Unsheltered Notice of Funding Opportunity – Input Session and Survey Summary

Background

On June 22, 2022, The U.S. Department of Housing and Urban Development (HUD) released a first of its kind package of resources to address unsheltered homelessness and homeless encampments. The Supplemental Unsheltered Notice of Funding Opportunity (NOFO) allows for the Chicago Continuum of Care (CoC) to apply up to $60 million ($20 million per year for 3 years). Through this Unsheltered NOFO, HUD will award funding to communities to implement coordinated approaches to reduce the prevalence of unsheltered homelessness, improve services, health outcomes, and housing stability.

The Chicago CoC conducted several input sessions with diverse stakeholder representation which provided input on the comprehensive plan and needed project types to support folks moving from unsheltered locations to housing. For more information on the input questions, please click here.

The NOFO requires CoC's to develop a comprehensive plan for Serving Individuals and Families Experiencing Homelessness with Severe Service Needs that should describe the items below. The CoC Board Executive Committee passed a motion on July 27, 2022, stating, "That the CoC Board vote on the strategic components of the Comprehensive Plan at the August 17 meeting. Strategic components include whether the three lead agencies of the CoC would need to expand to support the plan, which project types are eligible to apply, and how those project types would be coordinated for maximum impact."

The comprehensive plan strategic components will translate into the CoC's new project funding opportunities to be released in late August.

Input Sessions

Below are themes and ideas generated from the specific input sessions conducted by All Chicago. The Input sessions had attendance which held one or more of the following representations:

- People with Lived Experience (e.g., People recently housed within the homeless system, Youth Action Board, and Lived Experience Commission)
- Homeless service providers (e.g., outreach, drop in, and housing)
- Affinity groups
- Lead Agencies (e.g., Collaborative Applicant, Coordinated Entry)
- Government entities (e.g., Illinois Housing Development Authority, Chicago Department of Housing, Chicago Department of Public Health and Chicago Department of Family and Support Services)

Themes

The following items were mentioned as opportunities to pursue in the Special NOFO throughout several input sessions. For additional information on specific feedback generated during the input sessions, please refer to the detailed feedback section.

- Create a diverse portfolio of programs to support individuals experiencing unsheltered homelessness below are model types that were mentioned multiple times
  - Outreach
  - Standalone Daytime support services
  - Accelerated Moving Events (AMEs)
  - Housing Navigation
  - Bridge Housing
  - Temporary Housing – transitional housing or hotel placement
  - Permanent Supportive Housing
  - Joint Transitional Housing/Rapid Rehousing
  - Peer to Peer Support
- Ensure funding process incorporates a racial equity lens. For example, viewing if project has cultural competencies to serve specific populations, are programs located in neighborhoods where individuals are being served and/or preferred
- Increase outreach services and focus on the relationship building and trust building that supports people to move from unsheltered locations to a housing intervention
- Focus on individualized planning, support, and options for people experiencing unsheltered homelessness (no one size fits all solution) – the CoC needs to create a diverse housing portfolio and enhanced case management support
- Review and leverage the relationship with the Chicago Housing Authority (CHA) –
  - Review the homeless preference
  - Create a strong partnership with CHA.
  - Increase accessibility for CHA programs for individuals who may be able to exit homeless programs and only need affordable housing (e.g. individuals in RRH)
- Create system wide connections with other resources to support individuals as soon as outreach has occurred. For example, connection to hospitals, managed care organizations, employment, mental health, behavioral health, substance use support
  - Support for behavioral and substance use within the system is highly needed. Specifically, not only having a pathway to offer these services to individuals who may be willing to engage in these services but also providing more than just a brochure and address to a location because individuals are lost in transit
  - Increase access to SOAR
  - Allow for transportation accessibility
- System support to oversee handoffs between agencies to ensure roles and responsibilities are clear and accountability is maintained – ensure that all the entities are working together and are aware of each other’s role.
  - Ensure that communication and transparency from the staff at the emergency shelter, outreach team, Coordinated Entry staff and housing staff are aware of the stage the individual may be in the housing journey

