
- Although Medicaid-funded **inpatient medical care** and **outpatient psychiatric care** use increased post-supportive housing, the large increase was concentrated during the first 6 months after entry into supportive housing. After those 6 months of stabilization, the use of inpatient care reduced dramatically.
- While use of Medicaid-funded **outpatient medical care** increased 26% during the post-supportive housing time period, there was virtually no cost increase.

### Does living in supportive housing change the type of Medicaid services residents use?

Yes. There was a shift from using Inpatient/Acute Medicaid services prior to entry into supportive housing to relying more on Outpatient/Preventive Medicaid services after living in supportive housing.

- The use of Inpatient/Acute Medicaid services decreased 82%, while the use of Outpatient/Preventive services increased 32%.

### Does living in supportive housing decrease the cumulative cost of Medicaid services residents use?

Yes, there was a cost savings of over \$183,000 from pre- to post-supportive housing.

- Before supportive housing, the sample of 177 residents used a total of \$1,422,399 worth of Medicaid-reimbursed health services. After entry into supportive housing, the group used \$1,240,128 worth of services.
- Overall, the cost of Inpatient/Acute services decreased 38% from pre- to post-supportive housing, while the cost of Outpatient/Preventive services increased only 12%.



## Uncompensated Hospital Service Use (Local Hospitals)

Since not all residents had Medicaid health insurance coverage during the entire study period, residents were asked which local hospitals they used during the study period, and researchers collected records from those hospitals. There is a small chance that some in the sample had private insurance; however, due to the demographics of the sample and their lack of employment income, this is very unlikely. Reported here is the use of hospital services that were likely not reimbursed by Medicaid or other health insurance.

### Does living in supportive housing change the volume of uncompensated hospital services residents use?

Yes.

- **Emergency room** total use decreased over 40%.
- Use of **inpatient medical care** went down 83%.
- **Outpatient medical care** and the **emergency room** were the most commonly used services pre-supportive housing. **Outpatient medical care** and **inpatient psychiatric care** were the most commonly used services post-supportive housing.
- **Outpatient medical care** and **outpatient psychiatric care** use remained almost the same from pre- to post-supportive housing.

### Does living in supportive housing change the type of uncompensated hospital services residents use?

Yes, the number of uses of **Inpatient/Acute uncompensated hospital services** declined 17%; however, the number of uses of **Outpatient/Preventative uncompensated hospital services** remained the same.

### Does living in supportive housing decrease the cumulative cost of uncompensated hospital services residents use?

Yes, there was a total cost savings of **\$27,968** from pre- to post-supportive housing.

- Before supportive housing, the sample of 177 residents used \$133,429 worth of uncompensated hospital services. After entry into supportive housing, they used \$105,461 worth of services.
- There was a 25% cost decrease from pre- to post-supportive housing in **Inpatient/Acute services** and a 9% cost decrease from pre- to post-supportive housing in **Outpatient/Preventive services**.

## SUPPORTIVE HOUSING IN ILLINOIS: A WISE INVESTMENT

### *Results: System-Specific Service Analysis*



### **State Mental Health Hospital Use (Illinois Department of Human Services, Division of Mental Health)**

The Division of Mental Health in Illinois operates inpatient mental health hospitals that are not funded through Medicaid for adults and youth with mental disabilities. The goal of inpatient mental health hospitals is to help people through crises, stabilize them, and move them forward using outpatient services once they leave.

#### **Does living in supportive housing change the volume of mental health hospitalizations residents use?**

**Yes, there was a significant decline in mental health hospitalizations.**

- The number of users and uses of mental health hospitals decreased 90% from pre- to post-supportive housing.
- Overnight stays in mental health hospitals ranged from 1 to 415 during the pre-supportive housing time period. During the post-supportive housing time period, just one person stayed in a mental health hospital for 2 nights.
- The number of overnight stays in mental health hospitals went down almost 100%.

#### **Does living in supportive housing change the type of mental health services residents use?**

**Yes.**

- Mental health hospital care is considered an Inpatient/Acute service. There was a drastic reduction in this type of care.
- None of the 11 people who used state mental health hospitals in their pre-supportive housing time period used them in their post-supportive housing time period. Five of the 11 used Medicaid-reimbursed outpatient psychiatric care in their post-supportive housing time period.

#### **Does living in supportive housing decrease the cumulative cost of mental health hospitalizations?**

**Yes, there was almost a \$400,000 cost savings in mental health hospitalizations from pre- to post-supportive housing.**

- The sample of 177 residents used \$400,872 worth of state mental health hospital services before entry into supportive housing and only \$873 after entry into supportive housing.



## Substance Use Treatment Service Use (Illinois Department of Human Services, Division of Alcohol and Substance Abuse)

The Division of Alcoholism and Substance Abuse is responsible for coordinating all programs that deal with problems resulting from substance use. They focus on prevention, intervention, treatment, and rehabilitation for alcohol and other drug dependency.

**Does living in supportive housing change the volume of substance use treatment services residents use?**

While number of uses were not available for substance use treatment services, based on declines in users of all services except case management and toxicology, it can be assumed there was a decrease in the volume of substance use treatment services used.

**Does living in supportive housing change the type of substance use treatment services residents use?**

Yes.

- From pre- to post-supportive housing, users of Inpatient/Acute services decreased 60%, while the number of users of Outpatient/Preventive services increased 11%.

**Does living in supportive housing decrease the cumulative cost of substance use treatment services residents use?**

While cost data were not available for substance use treatment services, based on declines in the number of users of the most intensive services, it can be assumed that there was a significant cost decline.

- Expensive overnight services such as **halfway houses** and **recovery homes** decreased 100% from pre- to post-supportive housing.

# SUPPORTIVE HOUSING IN ILLINOIS: A WISE INVESTMENT

## Results: System-Specific Service Analysis



### Criminal Justice System Interactions

#### State Prisons (Illinois Department of Corrections)

**Does living in supportive housing change the amount of time spent in state prison?**

**Yes, there was a 100% decrease in time spent in state prison from pre- to post-supportive housing.**

- Overnight stays in prison ranged from 2 to 328 during the pre-supportive housing period, dropping to zero during the post-supportive housing time period.

**Does living in supportive housing decrease the cumulative cost of time spent in state prison?**

**Yes, there was a cost savings of over \$215,000 from pre- to post-supportive housing.**

- Before supportive housing, the time the sample of 177 residents spent in state prison cost \$215,759. After entry into supportive housing, residents did not spend any time in prisons; therefore, there was a 100% cost savings.

#### County Jails

**Does living in supportive housing change the amount of time spent in county jails?**

**Yes, there was a significant decrease in time spent in county jails from pre- to post-supportive housing.**

- The number of overnight stays decreased 86% from pre- to post-supportive housing.
- The length of stay in county jails ranged from 0 to 200 overnight stays during the pre-supportive housing period and 4 to 23 overnight stays during the post-supportive housing period--a significant reduction.

**Does living in supportive housing decrease the cumulative cost of time spent in county jails?**

**Yes, there was a cost savings of over \$27,000 from pre- to post-supportive housing.**

- Before supportive housing, the sample spent time in county jails costing \$32,099. After entry into supportive housing, this sample spent time costing \$4,618.



**Table 2: Summary of Change in the Cost of Services Used from the 2 Years Before to the 2 Years After Entry into Supportive Housing**

	Total Cost PRE-Supportive Housing	Total Cost POST-Supportive Housing	Dollar Change in Total Cost from Pre- to Post-Supportive Housing	Percent Change in Cost
<b>Medicaid-Reimbursed Service Use (Pre: N=84, Post: N=102)</b>				
Inpatient medical care	\$224,547	\$340,192	\$115,645	52%
Inpatient psychiatric care	\$230,119	\$74,223	-\$155,896	-68%
Nursing home	\$236,576	\$6,512	-\$230,064	-97%
Ambulance	\$3,531	\$7,232	\$3,701	105%
Pharmacy	\$220,592	\$258,776	\$38,184	17%
Home health care and medical equipment	\$35,253	\$70,443	\$35,190	100%
Outpatient medical care	\$151,210	\$151,401	\$191	0%
Outpatient psychiatric care	\$224,223	\$257,050	\$32,824	15%
Physician care	\$85,477	\$63,578	-\$21,899	-26%
Care by other providers	\$6,770	\$4,003	-\$2,767	-41%
Dental care	\$4,009	\$5,719	\$1,620	40%
<b>Total Medicaid-Reimbursed Services</b>	<b>\$1,422,299</b>	<b>\$1,239,128</b>	<b>-\$183,271</b>	<b>-13%</b>
<b>Uncompensated Hospital Service Use (Pre: N=37, Post: N=47)</b>				
Inpatient medical care	\$68,097	\$16,545	-\$51,552	-76%
Inpatient psychiatric care	\$24,245	\$55,519	\$31,274	129%
Emergency room	\$11,217	\$6,078	-\$5,139	-46%
Outpatient medical care	\$28,976	\$26,460	-\$2,516	-9%
Outpatient psychiatric care	\$894	\$859	-\$34	-4%
Outpatient care: Unknown type	-	-	-	-
<b>Total Uncompensated Hospital Services</b>	<b>\$133,429</b>	<b>\$105,461</b>	<b>-\$27,968</b>	<b>-21%</b>
<b>Mental Health Hospital Use (Pre: N=10, Post: N=1)</b>				
Inpatient mental health hospital care	\$400,872	\$873	-\$399,999	-100%
<b>State Prison Interactions (Pre: N=11, Post: N=0)</b>				
State prison	\$215,759	\$0	-\$215,759	-100%
<b>County Jail Interactions (Pre: N=9, Post: N=4)</b>				
County jail	\$32,099	\$4,618	-\$27,481	-86%
<b>Substance Use Treatment Service Use (Pre: N=48, Post: N=44)</b> No cost data were available for substance use treatment services through the Illinois Department of Human Services, Division of Alcohol and Substance Abuse				

# SUPPORTIVE HOUSING IN ILLINOIS: A WISE INVESTMENT

## Results: Cross-System Service Analysis



### Change in the Type of Services Used Over Time

Within each of the six systems studied, researchers looked at three different categories:

1. Inpatient/Acute: Services in this category are primarily expensive, overnight, and for emergency situations.
2. Outpatient/Preventive: Services in this category are less expensive, stabilizing, maintenance, and preventive care.
3. Incarceration: This includes county jails and state prisons.

There was a dramatic shift in the type of services used across all six systems (see Table 3). The majority of services used shifted from Inpatient/Acute and Incarceration before supportive housing, to Outpatient/Preventive after entry into supportive housing.

- There was a 77% decrease in the number of nights spent in Incarceration and an 83% decrease in the number of uses of Inpatient/Acute services after entry into supportive housing.
- These decreases in use correspond with a large decrease in the total cost. The total cost of Incarceration decreased 98% and Inpatient/Acute services decreased 58% in total cost.
- While Outpatient/Preventive service use increased 32%, there was only a corresponding 11% total cost increase from pre- to post-supportive housing.

**Table 3: Category Change Over Time**

	Percent Change from Pre- to Post-Supportive Housing				
	Number of Users	Number of Uses	Average Uses per User	Total Cost	Average Cost per User
Inpatient/Acute (not including substance use)*	0%	-83%	-83%	-58% (-\$692,030)	-58%
Outpatient/Preventive	13%	32%	17%	11% (\$80,793)	-2%
Incarceration	-77%	-98%	-91%	-98% (-\$243,240)	-92%

\*Substance use treatment services are not included in this analysis due to missing data on use and total cost.



## Cost Savings

In the 2 years prior to entry into supportive housing, the 177 residents used \$2,204,557 worth of services. In the 2 years after entry into supportive housing, these 177 residents used a total of \$1,350,081 worth of services. Post-supportive housing costs declined the longer residents lived in supportive housing (see Table 4). Thirty percent of the total cost was accrued in months 1 through 6, declining to 21% in months 19 through 24 of the 2-year post-time period. This illustrates that fewer costs were accrued by residents as time in supportive housing increased and that cost reduction may likely continue beyond this study's time frame, resulting in even greater cost savings for long-term supportive housing residents.

**Table 4: Post-Supportive Housing Cost Accrual in 6 Month Increments**

Months After Entry into Supportive Housing	Percent of Total Post-Supportive Housing Costs Accrued
1-6 Months	30%
7-12 Months	27%
13-18 Months	22%
19-24 Months	21%

For these 177 residents, there was a 39% reduction in total cost with an overall cost savings of \$854,477. This is an average cost savings of \$4,828 per person from pre- to post-supportive housing for the 2-year time period across all of the systems included in this study minus substance use treatment services. This averages to \$2,414 per person, per year.

Ten people in the sample can be considered high-cost users. High-cost users are those who used \$50,000 or more worth of services during the 2 years before entering supportive housing. Their total cost of services in the 2 years before supportive housing ranged from \$54,000 to \$194,000 with a median cost of \$107,000. Each of these 10 high cost users had a dramatic cost decrease from pre- to post-supportive housing. The average cost savings was \$73,000 per person, with a cost savings range of \$2,400 to \$180,000.

The biggest cost savings came from three systems: state mental health hospitals, state prisons, and Medicaid. The sample of 177 residents saved close to \$400,000 from a decrease in state mental health hospitalizations, over \$215,000 from a decrease in state prison admissions, and \$183,000 from a decrease in use of Medicaid-reimbursed services.

