Photography by Bert VanderVeen

Prepared by The Guilford County/High Point/Greensboro Task Force on Ending Homelessness

Guilford County/High Point/Greensboro Task Force on Ending Homelessness

Ten Year Plan

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I. Transmittal Letter

To the People of Guilford County, High Point, and Greensboro:

For most of us, this community is a wonderful place to live. But not for everyone. On any given night, over 1,200 men, women, and children will be living on our streets or in temporary shelters. Some have been there for many years. The majority of people who become homeless in Guilford County will move fairly quickly out of shelters and into transitional or permanent housing. But like many communities across the nation, Guilford County has struggled in its efforts to help those for whom homelessness has become a chronic condition. Many long-term, chronically homeless individuals are disabled by mental or physical illness or substance addictions, and most utilize large amounts of public and private crisis care services, including emergency rooms, mental health facilities, police time and jails, without achieving housing or personal stability. They utilize disproportionate amounts of resources for the homeless, yet do not move out of homelessness. For these individuals, the system isn't working.

In February 2006, our elected leaders, Carolyn Coleman, then the Chair of the Guilford County Board of Commissioners, Rebecca Smothers, Mayor of High Point, and Keith Holliday, Mayor of Greensboro, with supporting resolutions from the Guilford County Board of Commissioners, the High Point City Council, and the Greensboro City Council, appointed a Task Force on Ending Homelessness in our community.

Numerous community volunteers, led by the United Way of Greater High Point, the United Way of Greater Greensboro, and the Homeless Prevention Coalition of Guilford County, and sponsored by the City of High Point, City of Greensboro, Guilford County, the Community Foundation of Greater Greensboro, and the Weaver Foundation, have given their time and skills to this planning process. We have spent hundreds of hours gathering data on homelessness in our community, and reviewing the best practice approaches being used in other communities to reduce and end homelessness. We have held Town Hall Meetings in High Point and Greensboro, held focus groups with providers and consumers of services, and completed surveys and interviews with homeless individuals. We have attended forums on best practices, and worked with the U.S. Interagency Council on Homelessness and the North Carolina Interagency Council for Coordinating Homeless Programs to determine the best approaches for our community.

This plan represents the culmination of our work over the past year. We have learned that the most successful approaches in other communities have been based on helping chronically homeless persons achieve stability in housing. Helping these individuals achieve stability decreases their usage of existing resources and makes those resources more available to assist other community members, including other, non-chronic, homeless persons. Our plan builds on the evidence-based practices that are proving successful in other communities, and focuses on assisting the chronically homeless in our community to achieve a positive outcome of housing stability. The plan lays out specific recommendations for increasing our inventory of housing and for building our community's capacity to provide supportive services. It details how we can implement a community-wide policy of "zero tolerance" for discharge back into homelessness for those cycling through our crisis care systems. It recommends ways to maximize the ability of homeless individuals to obtain and maintain income. It provides a structural framework and projected budget for implementation of these recommendations.

In the aftermath of Hurricane Katrina in 2005, our community mounted an extraordinary and highly successful effort to help persons who had been made homeless by the storm, finding housing and developing support systems to ease the crisis in which they found themselves. We demonstrated our ability to take action and make a difference.

Building on that successful model of community action and partnership, we can make a commitment to a new, evidence-based approach of ensuring that our own chronically homeless community members are housed and receiving the services and support they need to remain in their homes.

On behalf of the Guilford County/High Point/Greensboro Task Force on Ending Homelessness, I present this plan to you and invite you to be a part of reducing all homelessness and ending chronic homelessness in our community.

Carole Bruce
Smith Moore LLP
Chair, Guilford County/High Point/Greensboro Task Force on Ending Homelessness

II. Executive Summary

On January 24, 2007, over 1,200 persons were homeless in Guilford County, sleeping on the streets or in temporary shelters. Over 200 of those persons had been homeless more than a year, some for as long as twenty years. The majority of people who become homeless in Guilford County are assisted by a full "Continuum of Care" which moves them from emergency shelter through transitional housing to permanent housing. Last year, 243 people moved from transitional living facilities into permanent housing situations.

But some homeless persons are unable to successfully move through our current system to stable housing. For these individuals, homelessness has become a chronic condition. Most long-term, chronically homeless individuals are disabled by mental or physical illness or substance addictions, and utilize large amounts of public and private crisis care services, including emergency rooms, mental health facilities, police time, jails, and shelters, without achieving a positive outcome.

This plan is targeted toward helping these chronically homeless persons in our community achieve stability in housing. Helping these individuals achieve stability will decrease their usage of existing resources and make those resources more available to assist other community members, including other, non-chronic, homeless persons. Our plan builds on evidence-based practices that are proving successful in cities such as New York, Denver, San Francisco, Portland, Asheville, and Raleigh, and many other communities.

The plan focuses on two major strategic areas: (1) *Housing,* and (2) *Prevention and Supportive Services*. The major objectives and recommended strategies to achieve them are as follows.

<u>Housing Objective:</u> ***Provide a variety of supportive housing for chronically homeless persons, targeting the least restrictive model under which the client can be successful and enabling the client to move within the levels as indicated by their circumstances.***

Strategy 1: Develop a Housing First model to be used with other housing models to meet the individual needs of chronically homeless persons.

Strategy 2: Increase the supply of permanent housing for chronically homeless persons.

Strategy 3: Address regulatory issues and community perceptions that inhibit the location and potential supply of permanent housing opportunities.
Strategy 4: Increase funding resources for permanent supportive housing.

<u>Prevention And Supportive Services Objective:</u> ***Provide prevention and supportive services to prevent persons from becoming chronically homeless and to enable those who are chronically homeless to move to and remain in a stable housing situation and maximize their self-sufficiency.***

Strategy 1: Ensure that every person being discharged from jail, hospitals, mental health care, or foster care has a discharge plan that leads to stable housing and supports a community policy of "zero tolerance" for discharge to homelessness.

Strategy 2: As a precondition for the success of other strategies to target chronic homelessness, develop a task force to enhance mental health and substance abuse services in Guilford County.

Strategy 3: Increase coordination between mainstream supportive services and providers of housing.

