Core Service Report

Homeless Shelters

Consumer Category:
Basic Needs

Primary Consumer Group:
Persons or Households that are Housing Insecure

February 2007

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COMPANION REPORTS

In addition to the information included in this report, a report of the other core services (80 in total), community leader key informant interviews, United Way - First Call for Help staff focus groups, consumer snapshots, and e-survey of United Way funded executive directors, board presidents, and United Way Community Investment staff are available at http://www.uws.org.

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SNAPSHOT

AIRS Code Level I: Basic Subsistence (B)
AIRS Code Level II: Housing (BH)
Core Service: Homeless Shelter (BH-180.850)

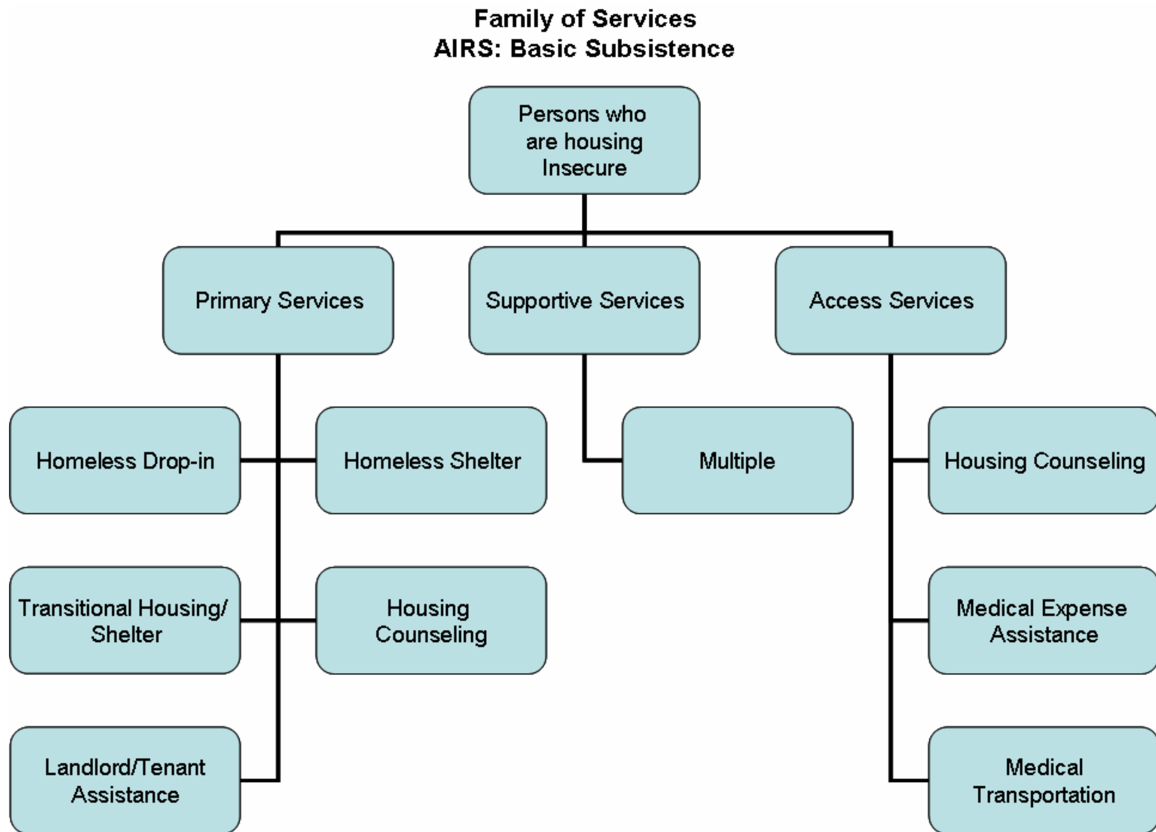
Investment Committee: Strong Families = Successful Children
Cluster: Basic Needs

AIRS Definition: Programs that provide a temporary place to stay for people who have no permanent housing.

Special Note: There are three reports that deal with homeless services. The consumers of each are distinguished as follows:

- **Homeless Drop-in Centers**: the unsheltered homeless.
- **Homeless Shelters**: sheltered homeless persons of all ages who have no permanent housing and need a temporary place to stay.
- **Transitional Housing/Shelter**: sheltered homeless persons needing extended shelter (longer than two weeks but typically sixty days or more) and who indicate a willingness to participate in developing and implementing a case plan with a goal of eventual independent living.

The Homeless Shelter Program is part of a family of service for persons who are housing insecure. It is one of five services targeting this consumer group. In addition, there are three services that help this consumer group access needed services. (See figure below.)



Core Service Environment
Beginning with the colonial era, the United States has had a population living without a permanent dwelling. Three trends are largely responsible for the rise in homelessness over the past 20-25 years: a growing shortage of affordable rental housing, a simultaneous increase in poverty, and deinstitutionalization of the mentally ill.

The federal government as a funder and policy maker drives much of what takes place at the local level. With the enactment of the Stewart B. McKinney Homeless Assistance Act of 1987, Congress recognized the need to supplement "mainstream" federally funded housing and human services programs with funding specifically targeted to assist the homeless.

As a primary funder of homeless services, the strategic direction HUD established is of utmost importance. HUD's FY 2006 to FY 2011 strategic plan's objective is to end chronic homelessness and move homeless families and individuals to permanent housing. This plan is driving the local agenda and has resulted in a joint effort with a ten year plan to prevent homelessness and expand affordable housing in Cleveland and Cuyahoga County.

Core Service Consumers
The target population addressed in this core service is sheltered homeless persons of all ages who have no permanent housing and need a temporary place to stay.

Still considered to be the most comprehensive data set available on the homeless population, the National Survey of Homeless Assistance Providers and Clients (NSHAPC) (McCarty, 2005) found that:

- Among homeless women, 60 percent have children under age 18, but only 65 percent of them live with at least one of these children.
- Among homeless men, 41 percent have children under age 18, but only 7 percent of these fathers live with at least one of their own children.
- Homeless families have, on average, two children. Members of these families comprise 34 percent of all homeless people using services.
- Children in homeless families using services are fairly evenly divided between males (53 percent) and females (47 percent).
- Clients were asked to name the three things they need most “right now,” and also to identify the single most important thing keeping them in a homeless condition. Help finding a job was the most frequently cited need (42 percent); followed by help finding affordable housing (38 percent); and assistance with paying rent, mortgage, or utilities in relation to securing permanent housing (30 percent). Insufficient income was cited most frequently as “the single most important thing” keeping clients homeless.
- Twenty-eight percent of homeless clients report that they sometimes or often do not get enough to eat.
- Twenty-four percent of homeless clients report that they needed medical attention in the past year but were not able to get it.

In 2003, Cleveland State University’s Maxine Goodman Levin College of Urban Affairs estimated that approximately 16,000 Cuyahoga County residents were homeless at some time during the course of a year while the Northeast Ohio Coalition for the Homeless (NEOCH) estimated that nearly 26,000 people are homeless in Cuyahoga County every year and that 3,900 are homeless on any given night. (Heading Home, 2005).

In January 2005, a point-in-time count of homeless persons in Cuyahoga County suggests there were over 2,208 homeless persons (Cuyahoga County Office of Homeless Services, 2005). Of these, 1,208 were in emergency shelters, 776 were in transitional housing, and 224 were unsheltered and living on the street. Two-thirds of the sheltered (emergency and transitional) homeless who are users of Homeless Shelters and Transitional Housing have a chronic substance use disorder and close to half are considered chronically homeless. Approximately a quarter of them are severely mentally ill and a fifth of them are veterans (Cuyahoga County Office of Homeless Services, 2005).

Core Service Delivery

The definition of homeless shelters for this report is: programs that provide a temporary place to stay for people who have no permanent housing.

> Along with homeless drop-in centers and transitional housing, homeless shelters are part of the continuum of services for homeless persons and families. They are residences in urban neighborhoods where homeless people can stay temporarily (similar to emergency shelters) when they otherwise would have to sleep on the street. The main difference is that homeless shelters are usually open to anyone, regardless of reasons they don't have a more typical residence available, although some limit their

> clientele by gender or age. A minor difference is that homeless shelters usually expect people to go elsewhere during the day, returning only to sleep or, if the shelter also provides meals, to eat, while people in emergency shelters are more likely to stay all day, except for work, school, or errands. Some homeless shelters, however, are open 24 hours a day. Homeless shelters are usually operated by a nonprofit agency or are associated with a church. Many get at least part of their funding from local government entities. Homeless shelters sometimes provide other services such as a soup kitchen, job-search skills training, job training, job placement, support groups, and/or chemical dependency treatment. If they do not offer any of these services, they can usually refer their clients to agencies that do (Wikipedia.com, n.d.).

Homeless persons often need more than housing; they need supportive housing, which is a form of co-housing designed to support individuals not only socially, but with basic life skills. Housing is coupled with social services such as job training, alcohol and drug abuse programs, and case management. This is often targeted at low-income workers and populations in need of assistance: the homeless, persons suffering from mental illness or substance abuse problems, and the elderly or medically frail. Supportive housing can be on an ongoing/permanent basis or during a transition period of dependence on others. The type and level of support depends on individuals and their families' specific needs, wishes and, in many instances, ability to pay.

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 10 homeless shelter program providers operating from 11 different sites, 9 of which are nonprofit and 1 other. In FY 2004 (July 2003 to June 2004), United Way funded one provider. FCFH call data shows an increase in the number of total requests for homeless shelter programs in the county: from 3,902 in 2000 to 6,085 in 2004 (56 percent increase). Over the same five-year period, FCFH had 26,111 requests for information about homeless shelter programs, which includes services for persons with insufficient resources to meet basic needs. Of these requests, they were able to make referrals to 94 percent of callers.

As of May 11, 2006, close to $2.2 million in revenues for homeless shelter programs has been identified countywide. This includes information from foundations; federated fundraising organizations; regional, county and municipal government; and United Way of Greater Cleveland. Eighty-four percent of the revenues are from contracts or grants from government organizations and 11 percent from United Way of Greater Cleveland.

Self-managed emergency shelters cost approximately $3 per person per night. Mixed-model mats-and-blankets severe-weather shelters costs approximately $6.50 per person per night. A professionally staffed shelter that offers beds, storage, phones, meals, showers, laundry, and case management counseling can cost $40 per person per night (Freeman, n.d.).

What Works; What Doesn't

The United States Interagency Council on Homelessness has developed a ten-year planning process to end chronic homelessness, including a step-by-step guide for communities to follow. The U.S. Conference of Mayors, the National Association of Counties, and the National League of Cities have endorsed the plan. Ten-year plans are currently underway in some of the nation's largest cities, including Chicago, San Francisco, and Cleveland.

In addition, the 10-year plan involves both prevention and intervention strategies. Examples of successful prevention efforts include the centralization of funding and service delivery to increase coordination among all parties, dedicated resources to house individuals discharged from psychiatric care, and discharge planning protocols to prevent homelessness. Likewise, successful intervention strategies include permanent supported housing with low threshold access for mentally ill homeless people; direct access to permanent supported housing for frequent users of acute health systems; and assertive community treatment, which relies on multi-disciplinary, clinically-based teams that engage chronically homelessness people on the streets and in shelters.

“Housing First” describes a set of policy initiatives and strategies promoting the concept that a permanent, safe, affordable place to live is a necessary prerequisite for helping homeless people work toward employment and recovery goals. It represents a departure from the widely used approach that requires homeless people to gain employment, achieve sobriety, and/or take other steps towards recovery before they are helped to find a permanent place to live. This latter practice, while motivating some, has also contributed to the creation of a semi-permanent “homeless underclass” of persons crowded into emergency shelters for months and years because they have no other recourse, and the barriers to recovery and employment remain unaddressed (Simpson, 2005).

University of Pennsylvania researchers conducted a five-year study that examined 10,000 mentally ill homeless persons in New York City. Half this group was placed in government-funded housing with mental illness services available. The homeless persons not placed in supportive housing cost the taxpayers an average of $40,500 a year for their use of emergency rooms, psychiatric hospitals, shelters, and prisons. However, individuals who were placed in supportive housing with assistance for mental illness issues used fewer emergency care services. The study found that taxpayers’ cost for providing supportive housing and treatment to mentally ill homeless persons was only $994 more than the $40,500 that it cost to do nothing and leave these people homeless and on the streets.

Gap Analysis

The estimated universe of possible consumers is 9,558, including both realized (6,004) and unrealized (3,554) access.

I. FOREWORD

INTRODUCTION

United Way of Greater Cleveland (UW), in partnership with the Cuyahoga County Board of Commissioners, has initiated a large scale core service planning process to generate data and engage in community-wide dialogue about the community's safety net of core service and consumer needs in the Greater Cleveland area. In addition, UW envisions this process as an opportunity to better understand its role in the community and its long term capacity to improve the lives of Greater Clevelanders.

The primary goal of the Cuyahoga County core service research is to identify consumer needs and assess whether there are service gaps/duplications on a community-wide level. The findings from this research will guide future funding decisions at UW, and they will also be used to stimulate dialogue with other funders and groups in the community. United Way intends to continue to fund a broad array of "safety net" services that are important to the Greater Cleveland area. But it is hoped that the research findings will inform how UW dollars may be dispersed to have the greatest impact on current realities, needs, and priorities in the Greater Cleveland community.

METHODOLOGY

United Way contracted with MCS Consulting Service, LLC, to conduct the core service research, which focuses on both the consumers served and services provided. (See Attachment 1 for list of members of the research team.) The research team has obtained information about each core service from multiple data sources. At the end of the research process there will be substantial information available for some services and less for others, which will provide a clearer picture of what information *is* available and where there are *significant gaps*.

The questions addressed are:

- Including public policies, what are the environmental influences that are impacting both service consumers and the capacity for service delivery?
- Who are the service consumers? What are the factors that lead to a need for services? How many consumers are there? How many have there been in the past several years and what factors influenced the historic trend line? What are the projected numbers for the future? What is their demographic profile? Where do they reside? How many are receiving services funded by government and/or United Way?
- What is the philosophy that drives service delivery? Has it changed? What does the service consist of? Who provides the service?
- What are the funding sources? What are the annual revenues from government sources, federated fund raising organizations, foundations, and United Way of Greater Cleveland? What are the historic government funding trends and what is projected for the future? What is the reimbursement amount?
- What works and what doesn't work in service delivery?
- Are there service gaps, duplication, under-utilization?

The primary information sources used for this report are:

- Results of 20 focus groups with 159 direct service staff of United Way member agencies and non-members, and key informant interviews with 93 experts in the respective service areas (February 2005). Participants were asked about consumer populations that are increasing and those with unmet needs; they provided insight about specific service gaps and duplication, as well as services they perceive to be outdated or under-utilized.
- United Way Program Report data for FY 2004 (July 2003 to June 2004). Each year United Way member agencies submit information to their respective investment committees on each funded core service they provide. Among other things, this information includes a demographic profile of the consumers served, the zip codes where the consumers reside, and all revenue sources that support the service. The research team has aggregated this information for each core service.
- United Way - First Call for Help call data (2000 to 2004) - United Way - First Call for Help provides a 24/7 information and referral service through its 211 telephone line The research team analyzed data from its large database, which includes the names of service providers for most core services, the activities they provide and the zip codes in which they and those they serve dare located, the number of calls received, and whether the need was met or unmet. Unmet needs are those for which there was no resource to reference.
- Literature reviews on service trends and issues as well as best practices (i.e., what works/ what doesn't work in service delivery), including impact on the individual/family and on the community.
- Searches for information on public policies that are currently impacting consumers or service delivery.
- U.S. Census and American Community Survey data for various time periods.
- Data from funders on actual consumer populations and funding levels.

(See Attachment 2 for technical notes on the research methodology as well as limitations of the data.)

II. THE CORE SERVICE ENVIRONMENT

CORE SERVICE ENVIRONMENT

Since the colonial era, there has always been a segment of the American population living without permanent dwelling. After the Civil War in the 1860s, discharged war veterans and immigrant laborers swelled the number, especially during the Great Depression in the 1930s. In the main, this population was referred to as "hobos," tramps or transients. The term "homeless" first entered the mainstream lexicon in the late 1970s, when America observed a startling increase of people forced to live on urban streets. The phenomenon was seen as a shocking aberration, garnering media attention and causing public outcry. Today, many Americans are resigned to it as an unchanging feature of the social landscape.

Homelessness results from a complex set of circumstances that require people to choose between food, shelter, and other basic needs. It has been a constant presence in American cities, towns, and rural areas for many years. During the recession of 1981-82, it was identified as a national issue for the first time since the Great Depression. Since the early 1980s, homelessness has been a regular focus of media interest and a topic of policy debate. The array of programs and services for the homeless increased greatly during this period, as has the funding needed to support them.

Three trends are largely responsible for the rise in homelessness over the past 20-25 years: a growing shortage of affordable rental housing, a simultaneous increase in poverty, and deinstitutionalization of the mentally ill. Reliable and comprehensive information about homeless clients has not been easy to obtain at the national level. In 1987, the Urban Institute conducted the first national study to interview homeless clients at some depth on a variety of topics. The data from that study was collected before the passage of the Stewart B. McKinney Homeless Assistance Act of 1987 and before the significant increase in federal involvement and program development that followed. Although national in scope, the Urban Institute study only went to central cities and collected data only from shelter and soup kitchen users, so it could not be used to characterize the entire picture of homelessness in the United States.

As the issue intensified and additional resources were directed at the problem, information became more readily available. The 1996 National Survey of Homeless Assistance Providers and Clients provided the following information:

- Among homeless women, 60 percent have children under age 18, but only 65 percent of them live with at least one of these children.
- Among homeless men, 41 percent have children under age 18, but only 7 percent of these fathers live with at least one of their own children.
- Homeless families have, on average, two children. Members of these families comprise 34 percent of all homeless people using services.
- Children in homeless families using services are fairly evenly divided between males (53 percent) and females (47 percent). This does not differ from American children in general. They are disproportionately younger than school age (ages 0 to 5) compared to all U.S. children (42 percent versus 34 percent).
- Clients were asked to name the three things they need most "right now," and also to identify the single most important thing keeping them in a homeless condition. Help

finding a job was the most frequently cited need (42 percent), followed by help finding affordable housing (38 percent), and assistance with paying rent, mortgage, or utilities in relation to securing permanent housing (30 percent). Other needs cited by more than 10 percent of clients were assistance with transportation (19 percent), clothing (18 percent), food (17 percent), job training and medical care (13 percent each), and a GED and dental care (11 percent each). Insufficient income was cited most frequently as "the single most important thing" keeping clients homeless.

- Twenty-eight percent of homeless clients report that they sometimes or often do not get enough to eat. Only 39 percent get enough of the kinds of food they want to eat.
- Being homeless removes the safety of a permanent residence and leaves one's person and possessions vulnerable to attack. Robbery and theft are common threats experienced by two in five homeless clients.
- Twenty-four percent of homeless clients report that they needed medical attention in the past year but were not able to get it.
- Ten percent report that their children needed to see a doctor or nurse in the past year but were not able to do so.
- Homeless shelters are the most common type of location where homeless clients may be found. More than twice as many homeless clients (73 percent) slept in one or more of a variety of shelters during the eight-day period examined as in places not meant for human habitation during the same period. Some, of course, slept in both venues. Shelters take many forms, including emergency shelters, transitional housing programs, and vouchers for emergency housing.

A single definition of homelessness is not available. However, most federal programs define a homeless individual as someone who lacks a fixed and night-time residence, or whose primary residence is a supervised public or private shelter designed for temporary living accommodations, an institution accommodating persons intended to be institutionalized, or a public or private place not designed for—or ordinarily used as—a regular sleeping accommodation for human beings (McCarty, 2005).