This cost savings is a conservative estimate due to substance use treatment services and some uncompensated outpatient hospital service costs not being included in this analysis. In addition, shelter costs, police costs, soup kitchens, community health clinics, and many other services related to homelessness were not captured; therefore, the overall cost savings after entry into supportive housing is likely much greater.

# SUPPORTIVE HOUSING IN ILLINOIS: A WISE INVESTMENT



## Discussion

This is the first statewide study that looks at the effects of permanent supportive housing on residents in Illinois and adds to the current research about the cost-effectiveness of supportive housing as a key component for eliminating homelessness. Supportive housing in Illinois not only reduced the homelessness and housing instability previously experienced by residents but also produced a large cost savings in a number of public systems. Based on resident interviews, many people also experienced enhanced quality of life, not solely as result of being stably housed, but also due to their increased use of preventive and maintenance services, particularly in health, mental health, and substance use service systems.

### Implications for Practice and Policy

**Supportive housing providers should give consideration to the following as they seek to enhance their services:**

- In the first 6 months of permanent supportive housing residents need support in order to stabilize their health. Some services, such as inpatient medical care, saw a spike in use in the first 6 months of supportive housing which quickly decreased thereafter. In line with findings from other supportive housing studies, use of health services increased after people were housed, likely due to increased contact with case managers who made referrals to health professionals. While homeless, many people did not have access to such systems and deferred needed care. Health and mental health needs are an important initial assessment and referral piece for case managers to consider.
- Medicaid-reimbursed services and substance use services were the most frequently used both pre- and post-supportive housing. Case managers have an opportunity to educate about and refer residents to Outpatient/Preventive services, which not only saves money, but can help residents maintain stability in their health and lives.
- Supportive housing is effective with the most expensive users of public services, such as those with a mental illness or substance users. While these groups used high-cost services before entry into supportive housing, they benefited from being housed and produced a dramatic cost savings after entering supportive housing.
- There are implications of this analysis for targeting supportive housing. Supportive housing has a tremendous cost savings impact for people who might be considered the hardest to house: those with a mental illness, those who were formerly incarcerated, those with a disability or health issue, and those with histories of drug use. As projects seek to target populations in need, tailoring outreach and services for those with the aforementioned characteristics will result in cost savings as well as appropriate housing in the least restrictive setting.



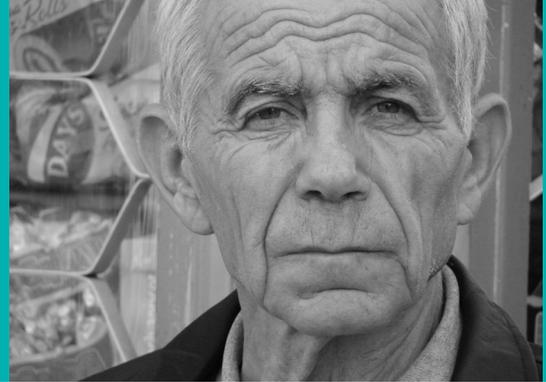
**Policymakers have an opportunity to prioritize people who are homeless and have barriers by housing them in supportive housing instead of in expensive, more restrictive settings:**

- People are often inappropriately housed in nursing homes due to a lack of available supportive housing options. In addition, many patients need more intensive nursing care after a medical crisis, and since nursing homes do not want to discharge people back to homelessness, they retain them longer than necessary. Nursing homes are a very expensive housing option that should be relied on only for people who need full-time care, and supportive housing should be available for those who need less intensive supports and services to remain healthy and housed.
- People with mental illness are often unnecessarily placed in Institutes for Mental Disease, which are nursing homes with over 16 beds in which the majority of residents have a mental illness. For nursing homes with this designation, the federal government will not provide Medicaid reimbursement for services provided to people age 22 to 64. The state of Illinois ends up paying an average of \$160 million annually to house people in these Institutes for Mental Disease. Many of these people could live on their own in supportive housing and save the state millions of dollars a year.

**Policymakers have an opportunity to invest funds more wisely in Illinois by making permanent supportive housing available to more people in need:**

- Time spent in jails and prisons plummeted for the supportive housing residents in this study, saving tens of thousands of dollars. Supportive housing is a better investment for the person who is homeless, for the community through reduced crime, and for the state in reduced correctional outlays.
- Once in supportive housing, residents can begin to stabilize their lives. They start receiving medical treatment, stabilize their medication, and are less likely to use expensive Inpatient/Acute services such as mental health hospitals and nursing homes.
- It is challenging to document cost savings from supportive housing and to fund services for supportive housing because government funding streams for different populations are compartmentalized. Funding for supportive housing services is needed from multiple state agencies, and there needs to be a mechanism for this to happen smoothly. For example, money seen from cost savings in prisons and nursing homes after entry into supportive housing needs to be able to easily shift to invest in supportive housing.

## SUPPORTIVE HOUSING IN ILLINOIS: A WISE INVESTMENT



### Residents' Perspectives

During in-depth interviews and a roundtable discussion with supportive housing residents, many indicated a variety of ways their lives had improved after entering supportive housing.

#### Residents reported that they:

- Learned how to pay bills
- Were able to be reunited with children and family
- Were able to save, especially for a car
- Experienced health improvements
- Were able to abstain from substance use
- Did not feel pressure to do things that they used to do, such as illegal activities
- Felt they had compassion, and they could give back to others
- Believed in themselves
- Had more confidence in themselves
- Felt great overall
- Felt like a human being again
- Were proud
- Were able to be around positive people and create a more positive outlook for themselves
- Reduced stress in their lives



## Conclusion

This is the first statewide study that looks at the effects of supportive housing for residents in Illinois and adds to the current research about the cost-effectiveness of supportive housing as a key component for eliminating homelessness.

Overall, there was a cost savings in every system studied from pre- to post-supportive housing. There was a 39% reduction in total services cost from pre- to post-supportive housing with an overall cost savings of \$854,477 for the 177 residents. This was an average cost savings of \$4,828 per resident from pre- to post-supportive housing for the 2-year time period or \$2,414 per resident, per year.

The true cost savings realized by supportive housing is likely to be much higher than reported here. There were a number of costs that were infeasible to include or beyond the scope of this analysis, including costs incurred by the homeless system and related services, substance use treatment costs, social costs, and many others.

Importantly, residents also shifted the type of services they used—from a high reliance on expensive Inpatient/Acute services (such as inpatient care, emergency rooms, and mental health hospitals) before they entered supportive housing to less expensive Outpatient/Preventive services (such as outpatient care, home health care, and case management) after they entered supportive housing. The volume of services used decreased for expensive Inpatient/Acute services and Incarceration and increased slightly for less expensive Outpatient/Preventive services.

This study underscores the importance of prioritizing more appropriate housing options for people living in restrictive settings who could live in the community if supportive housing were available. Supportive housing can not only reduce costs of public systems particularly in the areas of nursing homes, mental health, and criminal justice, but can also dramatically improve the quality of life for thousands of Illinoisans.

# Acknowledgements

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## The Heartland Alliance Mid-America Institute on Poverty

The Heartland Alliance Mid-America Institute on Poverty (MAIP) provides dynamic research and analysis on today's most pressing social issues and solutions to inform and equip those working toward a just global society. As such, MAIP:

- Conducts research to increase the depth of understanding and profile of social issues and solutions;
- Develops recommendations and action steps;
- Communicates findings using media, briefings, and web strategies to influence a broad base of decision makers; and
- Impacts social policy and program decisions to improve the quality of life for poor and low-income individuals.

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## Supportive Housing Providers Association

The Supportive Housing Providers Association (SHPA) is a statewide association of organizations who provide supportive housing. SHPA enables increased development of supportive housing and supports organizations that develop and operate permanent supportive housing. The Supportive Housing Providers Association:

- Connects its member organizations, both staff and residents, with each other, with best practices, and with state/national policymakers and funders;
- Educates stakeholders regarding the efficacy and cost effectiveness of supportive housing; and
- Advocates for increased and integrated resources for supportive housing.

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## Corporation for Supportive Housing (provided technical assistance for the study)

Established in 1992, the Corporation for Supportive Housing Illinois office works to promote the development of supportive housing to end long-term homelessness through three core products and services:

- Capacity building to enhance the supportive housing industry's skills and knowledge, so that the field has a greater ability to deliver high-quality housing and services over the long term;
- Financial and technical assistance to partners to expand the supply, availability, and variety of supportive housing;
- Promoting policy reforms and coordinated systems that make supportive housing easier to develop and operate.

For more information: 312.332.6690 | [ilinfo@csh.org](mailto:ilinfo@csh.org) | [www.csh.org](http://www.csh.org)

# Illinois Housing Task Force Supportive Housing Working Group

## Final Report

**Respectively submitted August 2008 by  
the Supportive Housing Working Group of  
the Illinois Housing Task Force:**

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# Illinois Housing Task Force Supportive Housing Working Group Final Report Executive Summary

Submitted August 2008

## Overview

Illinois' 2007 Annual Comprehensive Housing Plan included supportive housing as a priority focus. The plan called for appointment of the Supportive Housing Working Group in order to analyze in depth the State's supportive housing needs and to develop realistic short- and long-term goals for the production, servicing and evaluation of supportive housing in Illinois.

## Definition

In order to establish a baseline understanding, the Working Group devoted considerable thought and time toward developing a common definition for permanent supportive housing (PSH), as follows:

*The housing and services needs of persons with disabilities and households that are homeless or at-risk of homelessness are diverse, supporting the need for a range of housing options with services available, whether on-site or community-based. While service-enriched housing models such as those serving the elderly or youth meet many needs, Permanent Supportive Housing is a unique type of affordable housing with services that has been shown to reduce homelessness.*

*Supportive housing helps people live stable, successful lives through a combination of affordable, permanent housing and supportive services, appropriate to the needs and preferences of residents, either on-site or closely integrated with the housing. Supportive housing serves individuals and families who are homeless, at risk of homelessness, and/or have disabilities, and who require access to supportive services in order to maintain housing.*

## Housing Need and Production Goal

The Working Group focused on two systems to determine the need for PSH in Illinois: the homeless services system's Continuum of Care, which conduct a statewide biennial Point in Time (PIT) count of homeless persons in shelters and on streets; and the limited empirical data on persons in institutional care who could benefit from PSH. Persons in prisons were not counted separately, because ex-offenders who have become homeless are already included in the PIT count.

The Supportive Housing Working Group concludes that, in order to significantly reduce homelessness over the next seven years in Illinois, 7,700 additional units of PSH should be created or preserved. The 7,700 unit goal is lower than the total unmet need for units of PSH, estimated to be 8,200 units. A five percent reduction was considered to take into account current production levels, financial market conditions and assumptions in calculations of need. The 7,700 unit/seven year goal, however, is still ambitious, and it will take some time to overcome barriers to increased production levels. An orderly "ramp up" of policy changes, training, funding and development would be necessary to reach the 7,700 unit goal in seven years.

## Production Strategies

In an effort to estimate costs of meeting the seven-year, 7,700-unit production goals, the Working Group examined strategies that could be used to produce the desired units:

- A **leasing** strategy couples existing, privately-owned housing units in the rental housing market with a tenant-based rental voucher or subsidy to achieve affordability, along with access to services.
- A **development** strategy develops units through either acquisition/rehabilitation/preservation of existing units or new construction. Due to the extremely low incomes of most persons in need of PSH, this strategy must often include dedicated rental or operating subsidies to ensure the financial viability of the project.

To facilitate cost projections, it was assumed that half of the units would be leased via tenant-based subsidy and half of the units would be either newly constructed or preserved/rehabilitated and matched with dedicated rental or

operating subsidies. Based on the proportion of single homeless persons to homeless persons with children in Illinois, 7,000 units would be sized for single occupancy and 700 would be larger units designed for families.

## **Resources**

Aside from construction costs, PSH requires a higher level of operating subsidy than standard affordable housing, from which it is also distinguished by the need to build in costs for the provision of supportive services. As defined for this report, PSH tenants should pay no more than 30% of their income for rent. Because most PSH tenants have extremely low incomes, the rent they can pay will not fully support the continuing operating costs of their unit, nor will it provide for supportive services. The three necessary components of PSH funding are defined as follows:

- **Capital** – one-time financing (for PSH, preferably with no debt) that enables construction, preservation or rehabilitation
- **Operating** – dedicated rental or operating subsidies that ensure financial feasibility over the life of a project
- **Services** – funds to ensure supportive services are available on-site and/or in the community for PSH residents

## **Recommendations**

Each of the following recommendations is followed by the barrier(s) addressed.