    - The system support is also needed to provide trainings to agencies around engagement and rapport
- Coordinated Entry (CE) improvements are needed to focus on case conferencing, matching, transfer accountability, prioritization, and assessment.
    - Review how CE prioritization may be limiting for folks experiencing unsheltered homelessness, specifically for individuals exiting institutions such as hospitals and jails/prisons
    - Utilize AMEs as a matching tool with effective screening done prior to enrollment into a program so appropriate support is provided to individuals
- Review the chronic homeless definition prioritization within the community (e.g. review the inflow of individuals aging into chronic homelessness), and flexibility with documenting chronic homelessness
- Review housing program eligibility and landlord's criteria to avoid exclusion of individuals who were formerly incarcerated and/or are on the registry list
- Specific populations mentioned were families, youth and individuals fleeing gender-based violence

Detailed Feedback

Input Session Type	**Feedback**
DFSS Outreach Providers Meeting July 28, 2022 Total attendees: 30	<u>Program Types Needs</u> • Increase in temporary housing such as bridge housing and/or transitional housing • Temporary housing allows for people to move quickly into a unit until a permanent housing placement is identified • Need to ensure temporary housing does not become a barrier to permanent housing (people may not wish to move out of temporary housing) • Hotel placement is highly desired by individuals because of the private rooms • Low barrier shelters are declined when not located near unsheltered location • Low barrier shelters are declined due to lack of security • Permanent Supportive Housing (PSH) is declined when not located in areas near unsheltered location – need PSH units where people will want to live • Peer support workers would be key for rapport <u>Service Needs</u> • Supportive services only are needed to support engagement • Additional support is needed to obtain documents to move into housing (e.g. ID, birth certificate) • Ability to add in occupational therapy support for daily living guidance and skill building • Availability of workforce and substance use resources prior to entrance into housing • Increase access to government subsidized cellphones to increase communication

Input Session Type	Feedback
	• Strengthen case management support in particular during first year in placement to ensure individuals do not re-enter homelessness in short term programming <u>System Level Coordination/Support</u> • Need a coordination of substance use services • Focus on intake to identify what is most needed and wanted (e.g. SRO with private bathroom, TH, or other services) • Need persistent coordination of service providers every step of individual's housing journey • Need to ensure roles and responsibilities of service providers are clear to avoid duplication and/or disconnection of services • Focus on training to ensure rapport and consistency are the same across all outreach providers
ESG Rapid Rehousing Providers Meeting August 3, 2022 Total attendees: 43	<u>Program Types Needs</u> • Immediate housing opportunities for individuals with no income (SROs and studio apartments w/all utilities included). • More affordable units needed - Rapid Rehousing participants are heading to higher rent apartments; these are not sustainable for some families • Housing model should incorporate affordable housing rather than just Permanent Supportive Housing (PSH) • Need additional project-based PSH to allow for additional support • Increase PSH • Individuals need more TH to allow them to have a place to be while working toward more stability. • People refuse shelters for many reasons (lack of security, rules, room setup) and may prefer the street. • A bridge program could work prior to moving into an apartment. The participants that we meet often ask if we can put them in a hotel (especially in the winter). <u>Service Needs</u> • Include transportation services/resources for individuals to access various services • Incorporate background checks prior to housing placement, this will serve as a guidance for placement assessment and housing case management • Access to therapists to evaluate persons served who may have intense needs such as severe mental health issues, co-occurring issues, substance usage etc. • Intensive 24/7 mental health supports that can be accessed when needed • Increase literacy and bilingual resources to help serve participants • Use the low barrier model for ALL housing, so that those without documentation can still move in while we help them get those documents. • Need linkage between clinical case management support

Input Session Type	Feedback
	• Increase access to cell phones to access participant • Assistance with paying for educational programs • Individuals coming from unsheltered location require more life skills development • Increase outreach teams that can support with re-engagement • Equip team with resources around therapists and clinical case management System Level Coordination/Support • Revise how chronic homelessness time is calculated • Reinforcing enhanced participant responsibility through earlier and repeated (or required) engagement with life skills training • Additional wrap around services prior to enrollment in housing intervention • Matching improvements are needed to ensure individuals are matched appropriately to housing and connections to behavioral and mental health support • Allow participants that have completed a Coordinated Entry (CE) assessment a way to update their information. Sometimes a barrier is that a person has to go back into a shelter or connect with an outreach staff before can become active
Lived Experience Commission (LEC) and Youth Action Board (YAB) Input Session August 3, 2022 Total attendees: 8	• Street medicine and outreach vans are one way to connect with people in unsheltered situations • Including behavioral health supports in partnership with police encounters with encampments. Police encounters sometimes lead to ruptures in communication and having the support can restore communication and engagement • Include persons with lived experience to guide policies in particular when policies lead to criminalization of homelessness • Focus on case management and wrap around services to housing programs, in particular skills such as budgeting (around groceries), financial services, getting ready to be on your own, maintaining stability within a household • Increase case management support in particular with a Rapid Rehousing (RRH) program • In an AME, transportation and furniture were great • In EHI, need a coordination of services to avoid abandonment of opportunity. So many staff were involved but it was obvious they were not working in sync with one another • Investment of employment specialists. Case managers are not always specialized with workforce involvement and supports • Increase staffing within our sector. Emergency shelters rely on volunteers which leads to higher levels of disconnect on how the shelter staff can support the individual in the housing process. • Allowing for drop in services at all emergency shelters so individuals can connect and engage