While the definition of homelessness is murky, the causes of homelessness are slightly clearer. The lack of affordable housing, the lack of living wage jobs or sufficient incomes, and the lack of adequate health and supporting services all contribute to homelessness (Coalition on Homelessness and Housing in Ohio [COHHIO]).

The National Survey of Homeless Assistance Providers and Clients (NSHAPC) identified roughly 40,000 homeless assistance programs in 21,000 service locations in the United States, including food pantries (9,000); emergency shelters (5,700); transitional housing programs (4,400); soup kitchens (3,500); outreach programs (3,300); and voucher distribution programs (3,100) (McCarty, 2005).

Of the surveyed cities, 33 percent increased the number of emergency beds from the previous year. Overall, the number of shelter beds increased by 13 percent among the surveyed cities. In Cleveland, an improved and expanded women's shelter facility opened in February 2004. Additional overflow space for men opened in March 2004 to relieve overcrowding at the existing facility.

PUBLIC POLICY ISSUES

NATIONAL

Federation Regulations

McKinney-Vento Act

Congress enacted the Stewart B. McKinney Homeless Assistance Act in 1987 in response to the homelessness crisis that had emerged in the 1980s. This act recognized the need to supplement "mainstream" federally funded housing and human services programs with funding that was specifically targeted to assist homeless people. Over $11 billion in McKinney funds have been appropriated since then, and billions more have been provided through other federal, state, and local programs and benefits. Renamed the McKinney-Vento Act in 2000, the act authorizes funds for a small set of federal homeless assistance programs, including four administered by HUD: Emergency Shelter Grants (ESG); Section 8 Moderate Rehabilitation for Single Room Occupancy Dwellings for Homeless Individuals (SRO); Shelter Plus Care (S+C); and the Supportive Housing Program (SHP). Collectively known as HUD McKinney-Vento Homeless Assistance Programs, these programs are the key source of federal funding for homeless assistance programs (National Low Income Housing Coalition, 2006). SRO, S+C, and SHP are known collectively as the Continuum of Care Homeless Assistance under HUD's Super NOFA (Notice of Funds Available) grant process, a consolidated process for awarding grants that stresses local coordinated plans and the development of comprehensive assistance. Homeless shelters meet the criteria to receive grants from HUD McKinney-Vento Funds only through the Emergency Shelter Grant program.

In 2000, HUD realigned its funding policies to focus on permanent housing. As a primary funder of homeless services, the strategic direction established by the U.S. Department of Housing and Urban Development (HUD) is of utmost importance. HUD's FY 2006 to FY 2011 strategic plan's objective is to end chronic homelessness and move homeless families and individuals to permanent housing.

> HUD is committed through its Continuum of Care to ending chronic homelessness. HUD's working definition of a person experiencing chronic homelessness is an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has had recurring episodes of homelessness. Estimates of the number of persons experiencing chronic homelessness range from 150,000 to 200,000. Even when housing is available, disabilities sometimes make it difficult for chronically homeless persons to remain in that housing for long periods unless they also have supportive services, including case management and regular healthcare.
>
> While those experiencing chronic homelessness are often the most visible of the homeless population, there are also substantial numbers of families and individuals who experience a more temporary crisis, such as loss of employment or eviction, and become homeless. HUD's approach to replacing homelessness with housing stability relies on three coordinated efforts:

- Preventing homelessness;
- Developing permanent and transitional housing for both those persons experiencing chronic homelessness and the growing numbers of homeless families;
- Coordinating housing assistance with supportive services.

Given the variety of individual needs and locally available resources, communities are in the best position to design strategies to help each homeless person and family achieve permanent housing and self-sufficiency. HUD's homeless assistance programs will continue to foster local initiatives by providing flexibility while providing incentives to meet important national objectives, including ending chronic homelessness.

HUD allocates the federal government's largest amount of targeted homeless assistance under the McKinney-Vento Homeless Assistance Act through its annual Continuum of Care (CoC) competition and by formula through the Emergency Shelter Grants program. Communities also address homeless needs through the use of CDBG, HOME, and HOPWA programs and through the use of HUD's other mainstream housing programs, such as Housing Choice Vouchers and the public housing program.

The Cuyahoga County Office of Homeless Services, which manages the HUD Super NOFA funding process at the local level, is also focusing its grant applications on permanent housing, although other types of programs such as transitional housing continue to be renewed at flat rates.

Specifics of HUD McKinney-Vento Funds are addressed in Section IV of the report.

National Initiatives

National Alliance to End Homelessness

For many decades, the American public has assumed that homelessness is a problem to be managed, not solved. Building on the Housing First philosophy, the National Alliance to End Homelessness, a nonprofit organization whose mission is to mobilize society's nonprofit, public, and private sectors in an alliance to end homelessness has proposed another perspective: homelessness can end. It has developed a plan to end homelessness in ten years which includes the following elements:

Plan for Outcomes

Localities can begin to develop plans to end, rather than to manage, homelessness. There are two components. Every jurisdiction can collect data that allows it to identify the most effective strategy for each sub-group of the homeless population. Second, jurisdictions can bring to the planning table those responsible for mainstream as well as homeless-targeted resources.

Close the Front Door

Homelessness can be prevented by making mainstream poverty programs more accountable for the outcomes of their most vulnerable clients and wards.

Open the Back Door
Where homeless people are already accommodating the shortage of affordable housing, this should be facilitated and accelerated. Where there is no housing, particularly for those who are chronically homeless, an adequate supply of appropriate housing should be developed and subsidized.

Build the Infrastructure
Ending homelessness can be a first step in addressing the systemic problems that lead to crisis poverty:

- shortage of affordable housing
- incomes that do not pay for basic needs
- lack of appropriate services for those who need them.

LOCAL

County Initiatives

Plan to Prevent Homelessness and Expand Affordable Housing
Driven by HUD's Housing First policy, a joint local effort conducted by the Cleveland mayor's office, Cleveland City Council, and the Cuyahoga County Board of Commissioners, with the support of the St. Luke's Foundation of Cleveland, The Cleveland Foundation, and the Sisters of Charity Foundation of Cleveland, has resulted in a "Ten Year Plan to Prevent Homelessness and Expand Affordable Housing in Cleveland and Cuyahoga County." The plan's strategies for preventing homelessness include:

- Adopting a community-wide housing first policy that emphasizes stabilizing individuals and families in permanent housing with supportive services as soon as possible before addressing issues of employment or other recovery goals.
- Creating an infrastructure for preventing homelessness rather than ameliorating its effects.
- Holding shelters accountable for transitioning shelter residents into permanent housing as quickly as possible.
- Creating over 3,000 additional units of permanent supportive housing.
- Improving the transition process between prison and re-entry into the community.
- Improving the discharge options for youth who age out of the foster care system.
- Making safety net programs more effective so that homelessness does not become a reality.

III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

For counting purposes, the U.S. Department of Housing and Urban Development (HUD) distinguishes between sheltered and unsheltered homeless (HUD, 2004):

> A person is considered homeless **only** when he/she resides in one of the places described below at the time of the count:
>
> An *unsheltered* homeless person resides in:
> - a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street).
>
> A *sheltered* homeless person resides in:
> - an emergency shelter,
> - transitional housing or supportive housing for homeless persons who originally came from the streets or emergency shelters.

According to HUD (2004), along with street outreach teams, health care for the homeless networks, stationary (soup kitchens), and mobile (vans) food programs, drop-in centers are a primary service entity that caters to unsheltered homeless persons. HUD estimates that one-quarter to one-third of the homeless are unsheltered.

> HUD's definition of an episode of homelessness is:
>
> A separate, distinct, and sustained stay on the streets and/or in an emergency homeless shelter. (HUD's Chronic Homelessness Fact Sheet)
>
> HUD's definition of chronic homelessness is:
>
> An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in emergency shelter during that time. (2004 Continuum of Care application)
>
> Note that HUD's definition of chronic homelessness *does not* include families. In addition, to be identified as chronically homeless, an individual must have a *disabling condition,* defined as follows:
>
> A diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. (2004 Continuum of Care application)

The chronically homeless can be sheltered or non-sheltered homeless.

> Chronically homeless people are more likely than other homeless people to have one or more disabilities. Serious mental illness, drug and alcohol abuse, and chronic and acute physical illnesses are common and often co-occurring. Many people with serious mental illness are afraid of both shelters and street areas where other homeless people congregate. Instead, persons with serious mental illness are frequently found along major roads and transportation corridors at the fringes of downtown areas. Further, some people who are new to homelessness may not use shelters.

The newly homeless, could become chronically homeless if appropriate interventions are not available.

The target population addressed in this core service report is sheltered homeless persons of all ages who have no permanent housing and need a temporary place to stay.

DEMOGRAPHIC CHARACTERISTICS

National

Because of their transient nature, it is difficult to acquire data on the homeless population. There is no good estimate of the number of homeless people currently in the United States. However, based on sample research studies, it is believed that there are probably anywhere from 600,000 to 2.5 million homeless persons (Lowe, 2004). Better data will become available once the new Homeless Information Management System is implemented.

Contrary to what many may believe, most homeless persons are without a place to live for only a short period of time (SAMHSA, 2003):

> They usually become homeless as a result of an unexpected event such as an eviction, natural disaster, or house fire, and tend to have more social and economic resources to draw on than those who remain homeless for longer periods of time. A much smaller group of homeless people either is episodically homeless (i.e., have many episodes of homelessness but each for short periods of time) or is chronically homeless (i.e., have few episodes of homelessness but each for long periods of time). One study of shelter users in two large cities found that 80 percent were temporarily homeless, 10 percent were episodically homeless, and 10 percent were chronically homeless (Kuhn and Culhane, 1998 in SAMHSA, 2003).
>
> The estimated 200,000 people who experience chronic homelessness tend to have disabling health and behavioral health problems. Recent estimates suggest that at least 40 percent have substance use disorders, 25 percent have some form of physical disability or disabling health condition, and 20 percent have serious mental illnesses (Culhane, 2001 in SAMHSA, 2003). Often individuals have more than one of these conditions. These factors contribute not only to a person's risk for becoming homeless but also to the difficulty he or she experiences in overcoming it. People who experience chronic homelessness also tend to be slightly older than those who experience shorter homeless episodes, are non-white, and male (Culhane

> and Kuhn, 1998 in SAMHSA, 2003). Families and youth experience chronic homelessness, as well.

According to a recent report by SAMHSA entitled "Blueprint for Change, Ending Chronic Homelessness in Persons with Serious Mental Illness and Co-occurring Substance Use Disorders" (2003), the major societal risk factors of homelessness, especially for persons with mental illness, are:

- *Poverty*

  > People with serious mental illnesses are among the most impoverished in our Nation … Because many are unable to work full-time, they must rely on public benefit programs, such as SSI. For many individuals with serious mental illnesses, such benefits provide their only means of support.

  However, people with substance use disorders are not eligible for Supplemental Security Income (SSI) based on substance-related disability alone. And even when persons qualify for SSI, which is only provided by fewer than half the states, incomes are well below the federal poverty level. "Lack of benefits frequently leads to homelessness and the inability to exit homelessness."

- *Lack of Affordable Housing*

  > A dearth of appropriate, accessible, and affordable housing is considered by many to be the number one barrier to residential stability for people with serious mental illnesses and/or co-occurring substance use disorders. Not one housing market in the United States exists in which an individual receiving SSI benefits can afford to rent a modest efficiency or one-bedroom unit.

Housing Barriers for People with Serious Mental Illnesses
Many people with serious mental illnesses qualify for federal housing choice (formerly Section 8) vouchers where they need only 30 percent of their income for rent and utilities. However, many people are on waiting lists for years before they receive a subsidy. These vouchers are not helpful in communities with a shortage of affordable housing options. The result is that many very low income persons with mental illness live in overcrowded or substandard living environments or live with aging parents or relatives, many of whom themselves are living on fixed, low incomes. Many are one crisis away from becoming homeless.

Further, many mainstream affordable housing providers are reluctant to serve people with serious mental illnesses, especially those who have been homeless. That reluctance in part is because of the misperception that people with mental illnesses need supervision or round-the-clock support, and in part because of their low incomes and lack of credit history. Research, however, provides strong evidence that people with mental illnesses neither need to nor want to live in such settings (Carling, 1993 in SAMHSA, 2003).

Housing Barriers for People with Substance Use Disorders
Housing is especially problematic for people with substance use disorders, particularly for those with co-occurring mental illnesses. Their behaviors place them at high risk for eviction, arrest, and incarceration. Once homeless, they are unlikely to succeed in treatment without the availability of safe, sober housing (Baumohl and Huebner, 1991; Stark, 1987 in SAMHSA, 2003). Few housing landlords (public or private), mental health agencies, and nonprofit

developers will rent to people who are actively abusing alcohol or other drugs. Use of illegal drugs may be cause to deny admission or evict a person from federally assisted housing (Federal Register, 2001 in SAMHSA, 2003). Individuals who have engaged in drug-related criminal activity must be denied admission to public housing and most other federally assisted programs (Federal Register, 2001 in SAMHSA, 2003).

Discrimination and Stigma in Housing
Despite statutes such as the Fair Housing Amendments Act, allegations of housing discrimination based on mental illnesses are common (HHS, 1999 in SAMHSA, 2003). Stigma and discrimination can be overt, such as vocal community opposition to group living situations, or they can be less obvious, such as steering public funds away from housing initiatives that serve controversial populations.

Lack of Employment
People who are homeless want and need to work, but few are employed in jobs that can help them escape homelessness. A recent nationwide survey of homeless assistance providers and clients found that 44 percent of homeless people were working, but most were employed in short-term jobs with low pay and no benefits (Burt et al., 1999 in SAMHSA, 2003).

There are frequently barriers to employment by persons with mental illness and substance abuse disorders.

In addition, there are a number of individual risk factors:

Mental Illness
Though only about five percent of people with serious mental illnesses are homeless at any given point in time, as many as two-thirds of all people with serious mental illnesses have experienced homelessness or have been at risk of homelessness at some point in their lives (Tessler and Dennis, 1989 in SAMHSA 2003 in SAMHSA, 2003).

Alcohol and Drug Use
Substance use is both a precipitating factor and a consequence of being homeless (Zerger, 2002 in SAMHSA, 2003). Notes McCarty (1990, p.1): "Researchers estimate that as many as half of all people who are homeless have diagnosable substance use disorders at some point in their lives (McMurray-Avila, 2001; Baumohl and Huebner, 1991 in SAMHSA, 2003). Alcohol abuse is more common, occurring in as many as 30 percent to 40 percent of people who are homeless (Stark, 1987; Baumohl and Huebner, 1991 in SAMHSA, 2003). Indeed, there still exists a cadre of older, white male, skid row alcoholics (Koegel and Burnam, 1987 in SAMHSA, 2003). Increasingly, however, individuals who are homeless and have substance use disorders are younger and include women, minorities, poly-drug users, and individuals with co-occurring mental illnesses (McMurray-Avila, 2001 in SAMHSA, 2003). They have less education and fewer skills than their older counterparts.

Co-occurring Disorders
Substance use problems are a complicating factor for many people who have serious mental illnesses. An estimated 50 percent of adults with serious mental illnesses who are homeless have a co-occurring substance use disorder (Fischer and Breakey, 1991 in SAMHSA, 2003). Among veterans who are homeless, one-third to nearly one-half have co-occurring mental illnesses and substance use disorders (Kasprow, Rosenheck et al., 2002 in SAMHSA, 2003).

Once homeless, people with co-occurring disorders have more problems, need more help or are unable to benefit from services, and are more likely to remain homeless than other groups of people (Winarski, 1998 in SAMHSA, 2003). They are more likely to be older, male, and unemployed; to be homeless longer and living in harsher conditions; and to suffer greater distress, demoralization, and alienation from their families. They tend to be isolated, mistrustful, and resistant to help (Dixon and Osher, 1995 in SAMHSA, 2003). Lack of appropriate treatment for co-occurring disorders means that even individuals who are motivated to get help may be unable to find it or have to face long waits.

Physical Health Problems

People with serious mental illnesses and/or co-occurring substance use disorders often have significant co-morbid medical conditions, including malnutrition, diabetes, liver disease, neurological impairments, and pulmonary and heart disease. Homeless people with alcohol disorders are in especially poor health; they experience both the deleterious effects of alcohol and of homelessness (Wright and Weber, 1987 in SAMHSA, 2003). Further, life on the streets makes it difficult for individuals to receive appropriate care for chronic conditions and often leads to such acute problems as upper respiratory infections, skin conditions, and serious dental health problems. In addition, people who are homeless, particularly those with serious mental illnesses or co-occurring disorders, are at risk for life-threatening infectious diseases such as tuberculosis, Hepatitis B and C, and HIV/AIDS. (Federal Task Force on Homelessness and Severe Mental Illness, 1992; McMurray-Avila, 2001 in SAMHSA, 2003)

Victimization

The relationship among homelessness, mental illness, substance use, and victimization—including physical and sexual abuse—is multidimensional. People who have been abused are more vulnerable to ongoing stresses that may lead to mental illness, substance use, and homelessness. While the association between childhood abuse, mental illness, and substance use is increasingly recognized, a number of studies have found high rates of childhood physical and sexual abuse in adults who are homeless, as well (Fischer, 1992 in SAMHSA, 2003). Indeed, research points to high prevalence rates of sexual abuse and other trauma in the lives of people with serious mental illnesses and substance use disorders who are homeless, particularly women (Goodman et al., 1995; Herman et al., 1997 in SAMHSA, 2003).

> In studies that ask about lifetime abuse, between 51 and 97 percent of women with serious mental illnesses report some form of physical or sexual abuse, with a significant portion suffering multiple traumas (Goodman et al., 1997 in SAMHSA, 2003). Forty-one percent to 71 percent of women in treatment for drug or alcohol disorders report being sexually abused as children or adults, and more than one-third have been victims of violent crimes (Alexander, 1996 in SAMHSA, 2003).
>
> Abuse in childhood may leave individuals vulnerable to ongoing abuse in adult relationships. For some women, domestic violence precipitates homelessness. Mental health providers may treat women who have experienced physical and sexual abuse inappropriately by using such techniques as physical restraints or forced medication that may remind the women of the original abuse they suffered (National Association of State Mental Health Program Directors [NASMHPD], 1998 in SAMHSA, 2003). These women require trauma-sensitive services to help them regain psychiatric and residential stability.

Finally, people who are homeless may become victims of further assault on the streets and in shelters. Those individuals who have fewer resources and skills to overcome the effects of trauma—especially people who have serious mental illnesses, including post-traumatic stress disorder (PTSD)—are particularly likely to be victimized while homeless, and to suffer more severe consequences of ongoing abuse (Fischer, 1992 in SAMHSA, 2003).

- *Minority Status*

  Racial and ethnic minorities are dramatically overrepresented among homeless populations. Nationally, compared to all U.S. adults in 1996, individuals who were homeless were disproportionately Black non-Hispanics (40 percent versus 11 percent in the general population) and American Indians (8 percent versus 1 percent in the general population) (Burt et al., 1999). Though these percentages vary around the country, research shows that people of color comprise a disproportionate share of the homeless populations in their communities (Burt, 1999 in SAMHSA, 2003).

- *Sexual Minorities*

  Homeless sexual minorities, especially youth, also are at increased risk for negative outcomes. Forty-two percent of homeless youth identify as lesbian, gay, or bisexual (Orion Center, 1986 in SAMHSA, 2003). Researchers comparing gay, lesbian, bisexual, and transgender (GLBT) homeless youth with their heterosexual counterparts found that GLBT adolescents left home more frequently, were victimized more frequently, used highly addictive substances more frequently, had higher rates of psychopathology, and had more sexual partners than heterosexual homeless youth (Cochran et al., 2002 in SAMHSA, 2003).