1. Federal Advocacy Around Housing and Services Legislation and Funding  
Barriers Addressed: Loss of Federal Funding for Services, Limited Continuum of Care Funding for New Projects, Limited Rental Subsidies, Vulnerability to Housing Market Downturns, Systemic Funding Policy
2. Federal Advocacy for New Consolidated PSH Funding Program  
Barriers Addressed: Loss of Federal Funding for Services, Complex and Multiple Funding Requirements, Significant Upfront Development Costs
3. Improved Coordination Among IHDA, City of Chicago, DCEO, IDHS, DOC and Continua of Care  
Barriers Addressed: Complex and Multiple Funding Requirements, Significant Upfront Development Costs, Need for Coordinated and Focused Public Policy, Inaccessible Balance of State Housing Vouchers, Stigma Attached to Supportive Housing populations, Systemic Funding Policy
4. Improved Coordination Among Local Public Housing Authorities and Continua of Care  
Barriers Addressed: Limited PHA Participation in Continua of Care, Inaccessible Housing Vouchers, Need for Coordinated and Focused Public Policy
5. Identify a Supportive Housing Point Person within IHDA  
Barriers Addressed: Complex and Multiple Funding Requirements, Significant Upfront Development Costs, Need for Coordinated and Focused Public Policy
6. Use Illinois Affordable Housing Trust Fund Dollars for Housing Development, Not Services  
Barriers Addressed: Inadequate Federal, State and Local Funding, Vulnerability to Housing Market Downturns
7. Identify and Replicate PSH Production Models with State-Funded Pilot PSH Development Program  
Barriers Addressed: Inadequate Federal, State and Local Funding, Limited Rental Subsidies, Stigma Attached to Supportive Housing Populations, Limited Supportive Housing Development Capacity, Significant Upfront Development Costs
8. Create New or Expand Existing Operating Subsidy Sources  
Barriers Addressed: Inadequate Federal, State and Local Funding, Limited Rental Subsidies, Stigma Attached to Supportive Housing Populations

# Illinois Housing Task Force Supportive Housing Working Group Final Report

Submitted August 2008

## Background

In 2003 the Governor signed Executive Order 2003, establishing the first statewide comprehensive housing initiative and appointing the Housing Task Force to improve the planning and coordination of the State's housing resources through 2008. The Comprehensive Housing Planning Act (P.A. 94-965), signed by Governor Blagojevich into law in June 2006, codifies Executive Order 2003-18 and extends its intent through June 30, 2016.

**Three of six priority populations identified ... as being in most need in Illinois are targeted by permanent supportive housing.**

Three of six priority populations identified by Executive Order 2003 as being in most need in Illinois are served by permanent supportive housing (PSH): homeless persons and persons at-risk of homelessness; low-income households (with particular emphasis on households earning below 30% of area median income); and low-income persons with disabilities. The State of Illinois Consolidated Plan also prioritizes these populations, (see State of Illinois Consolidated Plan, 2008 Action Plan, Section V, pages 4-7.)

Eliminating homelessness remains a top social service and fiscal priority due to the high cost of emergency services and corrections admissions associated with chronically homeless individuals. Research has shown that PSH can end homelessness and improve the lives of persons who participate. More than 80% of supportive housing tenants stay housed for at least one year<sup>1</sup>, and their:

- Emergency room visits decline by 57%<sup>2</sup>
- Emergency detox services decline by 85%<sup>3</sup>
- Incarceration days in state prisons drop by 85%<sup>4</sup>
- Earned income increases by 50%<sup>5</sup>
- Employment rises by 40% when employment services are provided<sup>6</sup>

**Permanent supportive housing can end homelessness and improve the lives of persons who participate.**

Creating PSH for the State's priority populations is a complex endeavor due to their often high level of service needs and extremely low incomes. The difficulty in identifying ongoing services dollars, combined with the limited supply of zero debt capital financing and operating support to keep the rents extremely low, ensures that PSH development is an uphill battle. When local opposition and the housing market downturn are added to the mix, the difficulty in meeting the housing needs of the State's priority populations is exacerbated.

<sup>1</sup> Culhane, Dennis; Metraux, Stephen, and Hadley, Trevor. (2002) "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing." *Housing Policy Debate*. Volume 13, Issue 1. S. Barrow, G. Soto, P. Cordova. 2004. Final Report on the Evaluation of the Closer to Home Initiative. Corporation for Supportive Housing.

<sup>2</sup> Tia Martinez and Martha Burt. Impact of Permanent Supportive Housing on the Use of Acute Care Health Services by Homeless Adults (Psychiatric Services, July 2006 Vol. 57, No.7).

<sup>3</sup> Tia Martinez and Martha Burt. Impact of Permanent Supportive Housing on the Use of Acute Care Health Services by Homeless Adults (Psychiatric Services, July 2006 Vol. 57, No.7).

<sup>4</sup> Culhane, Dennis; Metraux, Stephen, and Hadley, Trevor. (2002) "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing." *Housing Policy Debate*. Volume 13, Issue 1.

<sup>5</sup> David A. Long and Jean M. Amendolia, Next Step: Jobs, Promoting Employment for Homeless People. (Oakland, CA: Corporation for Supportive Housing, 2003).

<sup>6</sup> David A. Long and Jean M. Amendolia, Next Step: Jobs, Promoting Employment for Homeless People. (Oakland, CA: Corporation for Supportive Housing, 2003).

## **The Supportive Housing Working Group of the Illinois Housing Task Force**

Illinois' 2007 Annual Comprehensive Housing Plan included supportive housing as a priority focus. The plan called for appointment of the Supportive Housing Working Group in order to analyze in depth the State's supportive housing needs and to develop realistic short- and long-term goals for the production, servicing and evaluation of supportive housing in Illinois. Specifically, the group's scope of work included developing a common definition of supportive housing; creating standards and production goals; identifying barriers to and recommendations for supportive housing development and maintenance; and incorporating housing-related components from other State-level plans.

Twenty-six housing, advocacy and human services professionals participated in the full Supportive Housing Working Group, which met on the following dates: 5/25/07, 6/13/07, 7/27/07, 9/5/07, 10/2/07, 10/29/07, 1/25/08, 2/29/08, 4/4/08 and 5/5/08. In addition, a Definition Subcommittee met on 6/5/07 and 6/13/07 and a Needs and Numbers Subcommittee met on 7/16/07, 9/18/07, and 2/11/08.

### **Supportive Housing Working Group Findings**

#### **I. Definition of Permanent Supportive Housing**

In order to establish a baseline understanding, the Working Group devoted considerable thought and time toward developing a common definition and principles for permanent supportive housing, as follows:

##### **Permanent Supportive Housing Definition**

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The housing and services needs of persons with disabilities and households that are homeless or at-risk of homelessness are diverse, supporting the need for a range of housing options with services available, whether on-site or community-based. While service-enriched housing models such as those serving the elderly or youth meet many needs, Permanent Supportive Housing is a unique type of affordable housing with services that has been shown to reduce homelessness.

Supportive housing helps people live stable, successful lives through a combination of affordable, permanent housing and supportive services, appropriate to the needs and preferences of residents, either on-site or closely integrated with the housing. Supportive housing serves individuals and families who are homeless, at risk of homelessness, and/or have disabilities, and who require access to supportive services in order to maintain housing.

##### **Permanent Supportive Housing Principles**

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1. Supportive housing is affordable, safe and decent. The tenant typically pays not more than 30% of household income towards rent.
2. The supportive housing tenant has a standard lease or similar form of occupancy agreement that adheres to normal conditions of tenancy. Regardless of who fills the roles of supportive services provider, property owner and manager, the rights of tenants should be protected through the delineation of separate functions of services provision and property management.
3. There are no limits on a person's length of tenancy in supportive housing as long as they abide by the conditions of the lease or agreement. Tenants are supported in their efforts to achieve their individualized goals, which may include eventually moving to other housing settings.

4. Services are integral to supportive housing, although a tenant’s use of services in supportive housing should be voluntary. By design, housing support services are intended to help ensure stability and to maximize each tenant’s ability to live independently.
  - Supportive housing tenants have access to supports that reinforce housing retention, including but not limited to money management and crisis prevention. These supports may be provided or coordinated via an enhanced property management role.
  - Supportive housing tenants also have access to a flexible array of individualized, comprehensive services that vary according to their needs and interests. Such services, offered on- and/or off-site and dependent upon tenant eligibility, may include medical and wellness, mental health, substance use management, treatment and recovery, vocational and employment and coordinated support (case management).

## II. Permanent Supportive Housing (PSH) Need and Unit Goals

The Supportive Housing Working Group concludes that, in order to significantly reduce homelessness over the next seven years in Illinois and to meet documented need, 7,700 additional units of PSH would need to be created or preserved.

**Table 1: Production Goal for PSH Units in Illinois**

	<b>PSH Unit Goals</b>
<b>Persons who are Homeless</b>	5700
<b>Persons in Nursing Facilities and NF-IMDs</b>	2000
<b>Total</b>	<b>7700 units</b>

The 7,700 unit goal is lower than the total unmet need for units of PSH, estimated to be 8,200 units (see Section B and Table 2 below). A five percent reduction was considered to take into account current production levels, financial market conditions and assumptions in calculations of need. The 7,700 unit/seven year goal, however, is still ambitious, and it will take some time to overcome barriers to increased production levels. An orderly “ramp up” of policy changes, training, funding and development would be necessary to reach the 7,700 unit goal in seven years.

### A. Methodology to Determine Unmet Need for PSH Units

The Supportive Housing Working Group obtained information from a variety of sources including Continua of Care, government partners, and nonprofit organizations. A program and financial model developed by the Corporation for Supportive Housing (CSH) was used to quantify the need for PSH units and project the costs for creating units to meet that need. The program and financial model is a tool that combines existing community data with the substantial local and national development expertise of CSH and its community partners.

**The Working Group recommends that data on PSH need be updated yearly and that production goals be modified as necessary.**

The CSH program and financial model for PSH goal development is currently the best tool at our disposal because it allows for local data on homelessness to be used as a base for calculations, and allows for use of locally-derived figures for projections of production and operation costs. The Working Group recommends that data on PSH need be updated yearly with Homeless Management Information System (HMIS) and Money Follows the Person (MFP) data, and that production goals be modified as necessary. More accurate data should become available as the Continua of Care implement the HUD-mandated HMIS, and the State implements MFP, which will garner data on efforts to find housing for persons with disabilities, including those who are elderly.

## B. Quantifying Unmet Need for PSH in Illinois

The Working Group focused on two systems to determine the need for PSH in Illinois: the homeless services system's Continua of Care, which conduct a statewide biennial Point in Time (PIT) count of homeless persons in shelters and on streets; and State goals to transition persons in nursing facilities and Nursing Facility Institutions for Mental Disease (NF-IMDs) to community-based housing and services. Persons in prisons were not counted separately, because ex-offenders who have become homeless are already included in the PIT count.

The Working Group decided to go beyond assessing the PSH needs of persons who are homeless to include persons in nursing facilities and NF-IMDs because, in addition to ongoing efforts to transition persons from these facilities back into their communities, the State's MFP Demonstration will transition an additional 3,400 people to community-based housing over the next five years.

In order to determine the total need for units of PSH, the Working Group examined existing supportive housing resources; reviewed data on the number of homeless in the State; utilized national formulas to estimate the annual number of homeless persons; and studied local data on turnover in existing PSH units. Percentages of subpopulations that would likely benefit from PSH were derived from the best data available from Continua of Care and took into consideration the number of persons homeless over the course of a year and percentage of households who were long-term or chronically homeless.

As of September 2007, Illinois had an estimated 6,500 supportive housing units<sup>7</sup>. Only those existing PSH units which become available via turnover each year can be expected to diminish unmet PSH need. The number of existing units of PSH available on an annual basis was subtracted from the estimated PSH units needed to arrive at the total unmet need. The Supportive Housing Working Group estimates that at minimum, there is a current shortage of approximately 8,200 units of PSH in Illinois.

**Table 2: Unmet PSH Need in Illinois<sup>8</sup>**

Subpopulation	Annualized Homeless Households	Percentage that Need PSH	Number that Need PSH	Existing PSH Units	PSH Units Available this Year*	Additional PSH Units Needed
<b>Homeless Households</b>			<b>(a)</b>	<b>(b)</b>		<b>(a) – (b)</b>
<b>Single Adults: Long-Term Homeless</b>	3029	100%	3029	5415	541	<b>4836</b>
<b>Single Adults: Not Long-Term Homeless</b>	23479	10%	2348			
<b>Family Households in Shelter or on Streets</b>	4169	15%	625	1085	108	<b>862</b>
<b>Family Households in Transitional Housing</b>	1379†	25%	345			
<b>Homeless Subtotal</b>	<b>32056</b>		<b>6347</b>	<b>6500</b>	<b>649</b>	<b>5698</b>
<b>Additional Populations with PSH Needs</b>						
<b>Youth Aging Out of Foster Care</b>						<b>500</b>
<b>Persons leaving Nursing Facilities and NF-IMDs</b>						<b>2000</b>
<b>Total Units of PSH Needed in Illinois</b>						<b>8198</b>

\*Existing PSH units multiplied by 10% annual turnover rate of PSH in Illinois (Supportive Housing Providers Association)

†Number of family households in transitional housing at Point-in-Time matches annualized number due to nature of transitional housing program tenure.

<sup>7</sup> Estimate based on Supportive Housing Providers Association data and HUD 2007 Housing Inventory data.

<sup>8</sup> Based on data collected in Illinois' 2007 Point in Time Count of homeless households.

## **1. PSH Need Based on Point in Time Homeless Count**

A recent HUD report<sup>9</sup> based on HMIS data on sheltered persons from October 1, 2006 to September 30, 2007 found that 1,589,000 unduplicated persons experienced homelessness during this period in the United States. This number does not include persons in domestic violence shelters ( these shelter providers are prohibited from entering client information into an HMIS pursuant to the Violence against Women and Department of Justice Reauthorization Act of 2005) and do not include unsheltered persons, so HUD acknowledges in the report that the 1,589,000 figure is low.

Because such data does not necessarily reflect the number of homeless persons in Illinois who need PSH, the Working Group applied a national multiplier to Illinois data. In January 2007, the 21 Continua of Care throughout the State conducted a Point in Time (PIT) count of persons experiencing homelessness in their service areas. In these areas of the State, 15,962 persons experienced homelessness in emergency shelters, transitional housing or on the street on the night of the PIT count. Of this number, 57% were single adults, while 43% were adults and children.