Strategy 4: Provide training and resources to providers for development of Treatment and Housing teams to wrap services around permanent supportive housing, building on the successful model used to assist persons displaced by Hurricane Katrina.

Strategy 5: Increase resources for supportive services.

Strategy 6: Provide training and technical assistance to housing and service providers to build capacity and usage of best practices.

Strategy 7: Provide training and technical assistance in obtaining benefits chronically homeless individuals are entitled to receive, including Social Security disability and other benefits, to ensure that they are obtained at the maximum entitlement level without lengthy delays.

Strategy 8: Create a centralized 24 hour Resource System with direct links to housing, health, mental health, and legal services.

Strategy 9: Establish a day center in High Point and a day center in Greensboro that have linkages to the Central Resource System.

Strategy 10: Increase coordination of services between mainstream job training employment and education programs, supportive employment agencies, homeless services agencies, and homeless clients.

This Task Force believes that implementing these evidence-based practices in our community will ultimately enable us to end chronic homelessness and reduce all homelessness within Guilford County.

III. Background: A New Approach

"Five years ago, the notion of cities having ten year plans to end homelessness was naïve and risky. No one thought it was possible. But the new research and new technologies have created such movement and innovation on this issue that it may now be naïve and risky not to have such a plan."

—Philip Mangano, *Executive Director*
U.S. Interagency Council on Homelessness

Homelessness is a problem in every community. Nationally, approximately 1,000,000 persons are homeless on any given night, and as many as 2.5 million to 3 million people experience homelessness over the course of a year. In Guilford County, over 1,200 people were homeless on January 24, 2007.

Homelessness can be temporary, due to job loss, domestic violence, or natural disasters. Or it can be chronic, a long term situation usually linked to disabilities such as mental illness, substance abuse, or physical disabilities. Anyone can become homeless; the disabled are more likely to remain homeless. National studies have shown that 75-80% of those who become homeless are homeless for two months or less, while another 10% remain homeless for approximately 6 months. Only about 10 - 15% remain homeless for more than a year, and these chronically homeless individuals typically utilize over 50% of emergency shelter resources. In Guilford County, over 200 of the persons counted in January 2007 were chronically homeless, remaining without a home for a year or more, or continuously cycling in and out of homelessness for years without reaching housing stability.

The majority of people who become homeless in Guilford County are assisted by a full "Continuum of Care" which moves them from emergency shelter through transitional housing to permanent housing. Last year, 243 people moved from transitional living facilities into permanent housing situations.

But like many communities across the nation, Guilford County has struggled in its efforts to help those for whom homelessness has become a chronic condition. For these individuals, the system isn't working.

In recent years, new and innovative ideas in some cities have begun to dramatically reduce the number of persons remaining chronically homeless. Most of these are based on the "Housing First" approach, which emphasizes placing homeless person in safe, permanent housing first, and then ensuring their access to the services necessary to remain housed. This approach recognizes housing as a primary human need, and studies have shown that stability in housing increases positive outcomes for mentally ill persons.

In New York, an organization called *Pathways* has developed a program of housing and services based on this "Housing First" concept that over the past five years has had an 88% success rate in keeping the chronically homeless housed. A University of Pennsylvania study of homelessness in New York, the most definitive done to date, tracked 4,679 homeless persons with psychiatric disabilities, and a control group with similar psychiatric disabilities, over a four year period. The study found that a homeless mentally ill person in New York City used an average of $40,449 in public services over the course of a year. When placed in service –enriched housing, his or her use of public services decreased by an average of $12,145 per year (*Culhane et al, 2002*). Since adopting this "Housing First" approach, New York has documented a 13% decrease in chronic homelessness. Other communities which have adopted this "Housing First" approach have also documented dramatic decreases in chronic homelessness. Denver has shown an 11% decrease; San Francisco a 28% decrease; Portland a 20% decrease, Miami a 30% decrease. Closer to home, Raleigh has shown an 11% decrease, Asheville has shown a 26% decrease (statistics from U.S. Interagency Council on Homelessness). "Housing First" works.

The success of these efforts has spurred the federal government, with bipartisan consensus, to encourage communities to re-think their current systems, and address them toward ending chronic homelessness and reducing all homelessness with these new techniques.

The U.S. Conference of Mayors, National Association of Counties, National League of Cities, and National Governor's Association have all endorsed this concept and encouraged their members to undertake a planning process to create a Ten Year Plan to End Homelessness. The Guilford County Board of Commissioners, the City Council of High Point, and the City Council of Greensboro have passed resolutions supporting this Task Force review and planning process for our community.

Where We Are Now

The Task Force has examined data from point in time counts, housing inventories, and qualitative surveys, and also conducted Town Hall meetings and focus groups to obtain community insight into the characteristics of homelessness in Guilford County.

Point in time counts conducted by the Homeless Prevention Coalition of Guilford County have detailed the numbers of the homeless population in Guilford County. The following chart shows the data as of January 24, 2007.

Guilford Homeless Population and Housing Data (1/24/07)

	In Emergency Shelter	Number of Emergency Beds	In Transitional Housing	Number of Transitional Beds	Unsheltered	Total
Persons in Families	132	122	140	205	11	283
Single Persons	272	258	319	361	113	692
Total	404	380	459	566	124	987
Chronically homeless *(included above)*	142				70	212

As part of the point in time count, an inventory was also undertaken of existing permanent supportive housing (persons residing in permanent housing are not considered homeless by federal standards, so are not included in the "homeless" population count). Guilford County's inventory of permanent supportive housing and unmet need for permanent supportive housing based on U.S. Department of Housing and Urban Development calculations is shown in the following chart.