  Transgender individuals are especially stigmatized. They may become homeless as a direct result of job or housing discrimination. Researchers report that as many as 60 percent have been victims of harassment or violence, and 37 percent have experienced economic discrimination (Lombardi, 2001 in SAMHSA, 2003).

- *Diminished Social Supports*

  People with mental illnesses who become homeless have less contact with their families and are more likely to have poor family relationships than those who are not homeless … Likewise, people with substance use disorders who are homeless have less social support than people who are not homeless. Yet, interestingly, among homeless groups, people who drink tend to report more support than people who don't drink, in part because drinking can be a social activity (Fischer and Breakey, 1987 in SAMHSA, 2003). Severing the bonds with their "friends" who use alcohol or drugs may compound feelings of social isolation among people who are homeless (McMurray-Avila, 2001 in SAMHSA, 2003).

- *Foster Youth*

  Numerous studies of homeless youth have found experiences of physical and sexual abuse, parental drug or alcohol use, childhood homelessness, foster care, and juvenile detention. Neglect and lack of emotional and

financial support from their families can also cause youth homelessness. Homeless youth also have special needs (National Alliance to End Homelessness, 2004). Youth aging out of foster care are particularly vulnerable. Within 2-4 years of exiting foster care, 25 percent of youth experienced homelessness (Annie E. Casey Foundation, 2004).

- *Criminal Justice System Involvement*
  Homeless people, especially those with mental illnesses and/or co-occurring substance use disorders, come into frequent contact with the criminal justice system both as offenders and as victims. Often, homeless people are arrested for minor offenses, including trespassing, petty theft, shoplifting, and prostitution … A person's contact with the criminal justice system may be even more likely following the enactment of "anti-homeless" legislation, including anti-begging, sleeping, and vagrancy ordinances, which is occurring in many of the country's largest cities (National Coalition for the Homeless [NCH] and National Law Center on Homelessness and Poverty, 2002 in SAMHSA, 2003).

Ohio
Much like national estimates, it is difficult to determine the true number of homeless people residing in Ohio. The Coalition on Homeless and Housing in Ohio (COHHIO) applied national estimates to Ohio's total population and estimated that over 179,000 Ohioans experienced homelessness in 2001. For the point-in-time estimate, COHHIO also applied national estimates to surmise that roughly 27,000 Ohioans experienced homelessness on any given night in 2001 (COHHIO).

Cuyahoga County
There have been several estimates of the number of persons in Cuyahoga County who are homeless within a year. They range from 16,000 to 26,000 persons. In addition, between 2,208 and 3,900 persons are estimated to be homeless on any given night. While these numbers are not exact, they paint a picture of the county's overall problem.

In 2003, Cleveland State University's Maxine Goodman Levin College of Urban Affairs estimated that approximately 16,000 Cuyahoga County residents were homeless at some time during the course of a year. The Northeast Ohio Coalition for the Homeless (NEOCH) estimated that nearly 26,000 people are homeless in Cuyahoga County every year and that 3,900 are homeless on any given night. This includes the shelter population of 2,100 people, along with approximately 1,800 sleeping on the streets, staying under bridges and overpasses, or living in abandoned buildings (Heading Home, 2005).

In January 2005, a point-in-time count of homeless persons in Cuyahoga County suggests there were over 2,208 homeless persons (Cuyahoga County Office of Homeless Services, 2005). Of these, 1,208 were in emergency shelters, 776 were in transitional housing, and 224 were unsheltered and living on the street. Two-thirds of the sheltered (emergency and transitional) homeless who are users of Homeless Shelters and Transitional Housing have a chronic substance use disorder and close to half are considered chronically homeless. Approximately a quarter of them are severely mentally ill and a fifth of them are veterans (Cuyahoga County Office of Homeless Services, 2005). (See Table 1.)

Table 1: Profile of Sheltered (Emergency & Transitional) Homeless Persons in Cuyahoga County from 2005 'Point in Time' Count

Contributing Factor	#	%
Chronic Substance Abuse	1,201	61%
Chronically Homeless	957	48%
Severely Mentally Ill	460	23%
Veterans	381	19%
Victims of Domestic Violence	206	10%
Persons with HIV/AIDS	36	2%
Youth (Under 18 yeas)	14	1%
Total Sheltered	**1,984**	**100%**
Emergency	1,208	61%
Transitional	776	39%

Cuyahoga County Continuum of Care Point in Time Count of Homeless Services, 2005. (Cuyahoga County Office of Homeless Services, February, 2006).

The U.S. Conference of Mayors' 2004 survey identified the following causes of homelessness, many of which Cleveland city officials also cited as explanations for its homeless population: 1) lack of affordable housing; 2) mental illness or lack of needed services; 3) substance abuse or lack of needed services; 4) low-paying jobs; 5) unemployment; 6) domestic violence; 7) poverty; and 8) prisoner reentry (Lowe, 2004).

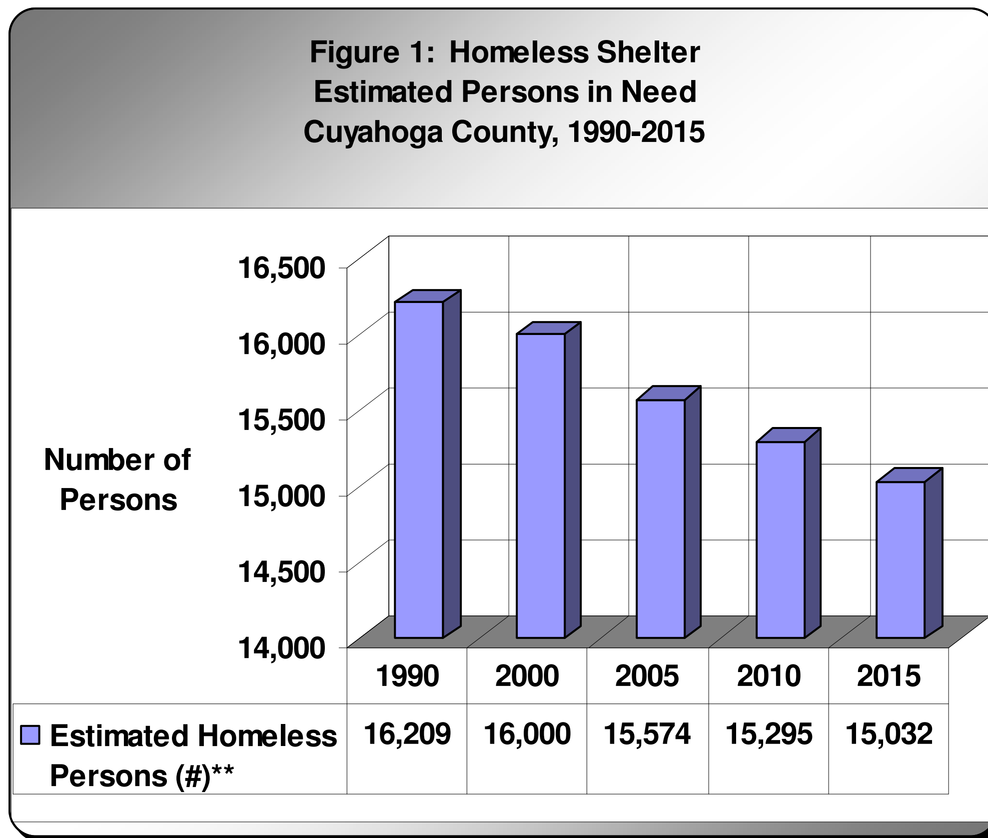
The same survey found that, nationally, people remain homeless for an average of eight months. Cleveland city officials responded that the city's increased emphasis on moving shelter residents more quickly into transitional, supportive, or permanent housing has shown success. However, this success is offset by increasing numbers of prison-released persons and others who face extensive barriers to getting out of the shelter system.

The following is feedback from the local United Way focus groups that were conducted for core service planning (2005) regarding the local service environment for all homeless shelters, including shelters:

- Agencies have been servicing older clients and many more senior citizens, both at their shelters and their hot meal programs.
- More women and families have been coming to agencies for help. In the past, it was rare to see children in the shelters, but now they are seen frequently. Aids Taskforce organizations have been helping women and children as young as 13 who are affected by the epidemic.
- The clientele being served is increasingly lacking in education and skills, and therefore are having a more difficult time finding employment and breaking the homeless cycle.
- Persons with criminal records are an underserved group and have difficulty finding employment and so end up in the shelters. Sex offenders, in particular, are lacking access to services and have many "basic needs that everyone else has."
- Other underserved groups include transgender groups who "can't stay in a women's or a men's shelter," and veterans who are losing benefits due to the downsizing of VA services.

- Persons with medical needs are not adequately serviced because most shelters will not take clients with special conditions, such as requiring oxygen or having infectious diseases. Some people released from hospitals need a temporary place to go to recover fully from a medical crisis, yet very few such places exist.
- Families are not properly served because they cannot as easily get into shelters, particularly if they have a father with them.

Estimated Persons in Need
In 2000, 16,000 individuals in Cuyahoga County were estimated to be homeless. The number of individuals estimated to be homeless is projected to decrease to 15,032 by 2015 because of shifts in population. (See Figure 1.)



Sources:
* U.S. Census 1990, SF1 (P1); 2000, SF3 (P8); 2005-2015, Ohio Department of Development, (July, 2003).
** Heading Home, The Cleveland/Cuyahoga County Ten Year Plan to Prevent Homelessness and Expand Affordable Housing: "A Five-Year Plan to Develop Supportive Housing for Long-Term Homeless Adults in Cleveland and Cuyahoga County." Prepared by the Corporation for Supportive Housing in collaboration with The Maxine Goodman Levin College of Urban Affairs, Cleveland State University, 2003 - estimated approximately 16,000 Cuyahoga County residents are homeless at some point in time during the course of a year. 1.1 percent total population. Assumes same percentage across periods.

It is recognized that this is a conservative estimate of persons in need of homeless shelter programs because methods for calculating homeless individuals is still often hit or miss, with

most estimates relying on point-in-time measures. However, it is a number that begins to offer some clarity about the extent of need in Cuyahoga County.

REALIZED ACCESS TO SERVICE

Realized access to service is represented by the numbers of consumers actually served. It includes the actual number of consumers reported by agencies funded by United Way and by government funders from which it was possible to obtain data. Thus, it is an underestimate of actual numbers of consumers receiving service.

In FY 2004, United Way funded 601 persons for homeless shelter programs. (See Attachment 3.) The Office of Homeless Services funded 5,132 unduplicated actual annual consumers. These are not noted in Attachment 3 because they represent services funded by multiple funders. Duplication with United Way funded consumers is assumed.

While 47 percent of the county's total population is male and 53 percent female, consumers funded by United Way were 65 percent female and 35 percent male.

In 2000, according to the U.S. Census, 67 percent of the county's total population was Caucasian, 28 percent African American, and 2 percent Asian. Consumers funded by United Way were 9 percent Caucasian, 90 percent African Americans, and less than 1 percent Asian.

Approximately 3 percent of UW-served homeless shelter consumers were Hispanic, which is about equal to the proportion of Hispanics in the total population of the county.

Forty-six percent of those funded by United Way reported annual household income below $15,000. Fifty-three percent were unreported.

United Way funded agencies reported zip codes for homeless shelter consumers; however, they are likely to reflect addresses of the shelters. (See Attachment 4.)

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

The definition of the core service for this report is as follows: programs that provide a temporary place to stay for people who have no permanent housing.

BACKGROUND ON CORE SERVICE

> Along with homeless drop-in centers and transitional housing, homeless shelters are part of the continuum of services for homeless persons and families. They are residences in urban neighborhoods where homeless people can stay temporarily (similar to emergency shelters) when they otherwise would have to sleep on the street. The main difference is that homeless shelters are usually open to anyone, regardless of reasons they don't have a more typical residence available, although some limit their clientele by gender or age. A minor difference is that homeless shelters usually expect people to go elsewhere during the day, returning only to sleep or, if the shelter also provides meals, to eat, while people in emergency shelters are more likely to stay all day, except for work, school, or errands. Some homeless shelters, however, are open 24 hours a day. Homeless shelters are usually operated by a nonprofit agency or are associated with a church. Many get at least part of their funding from local government entities. Homeless shelters sometimes provide other services such as a soup kitchen, job-search skills training, job training, job placement, support groups, and/or chemical dependency treatment. If they don't offer any of these services, they can usually refer their clients to agencies that do (Wikipedia.com, n.d.).

Nonprofit agencies predominantly operate homeless assistance programs (85%); 51 percent of them are run by secular nonprofits; 34 percent by faith-based nonprofits; and 14 percent by government agencies (McCarty, 2005).

There are several shelter models (Freeman, n.d.):

- **Staffed shelter.** This is the traditional shelter, with professional paid staff. It is the most expensive model. It needs space for beds, showers, and other amenities.

- **Volunteer staff.** Many local shelters run smoothly with a rotating staff of volunteers. Local service agencies send their referrals with blankets. The church provides space, including bathroom facilities and storage for mats. The volunteers provide light snacks and supervision. The shelter members set up their own mats and clean up after themselves.

- **Self-managed shelter.** This is a group of homeless and formerly homeless men and women who organize their own self-managed shelters and other survival resources while doing self-advocacy for the social changes to end homelessness. The SHARE program in Seattle is an example. The key to the shelter space is kept in a central

location. Each night a responsible shelter member picks up the key, the shelter record book, and bus tickets for shelter members. The shelter members go to the shelter, let themselves in, and set up for the night. They govern themselves according to agreed-upon rules. In the morning, they clean up after themselves and let themselves out. Shelter supplies are provided by the sponsoring organization. Once a week volunteers from the shelter wash the blankets in laundry facilities provided.

- **Mixed model.** A number of shelters run on a mixed model with both staff and volunteers, or are self-managed with one staff member or volunteer present to facilitate.

The U.S. Conference of Mayors' 2004 survey found that in Cleveland there were 1,156 shelter beds; 291 family shelter beds; 981 transitional units; 185 family transitional units; and 50 single room occupancy units. The report also noted that 70 percent of the surveyed cities reported an increase in requests for emergency shelters. The average increase in Cleveland was 6 percent. Cleveland city officials reported that the city's full-service family shelters remain filled to capacity. The emergency men's shelter, which does not turn anyone away, has experienced relatively constant numbers, even with increased efforts to move people into housing. For example, over a 12 month period, 810 persons moved from the men's shelter to more stable housing, but new arrivals kept demand at a high level. As for the women's shelter, which also accepts families on a short-term basis, there was also an increase in demand. City officials also reported that there were more people sleeping outside during the summer months (Lowe, 2004).

Cleveland and Cuyahoga County fall far short of sufficient affordable rental housing for the number of families who need it. A significant portion of the city's (and county's) population cannot afford the cost of standard quality housing, even when an excessive percentage of income is devoted to housing costs. Therefore, many individuals either live in substandard housing or are homeless (Heading Home Cleveland). As can be seen in Table 2 below, the lower the gross rent the more likely housing will be substandard. In Cuyahoga County in 2003, 19.3 percent of rental units with rents under $100 were substandard compared to 4.9 percent of those with rents $700 or more. The same pattern holds for the City of Cleveland although the percentages of substandard housing are far higher than for the county as a whole. There is far less substandard housing in the suburbs and the pattern from low to high rents is not a straight line.

Table 2: Percentage of Substandard Rental Housing Units in Cleveland and Cuyahoga County by Rental Cost, 2003

Gross Rent for Substandard Housing Units	County	City of Cleveland	Suburbs
Less than $100	19.3%	21.9%	2.8%
$100 - $149	16.7%	22.2%	2.2%
$150 - $199	16.3%	21.7%	2.8%
$200 - $249	16.3%	22.3%	1.9%
$250 - $299	19.8%	25.5%	2.7%
$300 - $349	16.7%	20.7%	3.8%
$350 - $399	15.6%	20.8%	3.9%
$400 - $449	11.5%	17.3%	2.6%
$450 - $499	11.1%	19.7%	2.2%
$500 - $549	9.1%	18.2%	1.6%
$550 - $599	7.8%	17.1%	1.4%
$600 - $649	7.6%	18.7%	1.1%
$650 - $699	6.9%	18.5%	1.2%
$700 or more	4.9%	16.1%	1.3%

2000 SF3 Data, US Census Bureau and 2003 Characteristics File, Cuyahoga County Auditor. Prepared by: Northern Ohio Data and Information Service – NODIS, Levin College of Urban Affairs, Cleveland State University

Federal guidelines state that 30 percent is the most of one's income that should be spent on housing in order for it to be "affordable." COHHIO's report shows that two people working full time for minimum wage would need to work to afford a one bedroom apartment; they need to make a combined $11.65 per hour, and minimum wage in Ohio is currently $6.85. For a family with children, a two-bedroom apartment is almost impossible—the two adults would need a combined income of $14.46 per hour. In the Cleveland area, they would need to work a combined 112 hours per week at minimum wage to afford a two-bedroom apartment. In order to keep a roof over her or his head, a single person is almost forced to "double-up" with someone to split the rent. Tragically, families with children are among the fastest growing segment of the homeless population. In addition, almost every major city in America has seen dramatic reductions in the number of affordable units available to lower income individuals as the federal government tries to get out of the business of owning housing.

Homeless persons often need more than housing; they need supportive housing, which is a form of co-housing designed to support individuals not only socially, but with basic life skills. Housing is coupled with social services such as job training, alcohol and drug abuse programs, and case management. This is often targeted at low-income workers and populations in need of assistance: the homeless, persons suffering from mental illness or substance abuse problems, and the elderly or medically frail. Supportive housing can be on an ongoing/permanent basis or during a transition period of dependence on others. The type and level of support depends on individuals and their families' specific needs, wishes and, in many instances, ability to pay. Some examples of supportive housing:

- A nursing home or retirement community, e.g. Eden Alternative;
- Halfway house, e.g. Elizabeth Fry Society, John Howard Society;
- Homes for the intellectually challenged or for those with "mental illness;" and
- Housing with supports for victims of abuse, e.g. rape, child molestation.

As a solution for homelessness, supportive housing addresses two key problems: without housing, there is no basis from which to mitigate the factors that lead to homelessness; without support services, the tenant is likely to return to homelessness for the reasons that led to their loss of housing in the first place (Wikipedia.com, n.d.).

As the major funder of services for homeless persons, HUD is the driving force behind the direction of services for homeless persons, as was discussed previously in this report (HUD, 2006). Its current strategic plan has spelled out its agenda for ending chronic homelessness and addressing the needs of other homeless households. More specifically, the goal is "to provide both flexible and targeted resources to communities, as well as to encourage planning and coordination to maximize the impact of these resources."