Data on average length of stay was not available from the Continua of Care, so the Working Group used the average of the October 1996 and February 1996 multipliers<sup>10</sup> from the National Survey of Homeless Assistance Providers and Clients (the most recent source of national statistics on homelessness). The multiplier is based on the proportion of homeless adults and children from a PIT count who were homeless within seven days prior to the PIT count, along with the proportion who had an episode of homelessness within the 12 months prior to the PIT count.

The Working Group used Illinois' PIT count results with the multiplier formula to estimate that 32,056 households, whether single or comprised of families, experience homelessness in Illinois over the course of a year. It is further estimated that eleven percent of the single adults who are homeless annually are considered to be "Long-Term Homeless" and therefore very likely to benefit from PSH. Using these estimates, Table 2 presents the unmet PSH need in the State of Illinois based on the State's most recent point-in-time count.

## **2. PSH Need Among Persons in Institutional Care and Youth Aging Out of Foster Care**

Although the Point-in-Time Count does not include persons in nursing facilities and NF-IMDs, it is acknowledged that some persons are homeless upon entry into and/or become homeless upon their exit from institutional care. In addition, the shift toward provision of long-term care in community- versus institutionally-based settings has begun via incentives provided to states by the federal government. This shift was furthered by the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), in which the Supreme Court declared that the unnecessary institutionalization of individuals in public programs may be unconstitutional. Because many of these persons are likely candidates for PSH, quantifying such housing need among persons in nursing facilities and NF-IMDs is critical to setting unit goals.

Under the State's Money Follows the Person Demonstration, approximately 3,400 persons with physical, mental and developmental disabilities will be moved from institutional care to community-based housing over the next 5 years, many of whom would likely benefit from PSH. This information, tempered by realism regarding existing PSH development capacity, leads the Working Group to recommend that an estimated 2,000 units will be needed over the next seven years for persons to move from institutional care to PSH. This need could be met by both newly available leased units and newly

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<sup>9</sup> The Third Annual Homeless Assessment Report to Congress. July 2008. Found at [www.hudhre.info](http://www.hudhre.info)

<sup>10</sup> Burt, M. R. and Wilkins, C. *Estimating the Need: Projecting from Point-in-Time to Annual Estimates of the Number of Homeless People in a Community and Using this Information to Plan for Permanent Supportive Housing*. March 2005.

constructed, preserved or rehabilitated units with subsidies. As additional data becomes available, this goal can be adjusted.

It is also difficult to determine the number of unaccompanied youth who are aging out of foster care and might benefit from PSH. Given that the current inventory of PSH units for youth is limited, the Working Group opted to assume a minimum need for 500 units, which would represent a significant boost in PSH for this population.

### III. PSH Production Targets

In an effort to estimate costs of meeting the seven-year, 7,700-unit production goals, the Working Group examined strategies that could be used to produce the desired units:

- A **leasing** strategy couples existing, privately-owned housing units in the rental housing market with a tenant-based rental voucher or subsidy to achieve affordability, along with access to services.
- A **development** strategy develops units through either acquisition/rehabilitation/preservation of existing units or new construction. Due to the extremely low incomes of most persons in need of PSH, this strategy must often include dedicated rental or operating subsidies to ensure the financial viability of the project.

**Table 3: PSH Production Targets by Strategy and Year**

Unit Type/Size	2009	2010	2011	2012	2013	2014	2015	Totals by Type
<b>Leased or Tenant-Based Units</b>								
0-bedroom	250	320	400	490	590	700	750	3500
3-bedroom	20	30	40	50	60	70	80	350
Subtotal by Year	270	350	440	540	650	770	830	Total Leased: 3850
<b>Development – New, Rehabbed and Preserved Units</b>								
0-bedroom	325	350	400	450	550	650	775	3500
3-bedroom	20	30	40	50	60	70	80	350
Subtotal by Year	345	380	440	500	610	720	855	Total New/Rehab: 3850
<b>Total by Year</b>	<b>615</b>	<b>730</b>	<b>880</b>	<b>1040</b>	<b>1260</b>	<b>1490</b>	<b>1685</b>	<b>Grand Total: 7700</b>

Based on the feasibility of each strategy in Illinois for singles and families, a projected development strategy for the 7,700 units is outlined and described in Table 3. To facilitate cost projections, it is assumed that half of the units would be leased via tenant-based subsidy and half of the units would be either newly constructed or preserved/rehabilitated and matched with dedicated rental or operating subsidies. Based on the proportion of single homeless persons to homeless persons with children, 7,000 units would be sized for single occupancy and 700 would be larger units designed for families. For purposes of simplification, unit size is listed as either 0-bedroom (studio) or 3-bedroom occupancy in Table 3. In reality, units developed should include studios, one-, two-, three- or more bedrooms.

While some buildings will contain 100% PSH units, others will contain a mix of PSH units and affordable, but not supportive, housing units. The actual size of buildings and percentage of PSH will vary based on many factors including the areas of the state in which the housing is being developed; the community need; the financial structure of the project; the developer of the project; and the population being served.

#### IV. Cost of Production

Aside from construction costs, PSH requires a higher level of operating subsidy than standard affordable housing, from which it is also distinguished by the need to build in costs for the provision of supportive services. As defined for this report, PSH tenants should pay no more than 30% of their income for rent. Because most PSH tenants have extremely low incomes, the rent they can pay will not fully support the continuing operating costs of their unit, nor will it provide for supportive services. The three necessary components of PSH funding are defined as follows:

- **Capital** – one-time financing (for PSH, preferably with no debt) that enables construction, preservation or rehabilitation
- **Operating** – dedicated rental or operating subsidies that ensure financial feasibility over the life of a project
- **Services** – funds to ensure supportive services are available on-site and/or in the community for PSH residents

**When estimating the cost of PSH, operating subsidy and services funding costs must be included for each unit**

Table 4 summarizes all three types of financing commitments needed to meet the PSH production goals, and each funding element is described separately along with a list of typical sources. It is important to note that when estimating the cost of PSH, operating subsidy and services funding costs must be included for each unit, regardless of the need for capital financing. There is already PSH in the pipeline that can count toward meeting unit goals for 2009; therefore some of the costs of these units in year one have already been funded.

Please note that Table 4 presents a very simplified cost forecast which only accounts for the cumulative nature of operating and services costs, not their actual per unit increase over time. For this reason, **the Working Group strongly recommends that a more detailed forecast of costs associated with production goals be prepared.**

It is also important to note that each type of financing – capital, operating and services – is accessed through a number of different federal, state or local sources and programs, each with their own application processes and priorities. Some sources “follow” a person, such as Section 8 tenant-based vouchers and Medicaid services, while others, such as tax credits and the State’s supportive housing services line item, are tied to units or buildings. Each of these financing components is discussed beginning on page 11, and typical sources are identified.

**Table 4: Annual Financing Commitments Required to Reach PSH Production Targets**

Financing by Unit Size	2009		2010		2011		2012		2013		2014		2015		7-Year Cost
	No. Units	Cost	No. Units	Cost	No. Units	Cost	No. Units	Cost	No. Units	Cost	No. Units	Cost	No. Units	Cost	
<b>Capital Financing</b>															
Leased 0BR	250	250,000	320	320,000	400	400,000	490	490,000	590	590,000	700	700,000	750	750,000	3,503,250
Leased 3BR	20	20,000	30	30,000	40	40,000	50	50,000	60	60,000	70	70,000	80	80,000	350,330
New/Rehabbed 0BR	325	40,625,000	350	43,750,000	400	50,000,000	450	56,250,000	550	68,750,000	650	81,250,000	775	875,000	437,503,175
New/Rehabbed 3BR	20	4,500,000	30	6,750,000	40	9,000,000	50	11,250,000	60	13,500,000	70	15,750,000	80	18,000,000	78,750,330
<b>Subtotal</b>	<b>615</b>	<b>\$45,395,000</b>	<b>730</b>	<b>\$50,850,000</b>	<b>880</b>	<b>\$59,440,000</b>	<b>1,040</b>	<b>\$68,040,000</b>	<b>1,260</b>	<b>\$82,900,000</b>	<b>1,490</b>	<b>\$97,770,000</b>	<b>1,685</b>	<b>\$115,705,000</b>	<b>\$520,107,085</b>
<b>Operating Financing</b>															
Leased 0BR	250	1,800,000	320	2,304,000	400	2,880,000	490	3,528,000	590	4,248,000	700	5,040,000	750	5,400,000	25,203,250
Leased 3BR	20	216,000	30	324,000	40	432,000	50	540,000	60	648,000	70	756,000	80	864,000	3,780,330
New/Rehabbed 0BR	325	2,340,000	350	2,520,000	400	2,880,000	450	3,240,000	550	3,960,000	650	4,680,000	775	5,580,000	25,203,175
New/Rehabbed 3BR	20	216,000	30	324,000	40	432,000	50	540,000	60	648,000	70	756,000	80	864,000	3,780,330
<b>Subtotal</b>	<b>615</b>	<b>4,572,000</b>	<b>730</b>	<b>5,472,000</b>	<b>880</b>	<b>6,624,000</b>	<b>1,040</b>	<b>7,848,000</b>	<b>1,260</b>	<b>9,504,000</b>	<b>1,490</b>	<b>11,232,000</b>	<b>1,685</b>	<b>12,708,000</b>	<b>57,967,085</b>
<b>Cumulative Totals</b>	<b>615</b>	<b>\$4,572,000</b>	<b>1,345</b>	<b>\$10,044,000</b>	<b>2,225</b>	<b>\$16,668,000</b>	<b>3,265</b>	<b>\$24,516,000</b>	<b>4,525</b>	<b>\$34,020,000</b>	<b>6,015</b>	<b>\$45,252,000</b>	<b>7,700</b>	<b>\$57,960,000</b>	<b>\$193,057,075</b>
<b>Services Financing</b>															
Leased 0BR	250	2,000,000	320	2,560,000	400	3,200,000	490	3,920,000	590	4,720,000	700	5,600,000	750	6,000,000	28,003,250
Leased 3BR	20	200,000	30	300,000	40	400,000	50	500,000	60	600,000	70	700,000	80	800,000	3,500,330
New/Rehabbed 0BR	325	2,600,000	350	2,800,000	400	3,200,000	450	3,240,000	550	4,400,000	650	5,200,000	775	6,200,000	28,003,175
New/Rehabbed 3BR	20	200,000	30	300,000	40	400,000	50	500,000	60	600,000	70	700,000	80	800,000	3,500,330
<b>Subtotal</b>	<b>615</b>	<b>5,000,000</b>	<b>730</b>	<b>5,960,000</b>	<b>880</b>	<b>7,200,000</b>	<b>1,040</b>	<b>8,520,000</b>	<b>1,260</b>	<b>10,320,000</b>	<b>1,490</b>	<b>12,200,000</b>	<b>1,685</b>	<b>13,800,000</b>	<b>63,007,085</b>
<b>Cumulative Totals</b>	<b>615</b>	<b>\$5,000,000</b>	<b>1,345</b>	<b>\$10,960,000</b>	<b>2,225</b>	<b>\$18,160,000</b>	<b>3,265</b>	<b>\$26,680,000</b>	<b>4,525</b>	<b>\$37,000,000</b>	<b>6,015</b>	<b>\$49,200,000</b>	<b>7,700</b>	<b>\$63,000,000</b>	<b>210,025,075</b>
<b>Annual Totals:</b>	<b>615</b>	<b>\$54,967,000</b>	<b>730</b>	<b>\$71,854,000</b>	<b>880</b>	<b>\$94,268,000</b>	<b>1,040</b>	<b>\$119,236,000</b>	<b>1,260</b>	<b>\$153,920,000</b>	<b>1,490</b>	<b>\$192,222,000</b>	<b>1,685</b>	<b>\$236,665,000</b>	
														<b>\$236,665,000</b>	
															<b>\$923,139,085</b>

Capital Assumptions - \$125K for new const/rehab 0BR unit plus \$1K for each leased 0BR unit  
 \$225K for new const/rehab 3BR unit plus \$1K for each leased 3BR unit

Operating Assumptions - \$600 per month for each 0BR and \$900 per month for each 3BR

Services Assumptions - \$8K/year for 0BR and \$10K/year for 3BR

Operating and Services are cumulative costs, i.e. services cost for 1st year units reoccur every year thereafter and so on unless they are fully paid for upfront.

Table 4 doesn't account for increase in rents or services costs over time.

## A. PSH Capital Costs and Sources

The Working Group’s Needs and Numbers Subcommittee consulted with IHDA Multifamily Program staff and decided to base capital cost projections on general averages. The group considered geography, unit size, and average cost of PSH construction from 2000-2007 and determined that **an average of \$125,000 per 0-bedroom unit and \$225,000 per 3-bedroom unit of PSH** in the State was appropriate. These per-unit costs are valid for units developed via acquisition and rehabilitation, preservation or new construction.

For purposes of this analysis, it is assumed that units created through leasing will be private market units that do not require funds for rehabilitation, including existing units made newly available as PSH. However, **Capital Projections in Table 4 reflect the addition of \$1,000 per unit for leased units, to be used as necessary** (e.g., to bring the unit up to quality standards).