	Permanent Supportive Housing Beds	Unmet need for PSH Beds
For persons in families	119	155
For single persons	48	403
Total	167	558
Need for Chronically homeless *(included in singles, above)*		263

The community cost of chronic homelessness: high usage of expensive services without achieving positive outcomes

Reducing and ending chronic homelessness improves a community's quality of life and social order and is also a more fiscally responsible approach than simply allowing the problem to persist. Homelessness is a crisis situation in which individuals often access expensive community resources without achieving outcomes that lead to stability in housing and health. The North Carolina Department of Health and Human Services has stated: *"Homeless individuals, in particular homeless individuals with behavioral health disorders, bounce between systems which provide extremely expensive short term care with negligible long term effect."*

Studies have shown that persons without stable housing have more health issues than those with housing; one third to one half of the homeless population has a chronic illness, compared to less than one fourth of the housed population (*Zerger, 2002*). Mortality rates for homeless person are three times higher than for housed persons of the same age (*O'Connell, 2005*). Homeless persons have higher rates of hospitalization and emergency department use than the general population (*O'Connell, 1999*). A report prepared in 2006 by the New York Department of Homeless Services and Department of Health found that health disparities between the homeless population and the housed population were "huge." For example, new HIV diagnoses among the homeless population were 16 times higher than among the housed population.

Homeless persons also are more likely to use jails and prisons than housed individuals. Individuals who were homeless at the time of arrest are overrepresented in the prison population (*Ditton, 1999*). Homeless populations have higher rates of former prisoners than the general population (*Burt et al, 1999*). The association between homelessness and imprisonment is bidirectional: imprisonment disrupts family and community contacts and decreases employment and housing prospects, while homelessness can increase the likelihood of arrest and imprisonment (*Kushel et al, 2005*). There are also linkages between imprisonment and severity of mental illness and substance abuse in homeless individuals (*McGuire, 2004*).

When chronically homeless persons continue to use crisis response resources over and over again, the costs can mount insidiously while no positive outcome is achieved. In Denver, police officers tracked the cost to their community in services for one chronically homeless man and found that over a decade, he had cost the community more than $1 million. But the community's investment in this man yielded no return; he died on the streets. One officer stated, "It cost us a million dollars to do nothing about Murray." (This chronically homeless individual, dubbed "Million Dollar Murray" was the subject of a highly publicized *New Yorker* article by Malcolm Gladwell that highlighted the problems and costs of chronic homelessness.)

In Guilford County, as in most communities, the cost of utilization of the criminal justice, health, and mental health systems far outweighs the cost of utilization of permanent supportive housing.

The cost per bed per night of the possible alternatives for homeless individuals is as follows:

Type of housing	Cost/night Range	Cost/night Median
Emergency shelter	$13 - 14	$13.50
Transitional housing	$18 - 59	$38.50
Permanent supportive housing	$26 – 47	$36.50
Jail $70.00		$70
Hospital *(incl. behavioral health)*	$300 – 700	$500.00

**Note: cost of transitional and permanent supportive housing includes supportive services costs; emergency shelter, jail and hospital costs do not include any health care or supportive services costs.*

A qualitative survey done in July of 2006 found that 43% of the homeless persons surveyed in Guilford County had been discharged from the jail system, mental health system, or a health care system within 30 days of their current episode of homelessness (*Homeless Prevention Coalition of Guilford County, 2006*). There were 171 individuals who had been involved in the criminal justice system and in jail, 50 who had needed the assistance of the public mental health system, and 88 who had been hospitalized. But for each of these individuals, their outcome ultimately did not improve; at the time of the survey they were again homeless and at risk.

An in-depth study of housing needs of Guilford Center clients done in 2005 by the Technical Assistance Collaborative indicated that of those consumers served by Guilford Center ACT teams, Diversion Teams, and Community Support Teams, only 38% were in a permanent housing situation. The survey indicated that at least 28% were in unstable or unsafe situations and in need of permanent supportive housing (*The Technical Assistance Collaborative, 2005*.)

The Greensboro Police Department and High Point Police Departments tracked time spent on calls dealing with homeless individuals during 2005. The High Point Police Department found an annual cost of $5,103 in police time just dealing with calls at High Point's two emergency shelters; the Greensboro Police Department found an annual cost of $156, 037 for calls involving homeless individuals, or an amount of officer time equal to more than two full time police officers.

Case studies of eight chronically homeless individuals in Guilford County highlight the human and social costs of homelessness.

Jack R.

A 50 year old black male, Jack has now been diagnosed with latter stage Multiple Sclerosis (MS). Prior to being housed, he spent time in hospitals, emergency shelter, and jails and participated in substance abuse treatment, utilizing services locally, in Salisbury, and in Winston–Salem. He spent increasing amounts of time hospitalized for back and leg problems until finally receiving a diagnosis of MS. Now using medication and therapy, he is essentially as stable as possible but continues to receive medical services and to participate in out-patient substance abuse counseling. From 2001 to 2005, while homeless, he utilized approximately $180,520 in services or an average of $36,104 annually; since being housed in 2006, he has used an annual amount of $34,688.

Mitchell M.

A 47 year old white male, Mitchell was honorably discharged from the military due to mental illness; he is a schizophrenic who self-medicated with substance abuse. He spent time in substance abuse and mental health treatment locally and at Dorothea Dix and John Umstead hospitals. Mitchell had lived on the streets and in the woods for 8 years prior to being housed. A good carpenter, he had built himself a small shelter with a door on vacant city property. While on the streets, he was shot during a robbery in which he was the victim; he subsequently had surgery and underwent extensive rehabilitation on his shoulder and arm. After being housed and being compliant with medication for his schizophrenia, he lost the desire to abuse substances and is now stable. While homeless during 2001 to 2004, he used services costing a total of $168,000, or an average annual cost of $42,000; after being housed, his average annual cost in services has been $25,603.

Bob O.

A 45 year old black male, he spent a great deal of time in jail and in the hospital prior to 1999 (before the study period began); he attempted suicide in 1999. In 2000 he suffered a broken leg and was hospitalized; he has been hospitalized and made Emergency Department visits numerous times since then, including one hospitalization for pneumonia. He has been HIV positive for 11 years. He has rarely used emergency shelter or other services voluntarily because he has difficulty in congregate situations. While homeless during 2001 through 2006, he utilized a total of $77,619 in services, or an annual average of $15,524; since being housed he has had an average annual cost of $16,670.