> HUD annually allocates over $1.1 billion in McKinney-Vento Act funds through 450 local Continuum of Care (CoC) planning jurisdictions. A Continuum of Care is a broadly representative public-private planning process that assesses local needs, determines local priorities for funding within national goals, and assesses local performance in ending chronic homelessness and moving homeless families and individuals to permanent housing. In order to target funds to serve the chronic homeless, HUD has developed a "Samaritan Initiative" that provides bonus funding for CoCs submitting a permanent housing project dedicated to serving chronically homeless persons. In the 2005 national competition, HUD funded 4,940 projects totaling $1.1 billion in 452 CoCs. Of these, 611 were new projects. There were 233 "Samaritan bonus" projects that received a total of over $100 million in funding.
>
> HUD will continue to seek tighter coordination and integration of its 10-year planning efforts to end chronic homelessness through standardizing homeless and chronic homeless planning components contained in its two resource-driven local planning structures: (1) the Consolidated Plan with homeless and chronic homeless elements that are submitted by states and 1,128 jurisdictions that receive over $5.8 billion in CDBG, HOME, HOPWA, and ESG program funding; and (2) the annual plan for addressing homelessness and ending chronic homelessness submitted by over 452 CoC planning jurisdictions. HUD is actively seeking to coordinate these jurisdictional CoC and Consolidated Plans with other 10-year plans.
>
> HUD will continue to work directly with other federal agencies, and through the U.S. Interagency Council on Homelessness, on collaborative efforts to address homeless needs and to end chronic homelessness. One tangible result of this effort is the $35 million Chronic Homeless Initiative between HUD and the Departments of Health and Human Services (HHS) and Veterans Affairs that weaves together housing and social services for homeless people with addictions, mental illness, prisons histories, and other root causes of persistent homelessness. Another is the jointly funded initiative between HUD and Department of Labor for $13 million focusing on the housing and employment needs of chronically homeless persons.

HUD also recently funded a new initiative, “Housing for Persons Who Are Homeless and Addicted to Alcohol,” to assist chronically homeless individuals who have a long-term addiction to alcohol. The initiative funds 12 pilot programs in 11 cities that serve approximately 555 persons. These programs received two-year grants totaling $10 million in funding, and were developed in collaboration with the U.S Interagency Council on Homelessness.

As homeless families and individuals obtain better access to the mainstream services they need, and as the coordination between HUD and other federal agencies coalesces, HUD is working to reduce the proportion of HUD homeless funds used for the provision of social services and to increase the proportion used for housing.

A key tool for ending chronic homelessness will be to provide permanent supportive housing–housing combined with services. The Department will continue to ensure that at least 30 percent of all available homeless funding is awarded for permanent housing. Providing permanent supportive housing will significantly reduce the cost of medical, mental health, and criminal justice resources that are used for persons experiencing chronic homelessness. In fact, recent research has demonstrated that providing permanent supportive housing costs about the same as leaving an individual on the streets and having him or her cycle through the various disconnected healthcare, correctional, mental health, and substance abuse treatment institutions.

HUD will scrutinize the policies of its mainstream housing programs to determine whether additional mainstream housing resources can be brought to bear on the problem of homelessness, including both persons experiencing chronic homelessness and homelessness among families.

HUD is also collaborating with other federal agencies in efforts to better connect HUD program recipients with resources made available to address health, human services, job development, education, and other services that are needed by persons with special needs. The results of these efforts should help ensure that HUD recipients achieve their housing mission with improved access to the related social services provided by other federal programs.

Finally, HUD will continue to:

- Assist communities in developing congressionally mandated Homeless Management Information Systems (HMISs) to track homeless persons moving through emergency shelter, transitional housing, and into permanent housing. HMISs will identify the characteristics of homeless persons and track milestones, including access to benefits, educational opportunities, and employment. In doing so, HUD will take steps to ensure adequate legal protections for privacy and confidentiality of homeless clienteles, particularly victims of domestic violence.

- Encourage states and communities to improve discharge planning from their healthcare, foster care, youth facilities and criminal justice programs, so that, upon discharge, people move to stable permanent housing rather than becoming homeless.

- Provide extensive technical assistance to applicants and potential applicants for the Department's homeless assistance programs. In addition to a continuation of the local, regional, and national technical assistance resources already in place, HUD will inaugurate targeted technical assistance specifically tailored to faith-based organizations. Existing targeted technical assistance efforts under way to veteran service organizations will also be expanded.

- Research methods to measure and optimize the cost of achieving housing stability for various populations.

In its strategic plan, HUD has spelled out specific performance measures to be achieved by 2011:

- The percentage of formerly homeless persons who remain housed in HUD permanent housing projects for more than 6 months will be 75 percent by 2011.
- By 2011, HUD will create 40,000 new units of permanent housing for chronically homeless individuals.
- By 2011, 65 percent of households leaving transitional housing will directly move to permanent housing.
- By 2011, 25 percent of homeless persons will be employed upon exiting HUD homeless assistance projects.

Issues with the Service System
The recent SAMHSA (2003) study referenced previously points out a number of service system challenges, primarily focusing on homeless persons with serious mental illness and/or co-occurring substance use disorders. These issues include funding restrictions and preference of service providers to institutional locations for service delivery, the complexities of navigating a fragmented funding and service delivery system, and the timing of assessments.

Funding Restrictions and Preference for Institutional Service Delivery Locations

> Payers who fund mainstream mental health and substance abuse treatment services favor clinic and institution-based care (Post, 2001 in SAMHSA, 2003). Though Medicaid has instituted some outreach efforts, it is not specifically targeted to homeless people (GAO, 2000a). When case management is available to people who are homeless, caseloads are usually high, permitting little more than office-based contact and infrequent monitoring. Providers struggle to pay for services provided in atypical settings, such as shelters and on the streets, or non-medical services, such as social model substance abuse treatment programs. Further, providers may be reluctant to serve people with no health insurance coverage, which is the case for many people with serious mental illnesses and/or co-occurring substance use disorders who are homeless. Many are eligible for, but unable to access, these benefits. Those covered by Medicaid or Medicare often are

not attractive to providers in managed care systems that receive less reimbursement than they would under a fee-for-service arrangement (Bianco and Milstrey-Wells, 2001 in SAMHSA, 2003).

Homeless people who have substance use disorders are less likely than those with serious mental illnesses or co-occurring disorders to be receiving Federal disability benefits (Baumohl and Huebner, 1991 in SAMHSA, 2003). This is in large part because individuals with substance use disorders, no matter how severe, are not considered disabled under Social Security Administration guidelines for the purpose of receiving SSI, unless they have other disabling health conditions not attributable to their substance use.

Complexities of Navigating a Fragmented Funding & Service Delivery System

Categorical funding—which requires that providers offer only a specific type of service with funds from a particular source (federal, state, local, private, etc.)—may make it difficult to tailor services to individual needs. In its report, "Ending Chronic Homelessness: Strategies for Action," the U.S. Department of Health and Human Services (HHS) uses the phrase "funding silos" to describe this problem, which arises in part because most mainstream programs administered by HHS were created to respond to a unique need or population (HHS, 2003 in SAMHSA, 2003). The same is true for categorical programs in other federal agencies, as well as in state and local programs.

People with serious mental illnesses and/or co-occurring substance use disorders who are homeless require a broad range of housing, health and mental health care, substance abuse treatment, and social services, all of which typically are provided by separate agencies with separate funding streams. The burden of coordination falls on the individual, but people with serious mental illnesses or co-occurring disorders, especially those who are homeless, are ill-prepared to negotiate a fragmented service system unaided.

Service system fragmentation is especially evident in the transition from an institution, such as a hospital or jail, to the community. Some people with serious mental illnesses may be released from a hospital before their symptoms are stabilized adequately, especially if their health insurance plan specifies a predetermined length of stay. Others are released without adequate discharge plans. People with substance use disorders may be discharged from detoxification programs back to the streets … Nationally, only one-third of inmates with mental illnesses in jails and prisons receive any discharge planning services. Frequently, they are released with bus tokens, a few pills, and the address of a mental health center (Bazelon Center for Mental Health Law, 2001 in SAMHSA, 2003). They are subject to further arrest or to unnecessary hospitalization as they attempt to cope with their mental illnesses and life on the streets. Likewise, individuals with substance use disorders who are not connected to appropriate community services are more likely to cycle repeatedly between jail or prison and the community.

> There is a lack of integrated treatment for co-occurring mental illnesses and substance use disorders. People who are homeless also interact with the homeless service system. People with co-occurring disorders who are homeless frequently are excluded from mental health treatment programs because of their substance use disorder, from substance abuse treatment programs because of their mental illness, and from homeless service programs because of their mental illnesses and substance use disorders. Those who do receive care may get treatment for their substance use or their mental illness, but the vast majority of individuals do not receive treatment for both (Watkins et al., 2001). More recent models emphasize the integration of mental health and substance abuse treatment for people with the most serious disorders, but few such programs are available (SAMHSA, 2002b in SAMHSA, 2003).

<u>Timing of Assessment</u>

Screening and assessment of homeless people is also complicated.

> Outreach workers may conduct an initial assessment, which often has to be short and unobtrusive to avoid frightening away potential clients. A more complete assessment may be possible when clients have developed a greater degree of trust and comfort with outreach staff (Interagency Council on the Homeless, 1991 in SAMHSA, 2003). Adequate initial assessment of persons with serious mental illnesses or co-occurring disorders is made more difficult by the fact that shelter staff may lack the training or time to conduct a thorough psychiatric assessment, and there are few reliable screeners for co-occurring disorders. There are, however, some agreed upon early assessment tools for substance use disorders. A study of different assessment methods in Boston's Long Island Shelter found that case managers could identify substance use problems by using a set of open-ended questions that include information on consumption patterns and personal problems associated with drinking (Garrett and Schutt, 1987 in SAMHSA, 2003).
>
> People who are homeless and have serious mental illnesses and/or co-occurring substance use disorders are eligible for a host of mainstream health, social service, and income support programs that are intended to meet the needs of all low-income people, not only those who are homeless. Though such programs are a valuable resource for providing needed services and supports, people who are homeless often face significant enrollment barriers (Post, 2001 in SAMHSA, 2003).

One of HUD's programs for permanent housing is the Shelter Plus Care Program, which provides rental assistance for hard-to-serve homeless persons with disabilities in connection with supportive services funded from sources outside the program. Shelter Plus Care (S+C) is a program designed to provide housing and supportive services on a long-term basis for homeless persons with disabilities (primarily serious mental illness, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome (AIDS) or related diseases) and their families who are living in places not intended for human habitation or in emergency shelters. The program allows for a variety of housing choices and a range of supportive services

funded by other sources in response to the needs of the hard-to-reach homeless population with disabilities. Program grants are used for the provision of rental assistance payments through four components:

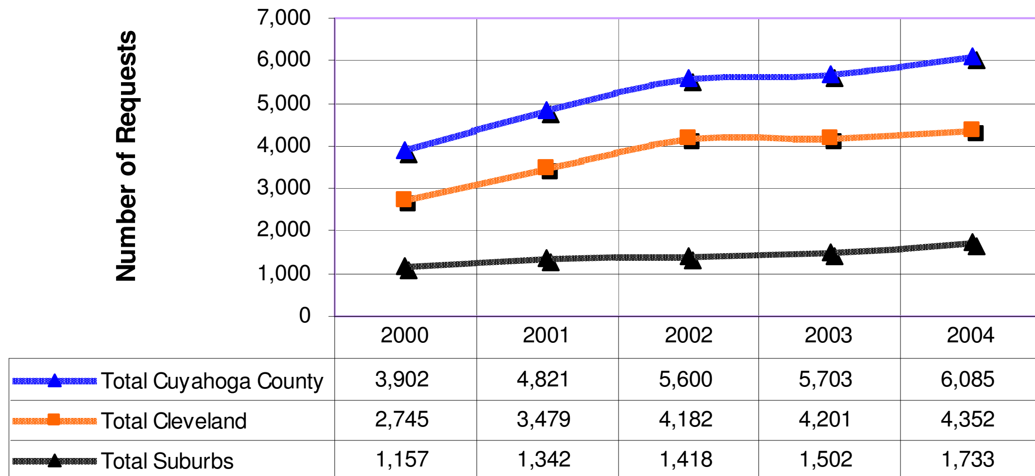
- Tenant-based Rental Assistance (TRA);
- Sponsor-based Rental Assistance (SRA);
- Project-based Rental Assistance with (PRAW)or without rehabilitation (PRA); and
- Section 8 Moderate Rehabilitation Program for Single Room Occupancy (SRO) Dwellings.

United Way - First Call for Help Call Data
Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 10 homeless shelter program providers operating from 11 different sites, 9 of which are nonprofit and one is other. In FY 2004 (July 2003 to June 2004), United Way funded two providers. (See Attachments 5 and 6.)

United Way - First Call for Help call data shows an increase in the number of total requests for homeless shelter programs in the county: from 3,902 in 2000 to 6,085 in 2004 (56 percent increase) with a 59 percent increase in Cleveland (2,745 to 4,352 requests) and a 50 percent in the suburbs (1,157 to 1,733 requests). (See Figure 2.) Calls came from the majority of Cuyahoga County zip codes with the following experiencing the highest average number of calls from 2000-2004:

- 44115 (Cleveland) – 677 calls
- 44114 (Cleveland) – 423 calls
- 44113 (Cleveland) – 222 calls
- 44110 (Cleveland/East Cleveland) – 205 calls
- 44111 (Cleveland) – 129 calls

(See Attachment 7.)

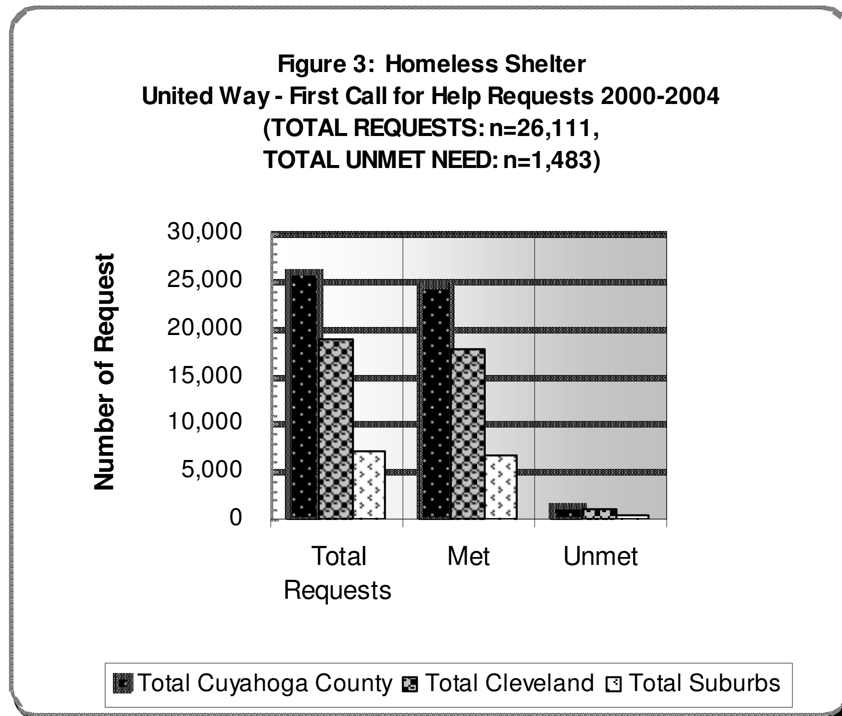


	2000	2001	2002	2003	2004
Total Cuyahoga County	3,902	4,821	5,600	5,703	6,085
Total Cleveland	2,745	3,479	4,182	4,201	4,352
Total Suburbs	1,157	1,342	1,418	1,502	1,733

Over the same five-year period, United Way - First Call for Help had 26,111 requests for information about homeless shelter programs. Of these requests, they were able to make referrals to 94 percent of callers; however, 6 percent of all Cuyahoga County callers (1,483) had an unmet need, meaning there was no agency to which to refer the caller. Callers from the City of Cleveland had a 6 percent unmet need rate, and from the suburbs, 5 percent. The largest unmet needs ranged from 1,103 requests in Cleveland to 380 requests in the suburbs over the five-year period, with the most unmet requests in zip codes:

- 44104 (Cleveland) - 61
- 44120 (Shaker Hts/Cleveland) - 51
- 44114 (Cleveland) - 41

(See Figure 3 and Attachment 8.)



FUNDING OF CORE SERVICES

Major Government Funders
The major sources of government funding for homeless shelters are the following:

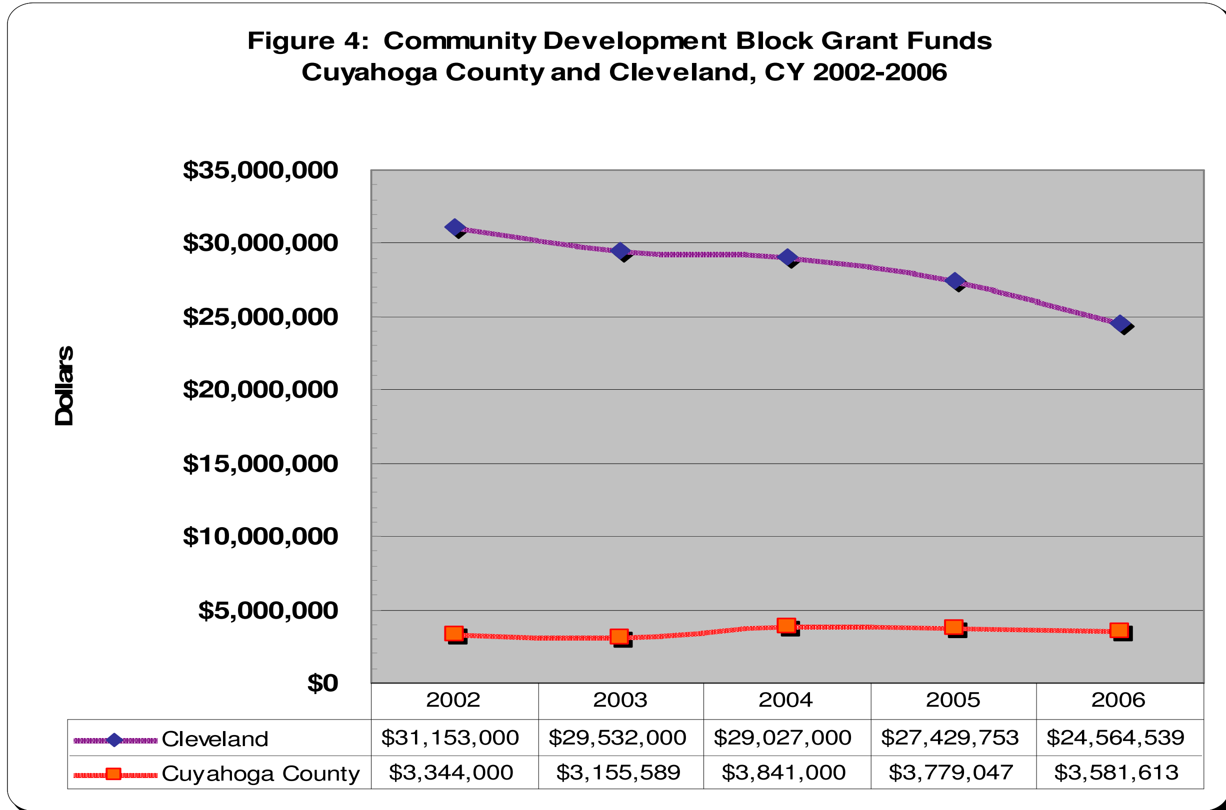
- Community Development Block Grant (CDBG)
- Cuyahoga County General Revenue Fund
- Emergency Shelter Grant Program
- FEMA's Emergency Food and Shelter National Board Grant Program
- Ohio Housing Trust Fund
- Temporary Assistance to Needy Families (TANF)

The majority of local funding for homeless shelters comes from the federal government and is passed through the state to local HUD programs as administered through the Office of Homeless Services within the Cuyahoga County Department of Development. Additional state and local sources are also available. Below is further explanation of major government funding sources for homeless shelters.