**Table 5: PSH Capital Development Costs by Production Strategy and Unit Type**

Production Strategy	Total Units	Total Development Costs			Development Costs Per Unit	
		Single	Family	Total	Single	Family
Leased Units	3850	\$3,500,000	\$350,000	\$3,850,000	\$1,000	\$1,000
Developed Units	3850	\$437,500,000	\$78,750,000	\$516,250,000	\$125,000	\$225,000
<b>TOTALS</b>	<b>7700</b>	<b>\$441,000,000</b>	<b>\$79,100,000</b>	<b>\$520,100,000</b>		

While capital sources for PSH are scarce, they are more attainable than sources for operating and services funding. Although each individual developer will obtain their own sources of capital financing based on the unique needs of the project, it is important to understand that among the variety of possible Federal and State sources for capital funding for PSH, only a few are viable as primary sources while most others are limited due to low allocations, complication in combining with other sources and interest/repayment obligations.

### 1. The most viable primary capital sources are those with zero debt financing.

HUD’s Supportive Housing Program (SHP) is the only funding source created solely for PSH. Recipients must match grants for acquisition, rehabilitation, and new construction with an equal amount of funds (cash or in-kind) from nonfederal sources (except CDBG funds). Because much of the annual SHP funding goes toward renewals of support for existing SHP units, PSH advocates have looked toward other sources that are flexible enough for PSH development. The HOME Program is one such source, but it is allocated to participating jurisdictions with their own established priorities for funding, making a uniform approach to accessing HOME funds difficult. The Illinois Affordable Housing Trust Fund has helped finance hundreds of units of PSH due to its relatively flexible financing terms, but with revenues negatively impacted by the real estate market downturn, Trust Fund dollars are significantly reduced not only for PSH, but also for other types of affordable housing. Low-Income Housing Tax Credits (LIHTCs) have shown potential for creating set-asides of PSH units within larger complexes, but LIHTC projects with a majority of units intended as PSH are very hard to achieve during a real estate downturn, as investors become more selective.

### 2. Other sources are used less frequently due to debt obligations or limits on funding, but can be used as a component of PSH financing.

Four percent Tax Credits and bonds carry debt obligations that make them highly unlikely components of PSH financing. Programs such as Community Development Block Grant and Section 811 either have limits on how they can be used or in the amount of funding available. For example, HUD’s Section 811 program funded only 6 units for persons with mental illness in Illinois in 2007. Housing Opportunities for Persons with AIDS (HOPWA) and the Federal Home Loan Bank’s Affordable Housing Program also produce some, but not many, PSH units.

## **B. PSH Operating Costs and Sources**

In analysis of operating costs, it was assumed that Fair Market Rents will be paid for all units. This assumes that either tenants are able to pay this rental amount or a rental subsidy will assist in paying for the unit. The Operating Financing calculation in Table 4 assumes that operating costs for single occupancy units will be \$600 per month or \$7,200 per year, and that operating costs for three bedroom family units will be \$900 per month or \$10,800 per year. These assumptions are based on per-unit costs of operating subsidies such as Shelter Plus Care and Project-Based Section 8, as well as HUD's proposed 2009 Fair Market Rents. The cost of operating subsidies is cumulative, as the subsidies on units funded in year one would be continued to house PSH tenants, even as more units with operating subsidies are added in future years.

If such subsidies cannot be obtained for all units, an operating deficit reserve (typically funded via an increase in capital funds allocated to the project) can be created to offset any shortfalls in revenue. In addition to subsidies that may be required to support units developed via rehabilitation, preservation or new construction, rental subsidies will also be required for units developed via leasing.

As with capital dollars, there are a variety of potential sources for operating subsidy funding for PSH, and some are more viable than others.

### **1. The most viable primary operating subsidy sources are those that are committed to the PSH project.**

Again, the SHP is the only funding source created solely for PSH and an SHP award includes operating subsidy, but the renewals of operating subsidy for existing SHP projects makes funding for new projects very limited. Although many of these units may be developed through the acquisition and project-basing of Section 8 housing vouchers, it is likely that there will not be enough available vouchers to cover the extent of the need. The development of local voucher subsidy programs or other operating funding sources will likely be necessary, and the federal Section 8 program should be expanded or supplemented by a program specifically for PSH.

### **2. Other sources are used less frequently due to limits on funding, but are very useful when available.**

Illinois' Rental Housing Support Program includes a small allocation for Long-Term Operating Support. While this program committed operating subsidy for 60 units in 2008, it is expected to assist less units in future years due to reduced RHSP funds. Section 811 and HOPWA funds are very limited, as is Shelter + Care, a HUD program to provide rental assistance and services to single persons with disabilities who are homeless. HOME-funded Tenant Based Rental Assistance is offered in a few participating jurisdictions, but it is not designed to offer long-term rental subsidies.

## **C. PSH Services Costs and Sources**

The Plan also assumes that service costs for individuals living in single units will be \$8,000 per year and that services costs for families living in three bedroom units will be \$10,000 per year. These estimates reflect costs to provide case management, whether on-site or in the community. Because PSH residents' services needs vary among persons and over time, many will continue to access services in the community in addition to case management, such as Medicaid-funded mental health services.

As with operating subsidies, the cost of services is cumulative, i.e. services costs for units funded in year one reoccur every year thereafter unless they are fully funded upfront for the life of the project. While a resident in year one may eventually move on, another resident with more or less services needs will take his/her place.

Therefore, as numbers of units increase, so do the total services costs. The per unit services costs could potentially be reduced, however, by a move toward a brokered model of case management.

**Permanent supportive housing reduces costs incurred by other service providers currently treating the chronically homeless.**

However, the net additional cost to society of new supportive housing is very small because PSH reduces costs incurred by other service providers currently treating the chronically homeless. Note that the combined yearly operating and services cost per individual in a single PSH unit is \$15,400. On the other hand, one must consider the potential savings to emergency and institutional care systems generated by bringing a homeless person with a mental illness or addiction problem into a supportive housing development.

A well known case study<sup>11</sup> comparing pre- and post-supportive housing placement in New York City as well as preliminary data from a similar study<sup>12</sup> underway in Illinois supports the assertion that emergency services utilization decreases with PSH placement. This suggests that the true cost of providing ongoing supportive housing (operating and services costs) to 615 individuals in 2009 is not the \$9.57 million shown because the savings from reduced emergency services utilization are not reflected.

Funding streams for other systems, such as nursing care facilities and correctional institutions, currently do not have the immediate flexibility to contribute directly to the operational or service costs of supportive housing, despite, for instance, the evidence that PSH can prevent recidivism. However, the potential exists for substantial savings in State general revenue costs with long-term planning to shift resources.

Supportive services are critical to the success of a PSH project, yet they are often the most difficult aspect to fund. This is due in part to most services being paid for based on each individual person's diagnosis and/or qualification for types of services.

**Medicaid-funded services**, for example, cannot be committed to a housing unit for the life of the project unless the unit of housing is licensed or certified – in other words, unless only people who are eligible for the services reside in the unit. In PSH, residents may remain in the housing regardless of evolving services needs, making licensure for Medicaid unlikely and undesirable.

Through advocacy, funding has been increased modestly in the last two years to the United States Department of Health and Human Services **Substance Abuse and Mental Health Services Administration (SAMHSA) line item called Grants for the Benefit of Homeless Individuals**. Other mainstream programs at the federal level have not stepped up efforts to provide services funding in Supportive Housing.

The **State budget has a Supportive Housing Services line item** that funds services in over 4,414 existing PSH units serving the general homeless populations, which also supplements Medicaid funding for individuals with mental illness living in PSH<sup>13</sup>.

**HUD's Supportive Housing Program (SHP)** also funds the services along with the capital and operating subsidy as a package. However, as mentioned before, SHP funding is very limited, requires a non-federal match, and a large portion of annual funding goes toward existing, not new SHP projects.

Some **local programs** offer services, including faith-based organizations such as Lutheran Family Services. Unfortunately there is no guarantee that community-based programs can make sustained commitments to serving PSH residents due to the typical budgeting challenges faced by nonprofits.

<sup>11</sup> Culhane, Dennis; Metraux, Stephen, and Hadley, Trevor. (2002) "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing." *Housing Policy Debate*. Volume 13, Issue 1.

<sup>12</sup> Chicago Housing and Health Partnership

<sup>13</sup> Illinois' Supportive Housing Providers Association (SHPA)

## V. Current Capacity-Building Efforts

While the level of need for and interest in PSH is high, development capacity is an issue. The following are some of the technical assistance efforts that are essential to building adequate local capacity for developing and managing PSH.

### A. Corporation for Supportive Housing's Supportive Housing Institute

Corporation for Supportive Housing (CSH) offers pre-development loans, grants, technical assistance and trainings to non-profit organizations developing PSH for people who are homeless and disabled. CSH's Supportive Housing Institutes build the capacity of PSH providers in Illinois through a series of trainings to assist them in developing specific projects for their communities. To date, CSH has conducted two rounds of training and technical assistance to participating development teams through the Institute, which is supported by the Illinois Affordable Housing Trust Fund.

**Teams...are provided with guidance, tools and detailed plans needed to develop and implement supportive housing programs.**

The teams selected are provided with guidance, tools and detailed plans needed to develop and implement supportive housing programs. Trainings include guest speakers from the field and IHDA, and are highly interactive. All teams receive individualized TA from CSH staff throughout the institute. Participation is limited to 10 teams, and priority is given to projects that will serve families and individuals who are chronically homeless. Participants have access to limited CSH pre-development financing for these projects.

Of the teams selected, 80% are outside the City of Chicago, identified as the neediest areas for such capacity building. In total, teams from the first round of training completed in March 2007 proposed over 300 units of supportive housing at sites in Chicago, Monmouth, Oak Park, Danville, DuPage County, Metropolis, Marion and Niles. Participants for the Fall 2007/Winter 2008 Institute included five teams in the Chicago metro-area including two in Chicago, two in Northern Illinois and one in Will/Kane County. Six additional teams were from southern Illinois including East St Louis, Mounds, Red Bud, Mt Vernon, DuQuoin, and Decatur. This second round of Institute trainings concluded in March 2008, and participants are proposing 283 units of supportive housing. With funding from the Illinois Affordable Housing Trust Fund, CSH has made \$400,000 in pre-development loans to agencies that have graduated from the Institute.

To reach out to affordable housing developers who do not traditionally create supportive housing, on November 6, 2007, CSH, Illinois Department of Human Services (IHDS) – Division of Mental Health (DMH) and IHDA held a training with affordable housing developers to increase interest in and discuss barriers to developing more housing for persons with mental illness.

### B. IHDA/IDHS Referral Networks

IHDA and IDHS have partnered to develop regional referral networks which will serve to increase access to affordable, accessible housing being developed, as well as other housing-related programs for persons with disabilities and households that are homeless or at-risk of homelessness. The networks will bring together local services providers, primarily funded by Medicaid, who are working with persons with any types of disabilities, including any providers working to transition MFP participants into community-based housing such as new or existing PSH.

These groups will collaborate to implement Referral and Support Plans for future units funded under the Low-Income Housing Tax Credit (LIHTC) Program that are targeted to these populations (see XIII. State Level Plans below), collectively working to assure that tenants living in a particular development have access to services they may need to live successfully in the community. In addition, these cross-disability networks will provide opportunities for education around rights of persons with disabilities under fair housing laws as well as

information sharing about different housing and Home and Community Based Services (HCBS) programs in their area.

### **C. Illinois Division of Mental Health PSH Initiatives**

The IDHS – Division of Mental Health (DMH) has committed to develop an array of PSH consistent with the flexible needs of its consumers. This policy will be associated with other new initiatives such as the Money Follows the Person (MFP) Demonstration and Supportive Employment. The Division’s approach will include the new construction, preservation or acquisition/rehabilitation of PSH units through new partnerships with housing developers, IHDA, and other financial intermediaries, as well as assisting consumers to lease scattered-site rental housing, including studio/efficiency units, one bedroom units, and shared apartments. By increasing the supply of decent, safe and affordable PSH units, and tracking these units through a housing stock database, DMH will significantly improve its capacity to help consumers obtain permanent housing that meets their preferences and needs.

### **D. Quality Standards**

The Supportive Housing Providers Association (SHPA) is the statewide association of providers of supportive housing and entities planning to develop supportive housing. SHPA’s 98 not-for-profit and for-profit members from across the State have quarterly meetings that feature capacity-building topics and the latest information on trainings and available funding sources. SHPA members, in partnership with the Corporation for Supportive Housing (CSH), have formed the Supportive Housing Standards and Best Practices Committee to develop standards and guidelines of best practices for supportive housing in Illinois. Consisting of a cross-section of supportive housing staff and residents from across the state, the Committee is adapting the Seven Dimensions of Quality that CSH developed nationally on Administration, Management and Coordination; Physical Environment; Access to Housing and Services; Tenant Rights, Input and Leadership; Supportive Service Design and Delivery; Property Management and Asset Management Activities; and Data, Documentation and Evaluation; to develop Illinois standards of Quality for PSH. The Supportive Housing Standards and Best Practices Committee meets regularly and plans to present its recommended standards to the Illinois Housing Task Force in Fall 2008. CSH will offer trainings and self-assessment assistance to providers striving to comply with the agreed-upon quality standards.

### **E. IDHS Bureau of Homeless Services and Supportive Housing**

Two of the four programs administered by the Bureau provide supportive services through local not-for-profit organizations in order to prevent or end homelessness. These programs ensure that people receive quality supportive services to assist them in gaining self-sufficiency and permanent housing. The Homeless Prevention Program is designed to stabilize families in their existing homes, shorten the amount of time that families stay in a shelter, and to assist families with securing affordable housing to prevent homelessness. The Supportive Housing Program provides State funds for services coupled with permanent housing to homeless and formerly homeless individuals and families. Local governments, community organizations and not-for-profit agencies provide case management, alcohol and substance abuse treatment, mental health programs, education and training, transportation, child care and other services needed by residents of transitional facilities, single room occupancy facilities and family developments.