James M.
A 60 year old black male, James was on the streets for 20 years. He is an alcoholic and has spent a great deal of time in jail and in hospital detox settings, eventually suffering seizures and kidney problems. He often supported himself by forgery or shoplifting, leading to arrests and jail time. Now housed, he is in recovery and participates in ongoing outpatient substance abuse treatment.

During the years 2001 through 2004, while homeless, he utilized services costing a total of $191,280, or an average annual cost of $47,820; since being housed, his annual average has been $24,900.

Leo J.
Leo is a 43 year old white male who has had severe problems with alcoholism, including suffering seizures. He has been through at least 11 detox and treatment programs. He was housed in 2006, but has since returned to living on the streets, with time in hospitals, substance abuse treatment facilities, and jails. While homeless during 2001 through 2005, he utilized services costing $246,090, or an average annual cost of $49,218; while he was housed, he used services costing $21,975 annually.

Larry B.
A 39 year old black male, he spent four years in Central Prison, where he was diagnosed as HIV positive. He was released to transitional housing, but was not successful there and had to leave. Then he had several hospitalizations and arrests and spent time homeless and in shelters. In 2005, his advancing kidney disease led to the need to begin dialysis, which he still continues. When he was able to apply for permanent housing, the required police report was 28 pages long. During his time homeless from 2001 through 2005, he had a total service cost of $220,644, or an average annual cost of $44,129; housed, his average annual cost has been $60,545 (primarily due to ongoing dialysis and medical care).

Melvin B.
A 50 year old white male, Melvin is an alcoholic for whom the physical toll of many years of constant alcohol use and abuse led to a stroke. The stroke resulted in paralysis of his left arm and leg and a speech impediment. He spent several years in rehabilitation and is now sober and mobile although he continues to have a speech impediment and is unable to lift heavy objects. He is able to live independently in permanent housing and receives disability payments as income but still requires some medical services. While homeless during 2001 through 2004, he used a total of $207,300 in services, or an average annual cost of $51,825; since being housed in 2005, his average annual cost of services has been $25,525.

Bill J.
A 51 year old black male, he spent time in jails, emergency shelter, and substance abuse detox treatment; he was diagnosed as HIV positive in 2002. He eventually moved to a permanent apartment in 2004. He is now a "success story" whose case manager notes that since moving to permanent housing and receiving services, he has remained stable, sober, and out of trouble. He does volunteer work to help others, and celebrates New Year's Eve (formerly a big party night for him) by attending an Alcoholics Anonymous meeting or church service. While homeless from 2002 through 2003, he utilized services costing a total of $49,800 or an average annual cost of $24,900; while housed in 2005 and 2006 his average annual cost was $15,884.

Although these eight cases do not comprise a scientific sample of the chronically homeless, their histories show the high human cost of homelessness, and the related community resource costs of dealing with their crises. Their stories track the conclusions reached by other communities through various analyses of service usage by chronically homeless individuals.

Costs of Chronic Homelessness for 8 Case studies in Guilford County: 2001 – 2006

Client	Average Annual Cost Homeless	Average Annual Cost Housed	Average Annual Differential
Jack R.	$ 36,104	$ 34,688	$ 1,416
Mitchell M.	$ 42,000	$ 25,603	$ 16,397
Bob O.	$ 15,524	$ 16,670	$ (1,146)
James M.	$ 47,820	$ 24,900	$ 22,920
Leo J.	$ 49,218	$ 21,975	$ 27,243
Larry B.	$ 45,038	$ 60,545	$ (15,507)
Melvin B.	$ 51,825	$ 25,525	$ 26,300
Bill J.	$ 24,900	$ 15,884	$ 9,016
TOTAL	**$ 312,429**	**$ 225,790**	**$ 86,639**
AVG. ANNUAL COST	**$ 39,054**	**$ 28,224**	**$ 10,830**

Sources: Guilford County emergency shelter, transitional and permanent supportive housing providers; Moses Cone Health System, High Point Regional Hospital, Wake Forest University Baptist Medical Center; Salisbury Veteran's Hospital, Guilford Center (Mental Health), Guilford County Sheriff's Department, High Point Veteran's Hospital, High Point Police Department, Greensboro Police Department, NC Central Prison

The financial amounts shown indicate the heavy usage of community resources by the chronically homeless. Dr. Steve Cureton, Professor of Sociology at the University of North Carolina at Greensboro, notes:

> *…homelessness indicates that there is a problem with social regulation and social order…homelessness as a condition represents a visual stain for a community that continues to promote itself as structurally, economically, culturally, and spiritually progressive.*

Community Input
Community input from Town Hall meetings and focus groups provided insight into specific areas of need and potential assets for targeting needs. This input, summarized on the matrix below, guided the Task Force in developing specific recommendations for a new approach to homelessness in our community. The recommendations that follow in Section V. address each of the needs identified.

Needs/Assets	Point in Time Counts	Housing Inventory	Services Inventory	Homeless Survey	Homeless Focus Group	Front Line Providers Focus Group	HPCGC Retreat	Town Hall Meetings	Other Studies
Need for additional permanent supportive housing	X	X		X	X	X	X	X	CCFG Study, TAC Study, 2001 Needs Assessment
Need for Housing First approach				X	X	X	X	X	Research studies (Burt, Culhane)
Need for stronger case management/supportive services			X	X	X	X	X	X	TAC, 2001 Needs Assessment, GCSAC study, GCAP study
Need for Single Portal/ No Wrong Door Approach			X	X	X	X	X		GCSAC Study
Need for employment opportunities and assistance			X	X	X	X	X	X	
Need for stronger prevention at discharge	X			X	X	X	X	X	TAC Study, GCSAC Study
Potential assets (housing and services) in existing providers		X	X			X	X	X	
Potential assets for support and mentoring in faith community				X	X	X	X	X	
Potential funding/employment assistance assets in business community				X	X				
Potential assets in existing hotlines/referral services							X		
Potential assets (skilled labor) of homeless persons				X	X				

IV. Vision and Guiding Principles

V. Objectives, Strategies and Action Steps

HOUSING

Objective: *Provide a variety of supportive housing for chronically homeless persons, targeting the least restrictive model under which the client can be successful and enabling the client to move within the levels as indicated by their circumstances.*