NATIONAL

Community Development Block Grant (CDBG) – County and City of Cleveland
Community Development Block Grant funds are intended to develop viable urban communities by providing decent housing and a suitable living environment, and by expanding economic opportunities, principally for low- and moderate-income persons. Thus homeless services are often funded from CDBG funds. The U.S. Department of Housing and Urban Development (HUD) determines the amount of federal funds that cities and counties are entitled to each year

through a formula based upon population, growth lag, poverty level, age of housing, and overcrowding. CDBG provides federal funding for locally initiated neighborhood improvement projects. City of Cleveland CDBG funding has been trending downward. Between 2002 and 2006, Cuyahoga County CDBG funds have increased slightly. Below is a trend of total CDBG funding in Cuyahoga County and the City of Cleveland. (See Figure 4.)



	2002	2003	2004	2005	2006
Cleveland	$31,153,000	$29,532,000	$29,027,000	$27,429,753	$24,564,539
Cuyahoga County	$3,344,000	$3,155,589	$3,841,000	$3,779,047	$3,581,613

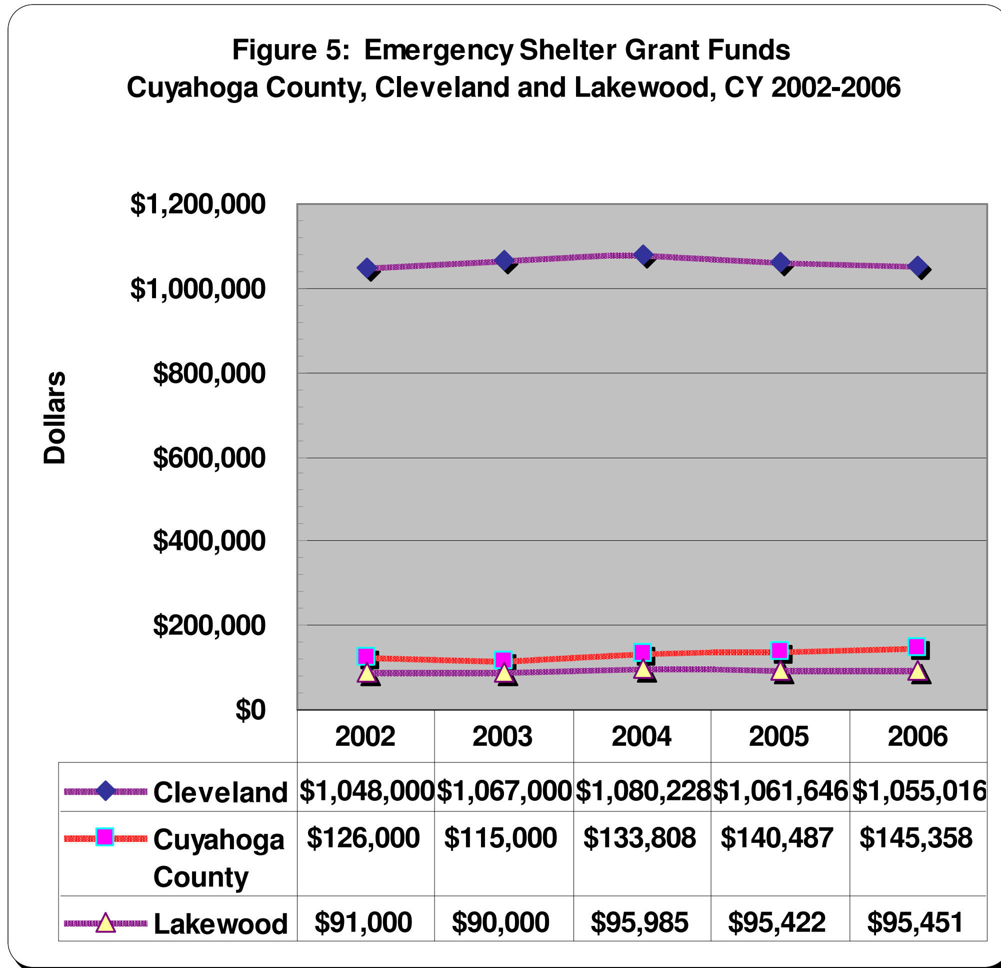
Source: Department of Housing and Urban Development Community Planning and Development Program Formula Allocations for 2002, 2003, 2004, and 2005 Information by State. Retrieved from http://www.hud.gov/offices/cpd/about/budget/index.cfm

For years 2002 through 2005, $631,000 was allocated annually from the City of Cleveland's CDBG to homeless shelters.

Emergency Shelter Grant Program (from HUD)
Homeless shelters receive grants from HUD McKinney-Vento Continuum of Care Funds only through the Emergency Shelter Grant program. Emergency Shelter Grant funds are made to states, metropolitan cities, urban counties, and territories based on the CDBG formula for emergency shelters and homeless prevention and require a dollar-for-dollar match of the federal share. Cuyahoga County, the City of Cleveland, and the City of Lakewood receive ESG funding. ESG funds are allocated to provide homeless persons with basic shelter and essential supportive services. It can assist with the operational costs of the shelter facility, and for the administration of the grant. ESG also provides short-term homeless prevention assistance to persons at imminent risk of losing their own housing due to eviction, foreclosure, or utility shutoffs. Grantees (state governments, large cities, urban counties, and U.S. territories) receive ESG grants and make these funds available to eligible recipients that can be either local government agencies or private nonprofit organizations. The recipient agencies and

organizations, which actually run the homeless assistance projects, apply for ESG funds to the governmental grantee, and not directly to HUD.

In 2003 the City of Cleveland and Cuyahoga County combined their ESG fund process so only one application needs to be made for these two sources. ESG is relatively stable, although there is some fluctuation. Below is a trend of ESG funding. (See Figure 5.)



	2002	2003	2004	2005	2006
Cleveland	$1,048,000	$1,067,000	$1,080,228	$1,061,646	$1,055,016
Cuyahoga County	$126,000	$115,000	$133,808	$140,487	$145,358
Lakewood	$91,000	$90,000	$95,985	$95,422	$95,451

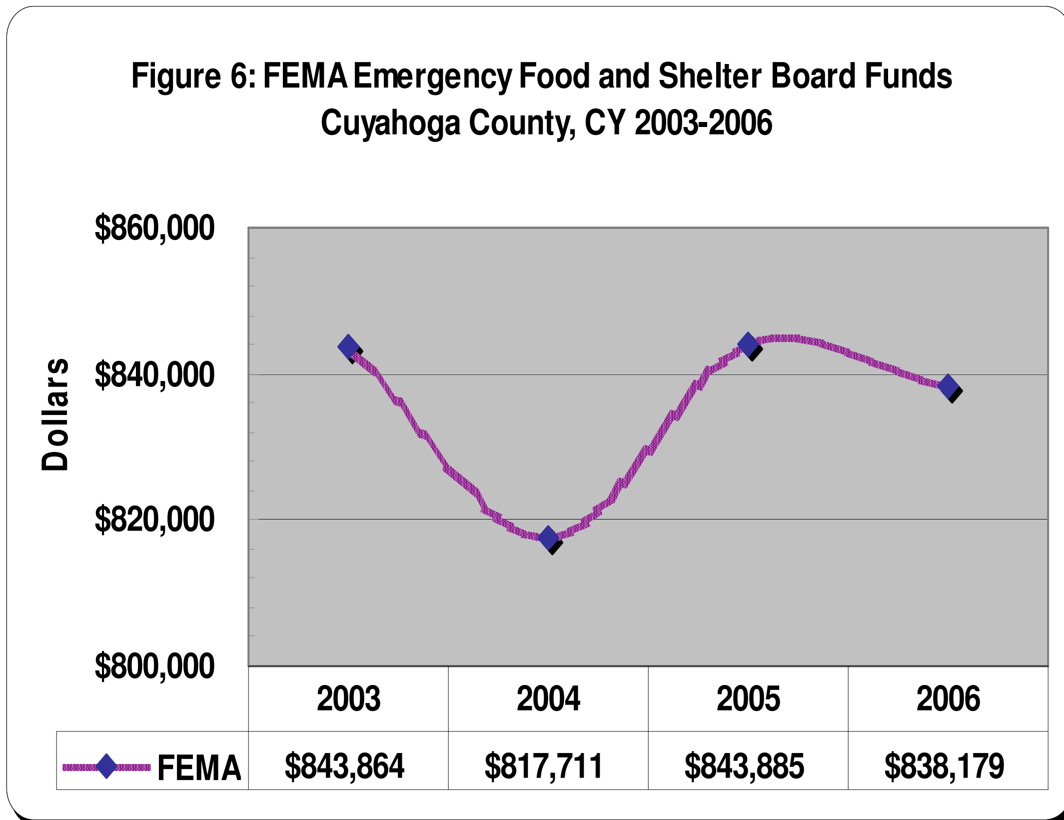
Source: Department of Housing and Urban Development Community Planning and Development Program Formula Allocations for 2002, 2003, 2004, and 2005 Information by State.

Fifty-nine percent (about $779,980) of the emergency shelter grant program funds are allocated to shelters.

Federal Emergency Management Agency (FEMA) Emergency Food and Shelter Program
FEMA's Emergency Food and Shelter Program, commonly referred to as FEMA (a distinct funding source from HUD's Emergency Shelter Grant program), was created by Congress in 1983 to help meet the needs of hungry and homeless people throughout the United States by allocating funds for the provision of food and shelter. The program is governed by a national board composed of representatives of the American Red Cross; Catholic Charities, USA; United Jewish Communities; the National Council of the Churches of Christ in the USA; The Salvation Army; and United Way of America. The board is chaired by a representative from FEMA. The

national board awards funds to jurisdictions based upon a formula involving population, poverty, and unemployment data. Local boards, which must be composed of representatives of the same organization as those on the national board, make allocation decisions. The purpose of the program is to provide emergency food (in the form of served meals and/or groceries) and shelter (such as mass shelter, one month's rent, or mortgage payment).

Cuyahoga County's FEMA funding has been relatively stable. Figure 6 below represents trends in the full FEMA allocation.



Source: United Way of Greater Cleveland.

The FEMA EFS Board in Cuyahoga County splits allocations of funds between shelter and food. Of the 50 percent that goes to housing (which was about $419,000 in 2006), 80 percent is allocated to shelter (approximately $335,200) and 20 percent (approximately $83,800) goes to supportive services such as mortgage or rental payment. The majority of FEMA shelter funding is for temporary shelter, although some funds are for transitional shelter. In 2006, most of the $335,272 in FEMA shelter grants went to homeless shelters. Funds have fluctuated over the past five years, but have increased since the 2002 level of $318,513. Funding trends are expected to be flat to decreasing.

Temporary Assistance to Needy Families (TANF)

Created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, TANF is administered at the federal level by the Department of Health and Human Services. TANF ended individual federal entitlement to welfare and replaced it with block grants to states, and states decide how funds will be spent within TANF guidelines. TANF funding has the flexibility to provide assistance to needy families for a range of services, including homeless shelters. Ohio

does use its TANF grant to fund homeless shelters. Each year since 1999, the State of Ohio receives $728 million in TANF funds. From 2004-2005, Temporary Assistance to Needy Families provided approximately $112,000 in funding for homeless shelters. Information for additional years was not found at the time this report was written.

STATE

Ohio Housing Trust Fund (HTF)
The Ohio Housing Trust Fund (HTF) is a flexible state funding source that provides affordable housing opportunities, expands housing services, and improves housing conditions for low-income Ohioans. Restructured in 2002 and 2003 with additional funding sources, and funded in part by a dedicated line item in the state budget from the real estate recordation fee, the HTF is partially protected from economic downturns that can affect general revenue allocations. The HTF provides the federally required match to enable the state to qualify for monies from the U.S. Department of Housing and Urban Development (HUD) HOME Investment Partnerships Program and the Emergency Shelter Grant program. Nonprofit organizations, for-profit organizations, lenders, and certain units of local government are eligible to participate in the HTF programs. Grants made from the HTF are on a competitive process and require a match. Homeless shelters have been funded by the HTF. Total allocations for all housing programs in Cuyahoga County from the HTC has fluctuated, but has increased from $1,542,400 in 2002 to $2,241,500 in 2005. However, due to the restructuring of the HTF, comparisons of allocations made in 2004 and later are inappropriate to make with previous years' allocation. Figure 7 below illustrates total allocations to Cuyahoga County from the Housing Trust Fund.

In 2006, at least $244,800 in grants specifically for homeless shelters were made from the HTC to Cuyahoga County, and at least $258,800 in grants were made in 2005 (Ohio Department of Development, n.d.). Further breakdown of grants made exclusively to homeless shelters was not available at the time of the writing of this report.

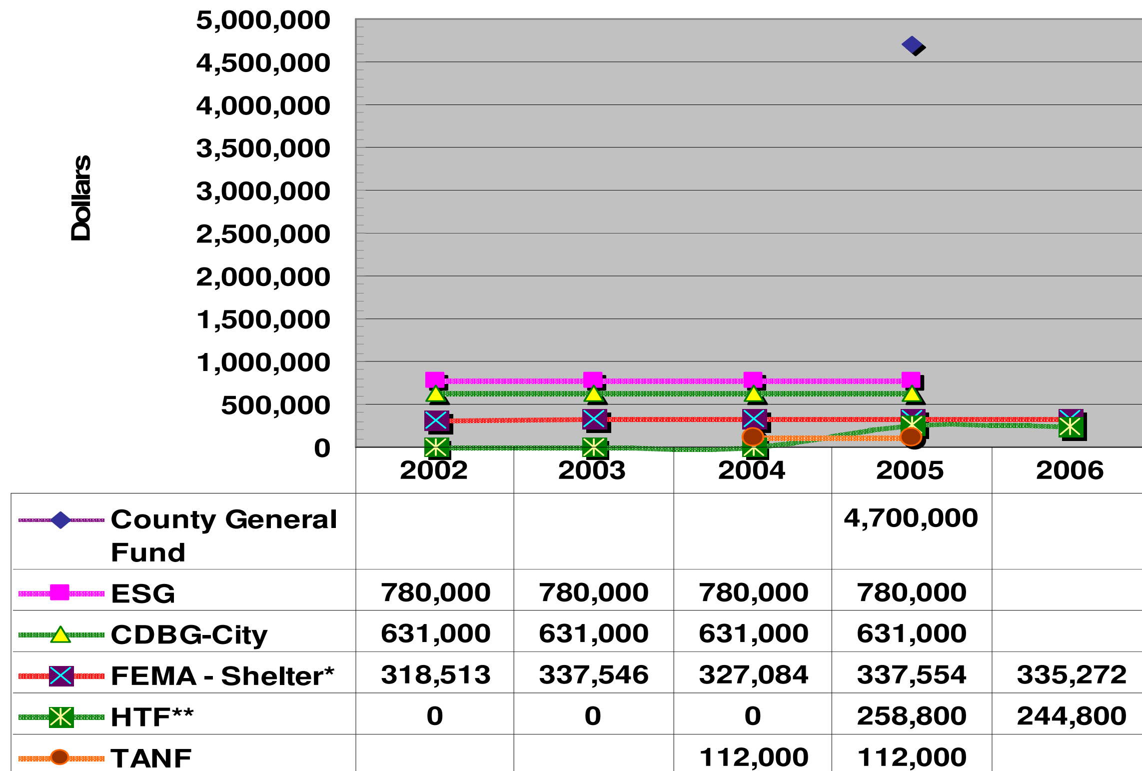
LOCAL

Cuyahoga County General Revenue Fund

Cuyahoga County's general revenue fund provided $4.7 million for emergency shelters in 2005.

Trends of Government Funders

As can be seen from Figure 8, both Emergency Shelter Grants and CDBG funding have remained flat since 2002. FEMA shelter monies fluctuate slightly. Additional sources of funding for which trend data was not found include county general fund, TANF, and the Housing Trust Fund (HTF).



	2002	2003	2004	2005	2006
County General Fund				4,700,000	
ESG	780,000	780,000	780,000	780,000	
CDBG-City	631,000	631,000	631,000	631,000	
FEMA - Shelter*	318,513	337,546	327,084	337,554	335,272
HTF**	0	0	0	258,800	244,800
TANF			112,000	112,000	

*The majority of FEMA *shelter* funding goes to emergency shelter; however, amounts listed above are approximations based on the assumption that 50 percent of the total county FEMA allocation is made to shelter grants, 80 percent of which are to actual shelters and not housing supportive services such as mortgage or rent assistance.
**With the restructuring of the Ohio Housing Trust Fund, comparisons made across years are not able to be made.

IDENTIFIED REVENUES

As of May 11, 2006, close to $2.2 million in revenues for homeless shelter programs has been identified countywide. This includes information from foundations; federated fundraising organizations; regional, county and municipal government; and United Way of Greater Cleveland.

Eighty-four percent of the revenues are from contracts or grants from government organizations. United Way of Greater Cleveland provided a significant contribution to this core service through Investment Committee allocations and designations (11 percent). (See Table 3.)

Table 3: Annual Revenue for Core Services: Identifiable Countywide and United Way of Greater Cleveland Homeless Shelter Programs, 2003/2004.

		A		B	
Funder	Period	Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Total - Contributions and dues (less UW designations)			**0.00%**	**10,370**	**0.67%**
Abington Foundation, The		15,000			
Bruening Foundation, Eva L. and Joseph M.		35,000			
Other Private Foundations - Not Elsewhere Classified				16,250	
Total - Foundations & Trusts		**50,000**	**2.27%**	**16,250**	**1.06%**
Jewish Community Federation		50,000			
United Black Fund of Greater Cleveland		10,000			
Total - Federated Fundraising Organizations		**60,000**	**2.73%**		
Department of Agriculture (USDA)				84,272	
Department of Health and Human Services (TANF)	2004	112,000			
Department of Housing and Urban Development				318,054	
Emergency Shelter Grant	2004	780,000			
Federal Emergency Management Agency (FEMA)	2004	327,084		30,465	
Subtotal Federal Government		***1,219,084***	***55.46%***	***432,791***	***28.15%***
Department of Development (includes CSBG)				237,175	
Subtotal State of Ohio				***237,175***	***15.43%***
Community Development Block Grant	2004	631,000		151,590	
Other City of Cleveland Funders - Not Elsewhere Classified				214,536	
Subtotal City of Cleveland Funding Sources		***631,000***	***28.71%***	***366,126***	***23.81%***
Total - Contracts/grants from government organizations		**1,850,084**	**84.17%**	**1,036,092**	**67.39%**
Total - Investment Income				**25,944**	**1.69%**
Total - All Other Revenue				**210,876**	**13.72%**
Subtotal Non - UWGrCle Support		**1,960,084**	**89.17%**	**1,299,532**	**84.52%**
Total - UWGrCle designations applied to program		**12,567**	**0.57%**	**12,567**	**0.82%**
Total - UWGrCle investment committee allocation		**225,416**	**10.26%**	**225,416**	**14.66%**
Subtotal UWGrCle Support - 4001, 4701 & 4703		**237,983**	**10.83%**	**237,983**	**15.48%**
Total Support/Revenue		**2,198,067**	**100.00%**	**1,537,515**	**100.00%**

REIMBURSEMENT/COST

Self-managed emergency shelters as described previously cost approximately $3 per person per night. Mixed-model mats-and-blankets severe-weather shelter costs approximately $6.50 per person per night. A professionally staffed shelter that offers beds, storage, phones, meals, showers, laundry, and case management counseling can cost $40 per person per night (Freeman, n.d.).

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works

The United States Interagency Council on Homelessness has developed a ten-year planning process to end chronic homelessness, including a step-by-step guide for communities. The U.S. Conference of Mayors, the National Association of Counties, and the National League of Cities have endorsed the plan. Ten-year plans are currently underway in some of the nation's largest cities, including Chicago, San Francisco, and Cleveland.