## VI. Barriers

The Working Group identified the following barriers that have prevented the development of an adequate supply of PSH in Illinois.

### A. Barriers Related to Policies and Limited Coordination and Capacity

- 1. Complex and multiple funding requirements** for projects. Funding for capital, operating, and services for PSH comes from many different state, federal, and occasionally private sources. Most sources have separate application processes as well as different areas of focus, deadlines, and reporting systems. A great deal of staff time must be devoted to complying with each source.
- 2. Significant upfront development costs** which must be incurred by providers with no assurance of obtaining all the necessary pieces of funding, often putting their agencies at risk. In addition, State services funding is not assured beyond the current year, requiring a large leap of faith on the part of developers and services providers.
- 3. Need for coordinated and focused public policy** to address supportive housing needs (creation of PSH, funding ongoing services, incentives for communities to permit the siting of PSH projects within their boundaries, ensuring that code enforcement for PSH is handled in a manner consistent with Fair Housing laws). Lack of metrics to track development and encourage increased capacity.
- 4. The stigma attached to supportive housing populations** (particularly mental health consumers) and their ability to recover and function in the community, which can deter developers, some Public Housing Authorities and others from backing PSH development.
- 5. All of these barriers have contributed to limited PSH development capacity** and low enticement of mainstream developers to engage in PSH development.
- 6. Limited PHA Participation in Continua.** Many local housing authorities do not participate in their local Continuum of Care. Since in many areas, the public housing authority is the largest source of subsidized housing for families and individuals who are homeless, this absence of working together reduces the operating support that could be available for PSH and access to housing vouchers through allowable preferences.
- 7. Inaccessibility of Balance of State Housing Vouchers.** Providers of PSH have found it difficult to access the limited number (approximately 250) of Housing Choice Vouchers administered by the Department of Commerce and Economic Opportunity (DCEO) for individuals who reside either in areas that have no local housing authority, or where local housing authorities are agreeable to DCEO's provision of vouchers in their jurisdiction. There is a need for DCEO to better coordinate the allocation of these resources with comprehensive housing planning efforts to further development of a statewide housing policy.

**All of these barriers have contributed to limited PSH development capacity and low enticement of mainstream developers to engage in PSH development**

## B. Barriers Related to Inadequate Funding Levels

1. **Inadequate federal, state and local funding** for PSH development, for capital costs, operating support, and funding supportive services.
2. **Systemic Funding Policy.** The foci on reducing institutional care and increasing PSH are two sides of the same coin. It is difficult to increase PSH without the resources currently committed to institutional care and it is difficult to reduce institutional care without increasing PSH. Both of these goals must be pursued in tandem. A clear policy and thoughtful plan that incrementally reduces institutional capacity while simultaneously increasing the supply of PSH is essential.

**A clear policy and thoughtful plan that incrementally reduces institutional capacity while simultaneously increasing the supply of PSH is essential.**
3. **Loss of Federal Funding for Services.** HUD has reduced its funding of supportive housing services, and the US Department of Health and Human Services (HHS) has not yet taken on the direct funding of these supportive housing services. Advocates are now working with Congress to authorize and fund a proposed program specifically for funding services in supportive housing. This program is part of the proposed Substance Abuse and Mental Health Services Administration (SAMHSA) reauthorization. Through advocacy, funding has been increased modestly in the last two years to the HHS SAMHSA line item called Grants for the Benefit of Homeless Individuals. Other mainstream programs at the federal level have not stepped up efforts to provide services funding in Supportive Housing.
4. **Limited Continuum of Care Funding for New Projects.** Securing funding for any new project, including operating support is a special challenge for Supportive Housing providers because operating support for ongoing Supportive Housing projects' renewals continues to be taken out of the same federal funding source allocation (HUD SHP) as operating support for new Supportive Housing projects. This reduces the amount of funding for new projects. In addition, the federal priority to focus on "chronically homeless," has meant that most new projects must serve the chronically homeless exclusively rather than on serving other equally needy populations, including families and others that do not fit the narrow definition.
5. **Limited Rental Subsidies.** The Illinois Rental Housing Support Program (RHSP) provides much-needed rental subsidy, some of which will go to Supportive Housing<sup>14</sup>. However, once this program is in place across the State, the only subsidy it will provide for new Supportive Housing is the small Long-Term Operating Support portion of the program, a source which many other affordable housing projects (without services) will also seek.
6. **Vulnerability to Housing Market Downturns.** Due to the weakening economy and soft housing market, fewer investors/syndicators are opting to purchase Low-Income Housing Tax Credits, upon which developers increasingly rely to produce Supportive Housing. With syndicators being more selective about the standard Tax Credit deals in which they invest, the comparatively smaller and more expensive Supportive Housing projects seem even less viable.

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<sup>14</sup> 30% of Local Administering Agencies RHSP-assisted units are targeted to special needs populations.

## VII. Recommendations

Each of the following recommendations is followed by the barrier(s) addressed.

### A. Federal Advocacy Around Housing and Services Legislation and Funding

**Barriers Addressed: Loss of Federal Funding for Services, Limited Continuum of Care Funding for New Projects, Limited Rental Subsidies, Vulnerability to Housing Market Downturns, Systemic Funding Policy**

Federal funding is integral to creation and ongoing operation of supportive housing and services, and several pieces of federal programs are relevant to the State's ability to maintain existing housing stock while increasing the supply of supportive housing. The Working Group recommends that the Housing Task Force urge the Governor to support federal legislation that will result in creation, expansion and ongoing operation of supportive housing and services, including but not limited to McKinney Vento and Section 8 appropriations, HUD 811 program (with its new rules to enhance ability to pair it with other types of funding), US Department of Health and Human Services line items, special purpose housing vouchers, and the HOME and Community Development Block Grant Programs.

### B. Federal Advocacy for New Consolidated PSH Funding Program

**Barriers Addressed: Loss of Federal Funding for Services, Complex and Multiple Funding Requirements, Significant Upfront Development Costs**

Advocate for a new HUD supportive housing production program that would set aside \$2.5 billion nationally and could net Illinois at least \$100 million per year (4% of the national total, based on Illinois' population as a percentage of the nation's) to meet its needs. The program should integrate capital, operating support and services funding into one funding application. A new administration in 2009 could present an opportunity to make supportive housing production a priority. Illinois should be ready with an action plan if new federal resources become available.

### C. Improved Coordination Among IHDA, City of Chicago, DCEO, IDHS, DOC, Continua of Care

**Barriers Addressed: Complex and Multiple Funding Requirements, Significant Upfront Development Costs, Need for Coordinated and Focused Public Policy, Limited Inaccessible Balance of State Housing Vouchers, Stigma attached to Supportive Housing Populations, Systemic Funding Policy**

The State's major affordable housing and services programs as well as Corrections should establish more formal communication regarding PSH in order to increase cross-agency awareness of available funds or vouchers and upcoming PSH applications for both State and federal funding sources. This will increase the ability to streamline and coordinate funding policies and processes as well as opportunities to meet various State Plan goals for jointly funded PSH. It will also open communication regarding Housing Vouchers administered by DCEO and help agencies develop a coordinated approach to localities that resist development of PSH. Finally, the agencies could develop a coordinated policy to increase housing "unbundled" from services, discouraging practices that sometimes occur when the services provider is the property manager, such as ending a lease if the PSH tenant chooses a different services provider, or requiring participation in services.

#### **D. Improved Coordination Among Local Housing Authorities and Continua of Care**

##### **Barriers Addressed: Limited PHA Participation in Continua of Care, Inaccessible Housing Vouchers, Need for Coordinated and Focused Public Policy**

Local Housing Authorities are under tremendous pressure to serve a maximum number of people with dwindling administrative funding, making it difficult to allocate staff time to administration of allowable waitlist preferences or coordination with local services providers. It is just this environment in which coordination is most important – to work together with local providers to bring the maximum possible resources to the community and to ensure that residents have access to supportive services that increase their housing stability, both of which could ultimately reduce demands on housing authority staff time.

#### **E. Identify a Supportive Housing Point Person within IHDA**

##### **Barriers Addressed: Complex and Multiple Funding Requirements, Significant Upfront Development Costs, Need for Coordinated and Focused Public Policy**

IHDA manages major federal and State housing funds that have been essential to PSH development in our State. It would be useful to identify staff to work across departments within IHDA to develop a consistent approach within IHDA toward PSH development, and to track PSH funding applications and developments. This approach could address coordination with Continua of Care, Public Housing Authorities and Supportive Housing Institute teams regarding upcoming applications for federal as well as IHDA-managed funding.

#### **F. Use Illinois Affordable Housing Trust Fund Dollars for Housing Development, Not Services**

##### **Barriers Addressed: Inadequate Federal, State and Local Funding, Vulnerability to Housing Market Downturns**

The Illinois Affordable Housing Trust Fund is a valuable source of funding for many types of affordable housing, but is especially critical for PSH development since the housing market downturn is making already-complicated PSH deals funded with Low-Income Housing Tax Credits even more scarce. While the Supportive Housing Working Group is in strong agreement about the importance of services programs that have recently been allocated Housing Trust Fund dollars, the Working Group agrees that those programs should be supported by other sources so that the Housing Trust Fund can finance more affordable housing, including PSH.

#### **G. Identify and Replicate PSH Production Models with State-Funded Pilot PSH Development Program**

##### **Barriers Addressed: Inadequate Federal, State and Local Funding, Limited Rental Subsidies, Stigma Attached to Supportive Housing Populations, Limited Supportive Housing Development Capacity, Significant Upfront Development Costs**

PSH models already exist in Illinois and in other States. In Chicago, a local company that owns and manages market rate housing partnered with services agencies and the City Department of Housing to renovate unused basement space into accessible housing affordable to persons with disabilities who were homeless<sup>15</sup>. This created integrated housing out of existing space while adding to the revenue received by the building owners. The model could be replicated in urban areas fairly quickly with the coordinated support of funders and policy makers.

North Carolina's General Assembly created the Housing 400 Initiative, providing capital dollars to NC Housing Finance Agency and operating funding to NC Department of Health and Services, and directing the two agencies to work together to create 400 new units of PSH. The agencies settled on several strategies

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<sup>15</sup> <http://abclocal.go.com/wls/story?section=news/local&id=6252912>

including mandating PSH set-asides for affordable properties receiving preservation funds, layering the operating subsidy on units in LIHTC properties set-aside for PSH, and funding new construction, preservation or acquisition/rehab of 100% PSH developments with 15 or fewer units. Illinois could take such a production program even further by offering potential developers a set of four to five models of PSH, including architectural plans, policies and procedures, etc. that can be replicated throughout the State. Although plans would have to be adjusted to fit local sites, it would help alleviate some of the predevelopment costs that exacerbate PSH development capacity issues.

## **H. Create New or Expand Existing Operating Subsidy Sources**

### **Barriers Addressed: Inadequate Federal, State and Local Funding, Limited Rental Subsidies, Stigma Attached to Supportive Housing Populations**

The State-funded Rental Housing Support Program has a small Long-Term Operating Subsidy Program component. Sixty units were funded with LTOS in 2008 but it is likely only approximately 30 new units will be funded in 2009. The Supportive Housing Working Group recommends an expansion of LTOS with changes to allow it to be targeted to PSH, or a new program to accomplish the same. If some of the operating subsidies are tied to already affordable housing financed by IHDA such as targeted Low Income Housing Tax Credit PSH units created through new incentives in the 2008-2009 Qualified Allocation Plan, the program could be efficiently administered and funds spread further to serve more households, in more integrated settings, avoiding the issue of stigma met by new PSH developments. This strategy, along with more LTOS or other operating subsidy to apply to newly-constructed – both integrated and stand-alone – PSH units, would be a very efficient way to create more PSH.

## **VIII. State-Level Plans**

Efforts to coordinate with State-level plans are ongoing through the work of the Illinois Housing Task Force, the Older Adult Services Advisory Committee, the Disability Services Advisory Committee and other State-level, inter-agency forums. Many of the individuals targeted by the State's Money Follows the Person Demonstration, an interagency, cross-disability effort, will be candidates for PSH units. The following is an overview of how an increase in PSH meets the goals of State-level plans.

### **A. Illinois Money Follows the Person Operational Protocol**

Before Illinois could transition one person under the MFP Demonstration, the State agency partners went through a planning process with a high level of consumer and stakeholder input. The process produced an **Operational Protocol (OP)** that was submitted for intensive review and was approved by Centers for Medicaid and Medicare Services (CMS) on June 30, 2008. The OP is the design of the MFP Demonstration, detailing processes that will be followed and changes that will be made to further the delivery of community-based long-term care services.

The OP, as required by CMS, describes the strategies that will be used to assure, or expand, availability of affordable and accessible housing options that serve as qualified residences for the approximately 3,400 persons who will transition to community-based housing under Illinois' MFP Demonstration. The housing strategy section of Illinois' OP is focused on allowing for policies and practices that support assisting the individual to move into situations that reflect the highest possible levels of personal choice and ownership.

The Illinois Housing Task Force's Supportive Housing Working Group's production goals for increased PSH are detailed in the OP under a required section on strategies the State is pursuing to promote availability, affordability or accessibility of housing for MFP participants. To that end, the expectation is that most MFP participants will seek apartments with individual leases, including many who seek PSH. The Supportive Housing Working Group, as described in Section II (PSH Unit Goals) has included MFP participants in its production goals for PSH.