Input Session Type	Feedback
	• Offer more support for staff on multiple tools for connections (e.g. phone calls , email, text, and social media) • Allow flexibility in rules and circumstances for people to access services (e.g. A person with a pet cannot access some shelters) • Case management and skillsets look different for staff who are working with people in emergency housing vs encampments
CoC Input Session Meeting August 5, 2022 Total attendees: 45	Program Type Needs • Need temporary housing such as bridge housing • Increase the number of PSH units, especially to match increase in bridge housing • Increase low barrier housing – in particular Single Room Occupancy (SRO) and/or master lease opportunities • Bridge housing seems to work but is complex for single individuals for individuals coming from encampments • Creating peer service/support • Increased funding for housing navigation and outreach • Increasing master leasing permanent housing for people who have barriers to units in their own name • Need to create more subsidies beyond PSH (eg. The absent of emergency housing voucher will make more people in RRH become homeless again) • Explore shared housing models Service Needs • Increase need of services for people exiting hospitals, IL Department of Corrections (IDOC), couples, youth aging out of foster care, individuals with medical barriers (need an in-home aid) • Need to increase supportive services and wraparound services • Increase transportation services • Increase Accelerated Moving Events (AME) – Limited impact, need to increase the total number, good approach and relevant for trans community System Level Coordination/Support • Systems enhancement with CHA and a more robust partnership • Revisit CHA homeless preference and how it is operationalized. Folks on the street are behind the hundreds of people who applied on days/weeks/months/years prior. Other communities allow people to move up on the list for public housing. Opportunity to leverage this NOFO • Flexibility with chronic homeless status – excludes those exiting jails, prisons, substance use treatment or hospitals • Need additional support so the system does not intervene until someone has reached chronic homeless status • Flexibility with documenting homelessness episodes for those with intellectual or developmental disabilities

Input Session Type	Feedback
	• Ensure we are viewing this opportunity with a lens of racial equities and disparities • Need system changes for intake, homeless call center, and other barriers that is not responsive to immediate need • AMEs need more holistic wraparound services and mental health services • Increase connection between outreach works and AME scheduling • Important to focus on governmental units buy-in at an aldermanic/commissioner level • Integration with hospitals/managed care organizations and broader health care system • System coordination with jail/prison • Coordinated Entry improvements – re-think reengagement with individuals, process, matches and rematches • Review assessment tool – many people do not complete the process because it is too challenging and not accessible to most vulnerable who we could prioritize • Increase funding for Coordinated Entry to improve processes • Provide technical assistance for under-resourced agencies to build internal coordinated entry capacity • Improve assessment process to match individuals with neighborhoods they are familiar with and enhance client choice. Increase Coordinated Entry System to support this. • Improve Coordinated Entry transparency/plain language for individuals experiencing homelessness • Address housing access barriers within system • At a system level, how do we leverage this opportunity to engage in meaningful partnership with alderman's/wards to ensure we do not hear only that encampments are a problem in our community • How do we leverage this opportunity to also use to support advocacy on the increasing price of rents due to average rent adjustments in our community
CoC Input Session Meeting August 8, 2022 Total attendees: 49	<u>Programs Needed</u> • Bridge housing was emphasized and requested by several people • Bridge serves as a buffer location to help with long term stability coming directly from encampments • Access to bridge housing must be a clear process • Affordable housing is needed in locations where people want to live • Diversion – how well is it working and whether an eligible program • Transitional Housing (TH) was highlighted in the NOFO as a Housing First approach, the CoC needs additional TH • The CoC may need more Joint TH RRH projects • Peer navigators can be helpful throughout the housing process