Identified need: *Need for Housing First approach*

Strategy: *Develop a Housing First model to be used with other housing models to meet the individual needs of chronically homeless persons.*

Action Step: *Fund and implement a Housing First model in High Point and a Housing First model in Greensboro with an identified responsible agency by the end of 2007.*

- ***Benchmark: Models are implemented by end of 2007.***

Action Step: *Evaluate model and use results to incrementally increase percentage of permanent supportive housing that is "Housing First."*

- ***Benchmark: Establish annual evaluation process by second quarter 2007***
- ***Benchmark: Increase net supply of housing that is "Housing First" by 20 housing units per year through 2016.***

Action Step: *Increase community infrastructure to provide "Housing First" by investing in building the capacity of multi-disciplinary, multi-jurisdictional providers of housing and services.*

- ***Benchmark: Public and private funders define joint priorities and dedicate funding for building "Housing First" capacity by first quarter 2008.***

Identified need: *Need for additional permanent supportive housing*

Strategy: *Increase the supply of permanent housing for chronically homeless persons.*

Action Step: *Increase inventory of permanent supportive housing by adding 20 units of housing per year, through a combination of rental assistance, new housing, and conversion of existing housing, through 2016.*

- ***Benchmark: Increase documented inventory of permanent supportive housing by adding 20 additional housing units per year.***

Action Step: *Provide interest-free and low interest loans to bring affordable rental property to code for use as permanent supportive housing for chronically homeless persons.*

- ***Benchmark: Have up to $250,000 available for loans by the end of 2009.***

Action Step: *Develop coalition of private landlords and private management companies to support permanent supportive housing for the chronically homeless.*

- ***Benchmark: Coalition developed and first annual meeting convened by mid 2007.***
- ***Benchmark: At least ten landlords representing both public and private units of housing attend.***

Action Step: *Encourage capable permanent housing providers to seek Community Housing Development Organization (CHDO) status with local participating jurisdictions (High Point, Greensboro, and Guilford County) in order to leverage local HOME funds to generate permanent housing.*

- ***Benchmark: At least one organization achieves CHDO status by year end 2008.***

Strategy: *Address regulatory issues and community perceptions that inhibit the location and potential supply of permanent housing opportunities.*

Action Step: *Continue to provide for, and consider expansion of, group housing opportunities within zoning districts through Guilford County.*

- ***Benchmark: Continuation of group housing opportunities as provided for within current zoning districts. Local jurisdictions work together to identify opportunities to expand group housing opportunities into other zoning districts by end of 2008.***

Action Step: *Develop a joint Geographic Information System (GIS) layer to track the location of approved group housing sites and to identify other viable sites.*

- ***Benchmark: Guilford County, in conjunction with the cities of Greensboro and High Point, develops a GIS layer of approved group housing sites by year end 2007.***

Action Step: *Establish a joint county-cities team to expedite the review and approval process for income-eligible projects with public water/sewer access.*

- ***Benchmark: Guilford County will take the lead in establishing a joint review team and approval processes and procedures for income-eligible properties by year end 2007.***

Action Step: *Seek the waiver of regulatory fees (e.g., building permit fees, site development fees, etc.) in conjunction with the review and approval of income eligible properties.*

- ***Benchmark: Procedures to waive regulatory fees for income-eligible properties approved by elected officials by year end 2008.***

Action Step: *Educate neighborhoods to encourage acceptance of housing for chronically homeless persons in their community.*

- ***Benchmark: Five neighborhoods participate in educational forums by second quarter 2008.***

Strategy: *Increase funding resources for permanent supportive housing.*

Action Step: *Apply for the maximum additional federal McKinney-Vento funding available through the HUD Continuum of Care process.*

- ***Benchmark: Secure federal funding for housing for at least 10 of the 20 units of housing to be added each year through 2016.***

Action Step: *Establish a coalition of faith-based, public, private, and foundation organizations to develop rental assistance, operating, and other funding for permanent housing.*

- ***Benchmark: Coalition is established by the end of 2007.***
- ***Benchmark: Funding is developed by the end of 2008.***

Action Step: *Advocate for additional state and local funding for housing resources.*

- ***Benchmark: Specific proposals are developed by third quarter 2007.***
- ***Benchmark: State legislators are contacted by mid 2008.***

PREVENTION AND SUPPORTIVE SERVICES

Objective: *Provide prevention and supportive services to prevent persons from becoming chronically homeless and to enable those who are chronically homeless to move to and remain in a stable housing situation and maximize their self-sufficiency.*

Identified need: *Need for stronger prevention at discharge*

Strategy: *Ensure that every person being discharged from jail, hospitals, mental health care, or foster care has a discharge plan that leads to stable housing and supports a community policy of "zero tolerance" for discharge to homelessness.*

Action Step: *Appoint a team of key agencies to serve as a Discharge Planning Task Force.*

- ***Benchmark: Discharge Planning Task Force is appointed by first quarter 2008.***

Action Step: *Work with the Discharge Planning Task Force to develop a comprehensive, county-wide plan for public and private criminal justice, health, and behavioral health systems that prohibits discharge of individuals to the streets or shelters or housing that has not been independently confirmed.*

- ***Benchmark: Discharges to unstable housing situations decrease by 80% by first quarter 2010.***

Action Step: *Provide tools, including the Central Resource System defined below, and training such as the state-sponsored Supplemental Security Income / Social Security Disability Income Outreach, Access, and Recovery (SOAR) training to caseworkers for public and private criminal justice, health, and behavioral health system to enable them to better connect individuals being discharged with housing and supportive services resources.*

- ***Benchmark: 100% of individuals discharged will be connected to housing and supportive services resources prior to discharge by first quarter 2010.***

Identified need: *Need for stronger case management /supportive services*

Strategy: *As a precondition for the success of other strategies to target chronic homelessness, develop a task force to enhance mental health and substance abuse services in Guilford County.*

Action Step: *Work with elected officials to appoint a task force that includes governmental representatives, public and private mental health and substance abuse service providers, consumers, advocates, and community representatives to develop a plan specific to the enhancement of mental health and substance abuse services in the county.*