The 10-year plan addresses the chronically homeless—the roughly 10 percent of the homeless population that is homeless for a year or more or multiple times over a several year period. The chronically homeless tend to consume a disproportionate amount of resources due to their heavy use of costly public resources such as emergency medical services, psychiatric treatment, and detox facilities. By addressing the chronic homeless problem, resources will be freed up for other needs.

The 10-year plan has ten components:

- Commit to developing a 10-year plan by getting a strong commitment from the mayor or county executive.
- Identify stakeholders, because broad support and participation from public, private, and nonprofit sectors are most successful. Stakeholders include: agency heads, the mayor, law enforcement, the public, faith-based organizations, hospital administrators, housing developers, service providers, and individuals experiencing chronic homelessness.
- Convene a working group that includes the relevant stakeholders to coordinate the planning process. Forums for broader community input should be created. Those involved should have the authority to make funding and resource decisions.
- Gather research and data on homelessness to create a solid foundation for the community's plan.
- Define the community's homeless problem by identifying and assessing the root causes of chronic homelessness.
- Develop both prevention and intervention strategies to address these problems. Prevention strategies reduce the number of people who become chronically homeless whereas intervention strategies increase placement into supported housing.
- Solicit stakeholder feedback and finalize the strategic plan to ensure support and consensus on the final plan.
- Create an action plan to implement the strategies that include specific activities and the parties responsible for them, costs and funding sources, timelines and benchmarks, and performance metrics.
- Announce and publicize the plan to ensure maximum visibility.
- Implement the plan by using it to guide activities and recognize that the plan may need to change and be updated as situations change.

Successful elements of the 10-year plan discussed above include a collaborative planning process, a research and data-driven approach, performance and outcome orientation,

innovation and creativity, endorsement by top city or county officials, involvement of stakeholders in resource enhancement, and a planned implementation strategy.

In addition, the 10-year plan involves both prevention and intervention strategies. Examples of successful prevention efforts include the centralization of funding and service delivery to increase coordination among all parties; dedicated resources to house individuals discharged from psychiatric care; and discharge planning protocols to prevent homelessness. Likewise, successful intervention strategies include permanent supported housing with low threshold access for homeless mentally ill people; direct access to permanent supported housing for frequent users of acute health systems; and assertive community treatment, which relies on multi-disciplinary, clinically-based teams that engage chronically homelessness people on the streets and in shelters.

You Gotta Believe

You Gotta Believe (YGB) is a Brooklyn, New York, based homeless prevention program for youth. Analyses about homelessness suggested that 40 to 50 percent of the homeless population come directly from foster care. So, YGB finds permanent homes with people youths identify as known to them, provides training for the adults, and certifies the adults' homes. When families are certified, they are certified for adoption, so they are aware that they could be taking the child forever. YGB supports recruiters through the Dave Thomas Foundation. The recruiters, who are former adoptive families and youth, take a nine-week training course, show up to community board meetings, churches, flea markets, and other family locations to talk about YGB.

YGB offers on-going training for placement homes. Classes meet for three hours once a week for nine weeks at one of four locations. Families are attracted to YGB because strong staff enthusiasm, a lack of hierarchy, and no hard and fast rules. After an adoption, YGB has to return the case to the foster care agency, but they assign a "shadow" post-placement worker (typically seasoned adoptive parents) to check in with the family on a weekly basis to catch any problems while they are small.

Housing First

"Housing First" describes a set of policy initiatives and strategies promoting the concept that a permanent, safe, affordable place to live is a necessary prerequisite for helping homeless people work toward employment and recovery goals. It represents a departure from the widely used approach that requires homeless people to gain employment, achieve sobriety, and/or take other steps towards recovery before they are helped to find a permanent place to live. This latter practice, while motivating some, has also contributed to the creation of a semi-permanent "homeless underclass" of persons crowded into emergency shelters for months and years because they have no other recourse and whose barriers to recovery and employment remain unaddressed (Simpson, 2005).

According to Heading Home, the shift to a housing first policy represents a major change in the future ways that the homeless continuum of care might be funded and configured. It will require resources to be re-oriented from programs that retain and serve the homeless in shelters and temporary housing to programs that promote permanent supportive housing. Length of stay in some transitional housing facilities may need to be reduced. Services once provided in residential facilities will need to be taken into the community and provided to clients at their permanent housing sites. Public and private funders that have previously invested in programs

to serve the homeless in shelter care may need to revise their grant making strategies to include grants for “bricks and mortar” purposes (Simpson, 2005).

The shift required to adopt a housing first policy runs deeper than simply the reallocation of resources. It demands the asking difficult questions about the causes of homelessness and what can help alleviate it. It pushes the community to see homelessness not as a discrete problem of individuals who have made “bad choices,” but as a symptom of larger social, educational, economic, political, and policy forces. It challenges service providers to think *first* of finding every client a permanent place to live, and secondarily to resolving their mental health, substance abuse, disability, and employment issues. And finally, it requires an examination of the ways in which the community has enabled homelessness by extending short term, feel-good charity rather than coming to terms with the long-term solutions required to stabilize a part of our civic body (Simpson, 2005).

The following is feedback from local United Way focus groups (2005) regarding their thoughts on what works for homeless shelter programs:

- Agencies work on homeless prevention programs by providing funds during medical crises or help with back rent and overdue utility bills, and negotiating with landlords to prevent evictions.
- There is also the creation of the “hybrid shelter” that is “between a homeless and a transitional shelter” and allows for a longer, 4-month stay. Although this type of shelter limits them to serving fewer, they are able to be more thorough and give proper training for greater success.
- Many agencies stress the importance of receiving funds for general operating costs and pointed out that grants should not solely exist for “the shiny new program” that offers very tangible results.

What Doesn’t Work

Programs can fail if they do not have a collaborative planning process, do not utilize research and past data when developing their plans, do not utilize a performance and outcome orientation, and do not involve stakeholders. Creativity and innovation are also important parts of the planning process.

Homeless shelters that do not provide both prevention and intervention programs may be doing a disservice. The goal of the program should be to assist participants in securing permanent housing.

IMPACT ON COMMUNITY

In a 1998 report published by the *New England Journal of Medicine,* it was found that homeless people spent an average of four days longer per hospital visit than their non-homeless counterparts in New York City. The study calculated the extra costs to be over $2,400 per hospitalization (Salit, Kuhn, Hartz, Vu, and Mosso, 1998).

The National Alliance to End Homelessness cited prison and jail expenses as a further cost of homelessness. Homeless men and women also tend to spend more time in prison than others, sometimes simply for loitering, which can be costly. The typical cost of a prison bed in a state or federal prison is roughly $20,000 per year. A two-year University of Texas survey of homeless

individuals found that each homeless person cost the taxpayers over $14,000 per year, predominantly due to jail costs.

In addition, the emergency housing of homeless men and women is expensive. The cost of an emergency shelter bed funded by HUD's Emergency Shelter Grants program was over $8,000 in 1994, which was more than the average annual cost of a federal housing subsidy (National Alliance to End Homelessness).

University of Pennsylvania researchers conducted a five-year study that examined 10,000 mentally ill homeless persons in New York City. Half of this group was placed in government-funded housing with mental illness services available. The homeless persons who were not placed in supportive housing cost the taxpayers an average of $40,500 a year for their use of emergency rooms, psychiatric hospitals, shelters, and prisons. However, individuals who were placed in supportive housing with assistance for mental illness issues used fewer emergency care services. The study found that cost to taxpayers for providing supportive housing and treatment to homeless persons with mental illnesses cost only $994 more than the $40,500 it cost to do nothing and leave these individuals homeless and on the streets.

Nationally, it is estimated that there are 110,000 mentally ill persons experiencing chronic homelessness. A study by Culhane and Metraux (2001) concludes that the net cost of ending homelessness for this population, using the most conservative estimates, is negligible. In other words, it costs essentially the same to house people as it does to leave them homeless.

The Cleveland/Cuyahoga County 10-year plan to prevent homelessness and expand affordable housing chronicles the social and economic costs of homelessness in Cuyahoga County. Despite the efforts of service providers, some homeless men and women still depend on emergency service care such as emergency room care, which is expensive for the county. Homelessness also results in isolation from civic organizations such as churches, which often provide a sense of context and continuity to a person's life (Simpson, 2005).

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

The Ohio Coalition for the Homeless and the Ohio Department of Development's Office of Housing and Community Partnerships released a manual on emergency shelter standards. The document, which can be found online at cohhio.org/resources/shelterstandards.pdf, outlines the basic standards relative to a shelter's administration, personnel, facilities, fiscal management, food services, health, and operations. While not exhaustive, the following are illustrative of basic shelter standards in Ohio.

Administration:

- The shelter shall be operated by a nonprofit organization, recognized under section 501(c)(3) of the Internal Revenue Code.
- The shelter shall not require clients to participate in religious services or other forms of religious expression.
- The shelter shall not discriminate on the basis of race, religion, or national origin. Shelters serving families with children shall also not discriminate on the basis of the sex or age of the children or the size of the family, except where limited by the facility.

Personnel:

- The shelter shall have adequate, trained, on-site staff coverage during all hours the shelter is open to residents, unless individual secured units are provided.
- All shelter staff shall receive training in at least the following: a) emergency evacuation procedures; and b) agency operating procedures.
- All relevant direct service staff shall receive additional training in at least the following: a) non-violent crisis intervention techniques; b) referral procedures to relevant community resources; and c) first aid procedures.

Facilities:

- The shelter shall comply with applicable local fire, environmental, health, and safety standards and regulations.
- The shelter shall be clean and in good repair.
- The shelter shall have private space to meet with clients.
- The shelter shall provide a bed or crib for each guest except in extenuating "overflow" conditions or unless the shelter has a Department of Development exemption based on size and/or type of shelter.

Fiscal Management:

- There shall be an accounting system, which is maintained in accordance with generally accepted accounting principles.
- The shelter shall have a record of accountability for clients' funds or valuables that the shelter is holding.
- The shelter shall receive an annual independent audit or audit review.

Food Service:

- Shelters providing food service shall make adequate provisions for the sanitary storage and preparation of foods.
- Shelters providing food for infants, young children, and pregnant mothers shall make provisions to meet their nutritional needs.

Health:

- The shelter shall have first aid equipment and supplies available at all times in case of a medical emergency.
- The shelter shall assure that at least one staff person on duty is trained in emergency first aid procedures.
- The shelter shall have a written policy regarding the control of infectious diseases, such as HIV, tuberculosis, etc.

Operations:

- In addition to sleeping arrangements and food, the shelter shall provide the following basic needs: a) humane care that preserves the individual dignity; b) a clean environment; c) reasonable security; and d) referrals to other agencies.

- The shelter shall have written policies for intake of clients and criteria for admitting people to the shelter.
- The shelter shall maintain an attendance list which includes, at least, the name and sex of each person residing in the shelter.

VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Homeless Shelters:

- An estimated 16,000 homeless persons need homeless shelters and transitional housing, which is the estimated number of homeless persons in Cuyahoga County.

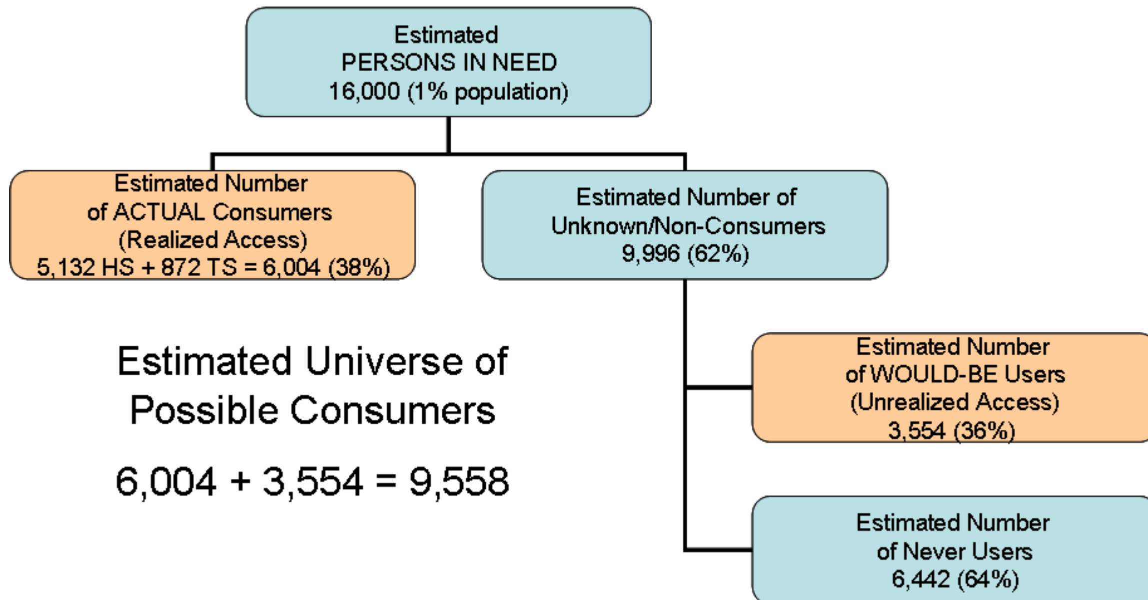
- Based on available information from the Office of Homeless Services' figures about actual consumers, approximately 5,132 persons have realized access to homeless shelters and 872 used transitional shelters (total 6,004). It is assumed that the 601 persons United Way funded for homeless shelters and the 488 for transitional shelters are included in the Office of Homeless Services' figures.

- This leaves a net estimate of 9,996 persons who are either receiving services from unaccounted-for sources or are not sheltered. (16,000 – 6,004 = 9,996)

- The US Conference of Mayors' 2004 survey found that Cuyahoga County has a minimum unmet need for at least 3,384 units of shelter for homeless individuals, and 170 units of shelter for homeless families—or a total of 3,554 additional units, according to an analysis completed for the Cuyahoga County Continuum of Care, Office of Homeless Services, (NEOCH). They are considered the "would-be users," bearing in mind that families comprise more than one person. (3,384 + 170 = 3,554)

- It must also be noted that some homeless persons will not use shelters even if they are available. Also, a policy in Cuyahoga County for shelters is not to turn anyone away. Furthermore, others will not use the formal shelter system because they use their informal network. According to local service providers, shelters are a last resort for families evicted into homelessness. Families tend to exhaust all other resources—doubling up with other families, moving in with parents, siblings, or friends, spending one night here and another somewhere else, sleeping in their cars (if they still have them)—before turning to homeless shelters for assistance. As a result, they do not come to the attention of the formal system of care and it is almost impossible to track either the actual number of homeless families in a given year in Cuyahoga County or what happens to these families once they have become homeless (Simpson, 2005).

- Including realized and unrealized access, there is an estimated universe of 9,558 possible consumers. (6,004 + 3,554 = 9,558). It must be noted that given the current philosophy of HUD and The Cuyahoga County Office of Homeless Services, the long-term solution may lie in developing permanent supportive housing rather than creating additional shelter services. (See Figure 9.)



Service Site Index
Countywide, there are 11 service sites for homeless shelters and 23 sites for transitional housing, a total of 34 sites. This is a ratio of 281 possible consumers (estimated 9,558 total) per service site countywide. No service site analysis by zip code was completed because of homeless persons' lack of addresses.

Service Capacity
The U.S. Conference of Mayors' 2004 survey found that requests for emergency shelters for families were on the rise—increasing 78 percent in the last year. Cleveland reported that evictions and foreclosures continue to be a significant problem and contribute to the family shelters always being full. However, national research indicates that only about 20 percent of evictions result in homelessness. Basic emergency shelter is available until space in a family shelter opens; however many families will double up with friends or relatives, which can make it difficult to accurately measure the need.

The majority of the cities surveyed (81 percent) were forced to turn away homeless families due to lack of resources. In 56 percent of the cities surveyed, families may need to break up before entering the shelter system. Cleveland city officials responded that families that are unable to get into a full service family shelter are housed overnight at the women's emergency shelter. They are moved to a full service shelter as soon as there is a vacancy. The wait is typically no more than 48 hours and no families are left without a place to sleep (Lowe, 2004).

VII. SUMMARY

The primary findings from the research on this core service are as follows:

- Beginning with the colonial era, the United States has had a population living without a permanent dwelling. Three trends are largely responsible for the rise in homelessness over the past 20-25 years: a growing shortage of affordable rental housing, a simultaneous increase in poverty, and deinstitutionalization of the mentally ill.
- The causes of homelessness are the lack of affordable housing, the lack of living wage jobs or sufficient incomes, and the lack of adequate health and supporting services, while the single most important factor that *keeps* people homeless is finding a job, followed by finding affordable housing.
- Among the major societal risk factors of homelessness, especially for persons with mental illness, are housing barriers for people with serious mental illnesses, housing barriers for people with substance abuse disorders, and discrimination and stigma in housing. In addition, there are a number of individual risk factors: mental illness, alcohol and drug use, co-occurring disorders, physical health problems, victimization, minority status, sexual minorities, diminished social supports, and criminal justice system involvement.
- Homeless persons often need more than housing; they need supportive housing, which is a form of co-housing designed to support individuals not only socially, but with basic life skills. Housing is coupled with social services such as job training, alcohol and drug abuse programs, and case management.
- The federal government is a primary actor in the area of homeless services. With the enactment of the Stewart B. McKinney Homeless Assistance Act of 1987, Congress recognized the need to supplement “mainstream” federally funded housing and human services programs with funding specifically targeted to assist the homeless.
- HUD’s FY 2006 to FY 2011 strategic plan’s objective is to end chronic homelessness and move homeless families and individuals to permanent housing. HUD’s approach to replacing homelessness with housing stability relies on three coordinated efforts: preventing homelessness, developing permanent and transitional housing for both those persons experiencing chronic homelessness and the growing numbers of homeless families, and coordinating housing assistance with supportive services.
- Driven by HUD’s Housing First policy, a joint local effort under the Cuyahoga County Office of Homeless Services has resulted in a ten year plan to prevent homelessness and expand affordable housing in Cleveland and Cuyahoga County.
- As of May 11, 2006, close to $2.2 million in revenues for homeless shelter programs has been identified countywide.
- The United States Interagency Council on Homelessness has developed a ten-year planning process to end chronic homelessness.
- The shift to a housing first policy represents a major change in the future ways that the homeless continuum of care might be funded and configured. It will require that resources be re-oriented from programs that retain and serve the homeless in shelters and temporary housing to programs that promote permanent supportive housing.
- Homeless people were found to increase costs for hospitalization and prisons.

- The cost of an emergency shelter bed funded by HUD's Emergency Shelter Grants was over $8,000 in 1994, which was more than the average annual cost of a federal housing subsidy.
- It must be noted that given the current philosophy of HUD and the Cuyahoga County Office of Homeless Services, the long-term solution may lie in developing permanent supportive housing rather than creating additional shelter services.
- The estimated universe of possible consumers is 9,558, including both realized (6,004) and unrealized (3,554) access.
- Countywide, there are 11 service sites for homeless shelters and 23 sites for transitional housing, a total of 34 sites. This is a ratio of 281 possible consumers (estimated 9,558 total) per service site countywide.

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ATTACHMENTS

Attachment 1: Researcher List

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Attachment 2: Technical Notes

Technical Notes:
Methodology, Caveats, Limitations of Data

The following provides descriptions, definitions, methodologies, caveats, or limitations of data for the following components of the core service reports:

- Unit of Analysis
- First Call for Help Data
- Funding Information for Core Services
- Consumer and Financial Data: Caveats
- Gap Analysis Methodology & Limitations
- Service Site Index

Unit of Analysis

The core service is the unit of analysis. United Way of Greater Cleveland either funds or could fund 80 core services. These are the object and subject of the research, specific to Cuyahoga County. A separate report has been developed for each service. It must be noted that the aggregate of any quantifiable data across all of the reports does not comprise a picture of the totality of health and human services in Cuyahoga County because there are many more than 80 services that comprise the community's safety net.

