

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:**

<u>Name</u>	<u>Agency</u>	<u>Name</u>	<u>Agency</u>
Pat Abrams	Renaissance Collaborative	Sharon Hess	So IL Coal for the Homeless
Sue Augustus (Chair)	Corporation for Supportive Housing	Jennifer Hill	Alliance to End Homelessness in Suburban Cook County
Lore Baker	Dove/Homeward Bound	Lindsay Huth	IDHS – Division of Mental Health
Elana Berenson	Metropolis 2020	Lisa Kuklinski	Mercy Housing
Jane Bilger	IHDA	Jennifer Novak	IHDA
Tracey Williams Boyd	Illinois Division of Mental Health, Region 5 office	Tara Peele	IHDA
John Cheney Egan	DCFS	Bill Pluta	IHDA
Liz Drapa	Corporation for Supportive Housing	Jean Summerfield	DHFS
Nancy Firfer	Metropolis 2020	Anne Tyree	Community Counseling Center of Northern Madison County
Andy Geer	Heartland Housing	Katrina Van Valkenburgh	Corporation for Supportive Housing
Brenda Hanbury	IDHS	Kirstin Williams	Metropolis 2020
Margaret Harkness	IL Council on DD	Ann Woodward	Mercy Housing
King Harris	Metropolis 2020	Tony Zipple	Thresholds
Janet Hasz	Supportive Housing Providers Association		

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 year¹, and their:

- Emergency room visits decline by 57%²
- Emergency detox services decline by 85%³
- Incarceration days in state prisons drop by 85%⁴
- Earned income increases by 50%⁵
- Employment rises by 40% when employment services are provided⁶

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.

¹ 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.

² 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).

³ 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).

⁴ 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.

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

⁶ 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

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

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

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

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 units⁷. 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 Illinois⁸

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

*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.

⁷ Estimate based on Supportive Housing Providers Association data and HUD 2007 Housing Inventory data.

⁸ 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 report⁹ 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 multipliers¹⁰ 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

⁹ The Third Annual Homeless Assessment Report to Congress. July 2008. Found at www.hudhre.info

¹⁰ 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
Leased or Tenant-Based Units								
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
Development – New, Rehabbed and Preserved Units								
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
Total by Year	615	730	880	1040	1260	1490	1685	Grand Total: 7700

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	
Capital Financing															
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
Subtotal	615	\$45,395,000	730	\$50,850,000	880	\$59,440,000	1,040	\$68,040,000	1,260	\$82,900,000	1,490	\$97,770,000	1,685	\$115,705,000	\$520,107,085
Operating Financing															
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
Subtotal	615	4,572,000	730	5,472,000	880	6,624,000	1,040	7,848,000	1,260	9,504,000	1,490	11,232,000	1,685	12,708,000	57,967,085
Cumulative Totals	615	\$4,572,000	1,345	\$10,044,000	2,225	\$16,668,000	3,265	\$24,516,000	4,525	\$34,020,000	6,015	\$45,252,000	7,700	\$57,960,000	\$193,057,075
Services Financing															
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
Subtotal	615	5,000,000	730	5,960,000	880	7,200,000	1,040	8,520,000	1,260	10,320,000	1,490	12,200,000	1,685	13,800,000	63,007,085
Cumulative Totals	615	\$5,000,000	1,345	\$10,960,000	2,225	\$18,160,000	3,265	\$26,680,000	4,525	\$37,000,000	6,015	\$49,200,000	7,700	\$63,000,000	210,025,075
Annual Totals:	615	\$54,967,000	730	\$71,854,000	880	\$94,268,000	1,040	\$119,236,000	1,260	\$153,920,000	1,490	\$192,222,000	1,685	\$236,665,000	
														Grand Total	\$923,139,085

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
TOTALS	7700	\$441,000,000	\$79,100,000	\$520,100,000		

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 study¹¹ comparing pre- and post-supportive housing placement in New York City as well as preliminary data from a similar study¹² 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 PSH units 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 PSH¹³.

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.

¹¹ 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.

¹² Chicago Housing and Health Partnership

¹³ 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 Housing¹⁴. 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.

¹⁴ 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 homeless¹⁵. 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

¹⁵ <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 assistance¹⁶ 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.

¹⁶ 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 statement¹⁷ 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.

¹⁷ Visit www.dhs.state.il.us/page.aspx?item=38631 and click on DMH Housing Policy.