- ***Benchmark: Task force on mental health and substance abuse services enhancement is appointed by second quarter 2007.***
- ***Benchmark: Task force convenes by third quarter 2007.***
- ***Benchmark: Task force completes and presents recommendations to community and elected officials by end of 2007.***
- ***Benchmark: Recommendations are implemented by mid 2008.***

Strategy: *Increase coordination between mainstream supportive services and providers of housing.*

Action Step: *Create a high-level coordination committee of mainstream services providers and housing providers within the Continuum of Care to review and improve coordination and provision of mainstream services to homeless persons.*

- ***Benchmark: Committee is developed by mid 2007.***

Action Step: *Develop and sign a "Declaration of Intent" by service providers to participate in and provide input for a full review and potential realignment of services to ensure full and coordinated service provision.*

- ***Benchmark: Declaration of Intent is signed by third quarter 2007.***

Action Step: *Develop and sign formal Memoranda of Understanding to provide specific services to clients of providers within the Continuum of Care.*

- ***Benchmark: Memoranda of Understanding developed and signed by second quarter 2008.***

Strategy: *Provide training and resources to providers for development of Treatment and Housing teams to wrap services around permanent supportive housing, building on the successful model used to assist persons displaced by Hurricane Katrina.*

Action Step: *Work with North Carolina Interagency Council for Coordinating Homeless Programs (NC ICCHP) and other training resources to provide training on development of Treatment and Housing teams.*

- ***Benchmark: Training sessions begin by mid 2007.***

Action Step: *Work with faith-based, private, and foundation funders to identify resources for Treatment and Housing teams.*

- ***Benchmark: Resources identified by second quarter 2007.***
- ***Benchmark: Resources obtained by first quarter 2008.***

Action Step: *Develop a model Treatment and Housing team in High Point and develop a model Treatment and Housing Team in Greensboro, preferably using differently structured models.*

- ***Benchmark: Treatment and Housing Team developed in High Point by end of 2007.***
- ***Benchmark: Treatment and Housing Team developed in Greensboro by end of 2007.***
- ***Benchmark: Treatment and Housing Teams have the capacity to serve 7 chronically homeless in High Point and 13 in Greensboro by end of 2007.***

Action Step: *Implement monthly meetings of the Treatment and Housing Teams.*

- ***Benchmark: Treatment and Housing Teams begin monthly meetings by first quarter 2008.***

Action Step: *Evaluate pilots and use results to incrementally increase percentage of chronically homeless individuals served by Treatment and Housing Teams.*

- ***Benchmark: Establish annual evaluation process by second quarter 2007***
- ***Benchmark: Increase capacity of Treatment and Housing Teams to serve chronically homeless individuals served by 20 individuals per year through 2016.***

Action Step: *Develop and implement a model for a representative payee system to incorporate with Treatment and Housing Teams.*

- ***Benchmark: Identify a model for a payee system by third quarter2007.***
- ***Benchmark: Implement a model payee system locally by second quarter 2008.***

Strategy: Increase resources for supportive services.

Action Step: *Work with The Guilford Center to apply for North Carolina Department of Health and Human Services Homeless Mental Health Initiative Pilot Program funding.*

- ***Benchmark: Application submitted by second quarter 2007.***

Action Step: *Apply for additional funding for supportive services, utilizing a broad array of public and private sources.*

- ***Benchmark: Sources identified by second quarter 2007.***
- ***Benchmark: Applications submitted by third quarter 2007.***

Strategy: *Provide training and technical assistance to housing and service providers to build capacity and usage of best practices.*

Action Step: *Work with NC ICCHP and other training resources to provide training for capacity building and best practices.*

- ***Benchmark: Training sessions held by second quarter 2007 and coordinated with implementation of Treatment and Housing Teams.***

Strategy: *Provide training and technical assistance in obtaining benefits chronically homeless individuals are entitled to receive, including Social Security disability and other benefits, to ensure that they are obtained at the maximum entitlement level without lengthy delays.*

Action Step: *Work with NC ICCHP and other training and technical assistance resources to provide training and assistance to providers and individuals in obtaining Social Security disability, Earned Income Tax Credit, and other benefits.*

- ***Benchmark: Training sessions held by mid year 2007.***

Action Step: *Develop technical assistance partners, such as the legal community, to assist in obtaining benefits.*

- ***Benchmark: Partnerships developed by end of 2007.***

Identified need: *Need for Coordinated Portal of Entry System*

Strategy: *Create a 24 hour Central Resource System with direct links to housing, health, mental health, and legal services.*

Action Step: *Work with existing and new resource providers to develop a 24 hour a day, 7 day a week comprehensive housing resource system to link consumers with short term temporary housing leading to permanent supportive housing or permanent supportive housing and appropriate supportive services.*

- ***Benchmark: Resource System model is identified by first quarter 2008.***
- ***Benchmark: Resource System is implemented by first quarter 2009.***

Action Step: *Ensure that providers of housing and services have electronic and voice linkages to the Central Resource System and that provider staff are trained to utilize the links.*

- ***Benchmark: 100% of providers of housing and services are linked to the Resource System by first quarter 2010.***

Strategy: *Establish a day center in High Point and a day center in Greensboro that have linkages to the Central Resource System.*

Action Step: *Establish a day center in High Point and a day center in Greensboro where homeless individuals can go during daytime hours for shelter and assistance and which provide linkages to the central Resource System.*

- ***Benchmark: A day center will be established in High Point by first quarter 2009.***
- ***Benchmark: A day center will be established in Greensboro by first quarter 2009.***

Identified need: *Need for employment opportunities and assistance*

Strategy: *Increase coordination of services between mainstream job training employment and education programs, supportive employment agencies, homeless services agencies, and homeless clients.*