The unit of analysis for estimates of service consumers is the individual, the family, or the household.

United Way - First Call for Help Data

For most core services, United Way First Call for Help (FCFH), the community's resource and referral service data, was used in tables that show the number of service providers and service sites, the geographic location of service providers by zip code, the service area by zip code as reported by providers of the respective services, and to show unmet need and greatest increase/decrease in calls received by FCFH for a particular core service.

It is important to remember that FCFH receives calls from a variety of sources that include people calling on behalf of a prospective consumer such as social workers, provider agencies, relatives, etc. Not all calls come directly from a prospective consumer, so some of the zip codes are for hospitals and business addresses, although the numbers for these zip codes are relatively small.

Calls also may be from people who are not interested in receiving a service, but wish instead to make a contribution to a program such as clothing, household items, food, books, crafts supplies, etc.

Because, in many instances, FCFH codes its data with a different level of core services than the 80 core services identified by the United Way Community Investment staff as fundable services, it was necessary to develop a crosswalk. This crosswalk was used for a number of services,

however, seven services did not have a match in the FCFH database. The staff of United Way - First Call for Help gave explanations which follow each core service):

- Adolescent/Youth Counseling: A caller asking about help with their troubled teenager would be referred by the type of counseling rather than age. (Example: counseling for drugs, family, sexual abuse, etc.)
- Advocacy: FCFH does not receive calls from people about advocacy.
- Child Care: Calls are directed to Starting Point.
- Condition Specific Rehabilitation Services: FCFH would refer caller back to their primary care physician for a referral.
- Early Intervention for Mental Illness: FCFH does not receive calls for this, but if they did, they would refer to the county's Help Me Grow program.
- Family Support Centers: FCFH defines data by specific service rather than type of agency. Depending on the call, the caller may be referred to General Counseling or Early Intervention for Infants and Toddlers with Disabilities, and so on.
- Preschools: Calls are directed to Starting Point.

A different match was used for other services that had no crosswalk.

- Medical Transportation and Senior Ride: FCFH uses "Paratransit" as they do not differentiate between senior transportation, medical transportation, and transportation for the disabled.
- Outpatient Mental Health Facilities: FCFH uses "Mental Health Drop-in Centers."

It must also be noted that, for the most part, the FCFH database does not include for-profit agencies. In the case of home health care providers, we contacted the Long Term Care Ombudsman for a more complete list of provider agencies which includes for-profit organizations.

There were several instances where the FCFH database did not code a United Way-funded agency with the core service for which they were receiving funding. In these instances, the agency was added manually to the Service Provider Table along with their site locations. The core services with the respective United Way of Greater Cleveland agencies that were added are:

- Case/Care Management – Care Alliance, Cystic Fibrosis, Epilepsy Foundation, Golden Age Centers
- Comprehensive Outpatient Substance Abuse Treatment – The Covenant
- Disease/Disability Information – The Muscular Disease Society of Northeastern Ohio
- Early Intervention for Infants and Toddlers with Disabilities – United Cerebral Palsy
- Medical Expense Assistance – North Coast Health Ministry
- Medical Transportation (Paratransit in FCFH) – Kidney Foundation of Ohio
- Senior Centers – Catholic Charities Services Corporation, Jewish Community Center of Cleveland, Jewish Family Service Association of Cleveland, University Settlement House.
- Volunteer Development – Neighborhood Leadership Institute

It must also be noted that when numbers are low for trend data reported, the high percentages are slightly exaggerated.

Funding Information for Core Services

We collected financial information for each core service on a countywide level from multiple sources including major government funders, foundations, federated fund raising organizations, and United Way of Greater Cleveland. While we were successful in gathering a substantial amount of data, there is much that has not been collected. It must also be noted that even if we had all major public and private funding gathered, this would not create a total picture of health and human service funding in Cuyahoga County because there are more than 80 core services provided. The following provide highlights of data collected and some of the limitations for each source. It is important to note that funding in each source is changing and represents point in time amounts. The typical period for trend data, when available, is 2002, 2003, and 2004. Note: some services are funded by private insurance or other self-pay arrangements.

Foundation Funding
We attempted to obtain foundation funding amounts for each core service from the latest annual report or 990 PF (foundation tax return to the IRS) of each major foundation that funds social services in Greater Cleveland. Wherever a description of the grant purpose was given, we used our best judgment to match the grant to the appropriate core service. If the grant fell within more than one core service area, it was not listed. When no description was given, the grant was treated like a general operating grant and assigned to a core service only when the mission of the grant recipient fell mainly within one particular core service. In-kind donations, grants for capital and equipment expenses and administrative salaries were not used. When grants were $10,000 or greater, they were listed by name of the foundation. All others were placed under Other Foundations and not listed. Typically, we did not attempt to provide trend financial data for foundation funding of core services because of the changing nature of funded programs from year to year.

Federated Funding Sources
We approached the major federated funders of core services in Greater Cleveland for funding and consumer information. Some data provided was for a single point in time; others provided three years of trend data. We often had to do a cross walk of United Way of Greater Cleveland funded core services against those funded by federated agencies to agree on the services.

Government Funding
We approached every major government funder for funding amounts for each core service and also did Internet searches for some federal government sources. Due to the constant state of change in government funding, it is important to note that the data provided is a snapshot in time and that many of the programs funded in 2004 have changed definition, are funded through different revenue sources, or no longer exist at all due to a lack of funding. This is particularly true of Community Development Block Grant dollars which have decreased due to shifting federal priorities.

Every effort was made to appropriately match government funding data to the correct core service area; however, this was not always possible as frequently the service definitions were not a one-to-one match. It was necessary, in some instances, to take the closest match or use the sore service which represented a majority of the services being provided.

In other cases, it was not possible to select a specific core service. An example is Medicaid in which Medicaid-defined services crossed over more than four core services in some instances.

In cases where Medicaid is a significant source of revenue, the data was entered as an aggregate total at the appropriate AIRS level. These aggregates are footnoted under the appropriate funding table.

Every effort was made to include data from municipalities. However, many did not respond after repeated requests for information. We would like to thank those who took the time to help with this project.

Medicaid Funding
A significant portion of Medicaid funding was NOT entered under the countywide total in the core service reports for two reasons: first, because many of the Medicaid services are not a one-to-one match with United Way core services, and second because some Medicaid services fall into more than one AIRS Level 1 categories. In the first instance, Medicaid funding was entered as an aggregate total at the AIRS 1 level, and in the second instance Medicaid funding was entered as an aggregate total under Third Party Payee/Direct Bill in the combined Master Revenue file of funding across all nine AIRS Levels. They are as follows:

Entered as Aggregate Total Under Appropriate AIRS Level

- Medicaid Service - Home Care ($17,787,703 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: daily living aids and home health care.
- Medicaid Service - CADAS ($8,522,183 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: comprehensive outpatient substance abuse treatment, residential substance abuse treatment programs, substance abuse education and prevention.
- Medicaid Service - Therapy ($2,257,394 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: condition specific rehabilitation, and speech & hearing.
- Medicaid Service - CMH ($67,773,487 in 2004) - Falls into AIRS 1 Mental Health Care & Counseling and includes the following core services: supportive therapies, adolescent/youth counseling, children's residential treatment facilities, early intervention for mental illness, general counseling services (outpatient mental health facilities), and psychiatric day treatment.

Entered as Aggregate Total Under Third Party Payee/Direct Bill

- Medicaid Service - Inpatient Hospital ($188,329,269 in 2004) - Falls into two different AIRS 1 categories: Basic needs and health care. It includes the following core services: condition specific rehabilitation and medical expense assistance.
- Medicaid Service - Waiver ($128,921,354 in 2004) – This category included all PASSPORT services. Since we reported PASSPORT separately, in order to avoid duplication, we deducted the PASSPORT total of $52,676,048 from this number and reported the remaining $76,245,306. This total falls into AIRS 1 Basic Needs, Health Care and Individual & Family Life and includes the following core services: adult day care, home-delivered meals, home health care and in-home assistance.
- Medicaid Service - Habilitation ($55,550,307 in 2004) - Falls into AIRS 1 Health Care and Individual & Family Life and includes the following core services: condition specific rehabilitation services, early intervention for infants and toddlers with disabilities/delays, and residential living options for people with disabilities.

United Way of Greater Cleveland Funding
Financial data for core services funded by United Way of Greater Cleveland was for FY 2004 (July 2003 to June 2004). It included allocations through the community investment committees and donor designations that United Way funded agencies applied to the respective core services. It is important to note that not all United Way funded agencies applied donor designated gifts, which are unrestricted, to the core service for which they receive United Way funding. It did not include donor designations that non-United Way funded agencies used for any of the 80 core services.

United Way Agency Revenues
Annually United Way-funded agencies submit revenue budgets to United Way for each funded core service. This information for FY 2004 is reported. However, all of the agency data may not be included in the countywide data as agencies may have assigned dollars from unrestricted grants to a specific core service, or allocated a portion of grant monies that fell within two or more core service areas. It was not always possible to match countywide government or foundation funding with that reported by the agencies and that gathered from other funding sources.

Consumer and Financial Data: Caveats

The following applies to revenue sources on tables and graphs and their corresponding consumer data used in the consumer demographics and zip code tables.

All Core Services
Data was self-verified by the funder/provider. Whenever data provided by a funder appeared to be inconsistent or incorrect, an attempt was made to contact the funder. If the funder responded, the data was either adjusted according to their instructions, or the reason for discrepancies footnoted. If they did not respond, or if they said it was correct, the data was left as submitted.

Demographic and zip code data provided by the funder/provider is frequently taken from consumer intake forms which may have missing or incomplete data, or from provider agency databases which contain data entry errors or incomplete consumer intake forms. Whenever possible, the funder was asked for corrected data. In cases where a correction was not possible, the data was counted as either unknown or missing. The usage of these terms is footnoted at the bottom of each table and is explained more fully in the Gap Analysis section of this attachment.

It was not always possible to get information in the format requested as each funder tracks data differently, using different service definitions, terminology and variables. Wherever possible, data was matched to a consistent report format.

When a funder could not provide consumer demographics, but could provide an estimated percentage of consumers by category, we took the total number of consumers and applied the percentages to come up with estimated numbers for the consumer tables. For example, Medicaid tracks individual recipients throughout the year, entering new data if there is a change, each time a claim occurs. Thus, a consumer who has a birthday between claims will appear in the system for that year with two different ages.

To resolve this, the percentage of consumers in each age range was determined for the total number of duplicated consumer ages. Those percentages were then applied to the total number of unduplicated consumers for the year in order to reach a total number of unduplicated consumers for each age range.

The time periods for both revenue and consumers vary by funder/provider. United Way Program Report data is for FY 2004 (July 2003 to June 2004). Other funder/provider data is for either a January to December or July to June fiscal year.

Gap Analysis Methodology & Limitations

Based on Anderson's (1964) seminal needs assessment model, realized access is defined as the number of consumers who receive service while unrealized access is the estimated number of consumers who need and would utilize a service, but are not currently receiving it. This could be considered the service gap. Unrealized consumer access to services drives the need for change in the social service delivery system. Ensuring unrealized consumer access to services requires new models of service delivery related to access, effective use of resources, data management, and funding. There were multiple steps used to conduct a gap analysis:

- *Estimate of persons in need of the service*: Unless local research was conducted to determine need for a given service, this estimate was obtained by either using U.S. Census data for Cuyahoga County or applying percentages from national studies and reports to the census data. All references and percentages are footnoted in the respective graphs or tables. In most cases this percentage was also applied to actual 1990 Census figures and population projections 2005 through 2015 that were done by the Ohio Department of Development.
- *Estimate of number of ACTUAL consumers in the public systems (realized access):* Data submitted to United Way by funded agencies was aggregated to determine the number of consumers for each core service. The period was FY 2004, which is July 2003 through July 2004.
    - In some cases data was "unknown," defined as data not collected by agency because no tracking system was available or the type of service delivered made it difficult (i.e., group presentations, telephone information and referral, and drop-ins). This also represents data not completed by consumers either deliberately or inadvertently on intake forms.
    - In other cases, data was missing that, for United Way data, represented computational errors or incorrect completion of online reports. For all other data, "missing" represents data funders/providers were unable to provide.
    - There was no check of the accuracy of data submitted by agencies.
    - Major government funders were asked to provide information about the number of consumers for the respective core services that they funded. In most cases, services were not defined in the same way as the United Way core services which are based on the Alliance for Information and Referral Systems (AIRS) taxonomy. To accommodate these differences, customized crosswalks were developed.
    - We assumed that the numbers of consumers across funding sources were not unduplicated and thus made a judgment about which numbers would be the best estimate of an unduplicated number.
    - The estimate of consumers is not inclusive since it does not include numbers of consumers who use their personal resources to pay for services, nor for other

private resources such as insurance or agency fundraising. In addition, it was not always possible to obtain information from some government funders.

- *Estimate of number of "unknown/non-consumers":* This is the difference between the estimated number of actual consumers and the estimate of persons in need.
- *Estimate of number of "would-be users" (unrealized access)*: This is the estimate of persons who would use a service if it were available, typically based on research.
- *Estimate of number of "never users":* This is the difference between the estimated number of unknown/non-consumers and would-be users.
- *Estimate of "universe of possible consumers":* This is the total of those actually receiving the service (realized access) and those would-be users (unrealized access).

We recognize that this is not a perfect method for assessing either realized or unrealized access to core services. However, we opted to use an imperfect method rather than no method to demonstrate both the complexity and the usefulness of quantifying realized and unrealized access to services as a first step toward a more rigorous methodology. In the business sector this would be a form of market analysis. We also recognize that actual consumer numbers are not unduplicated across funders, or across core services. Thus, there is much work yet to be done to gain realistic estimates of needs.

The numbers we provided are on a countywide level. We recognize that there could be, and often are, differences by demographics and geographical area. In the Actual Consumer Demographics attachment, we have identified the profile of the base consumer group from census, but have little on the estimated persons in need. Occasionally, there is information from other research that describes differences among different racial, ethnic, gender, age, or income groups that is discussed in the narrative. There is also inconsistent information for consumers funded by various governmental bodies. In other words, some funders provided demographic data and others did not. In the Actual Consumer Zip Codes attachment, we have also attempted to identify the geographic profile of the estimated persons in need and actual consumers. However, this information has the same limitations as the demographics.

Service Site Index

For many services a service site index was developed. It provides a ratio of estimated consumers per service site on a countywide level and for each zip code within the county. The ratio is based on the number derived from the gap analysis described in the previous section and on the number of providers who reported to United Way – First Call for Help whether a specific service site includes a given zip code in its service area. A provider site is located in a single zip code, but could serve multiple zip codes. The ratio is a measure of potential service accessibility by estimated universe of service consumers per zip code area. This measure does not include the capacity of providers to offer the service, for example, the number of consumers that can be served on a daily basis. It is only capturing whether there is a possibility of being a consumer. The lower the ratio, the greater is the chance of receiving service. The index also gives an indication of which zip codes have higher ratios which means that consumers have a lower probability of receiving a service as well as any patterns in zip codes that have high percentages of African Americans, Asians, or Hispanics. A map is also attached which provides a graphic picture of the estimated consumers by zip code.

Based on the numbers of providers that report to FCFH whether they serve a given zip code, we had assumed that there would be greater variability across zip codes. In reality, many report that they serve the entire county. Thus the variability across zip codes is often primarily because

of differences in the population numbers rather than in service sites that offer service in a given zip code.

Specific Service Issues

Senior Services
"Senior Centers" was used as a catch-all category when the funder-defined service covered more than one senior success core service and could not be accurately allocated among the separate core services. Often, funding for transportation and home-delivered meals was not broken out from senior activities and supportive services at the municipal level, so it was placed under Senior Centers. Because the core services for congregate and home-delivered meals and senior ride were tracked separately, funding for these core services was not included under Senior Centers to avoid duplication of resources, even though senior center activities can and do include congregate meals.

Senior Ride includes disabled individuals of all ages as well as seniors for most funders with the notable exception of Western Reserve Area Agency on Aging (WRAAA) that requires an individual to be 60 years of age or older in order to receive services. If the transportation service was not provided by a senior center, the number of consumers reflects the number of riders using the system and contains duplicates (e.g. paratransit).

Home improvement/accessibility data includes programs for low-income families and people of all ages with disabilities, as well as seniors.

References

Anderson, Ronald M. (1995, March). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior,* 36(1): 1-10.

Wan, Thomas T. H., Odell, Barbara Gill, & Lewis, David T. (1982). *Promoting the well-being of the elderly: A community diagnosis.* New York: The Halworth Press.

Attachment 3: Actual Consumer Demographics

Core Service: Homeless Shelter BH-180.850								
		Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ***					
	Total Population (%)*	Estimated Homeless Persons (%)**	UW Program Report Data Cuy Cnty Only 42.5%(%)	TANF (%)	ESG (%)	FEMA (%)	CDBG - Cleveland (%)
PERIOD	12/31/2000	12/31/2000	6/30/2004	2004	2004	2004	2004
TOTAL	**1,393,978**	**16,000**	**601**	**Missing**	**Missing**	**Missing**	**Missing**
Percent		**1.1%**					
GENDER							
Male	47.2%	N/A	34.7%	0.0%	0.0%	0.0%	0.0%
Female	52.8%	N/A	65.3%	0.0%	0.0%	0.0%	0.0%
Unknown Data****			0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data*****			0.0%	100.0%	100.0%	100.0%	100.0%
RACE****							
White alone	67.1%	N/A	9.4%	0.0%	0.0%	0.0%	0.0%
Black or African American alone/combination	27.9%	N/A	89.7%	0.0%	0.0%	0.0%	0.0%
Asian alone/combination	2.1%	N/A	0.4%	0.0%	0.0%	0.0%	0.0%
American Indian and Alaska Native alone/combination	0.7%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
Some other race alone/combination	2.1%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%
Unknown Data****			0.3%	0.0%	0.0%	0.0%	0.0%
Missing Data*****			0.0%	100.0%	100.0%	100.0%	100.0%
HISPANIC*****	3.3%	N/A	3.0%	0.0%	0.0%	0.0%	0.0%
AGE							
0-4	6.5%	N/A	21.2%	0.0%	0.0%	0.0%	0.0%
5-9	7.3%	N/A	18.5%	0.0%	0.0%	0.0%	0.0%
10-14	7.1%	N/A	10.9%	0.0%	0.0%	0.0%	0.0%
15-19	6.4%	N/A	6.6%	0.0%	0.0%	0.0%	0.0%
20-34	19.1%	N/A	26.8%	0.0%	0.0%	0.0%	0.0%
35-54	29.3%	N/A	15.3%	0.0%	0.0%	0.0%	0.0%
55-64	8.7%	N/A	0.6%	0.0%	0.0%	0.0%	0.0%
65-74	7.8%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%
75+	7.8%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Data****			0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data*****			0.0%	100.0%	100.0%	100.0%	100.0%
INCOME******							
Average Household Size	N/A	N/A	N/A	N/A	N/A	N/A	N/A
$0-$9,999	11.3%	N/A	42.6%	0.0%	0.0%	0.0%	0.0%
$10,000-$14,999	6.9%	N/A	3.4%	0.0%	0.0%	0.0%	0.0%
$15,000-$19,999	6.7%	N/A	1.1%	0.0%	0.0%	0.0%	0.0%
$20,000-$29,999	13.6%	N/A	0.4%	0.0%	0.0%	0.0%	0.0%
$30,000 and above	61.5%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%
Unknown Data****			52.5%	0.0%	0.0%	0.0%	0.0%
Missing Data*****			0.0%	100.0%	100.0%	100.0%	100.0%
Totals	**100.0%**	**N/A**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Attachment 3: Actual Consumer Demographics (continued)

*U.S. Census 2000, SF1(P1); SF4 (PCT 144)
** *Heading Home,* The Cleveland/Cuyahoga County Ten Year Plan to Prevent Homelessness and Expand Affordable Housing: "A Five-Year Plan to Develop Supportive Housing for Long-Term Homeless Adults in Cleveland and Cuyahoga County." Prepared by the Corporation for Supportive Housing in collaboration with The Maxine Goodman Levin College of Urban Affairs, Cleveland State University, 2003 - estimated approximately 16,000 Cuyahoga County residents are homeless at some point in time during the course of a year. 1.1 percent total population
***Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake
*****Missing Data - For United Way Data - represents computational errors or incorrect completion of online report. For all other data - represents data funder was unable to provide.
*****The race categories and data utilize US Census SF4 "Race Iterations," which allow for multiple races to be selected by census respondents. As a result, totals will add to > 100% of population. Universe is "Total Races Tallied." Except "White Alone", all racial categories are "... alone or in combination with some other race". This method isolates and minimizes the non-minority population ("White alone").
*******Hispanic - Amount in this field is from data provided by clients on intake forms and may not be accurate as clients may either deliberately or inadvertently provide incomplete data, or data may not be collected by the agency.
********The U.S. Census reports income by household or family, not individuals. Estimates by income category were derived by applying the ratio of total county population (1,393,978) to total households (571,606) = 2.4. The number of households in each income category was multipled by 2.4 to arrive at an estimate of individuals by income category. The assumption is that the average household size applies to each income category, which may result in more conservative estimates for children, and the "old old," which may actually have larger proportions of persons in the lower income categories.