## **B. Illinois Low-Income Housing Tax Credit Qualified Allocation Plan**

Several of IHDA's changes to the 2008-2009 Qualified Allocation Plan reflect the Supportive Housing Working Group's PSH definition and principles, and incentivize a range of PSH development using Low-Income Housing Tax Credit funding.

## **C. Illinois Disabilities Services Plan and Disability Services Advisory Committee Recommendations**

The Disabilities Services Plan developed by the DSAC and submitted to the Governor's Office in March 2006 provides a framework for change to improve Illinois' compliance with both the Americans with Disabilities Act (ADA) and the Olmstead decision. In November and December 2007, DSAC met to initiate planning for 2008 activities: 1) to formulate recommendations for the Governor and 2) to provide input into implementation of the Illinois Money Follow the Person Demonstration. Recommendations, submitted to the Governor's Office in January 2008, include \$3 million recurring funding for a cross-disability, long-term bridge rental subsidy program for persons with disabilities who are transitioning from institutional care, and a \$2 million increase in annual funding to expand options for supported community-based housing for persons with mental illness choosing to live in the community. Both of these recommendations speak to the need for increased access to PSH.

## **D. Older Adult Services Advisory Committee's 2008 Report to the General Assembly**

The Third Report to the Illinois General Assembly from the Illinois Department of Aging (IDoA) was sent in January 2008 in compliance with the Older Adult Services Act (P.A. 093-1031). Goals include improving services for older adults in the State, including reduction of the number of persons in nursing homes across the State and the encouragement of assisted and supported living facilities, as well as increasing home- and community- based living and service opportunities for older adults. Increased supportive housing will further these goals by creating more community-based living options.

## **E. Community Safety and Reentry Commission's May 2008 Report "Inside Out: A Plan to Reduce Recidivism and Improve Public Safety"**

The Commission's recommendations on housing include developing new supportive housing units for persons with mental illness, HIV/AIDS or substance abuse issues. A specific recommendation was made to issue a request for proposals with funding from multiple State agencies to fund 100 PSH units for re-entering individuals. The funding would cover capital costs, operating subsidies and services. The report recommends strategies to remove barriers to housing for ex-offenders that are similar to the Supportive Housing Working Group's recommendations, such as advocacy for additional housing vouchers.

## **F. Illinois Department of Public Health HIV/AIDS Housing Plan**

The Illinois HIV/AIDS Housing Plan: A HOPWA Program Planning Tool for the State of Illinois, was published in October 2006. It contains a Strategic Plan which includes recommendations for the HOPWA and Ryan White CARE Act Programs, which provide short-term housing assistance<sup>16</sup> to persons with HIV/AIDS, as well as the following recommendations to increase access to housing resources:

- Strengthen HIV/AIDS housing advocates' participation in local and State planning processes to leverage HOPWA funding and partnerships to increase housing access for people with HIV/AIDS.
- Increase collaboration with other service systems in the creation of housing opportunities, including development projects and/or set-asides.
- Advocate for less restrictive housing authority eligibility guidelines for people with criminal histories.
- Increase access to long-term rental assistance programs for people living with HIV/AIDS, including Shelter Plus Care, project-based Section 8, and the Illinois Rental Housing Support Program.

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<sup>16</sup> Effective March 2008, Ryan White housing assistance now has a 24-month lifetime limit per household.

## **G. Illinois Division of Mental Health Housing Policy**

As referenced under Section V (Current Capacity Building Efforts), Illinois Department of Human Services – Division of Mental Health has developed a housing policy statement<sup>17</sup> that is centered on increased access to PSH: “The Department of Human Services, Division of Mental Health is committed to, as a priority toward systems rebalancing, the development and expansion of Permanent Support Housing (PSH) for individuals who meet defined criteria of eligibility and who are diagnosed with a serious mental illness. The goal of this initiative is to promote and stabilize consumer Recovery with elective support services in one’s leased or owned home that (1) provides safety, (2) ensures comfort and decency and (3) is financially manageable within the resources that the consumer has available.”

## **IX. Summary**

The Supportive Housing Working Group urges the Illinois Housing Task Force to recommend to the Governor that Illinois adopt a seven-year Supportive Housing Action Plan which would include:

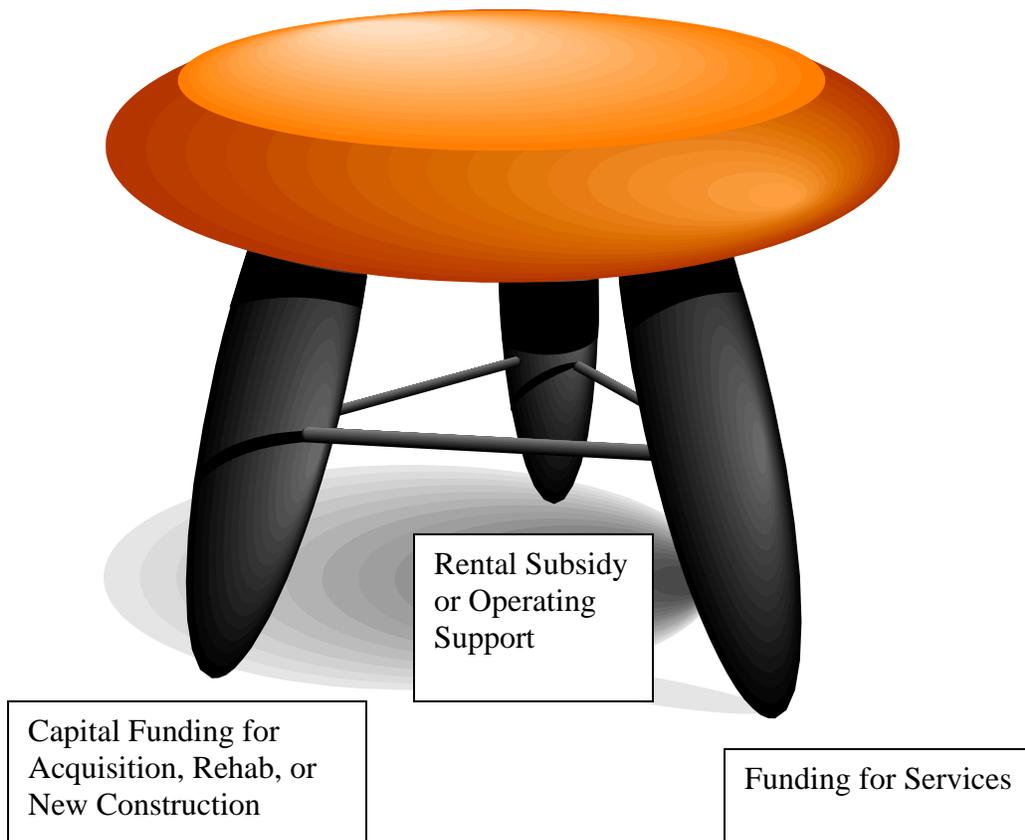
- Specific targets for the creation and/or support of supportive housing units
- Ongoing quality control measures for supportive housing operations
- Specific plans for training and development of supportive housing providers
- Programs aimed at overcoming local resistance to the establishment of supportive housing facilities.

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<sup>17</sup> Visit [www.dhs.state.il.us/page.aspx?item=38631](http://www.dhs.state.il.us/page.aspx?item=38631) and click on DMH Housing Policy.

## Attachment D

### Funding Needed for Supportive Housing



FY 2011 New Supportive Housing List								
								Line Item Name
								Supportive Mentally Ill Housing
Organization	Project Name/ Location	Who Serve	# served	# units	Additional Description	Federal Funding	Needed State Funding	Legislators
AIDS Foundation of Chicago 411 S. Wells Street, Suite 300 Chicago, IL 60607 Mark Ishaug, Executive Director Angelique N. Miller, Contact, Housing Director 312-334-0926	AFC Supportive Housing for Health Partnership- HUD Bonus Project	Homeless individuals with HIV/AIDS	135	135	Scattered sites	HUD SHP Bonus Project (pending)		Rep. Kenneth Dunkin, D Sen. Mattie Hunter, D
Alexian Brothers Bonaventure House/The Harbor 825 W. Wellington Ave. Chicago, IL 60657-5123 Bart Winters, Executive Dir. 773-327-9921 x130 bwinters@abam.org Martin Hansen 773-327-9921 x123 mhansen@abam.org	Bettendorf Place 8425 S. Saginaw Ave. Chicago, IL 60617	Homeless individuals with HIV/AIDS, mental illness, veterans, substance abuse disorders	23	24	Rehab	IHDA HOME-\$921,884 Chicago LIHTC- \$1,030,750 (Currently seeking investors for the tax credits.) Equity Bridge Loan- \$2.4M Fdn. Grant-\$100,000 Deferred Developer Fee- \$78,250		Rep. Marlow Colvin, D Sen. Donne Trotter, D
Chestnut Health Systems 50 Northgate Industrial Drive Granite City, IL 62040 Orville Mercer, Southern Region Manager 618-877-4420 omerger@chestnut.org Amy Gibbar, Contact 618-877-4420 agibbar@chestnut.org	The Road to Recovery Madison County	Homeless Individuals with mental illness and substance abuse disorders, some veterans.	20	16	Rehab	Local Government HOME funds		Rep. Daniel Beiser D Rep. Jay Hoffman D Sen. William Haine D
Cornerstone Services 777 Joyce Road Joliet, IL 60436 Jim Hogan, President/CEO 815-741-7080 jhogan@cornerstoneservices.org Benjamin T. Stortz, Contact 815-741-7042 bstortz@cornerstoneservices.org	Housing Opportunities for Persons with AIDS and Mental Illness	Homeless families and individuals with mental illness, HIV/AIDS, and/or physically disabled, victims of domestic violence, or substance abuse disorders.	25	18	Scattered sites	DMH Bridge Subsidy Program		Rep. Jack McGuire, D Sen. AJ Wilhelmi, D
Human Support Services 988 N. Illinois Route 3 Waterloo, IL 62298 Robert J. Cole, Executive Director 618-939-4444 x211 rcole@hss1.org Deb West, Contact 618-939-4444 dwest@hss1.org	Supportive Apartment Living Program II Monroe County scattered sites	Individuals and families with mental illness	15	15	Scattered site rental			Rep. Dan Reitz, D Sen. David Luechtefeld, R
Mental Health Center of Champaign County 1801 Fox Drive Champaign, IL 61820 Sheila Ferguson, Executive Director 217-398-8080 sferguson@mhcenter.org Lisa Benson, Contact 217-693-4627 lbenson@mhcenter.org	Homelessness to Supported Housing Scattered sites in Champaign County	Homeless individuals and families with mental illness	40	24	Scattered sites			Rep. Naomi Jakobsson, D Sen. Michael Frerichs, D

Organization	Project Name/ Location	Who Serve	# served	# units	Additional Description	Federal Funding	Needed State Funding	Legislators
<p>Mercy Housing Lakefront 247 S. State, Suite 810 Chicago, IL 60604 Cindy Holler, Pres./CEO 312-447-4710 choller@mercyhousing.org Felix R. Matlock &amp; Maria Kamenaki, Contacts 312-447-4532; 312-447-4620 fmatlock@mercyhousing.org, mkamenaki@mercyhousing.org</p>	<p>Englewood Project 901 W. 63rd St. Chicago, IL 60621</p>	Homeless individuals	50	50	New construction Part of Mayor Daley's Supportive Housing Initiative	<p>IL Clean Energy Fdn - \$267,000 Chgo Dept of Envirn- \$200,000 IDCEO-\$157,000 State Donation Tax Credit-\$255,000 Deferred Developer Fee- \$305,000 IHDA HOME-\$2M Chgo TIF-\$2M DOH Tax Credits- \$11.5M</p>		Rep. Esther Golar, D Sen. Mattie Hunter, D
<p>A Safe Haven 180 W. Washington Street, Suite 1000 Chicago, IL 60602 Brian Rowland Executive Director 312-372-6707 browland@asafehaven.com Mike Kirk, Contact 312-372-6707, Option 5 mikek@asafehaven.com</p>	<p>Homeless Veterans Transitional and Supportive Housing 2049 W. Jarvis Chicago, IL 60626</p>	Homeless veterans with substance abuse disorders	25	25	Expansion of existing project Mixed populations			Rep. Harry Osterman, D Sen. Heather Steans, D
<p>Janet Wattles Center 526 W. State Street Rockford, IL 61101 Frank H. Ware President 815-968-9300 Fware@janetwattles.org</p>	<p>Homeless Supportive Housing 215 Carlton Terrance, Rockford 4802 Javelin Drive</p>	Individuals with mental illness	11	11	Expansion of existing project	Agency-\$130,695 \$259,336		Rep. Chuck Jefferson, D Sen. Dave Syverson, R Rep. Ronald Wait, R Sen. Bradley Burzynski, R
<p>AIDS Foundation of Chicago 200 W. Jackson, Suite 2200 Chicago, IL 60606 Mark Ishaug, Executive Director 312-922-2916 mishaug@aidschicago.org Angelique Miller, contact 312-334-0926 amiller@aidschicago.org</p>	<p>Scattered site around Chicago</p>	Homeless individuals with physical disabilities, HIV/AIDS, substance abuse, some veterans	40	40	Scattered site leasing	HUD/SHP \$493,500 application pending		
<p>Brand New Beginnings 103-115 E. 58th St. Chicago, IL 60637 Della Mitchell, Executive Director 773-955-5780 brandnewbeginnings@comcast.net</p>	<p>Washington Park Townhomes 122 E. 58th St. Chicago</p>	Homeless women w/children who are survivors of DV, substance abuse	122	40	New Construction	HUD/SHP \$100,406 HUD S+C \$186,000 HUD Section 8 \$86,000		
<p>Carpenter's Place 1149 Railroad Ave. Rockford, IL 61104 Kay Larrick, Executive Director 815-964-4105x211 KayL@carpentersplace.org</p>	<p>Permanent Housing Program for Chronically Homeless Adults</p>	Homeless individuals with DV, SA, HIV/AIDS, Physical or Developmental Disabilities, some veterans	7	7	Leasing			