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	<u>Services Needed</u> • Need health specialists/ health navigators: basic medical care is essential to keep people healthy and build a trusting relationship • Additional outreach teams are needed for CTA coverage • Access to substance use on the way into and once someone is housed (cannot significantly improve if we do not address Substance Use Disorder) • Outreach and engagement teams are in high need for serving frequent utilizers in the Emergency Rooms (ER) • Documentation assistance and navigation is needed • Ensuring people are connected to services • Utilities and income supports available and accessible • Need connection with employment and income to connect people to benefit enrollment <u>System Coordination/Support</u> • Connections between ERs/hospitals and outreach teams • Mental health supports that follow the person – supporting them in obtaining and maintaining housing • Organization relationships are important when it comes to PSH referrals. This is extremely helpful if a PSH referral comes from someone connected with a staff who is helpful in getting someone housed and has ongoing relationship • Advocacy for increase in governmental subsidies funding to be competitive with market rate and/or incentives for landlords to partner • System needs robust, intensive training to support people moving into housing. This would help with the staffing shortage and clarify roles and responsibilities • Case conferencing to ensure people supporting a participant are coordinating effectively • CES improvements and support connecting people from outreach opportunities to housing • People leaving incarceration often have to become homeless in order to connect with CES and receive housing due to prioritization policies • Need coordination between street medicine teams, outreach teams • Need coordination and support for all handoffs between agencies • Handoffs within an agency are clean, clear and supported but between agencies, lines of accountability and responsibilities are blurred • AME handoffs between housing liaisons to case managers are difficult and need improvement • Coordination activities examples: Understanding the concept of service coordination across agencies involved in the activities of this NOFO; experience in delivery of services across agencies; job descriptions of staff taking on specific tasks with the outcome of successful linkage of services; an entity that can manage a list of contacts for all providers; manage the list, which would include what services are available and who is the contact

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	person at each agency; If the agency experiences turnover in staff, then the agency could report to the entity who the new contact is, thus keeping a flow to the system; Must be a social contract that requires the referring and receiving agencies to respond in a timely manner, even if it's not an appropriate referral. There needs to be accountability to make such arrangements work. • Leveraging existing programs to increase and draw more direct line to housing programs such as: 1. Programs such as Chicago House 4 week training program (Community Health Apprenticeship Program) to jumpstart advancement into community health work can help support in hiring graduates for other social service positions. 2. Chicago Help initiative where volunteers are trained to get IDs and have a meal program. Provide Renters Rights trainings or resources before are housed
In-Person Input Session for Individuals Recently Housed August 10, 2022 Total attendees: 12	Program Types Need • Individualized planning and support and options for people. No one size fits all • Bridge housing is an option for stabilization but needs flexibility – not a requirement but an option for some • Peer navigators/outreach led by people with lived experience • RRH for 12 months is stressful/traumatic to think only have 12 months before become homeless again – it takes too long to get connected to jobs • RRH case management support on a monthly basis is not enough or intensive enough – need support with daily living such as paying bills, budgeting for the grocery, getting connected to jobs etc Service Need • Peer support as part of outreach to support in the relationship building • Homeless hotline – someone to call when someone needs help • Need orientation to being able to live in housing and take care of daily living skills • Some people need stabilization housing, but not all – someone could assess to determine if it is needed • Daily help and support is critical – intensive case management support is needed beyond just one time a month • Need Employment and/or Income Services • Need Mental Health support • Need addiction supports • Need Transportation supports • Ability to have a relationships and access to outreach folks who have been with you would be great • Create community among those who have been recently housed (e.g. support groups) • Ability to address medical needs