Attachment 4: Actual Consumer Zip Codes

Core Service: Homeless Shelter BH-180.850								
			Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ***				
	City/Town (% Cleveland)	Total Population (%)*	Estimated Homeless Persons (%)**	UW Program Report Data (%)	TANF (%)	ESG (%)	FEMA (%)	CDBG - Cleveland (%)
Period		1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004	2004	2004	2004	2004
TOTAL		1,393,978	16,000	601	Missing	Missing	Missing	Missing
Percent			1.1%					
44017	Berea	1.4%	NA	0.7%	0.0%	0.0%	0.0%	0.0%
44022	Bentleyville	1.3%	NA	0.2%	0.0%	0.0%	0.0%	0.0%
44040	Gates Mills/Mayfield Village	0.2%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44070	North Olmsted	2.4%	NA	0.2%	0.0%	0.0%	0.0%	0.0%
44101	Cleveland (100%)	0.0%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	NA	12.8%	0.0%	0.0%	0.0%	0.0%
44103	Cleveland (100%)	1.8%	NA	5.7%	0.0%	0.0%	0.0%	0.0%
44104	Cleveland (100%)	2.1%	NA	8.2%	0.0%	0.0%	0.0%	0.0%
44105	Cleveland/NewburghHts/GarfieldHts	3.9%	NA	7.2%	0.0%	0.0%	0.0%	0.0%
44106	Cleveland/Cleveland Hts (60%)	2.3%	NA	2.5%	0.0%	0.0%	0.0%	0.0%
44107	Lakewood/Cleveland	4.0%	NA	1.8%	0.0%	0.0%	0.0%	0.0%
44108	Cleveland/Bratenahl (90%)	2.6%	NA	5.5%	0.0%	0.0%	0.0%	0.0%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	NA	2.2%	0.0%	0.0%	0.0%	0.0%
44110	Cleveland/East Cleveland (98%)	1.9%	NA	3.7%	0.0%	0.0%	0.0%	0.0%
44111	Cleveland (100%)	3.1%	NA	1.5%	0.0%	0.0%	0.0%	0.0%
44112	East Cleveland/Cleveland	2.4%	NA	5.7%	0.0%	0.0%	0.0%	0.0%
44113	Cleveland (100%)	1.4%	NA	0.7%	0.0%	0.0%	0.0%	0.0%
44114	Cleveland (100%)	0.3%	NA	0.5%	0.0%	0.0%	0.0%	0.0%
44115	Cleveland (100%)	0.6%	NA	1.3%	0.0%	0.0%	0.0%	0.0%
44116	Rocky River	1.5%	NA	0.2%	0.0%	0.0%	0.0%	0.0%
44117	Euclid/Cleveland	0.9%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44118	ClevelandHts/UniversityHts/ShakerH	3.2%	NA	1.0%	0.0%	0.0%	0.0%	0.0%
44119	Cleveland/Euclid (50%)	1.0%	NA	0.3%	0.0%	0.0%	0.0%	0.0%
44120	Shaker Hts/Cleveland	3.4%	NA	6.0%	0.0%	0.0%	0.0%	0.0%
44121	University Hts/South Euclid	2.5%	NA	0.7%	0.0%	0.0%	0.0%	0.0%
44122	Beachwood/Highland	2.5%	NA	1.0%	0.0%	0.0%	0.0%	0.0%
44123	Euclid	1.3%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	NA	0.2%	0.0%	0.0%	0.0%	0.0%
44125	Valley View/Garfield Hts	2.1%	NA	0.8%	0.0%	0.0%	0.0%	0.0%
44126	Fairview Park/Cleveland	1.2%	NA	0.2%	0.0%	0.0%	0.0%	0.0%
44127	Cleveland (100%)	0.6%	NA	3.8%	0.0%	0.0%	0.0%	0.0%
44128	Warrensville Hts/Cleveland	2.4%	NA	2.0%	0.0%	0.0%	0.0%	0.0%
44129	Brooklyn/Parma/Cleveland	2.1%	NA	0.3%	0.0%	0.0%	0.0%	0.0%
44130	Parma/Cleveland	3.8%	NA	0.8%	0.0%	0.0%	0.0%	0.0%
44131	Independence/Seven	1.5%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44132	Euclid	1.1%	NA	0.5%	0.0%	0.0%	0.0%	0.0%
44133	North Royalton	2.0%	NA	0.2%	0.0%	0.0%	0.0%	0.0%
44134	Parma/Cleveland	2.9%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44135	Cleveland/Linndale (90%)	2.0%	NA	18.5%	0.0%	0.0%	0.0%	0.0%
44136	Strongsville	3.1%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44137	Maple Hts/Cleveland	1.9%	NA	1.5%	0.0%	0.0%	0.0%	0.0%
44138	Olmsted Twp/Olmsted Falls	1.3%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44140	Bay Village	1.1%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44141	Brecksville	1.0%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44142	Brookpark/Cleveland	1.5%	NA	0.2%	0.0%	0.0%	0.0%	0.0%
44143	Highland Hts/Richmond Heights	1.7%	NA	0.2%	0.0%	0.0%	0.0%	0.0%
44144	Brooklyn/Cleveland	1.6%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44145	Westlake	2.3%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	NA	0.5%	0.0%	0.0%	0.0%	0.0%
44147	Broadview Hts	1.1%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
44149	Strongsville	0.0%	NA	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Cuyahoga County Zip Codes*****				1.2%	0.0%	0.0%	0.0%	0.0%
Missing****				0.0%	100.0%	100.0%	100.0%	100.0%
Unknown *****				0.0%	0.0%	0.0%	0.0%	0.0%
Total Cuyahoga County******		**100.0%**	**NA**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Total Known Cleveland		**30.7%**	**NA**	**74.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Total Known Suburbs		**69.8%**	**NA**	**24.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Unknown & Missing				**98.8%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Attachment 4: Actual Consumer Zip Codes (continued)

* U.S. Census 2000, SF1 (P1)
** *Heading Home,* The Cleveland/Cuyahoga County Ten Year Plan to Prevent Homelessness and Expand Affordable Housing: "A Five-Year Plan to Develop Supportive Housing for Long-Term Homeless Adults in Cleveland and Cuyahoga County." Prepared by the Corporation for Supportive Housing in collaboration with The Maxine Goodman Levin College of Urban Affairs, Cleveland State University, 2003 - estimated approximately 16,000 Cuyahoga County residents are homeless at some point in time during the course of a year. 1.1 percent total population
*** Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
****Missing Data - For United Way - represents computational errors or incorrect completion of online report. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County. For all other data - represents data funder was unable to provide.
*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County.
****** Totals vary because of rounding. County total population 1,393,978 does not correspond to the total of zip codes because some zip codes include data from adjacent counties

Attachment 5: Profile of Core Service Providers – 2005

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
Total Number of Providers	10	3
Number of Providers by Type		
Nonprofit	9	-
For-profit	-	-
Government	-	-
Other	1	-
Total Number of Sites	11	-
Number of Service Sites per Provider		
1	9	-
2 – 5	1	-
6 – 10	-	-
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
44017 - Berea	-	-
44022 - Bentleyville	-	-
44040 - Gates Mills/Mayfield Village	-	-
44070 - North Olmsted	-	-
44101 - Cleveland	1	-
44102 - Cleveland/Brooklyn	-	-
44103 - Cleveland	1	-
44104 - Cleveland	-	-
44105 - Cleveland/Newburgh Hts/Garfield Hts	-	-
44106 - Cleveland/Cleveland Hts	-	-
44107 - Lakewood/Cleveland	-	-
44108 - Cleveland/Bratenahl	-	-
44109 - Cleveland/Brooklyn Hts	-	-
44110 - Cleveland/East Cleveland	-	-
44111 - Cleveland	1	-
44112 - East Cleveland/Cleveland	1	-
44113 - Cleveland	3	-
44114 - Cleveland	3	-
44115 - Cleveland	-	-
44116 - Rocky River	-	-
44117 - Euclid/Cleveland	-	-
44118 - ClevelandHts/UniversityHts/ShakerHts	-	-
44119 - Cleveland/Euclid	-	-
44120 - Shaker Hts/Cleveland	-	-
44121 - University Hts/South Euclid	-	-
44122 - Beachwood/Highland Hills/Shaker Hts.	1	-
44123 - Euclid	-	-
44124 - Pepper Pike/Mayfield Hts./Lyndhurst	-	-
44125 - Valley View/Garfield Hts	-	-
44126 - Fairview Park/Cleveland	-	-
44127 - Cleveland	-	-
44128 - Warrensville Hts/Cleveland	-	-

Attachment 5: Profile of Core Service Providers – 2005 (continued)

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
44129 - Brooklyn/Parma/Cleveland	-	-
44130 - Parma/Cleveland	-	-
44131 - Independence/Seven Hills/Brooklyn Hts	-	-
44132 - Euclid	-	-
44133 - North Royalton	-	-
44134 - Parma/Cleveland	-	-
44135 - Cleveland/Linndale	-	-
44136 - Strongsville	-	-
44137 - Maple Hts/Cleveland	-	-
44138 - Olmsted Twp/Olmsted Falls	-	-
44139 - Bentleyville/Glenwillow/Solon	-	-
44140 - Bay Village	-	-
44141 - Brecksville	-	-
44142 - Brookpark/Cleveland	-	-
44143 - Highland Hts/Richmond Heights	-	-
44144 - Brooklyn/Cleveland	-	-
44145 - Westlake	-	-
44146 - Walton Hills/Oakwood/Bedford	-	-
44147 - Broadview Hts	-	-
44149 - Strongsville	-	-

Attachment 6: Providers and Functions – 2005

Services Providers and Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	**Services**
AIDS Taskforce of Cleveland	Shelter For Teen-Age Girls
City Mission	Shelter - Homeless Males
East Side Catholic Center And Shelter	Emergency Shelter - Homeless And / Or Abused Women
Interfaith Hospitality Network Of Greater Cleveland	Shelter And Support For Homeless Families
Lutheran Metropolitan Ministry	Emergency Shelter - Single Adult Men - Lakeside
Mental Health Services	Emergency Overflow Shelter For Women And Children, Emergency Shelter - Homeless Men
St. Herman's Monastery/House Of Hospitality	Emergency Shelter
Salvation Army	Emergency Shelter/Respite - Youth
Volunteers Of America - Northeast And North Central Ohio	Emergency Shelter For Homeless Men

Bold represents agencies funded by United Way for this service. Note that Mental Health Services first was funded by United Way for this service beginning in FY 2005.

Attachment 7: United Way - First Call for Help Homeless Shelters Requests – 2000-2004: Greatest Increase/Greatest Decrease

BH-180.850 Homeless Shelter United Way - First Call for Help Requests 2000-2004 Greatest Increase/(Greatest Decrease)								
Zip Code		TOTAL REQUESTS					%Change*	Avg. #
		2000	2001	2002	2003	2004	00&04	Calls 00-04
44114	Cleveland	99	184	425	636	770	678%	423
44149	Strongsville	0	0	3	5	5	N/A	3
44022	Bentleyville	2	2	2	3	9	350%	4
44147	Broadview Hts	2	2	3	5	8	300%	4
44101	Cleveland	2	4	8	7	7	250%	6
44133	North Royalton	3	5	11	6	10	233%	7
44142	Brookpark/Cleveland	6	10	19	13	19	217%	13
44140	Bay Village	1	1	2	4	3	200%	2
44139	Bentleyville/Glenwillow/Solon	4	4	2	6	12	200%	6
44145	Westlake	5	11	15	17	13	160%	12
44138	Olmsted Twp/Olmsted Falls	2	4	4	5	5	150%	4
44121	University Hts/South Euclid	26	43	35	43	62	138%	42
44144	Brooklyn/Cleveland	9	11	16	20	21	133%	15
44137	Maple Hts/Cleveland	39	50	33	49	79	103%	50
44131	Independence/Seven Hills/BrooklynHts	3	1	6	9	6	100%	5
44129	Brooklyn/Parma/Cleveland	12	20	14	18	22	83%	17
44111	Cleveland	83	104	146	161	152	83%	129
44123	Euclid	21	43	24	39	38	81%	33
44117	Euclid/Cleveland	28	41	39	47	50	79%	41
44136	Strongsville	13	15	18	10	23	77%	16
44070	North Olmsted	10	6	22	11	17	70%	13
44132	Euclid	19	24	31	36	32	68%	28
44113	Cleveland	151	215	266	228	250	66%	222
44130	Parma/Cleveland	26	25	39	58	43	65%	38
44115	Cleveland	338	615	998	876	558	65%	677
44017	Berea	11	10	14	13	18	64%	13
44134	Parma/Cleveland	8	15	16	16	13	63%	14
44110	Cleveland/East Cleveland	167	181	221	185	269	61%	205
44125	Valley View/Garfield Hts	22	18	32	30	35	59%	27
44135	Cleveland/Linndale	55	57	67	66	87	58%	66
Total Cuyahoga County		**3,902**	**4,821**	**5,600**	**5,703**	**6,085**	**56%**	**5,222**
Total Cleveland		**2,745**	**3,479**	**4,182**	**4,201**	**4,352**	**59%**	**3,792**
Total Suburbs		**1,157**	**1,342**	**1,418**	**1,502**	**1,733**	**50%**	**1,430**

* Extremely high percentages are due to low numbers.

** These totals do not reflect the sum of the numbers above which are the zip codes reflecting the greatest increase or decrease. Rather, they are the total of calls from ALL zip codes many of which do not appear on this table.

Attachment 8: United Way - First Call for Help Homeless Shelters Requests 2000-2004: Unmet Need

BH-180.850 Homeless Shelter					
United Way - First Call for Help Requests 2000-2004					
Unmet Need					
Zip Code		TOTALS 00-04			%
		Requests	Met	Unmet	Unmet
44040	Gates Mills/Mayfield Village	3	2	1	33%
44136	Strongsville	79	70	9	11%
44139	Bentleyville/Glenwillow/Solon	28	25	3	11%
44017	Berea	66	59	7	11%
44115	Cleveland	3,385	3,070	315	9%
44146	Walton Hills/Oakwood/Bedford	242	220	22	9%
44130	Parma/Cleveland	191	175	16	8%
44113	Cleveland	1,110	1,026	84	8%
44101	Cleveland	28	26	2	7%
44111	Cleveland	646	601	45	7%
44112	East Cleveland/Cleveland	1,576	1,470	106	7%
44121	University Hts/South Euclid	209	195	14	7%
44144	Brooklyn/Cleveland	77	72	5	6%
44124	Pepper Pike/MayfieldHts/Lyndhurst	80	75	5	6%
44110	Cleveland/East Cleveland	1,023	960	63	6%
44070	North Olmsted	66	62	4	6%
44108	Cleveland/Bratenahl	1,635	1,536	99	6%
44122	Beachwood/Highland Hills/ShakerHts	204	192	12	6%
44102	Cleveland/Brooklyn	1,729	1,628	101	6%
44125	Valley View/Garfield Hts	137	129	8	6%
44107	Lakewood/Cleveland	387	365	22	6%
44106	Cleveland/Cleveland Hts	1,145	1,081	64	6%
44119	Cleveland/Euclid	109	103	6	6%
44123	Euclid	165	156	9	5%
44126	Fairview Park/Cleveland	74	70	4	5%
44103	Cleveland	1,226	1,162	64	5%
44128	Warrensville Hts/Cleveland	662	628	34	5%
44116	Rocky River	41	39	2	5%
44137	Maple Hts/Cleveland	250	238	12	5%
44195	Cleveland - Cleveland Clinic	42	40	2	5%
44105	Cleveland/NewburghHts/GarfieldHts	1,794	1,709	85	5%
44109	Cleveland/Brooklyn Hts	936	892	44	5%
44127	Cleveland	294	281	13	4%

Attachment 8: United Way - First Call for Help 2000-2004: Unmet Need (continued)

BH-180.850 Homeless Shelter					
United Way - First Call for Help Requests 2000-2004					
Unmet Need					
Zip Code		TOTALS 00-04			**%**
		Requests	**Met**	**Unmet**	**Unmet**
44117	Euclid/Cleveland	205	196	9	4%
44104	Cleveland	1,409	1,348	61	4%
44135	Cleveland/Linndale	332	318	14	4%
44131	Independence/Seven Hills/BrooklynHts	25	24	1	4%
44120	Shaker Hts/Cleveland	1,375	1,324	51	4%
44118	ClevelandHts/UniversityHts/ShakerHts	379	366	13	3%
44141	Brecksville	30	29	1	3%
44145	Westlake	61	59	2	3%
44142	Brookpark/Cleveland	67	65	2	3%
44129	Brooklyn/Parma/Cleveland	86	84	2	2%
44114	Cleveland	2,114	2,073	41	2%
44143	Highland Hts/Richmond Heights	60	59	1	2%
44134	Parma/Cleveland	68	67	1	1%
44132	Euclid	142	140	2	1%
	*** Total Cuyahoga County**	**26,111**	**24,628**	**1,483**	**6%**
	*** Total Cleveland**	**18,959**	**17,856**	**1,103**	**6%**
	*** Total Suburbs**	**7,152**	**6,772**	**380**	**5%**

FCFH DATA NOTES

Met = service request resulting in referral to an organization. (Does not mean agency was able to provide the service.)

Unmet = service request for which there was no referral.

Note: Zip Codes shared by Cleveland and surrounding suburbs whose boundaries fall 50% and greater within the city of Cleveland are highlighted and totaled as Cleveland. Others are totaled as Suburbs.

* These totals do not reflect the sum of the numbers above which are the zip codes reflecting unmet need in 2004. Rather, they are the total of calls from ALL zip codes some of which do not appear on this table.

United Way of Greater Cleveland

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Cleveland, Ohio 44115

uws.org/CoreServicesPlanning