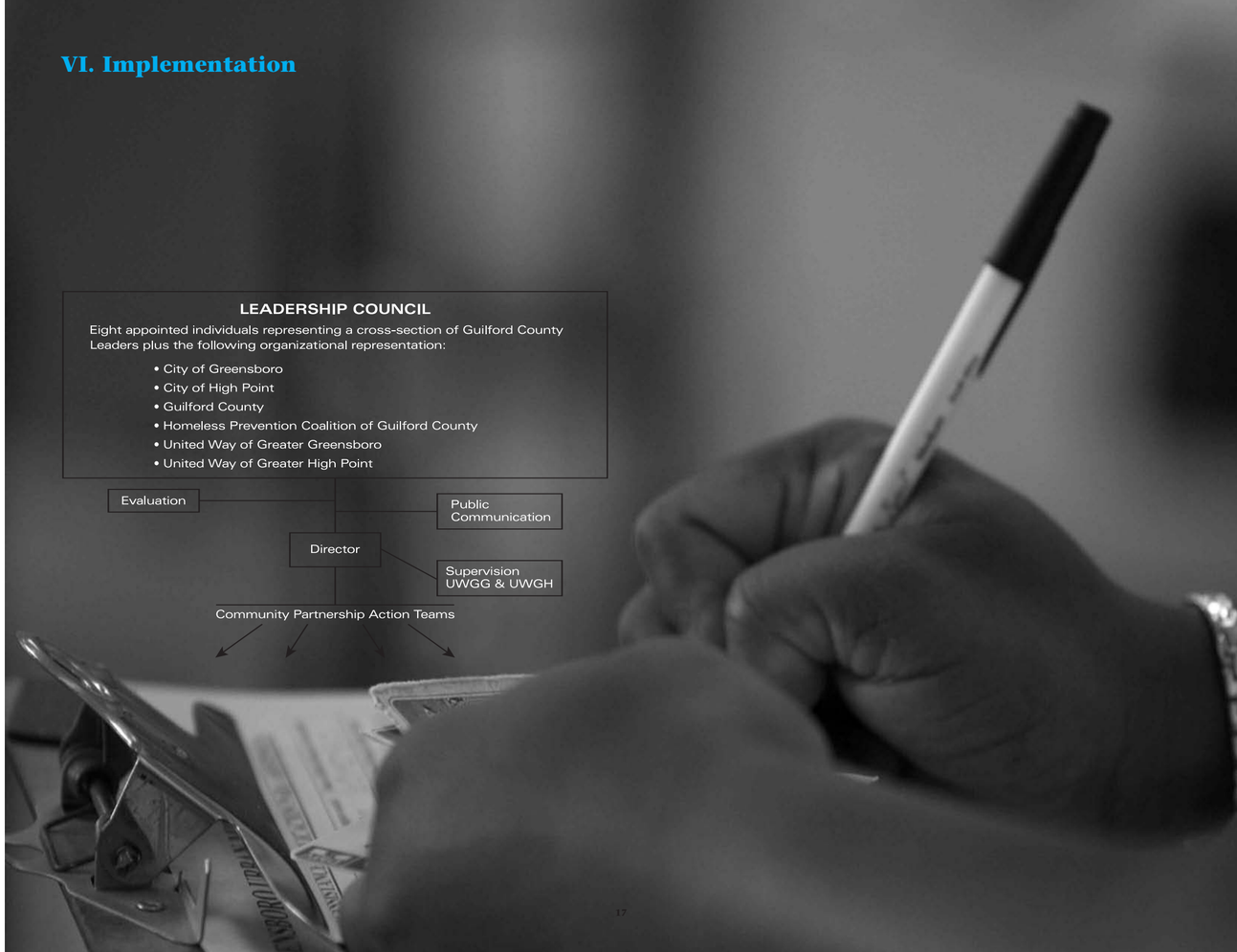
Action Step: *Convene a multi-departmental hosted meeting with employment resource centers, supportive employment agencies, the Employment Security Commission, Joblink, and employers to discuss hiring and retention strategies for homeless individuals.*

- ***Benchmark: Meeting is held by first quarter 2008.***

Action Step: *Continue working relationship with employment resource centers, employers, and other organizations to implement strategies and track results.*

- ***Benchmark: Stable employment of homeless persons increases by 30% by end of 2009.***

VI. Implementation



B. Implementation Budget

Ten Year Plan Implementation Budget

	Year 1 Total Cost 20 individuals	Covered Expense Projection	Uncovered Expense Projection	Year 2 Total Cost 40 individuals	Covered Expense Projection	Uncovered Expense Projection	Year 3 Total Cost 60 individuals	Covered Expense Projection	Uncovered Expense Projection
Program Budget									
Housing (HUD Reimbursement)									
20 additional rental assistance vouchers per year $632 per 1 bedroom voucher per month	$151,680	$75,840	$75,840	$303,360	$151,680	$151,680	$455,040	$227,520	$227,520
Cost of voucher administration	$12,000	$0	$12,000	$24,000	$0	$24,000	$36,000	$0	$36,000
Support services team (Medicaid Reimbursement) Based on Recovery Model Team providing case management, mental health treatment, community support and life skill education $9,440 per client per year, 20 additional clients each year	$188,800	$113,280	$75,520	$377,600	$226,560	$151,040	$566,400	$339,840	$226,560
Furniture and household supplies $1,000 per 20 new clients per year	$20,000	$0	$20,000	$20,000	$0	$20,000	$20,000	$0	$20,000
Subtotal	$372,480	$189,120	$183,360	$724,960	$378,240	$346,720	$1,077,440	$567,360	$510,080
Unit Cost	$18,624	$9,456	$9,168	$18,124	$9,456	$8,668	$17,957	$9,456	$8,501
Planning, Implementation and Evaluation									
Implementation team staffing and costs Project Manager & Admin. Support	$131,480	$0	$131,480	$136,897	$0	$136,897	$142,864	$0	$142,864
Provider training and development	$5,000	$3,000	$2,000	$5,000	$3,000	$2,000	$5,000	$3,000	$2,000
Evaluation and benchmarking	$10,000	$0	$10,000	$10,000	$0	$10,000	$10,000	$0	$10,000
Community meetings	$2,500	$0	$2,500	$2,500	$0	$2,500	$2,500	$0	$2,500
Project Homeless Connect	$10,000	$0	$10,000	$10,000	$0	$10,000	$10,000	$0	$10,000
Subtotal	$158,980	$3,000	$155,980	$164,397	$3,000	$161,397	$170,364	$3,000	$167,364
TOTAL	$531,460	$192,120	$339,340	$889,357	$381,240	$508,117	$1,247,804	$570,360	$677,444

C. Communications Plan

Regular and consistent communications with key stakeholders and the community at large will be a key part of the implementation strategy, both to share information and to gain continuing community feedback. Full support and buy-in of the whole community will be critical to impact the issue of homelessness.