Input Session Type	Feedback
	• Landlord support: where to go if issue with landlords and units. Sometimes landlords are not responsive to issues System Coordination/Support • Too many handoffs are very difficult for people transitioning into housing • Need standardized case management training to support people • Case management turnover makes it difficult to understand who to contact and ask for help
Front Door Leadership Meeting August 11, 2022 Total attendees: 14	Program Types Need • Outreach: Increase staff capacity to ensure individuals are not only trained well (and offer mentorship among staff) but are also paid well. A salary scale will allow opportunities for agencies to not have to compete with one another for staff • Shared housing – can be an opportunity for specific age groups such as seniors or youth • Safe Haven: allowing low barrier upon entry so individuals can easily move into housing, services are offered in a guided not mandatory way to increase engagement, are smaller (no more than 15-20 units) Services Need • The following services were mentioned to increase access to: physical health services, substance abuse support • Work with managed care organizations to do leg work when individuals access medical care • Allow the ability for individuals experiencing unsheltered homelessness to know the resources and what would work best for them (PSH, RRH, wraparound, etc.) • Allow individuals to move into their own units first before addressing other barriers (adhering to housing first approach) System Coordination Support • Collaboration and training for outreach should be a focus. One agency can serve a point of contact • Elements of collaboration include: communicating on individual's housing journey to all entities involved, leveraging individual organization's resources and offer choice to individual • Open HMIS system so all organizations know where someone is connected to and the services being provided • A mechanism needs to be created to remove barriers to services • An additional element to AMEs would be to factor in long-term support to keep individuals housed and meet other needs • AMEs were great but put a lot of pressure on RRH case managers to identify a long-term, housing pathways with limited resources • Case conferencing/System Integration Teams (SIT) meetings were higher in attendance in the past but now it is difficult because of staffing and capacity

Input Session Type	Feedback
	issues – balancing the need to support individuals and the agency, to agency coordination
Special NOFO Feedback Survey Available August 3, 2022 to August 12, 2022 30 Respondents	• I would like to see more emphasis placed on older individuals that need housing. • More Intensive Case Management once a client is housed so they are successful • Revamp Diversion to make it more successful • Providing more affordable housing options to individuals w/o disabilities would be great. • With new funds available to support the unsheltered who are in our tents cities, on the streets, riding transit system that are often hardest to reach. I believe that one of the biggest mistakes that Chicago COC made was closing all of the standalone daytime support service center without have a real plan. Now, the tent cities have taken the place of such entries, to the point where the city has place porta potty at tent city, regularly having to pick up trash and work to keep client safe. I strongly and an advocacy for the housing first model. However, of the unsheltered who have lived and survived on street will need a great deal of supportive services that is accessible and available. In saying this, I believe some of the best these millions for three years would be: 1) Develop a strategy that includes supporting the two stand along supportive services to hire additional staff such as case managers and mental health professionals. Provide resources for these entries to assist clients with needed transportation and other services that is geared to assist client who is housed to remain housing. This will include outreach. 2) Accelerated Housing Programs should also be included. It was a great program and assisted with getting a lot of individuals housed. 3) Funds earmark for treatment is also needed to include mental health, health care, and substance abuse. 4) Infrastructure for is also considered for increase in family homelessness. We've experience mothers who children are in school seating and waiting until school ended, then living in their cars. Family homelessness is growing and before it get's out of hand it must be address. 5) Program funds to assist with transportation and outreach 6) With racial equity being the buzzed word, the funds need to go to agencies with track record who services this population. Often time the larger agencies with more resources with set up shop in black and brown communities, hire staff to make others think it is concerned about racial equity but truly don't have a clue of how to service these communities. Priority should be given to agencies who have been in the community not organization who suddenly have a location within the community. 7) There needs to be consideration for hiring Lived Experience (LE). In my opinion it is often very difficult for them secure employment that pays a livable wage (above minimum) that assistance them to gain more independence.