Organization	Project Name/ Location	Who Serve	# served	# units	Additional Description	Federal Funding	Needed State Funding	Legislators
Cornerstone Services, Inc. 777 Joyce Rd. Joliet, IL 60436 Jim Hogan, Executive Director 815-741-7080 jhogan@cornerstoneservices.org Ben Stortz, contact 815-741-7042 bstortz@cornerstoneservices.org	Housing Opportunities for Persons with AIDS & Mental Illness	Homeless Individuals and Families with MI, SA, HIV/AIDS, DV, Physical Disabilities, some veterans	40	18	Scattered site leasing	HUD/SHP \$192,000		
Cornerstone Services, Inc. 777 Joyce Rd. Joliet, IL 60436 Jim Hogan, Executive Director 815-741-7080 jhogan@cornerstoneservices.org Ben Stortz, contact 815-741-7042 bstortz@cornerstoneservices.org	Cornerstone Duplexes	Homeless Individuals and Families with MI, SA, HIV/AIDS, DV, Physical Disabilities, some veterans	10	6	New Construction	HUD 811 \$987,100 application pending		
DuPage PADS 705 W. Liberty Wheaton, IL 60187 Carol Simler, Executive Director 630-682-3846x231 csimler@dupagepads.org Beth Epstein, contact 630-682-3846x241 bepstein@dupagepads.org	Scattered sites	Homeless individuals with DV, SA, HIV/AIDS, Physical or Developmental Disabilities, some veterans	7	7	Scattered site leasing	HUD/SHPA \$98,980		
DuPage PADS 705 W. Liberty Wheaton, IL 60187 Carol Simler, Executive Director 630-682-3846x231 csimler@dupagepads.org Beth Epstein, contact 630-682-3846x241 bepstein@dupagepads.org	Scattered sites	Homeless individual with DV, SA, HIV/AIDS, Physical or Developmental Disabilities, some veterans	4	4	Scattered site leasing	HUD/SHP \$98,980		
Ford Heights Community Service Organization 943 East Lincoln Highway Ford Heights, IL 60411 Angelia F. Smith, ED 708-758-8142 angelia.smith@fordheights.org	FHCSO Affordable Housing Square Block of Route 30, Berkeley, Lexington and East 13th Street Ford Heights	Homeless families with SA, DV, some veterans	90	30	New Construction	Rural Development \$750,000		
Illinois Facilites Fund 1 North LaSalle, Suite 700 Chicago, IL 60602 Trinita Logue, ED 312-629-0060 tlogue@iff.org Kate Ansoerge, contact 312-596-5129 kansorge@iff.org	IFF NSP Social Service Collaboration Counties: Cook, Lake, Will, DuPage, Kane, Kendall, LaSalle, Whiteside, Winnebago	Homeless Individuals and Families with MI, SA, HIV/AIDS, DV, Physical Disabilities, some veterans	?	33	Scattered Site Rehab	NSP \$5,133,000		
Inspiration Corporation 4554 North Broadway St., Suite 207 Chicago, IL 60640 John Pfeiffer, ED 773-878-0981x206 jpfeiffer@inspirationcorp.org Shannon Stewart, contact 773-878-0981x224 sstewart@inspirationcorp.org	Inspiration Corporation's (IC) Family Housing	Homeless families with SA, DV	18	6	Rehab	HUD/SHPA \$199,224		

Organization	Project Name/ Location	Who Serve	# served	# units	Additional Description	Federal Funding	Needed State Funding	Legislators
La Casa Norte 3533 W. North Ave. Chicago, IL 60647 Sol Flores, ED 773-276-4900x206 sol@lacasanorte.org	La Casa Norte Scattered Site PSH Project	Homeless families with DV, SA, HIV/AIDS, Physical Disabilities, some veterans	87	30	Rehab	HUD/SHP \$261,120 application pending		
Lutheran Child and Family Services of Illinois 7620 Madison River Forest, IL 60305 Gene Svebakken, ED 708-771-7180 Gene_svebakken@lcfs.org Mike Bertrand, contact 708-771-7180 Mike_betrand@lcfs.org	North Street Commons 929 & 931 W. North St. Decatur	Homeless Veterans, Individuals or Families with MI, SA, HIV/AIDS, physical disabilities	24	19	Rehab	NSP \$900,000 HUD Section 8 \$80,880		
New Foundation Center, Inc. 444 Frontage Rd. Northfield, IL 60093 Sue Shimon, ED 847-501-2939 sshimon@newfoundationcenter.org	New Foundation Center Apartment Project 3500 Highland Park	Homeless Individuals and couples with MI, SA, some veterans	23	20	Rehab			
Pillars Community Services 333 N. LaGrange Rd., Suite 1 LaGrange Park, IL 60526 John Shustitsky, ED 708-745-5277 jshustitsky@pillarscommunity.org Theresa Curran, contact 708-935-9057 tcurran@pillarscommunity.org	Project WCHANCE (West Cook Housing Action Network Choice Endeavors)	Homeless Individuals with MI, SA, HIV/AIDS, Physical or Developmental Disabilities, some veterans	25	25	Leasing	HUD/SHP \$558,750 application pending		
Pillars Community Services 333 N. LaGrange Rd., Suite 1 LaGrange Park, IL 60526 John Shustitsky, ED 708-745-5277 jshustitsky@pillarscommunity.org Theresa Curran, contact 708-935-9057 tcurran@pillarscommunity.org	Project WCHIP (West Cook Housing Initiative Project) Expansion III	Homeless Individuals and Families with MI, SA, HIV/AIDS, Physical and Developmental Disabilities, some veterans	15	12	Leasing	HUD/SHP \$202,752 application pending		
A Safe Place/Lake County Crisis Center 2710 17th St., Suite 100 Zion, IL 60099 Phyllis DeMott, ED 847-731-7165x105 pdemott@asafeplaceforhelp.org Noelle Moore, contact 847-731-7165x109 nmoore@asafeplaceforhelp.org	PSH for Victims of Domestic Violence 2720 17th St. Zion (pending subdivision)	Single women and women with children surviving domestic violence	49	20	New Construction			
Sarah's Circle 4750 N. Sheridan Rd. Chicago, IL 60640 Katherine Ragnar, ED 773-728-1014 kragnar@sarahs-circle.org	Sarah's Circle SH 4836 N. Sheridan Rd. Chicago	Homeless single women with MI, SA, HIV/AIDS, DV, Physical and Developmental Disabilities	10	10	Rehab	HUD/SHP \$634,575 HUD S+C \$93,720 applications pending		

Organization	Project Name/ Location	Who Serve	# served	# units	Additional Description	Federal Funding	Needed State Funding	Legislators
Single Room Housing Assistance Corporation (SRHAC) 28 E. Jackson Blvd, Suite 605 Chicago, IL 60604 Eric Rubenstein, ED 312-212-1212 ericrubenstein@srhac.org	PSH for Homeless Single Adults w/Documented Disabilities	Homeless Individuals with MI, SA, HIV/AIDS, DV, Physical or Developmental Disabilities, some veterans	37	37	Leasing	HUD/SHP \$370,000 application pending		
Southern Illinois Coalition for the Homeless 801 N. Market St. Marion, IL 62959 Sharon Hess, ED 618-993-0094 sichome_05@yahoo.com	Phoenix Project 814-816 Foch St. Herrin	Homeless Individuals with MI, SA, HIV/AIDS, DV, Physical or Developmental Disabilities, some veterans	8	8	New Construction	HUD Section 8 \$40,032		
Southern Illinois University School of Medicine Community Support Network 901 W. Jefferson St. Springfield, IL 62794-9642 Karen Lee, ED 217-545-7658 klee@siumed.edu Andrea Bennett, contact 217-545-8251 abennett2@siumed.edu	Hope Springs Apartments 1135 N. 9th St. Springfield	Individuals and Couples (no children) with MI	45	36	New Construction			
Total Number of People Served and Number of Units of Supportive Housing			1005					
Total Estimated Additional Funding Needed					726		\$3,600,000	
Guide to abbreviations:								
	SHP-PH = Supportive Housing Program-Permanent Housing							
	PHA = Public Housing Authority							
	FHLB = Federal Home Loan Bank							
	IHDA FAF = Illinois Housing Development Authority							
	CLIHT = Chicago Low Income Housing Trust Fund							
	CDBG = Community Development Block Grant							

Line Item Name		FY 2012 Supportive Housing MI Line Item						
Supportive Mentally Ill Housing								
New FY 2012 Supportive Housing Projects								
Organization	Project Name/ Location	Who Serve	# served	# units	Additional Description	Federal Funding	Needed State Funding for Services	
Cornerstone Services, Inc. 777 Joyce Road Joliet, IL 60436 Jim Hogan, Executive Director 815-741-7080 jhogan@cornerstoneservices.org Ben Stortz, Contact 815-741-7042 bstortz@cornerstoneservices.org	Cornerstone Duplexes	Homeless individuals or families with MI, SA, PD, DV and Veterans	10	6	New Construction, scattered sites	HUD 811 applied for	\$90,000	
Daveri Development Group 6160 N. Cicero Ave., Suite 620 Chicago, IL 60646 Cullen J. Davis, Executive Director 773-777-5507 cullen@daveridevelopment.com Jessica Berzac, Contact 773-777-5507 jessica@daveridevelopment.com	Mather Wells Place 1601, 1605, 1609, 1619, 1623, 1627-29 E Cook St. Springfield, IL 62703	Homeless individuals	40	40	New Construction  Helping Hands of Springfield, SS provider	Applying for various IHDA funding streams	\$43,000	
Delta Center, Inc. 1400 Commercial Ave. Cairo, IL 62914 Lisa S. Tolbert, Executive Director 618-734-2665x213 ltolbert@deltacenter.org	Delta Terrace Apartments 208 12th St., 209 13th St. Cairo, IL 62914	Homeless Individuals and families with MI, SA, HIV/AIDS, PD, and Veterans	14	10	New Construction	NSP Funding from Feds through the state have been awarded	\$154,844	
Delta Center, Inc. 1400 Commercial Ave. Cairo, IL 62914 Lisa S. Tolbert, Executive Director 618-734-2665x213 ltolbert@deltacenter.org	Delta 12 Apartments 334 Enterprise Lane Mounds, IL 62964	Homeless Individuals and families with MI, SA, HIV/AIDS, PD, and Veterans	15	12	New Construction	HUD 811 applied for	\$183,065	

<p>Heartland Housing, Inc. 208 S. LaSalle St., Suite 1818 Chicago, IL 60604 Andrew E. Geer, Executive Director 312-660-1381 ageer@heartlandalliance.org Hume An, Contact 312-660-1345 han@heartlandalliance.org</p>	<p>Family Supportive Housing Blue Island and W. 15th St. (Roosevelt Square Development) Chicago, IL</p>	<p>Homeless families with MI, SA, PD, and Youth</p>	120	30	New Construction	<p>HUD S+C HUD HOME funds and IHDA funding applied for</p>	\$215,916
<p>Heartland Housing, Inc. 208 S. LaSalle St., Suite 1818 Chicago, IL 60604 Andrew E. Geer, Executive Director 312-660-1381 ageer@heartlandalliance.org Sam Mordka, Contact 312-660-1348 smordka@heartlandalliance.org</p>	<p>Viceroy Apartments 1519 W. Warren Blvd. Chicago, IL 60607</p>	<p>Homeless individuals with MI, SA, HIV/AIDS, DD, PD, DV, and Veterans</p>	89	89	<p>Rehab, mixed populations will be housed throughout the project</p>	<p>HUD HOME and various IHDA funds applied for as well as other state funding sources that have been applied for</p>	\$146,855
<p>Human Service Center of Southern Metro-East 10257 State Route 3 Red Bud, IL 62278 Gary Buatte, Executive Director 618-282-6233 g.buatte@humanservicegroup.com</p>	<p>Evansville Project 3rd and Spring Streets Evansville, IL 62242</p>	<p>Individuals with SPMI</p>	8	8	New Construction	<p>Applying for IHDA trust fund funds</p>	\$35,000
<p>Land of Lincoln Goodwill Industries 800 N. 10th St. Springfield, IL 62702 Sharon Durbin, Executive Director 217-789-0400 sharon.durbin@llgi.org Mike Steinhauer, Contact 217-789-0400 mike.steinhauer@llgi.org</p>	<p>Freedom Village 800 N. 10th St. Springfield, IL 62702</p>	<p>Homeless individuals with MI, SA, HIV/AIDS, PD, and Veteran</p>	51		<p>Rehab  Mental Health Centers of Central Illinois service providers</p>	<p>HUD Section 8 Vouchers from SHA Applying for various IHDA funding streams</p>	\$300,000