Input Session Type	Feedback
	• My family has been in need of help, depending and waiting on the city for years. My brother a mental disability and so does my mother. They both need housing. Its ridiculous how long you all make people wait to be sheltered but want taxes and votes by a certain time frame. I only have two siblings left I can't keep losing jobs helping them cause they don't understand not to call me during work or needing something. I just got into a program myself after being homeless over a year. I have no income nor funding for myself. Food stamps aren't enough when it comes to housing, clothing, bathing and using the restroom. If you all can't help then help me become approved to start a shelter on the SOUTH and EAST side of Chicago. I guarantee I'll make use of out, I've helped and fed homeless ppl my whole life even while being homeless. All kinds of run ins due to the mess Illinois is causing from no shelters. • Increase transitional housing if you are going to provide all the wrap around services more intensely • Provide intensive case management, support employment services connections and Mental Health support • The emergency housing voucher (EHV) opportunities were vital for many of my clients, but there were far too few to service the needs of people who do not qualify for permanent supportive housing (PSH). I would love to see additional vouchers or similar subsidies for rapid re-housing (RRH) participants who are stable enough to live independently. The 12-month chronic homelessness requirement for PSH is also a barrier for many of my clients who do require more intensive support but have not necessarily spent a full 12+ months unhoused. To turn them away from the housing services that they require and ask them to accrue additional months of homelessness is inhumane. The lack of housing stock in Chicago is part of the problem, so additional SROs, PSH units, and affordable housing would be tremendously helpful. • Working in an RRH program with a high caseload, I would love to see additional funding for critical mental health services for clients in RRH. Perhaps with a full-time counselor or mental health provider on staff at all RRH partner agencies. Additionally, budgets for bus cards and transportation assistance, as my agency currently has no bus cards to offer clients and transportation remains a significant barrier for our participants (especially if they do not qualify for free or reduced fares through the Department of Aging or RTA). Short-term transitional housing for unhoused clients seems to be a missing link in the current CoC, especially for those clients who may require more support than what is available in RRH and similar programs. • As for system-wide changes, I do feel that coordinated entry could be improved with additional investment. Accelerated Moving Events (AMEs) could certainly screen folks more effectively and begin making more connections to permanent housing before clients enroll in RRH.

Input Session Type	Feedback
	• Enhanced outreach to unsheltered folks with medical and psych professionals as part of the outreach teams, RNs and NPs. • 1. We must prioritize Reentry housing. Individuals returning from imprisonment need to be stabilized with housing so as to remove any perceived need to harm the community in order to provide for basic needs/human rights such as housing.2. Housing solutions provided by directly impacted persons need to be centered in this funding opportunity. • I encourage us to develop outreach teams made up primarily of people with lived experience where the staff to client ratio is about 1:15 or less. I would like to see short-term, service rich stabilization housing for people with significant needs. However, I expect most people to move from unsheltered settings to PSH without a need for stabilization housing. The outreach staff should partner with first responders—to assist with turning a crisis into an opportunity for engagement. However, it's imperative that outreach staff also establish their own partnerships with individuals living unsheltered, especially in encampment settings. • It's really all about relationships. We have to earn a person's trust—usually by helping them resolve an issue they deem important—and build on that trust to help them resolve their ambivalence about moving into shelter or housing. We need to be ready to answer all of their questions and address their concerns. Linking them to others with similar experience in making such a decision is also helpful. • Outreach services that partner with encampment leaders while also having the flexibility to engage single individuals residing on the streets are essential. Ideally, people with lived experience of unsheltered homelessness would be members of these outreach teams or manage these teams. Additionally, the teams would need to be prepared to address basic needs, both social and material to engender trust and speed commitment. • Best practices include enlisting the support of encampment leaders immediately; respect existing culture, norms, and relationships within encampments; and finding opportunities for encampment dwellers to maintain connections with one another post-move into housing. Those living more independently in unsheltered situations are more likely to have serious mental health issues than those in encampments and shelters, be prepared to engage them with patience and respect, build motivation for change within the context of relationship, while having the ability to link them to clinical services when ready. • I envision us developing an integrated system of services and housing that includes outreach (SSO), stabilization housing (service rich, time-limited for a small yet high-need subset of people), and additional PSH units. • There should be an allocated amount for Justice Involved Individuals. Permanent Housing has been a problem for these individuals seeking permanent housing.

Input Session Type	Feedback
	• There is a Great Need for transitional housing for returning citizens, victims of domestic abuse and other emergency housing needs. Recently that need has increased considerably with the large influx of asylum seekers from other countries. Transitional living space can provide a security to allow individuals and families to build an economic and support base to move into permanent housing. • Please expand support for LEC through this Special NOFO and create PSH for Returning Citizens/Reentry/People with Carceral backgrounds • It's important that people get housing first, but this requires wrap-around services including access to employment services and/or access to benefits (e.g. SOAR services). All Chicago currently has a pilot to employ navigators to connect people in Rapid Rehousing to employment and/or benefits services. It would be great if the HUD funding could help sustain that program. • Find out what each person wants and needs, for housing and for their lives. Create housing that creates community and has amenities like grocery stores, pharmacies, medical care, parks and recreation. Enable families, relatives and friends, and pets, to remain together –especially people who have created community in the encampments. If they are from a specific community and want to return there, find them housing where they are familiar and comfortable. As someone is getting housed, connect them to a buddy, someone who has successfully transitioned to permanent housing. And support the newly housed to find community and people to connect with in their new neighborhood, through community centers, park districts, libraries, faith communities, senior centers etc. See Ogden Commons in North Lawndale. • What is needed for those living unsheltered or in inappropriate shelter (abandoned buildings, tents) is a Welcome Center. A bright, welcoming, cheerful place, easily accessible - where anyone experiencing homelessness can come (with space for pets, ie, low or no barriers) and get coffee, a shower, and clothing, and immediate emergency shelter, food, and medical and mental health care if needed (eg, frostbite or COVID), and social services to place them in temporary shelter leading to stable housing. It would be the place to bring people to, before they are assessed for shelter. Everyone could come to one place. People who do outreach could offer the people they meet to be taken to this Welcome Center. The Welcome Center would also be an alternative to police stations and hospital emergency departments, which are not equipped to serve the unsheltered, yet all the info on the Chicago Website tells people to go the a police station or hospital ED and call 311. And PS, the people who need this kind of shelter do not have access to the Internet and often do not have a phone. This builder creates this kind of Homeless Navigation Center: Please check them out: Sprung—Homeless Facilities webpage: https://www.sprung.com/structures/municipal-buildings/homeless-shelters/ Sprung—Navigation Shelters brochure:

Input Session Type	Feedback
	https://webapps.sprung.com/api/getfile?id=bizsql1-69511705-3350-11ec-a81b-525400bc52e2&mod=salesrep_docs. The structures are quick and easy to set up, are less expensive that more permanent shelters, can also be taken down easily when no longer needed or needed in a different location. Once someone is connected to services, there should be one person to keep in touch with them, to walk with them through all the many and confusing steps of the process. Such a person does not need to be a licensed social worker. Legal Aid provide some of this type of support. And the Chicago Help Initiative has a whole program (fully funded) to train volunteers to provide this type of support to those living homeless or are at risk of becoming homeless. Doug Fraser, Executive Director, is eager to share and expand his program to other organizations. • Please prioritize requesting SSO funding to support employment and SOAR services for individuals who are unsheltered. While housing is essential, employment and income provide sustainability, improved quality of life and wellbeing. Working even part-time is proven to support harm reduction efforts. This NOFO is an opportunity for Chicago to grow as a national leader in supporting job seekers experiencing homelessness through connecting workforce systems with homeless response. The current Employment and Income Navigation Pilot has made tremendous progress in bringing new key systems stakeholders and new public and private resources to this crucial effort. Advancing that effort through the NOFO response will advance sustainability efforts for this important work and build a foundation for continued and increased braided public and private support. • Please expand support/capacity building for the Lived experience/expertise Commission (LEC) through this Special NOFO, and create PSH for Returning Citizens/Reentry/People with Carceral backgrounds. • A gap of services that continues to come up is the housing opportunities available to individuals on public crime registries who are subject to housing banishment laws. Many individuals who are subject to these residency restrictions are excluded from a majority of housing (and are often also excluded from many shelter settings as well, but this is its own issue). Policy advocacy to reduce (and ultimately end) residency restrictions/housing banishment laws in Illinois is a crucial piece of ending homelessness. Hundreds of Chicago residents (a majority of whom are Black and Brown men) are made homeless by residency restrictions. As we already know, housing options are very limited when you have a past conviction. Landlords are less likely to rent to these individuals (even if the individual is part of a PSH program). The Just Housing Amendment was a major legislative win, but landlords still find ways to discriminate against folks with backgrounds (by using measures such as credit score requirements). Then on top of an already limited pool of housing options in the housing market for individuals with past convictions, residency restrictions often make the housing options that are

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	remaining, illegal. Housing Banishment laws do not make any of our communities safer, and are not a proven public safety measure. I would love to see additional funding go specifically to finding creative housing solutions for individuals subject to Housing Banishment laws. I would also love to see this matter (of ending Housing Banishment Laws) made a legislative priority for Continuum of Care and housing advocacy coalitions within the state of Illinois. • Given the trends we are experiencing with our clients, we would propose using the funding to expand housing stock and also to consider funding beyond the provision of housing to a full spectrum of supportive and stabilizing services. • Please provide mental health and healthcare services for this population as they are housed. • I am submitting this feedback on behalf of The Network. We ask that the COC use the recent HUD unsheltered NOFO to in part address the large gap in services we provide survivors and to make available beds at domestic violence shelters. Our current network of housing supports for survivors, consists of time-limited housing programs for survivors, which are often not a sufficient support for survivors to get back on their feet after experiencing violence. Additionally, domestic violence shelters are often full, which means unsheltered survivors have no place to go when they need to flee. In August 2022 thus far, there have been 7 days without any beds available at Chicago domestic violence shelters. When survivors are turned away because we have nowhere to house them on an emergency basis, they stay unsheltered (and at increased risk of further gender-based violence) or stay in unsafe situations. For Chicago survivors, a common pathway to housing is the Domestic Violence/Human Trafficking Coordinated Entry System (DV/HT CES), which is resourced in large part from Department of Housing and Urban Development DV Bonus funds and connects survivors to 24-month time-limited rapid rehousing or transitional housing. Other programs, including housing programs from the Department of Family and Support Services, also utilize the rapid rehousing model, which can serve as a short-term solution to a survivor's housing crisis. While 24 months may help some survivors transition into market-rate housing, often survivors are not able to transition to market-rate housing after that time and, at the end of the program, they return to shelter, stay doubled-up with family or friends, or become unsheltered. For all of these reasons, while funding reports may indicate that resources have been dedicated to survivors, this picture overlooks the most vulnerable survivors who do not have access to long-term supports. For these survivors, our systems fail them and subject them to ongoing housing instability, which is a known vulnerability factor to experiencing additional gender-based violence. We ask that the COC use some of the HUD unsheltered NOFO to house survivors of gender-based violence in PSH.

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	• I really would like to see peer to peer lived experience services offered to housing clients to access to stay housed. I also would like to see SOAR and employment services operationalized to strengthen rapid rehousing and for client long term success. I also would like to see better supports for those in shelters and a lower barrier model to include access for emotional support animals. I would like to see legal protections for tenants to ensure housing stability. I would like to less harassment of encampments and those surviving on the CTA. I would like to warming and cooling shelters have an expanded time for access for those in need. I would like to see better navigation to resources for those leaving institutions including behavioral and justice related clients. I also would like to see housing services for those who would access other housing remedies. I would like to some protection for those with sex related crimes for sustainable housing after detention. • Any CoC plan to address unsheltered homelessness must necessarily include people in public conviction registries who are banished from housing by discredited Illinois laws. People on registries are a population incredibly vulnerable to homelessness and housing insecurity, who are then further criminalized for their homeless status. They are routinely excluded from emergency services, shelters, housing programs and accelerated events on the basis of their past conviction, even though many of them are decades out from completing their punishment and attempting to rebuild their lives. Failing to provide housing for all people with past convictions, including those on registries, is detrimental to individuals, families, and communities. For future housing programs to continue excluding this population is willfully indifferent and an act of violence. • Expanding in a few areas that currently exist in our system. Focusing in on ensuring true low barriers to address unsheltered homelessness. More PSH units but without the requirement of chronicity and prioritizing people with chronic health conditions. Especially households at high-risk of complications (including shortened life expectancy) from underlying chronic health conditions exacerbated by living unsheltered, such as people living with HIV/AIDS, people on dialysis, people with things like catheters implanted that need to be kept clean. Also households with physical disabilities, such as use of assistive equipment to ambulate, putting them at high-risk for safety concerns by living unsheltered. It is necessary to lower the barrier of chronicity. A lot of household we see moving through the front door do not meet this or if they do, cannot provide the necessary documentation. • To improve service and engagement, expanding outreach services however possible to include case management type services that follows someone to housing. This could be challenging since time frames vary for when someone may be matched to housing. This is important in engaging households to build trust, to trying to prevent re-traumatizing, to ensure assistance in gathering

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	documents which could take time, and trust is also important if someone needs to be linked to mental health and behavioral health services. • Ensuring the availability of transitional housing (including bridge housing) for those unsheltered and matched to housing. • Strengthening a directory of resources skilled assessors and other front door service providers have to give household being assessed to complement the assessment for the CES list. Things that can be followed up on in the meantime. Our community has a wealth of resources and if part of the CoC is a coordinated system, we need to ensure we're doing all we can to link households to resources that align with what their housing need is. For example, AIDS Foundation Chicago is established within HIV housing and has a Housing Navigation Program. Households that identify as living with HIV can call or get referred to AFC for the navigation program.