The Implementation Team will continue to follow the principle of an open and collaborative process, and will develop a detailed communications plan, incorporating suggestions received during the planning process. Among the strategies anticipated will be:

Annual Community Report Card: presentation of an annual Community Report Card based on the benchmarks established in this plan and in the North Carolina Interagency Council for Coordinating Homeless Programs 10 Year Plan Accomplishment Report.

Project Homeless Connect: development and implementation of this best practice concept for our community. Project Homeless Connect is a one-stop shop outreach model for delivering services to homeless persons. Typically public agencies, service providers, businesses, faith communities, and other citizens partner to bring multiple resources to one location on one day where people can come and find the services that they need. Services may include housing, employment, medical care, mental health care, benefits and legal assistance, haircuts, transportation assistance, food, and clothing. This event not only provides a way to connect with and communicate with homeless persons but also gives community volunteers an opportunity to better understand homelessness and to be a part of the solution.

D. Evaluation and Reporting to the Community

Evaluation will be another key aspect of implementation. Ongoing assessment of progress will provide accountability to the community, and enable the Implementation Team, with community input, to adjust and update the plan as needed to improve performance toward objectives. There will be several major components to the evaluation work:

Full implementation of the Carolina Homeless Information Network (CHIN). This Internet-based information system is currently implemented by many local providers of housing and services for the homeless. Full implementation will increase data collection and reporting capability, and will also be a part of coordinating agencies into a seamless system for homeless consumers, easing access to housing and services. Participation in the statewide system will also enable better coordination with statewide initiatives and reporting.

Full participation in the annual Homeless Point in Time Count. The Point in Time Count is a one day, unduplicated count of sheltered and unsheltered homeless individuals and families in Guilford County and serves as a census of the homeless population in Guilford County. Each year during the last week of January the Homeless Prevention Coalition of Guilford County organizes the 24 hour count. Full participation by service providers, government and local volunteers will ensure that Guilford County has a representative sample of the homeless population. This representative sample of the homeless population is used to estimate needs and services when applying for federal and state grants and other funding for the remainder of the year of the Point in Time Count

Contracting for evaluation. A full and complete evaluation process is essential to successfully reporting outcomes to the community and for future planning. A multi-year evaluation effort should be led by a professional or university/college evaluators to determine our success in reaching plan benchmarks and benchmarks set in the North Carolina Interagency Council for Coordinating Homeless Programs 10 Year Plan Accomplishment Report.

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Online resources:

Guilford County / High Point / Greensboro Task Force on Ending Homelessness, *www.partnersforhomeless.org*
Homeless Prevention Coalition of Guilford County, *www.hpcgc.org*
N.C. Interagency Council on Homelessness, *www.dhhs.state.nc.us/homeless*
U.S. Interagency Council on Homelessness, *www.usich.gov*
U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services, *www.samhsa.gov*
U.S. Department of Housing and Urban Development, *www.hud.gov*
National Alliance to End Homelessness, *www.endhomelessness.org*

Glossary of Terms

Affordable Housing – Housing for which the occupant is paying no more than 30 percent of gross income for total housing costs, including rent, mortgage payments, condominium fees, utilities, taxes and insurance, as applicable for rental or owned housing units

Chronically Homeless – An unaccompanied individual with a disabling condition who has been continuously homeless for one year or more or who has had four or more episodes of homelessness in the past three years.

Continuum of Care – A local consortium of agencies that HUD requires be formed by community organizations and stakeholders to apply for and receive HUD funding through its annual competitive process. In Guilford County, this continuum is the Homeless Prevention Coalition of Guilford County. It includes a majority of the community's non-profit and faith-based service providers and also law enforcement, local government, and other organizations.

Housing First – A new model of homeless services that involves moving persons directly from the streets and placing them into permanent housing accompanied by intensive services. Initially a research project, this model has been shown to be very effective with persons who are chronically homeless and cost neutral to communities. This model has also been shown to work well with families and young adults who are homeless.

Homeless – (HUD definition)

(a) an individual or family which lacks a fixed, regular and adequate nighttime residence; or

(b) an individual or family which has a primary nighttime residence that is:

(1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for persons with mental illness;

(2) an institution that provides a temporary residence for individuals intended to be institutionalized; or

(3) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for humans.

The definition does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or State law.

The definition does include a person who will be discharged from an institution, such as a jail or mental health hospital, within 7 days but who does not have an identified place to live upon discharge.

HUD – United States Department of Housing and Urban Development

Shelter – Housing with varying levels of services for people who are homeless. Emergency shelter is usually considered to last six months or less.

Supportive Housing - Permanent housing with services. The type of services depends on the need of the individuals. Services maybe short-term, sporadic, or ongoing indefinitely. The housing is usually affordable, or intended to serve persons with very low incomes.

Supportive Services – Services such as case management, medical or psychological counseling and supervision, child care, transportation, and job training provided for the purpose of facilitating a person's stability and independence.

Transitional Housing – Usually considered temporary supported housing – housing with services – where individuals or families live for six months to two years. During that time they receive intensive case management services that prepare the household for independent living.

Guilford County / High Point / Greensboro Task Force on Homelessness

Carole Bruce, *Chair*
Smith Moore LLP

Rev. Mike Aiken
Greensboro Urban Ministry

Jennifer Baptiste
Guilford County Planning & Development

Timothy Bellamy
City of Greensboro Police Department

Tom Blount
High Point Enterprise

Cynthia Blue
City of Greensboro Housing and Community Development

Strib Boynton
City of High Point

Steve Branch
Greensboro Merchants Association

Tina Akers Brown
Greensboro Housing Authority

Tania Castillero
Hispanic Center

Dr. Steven Cureton
UNCG (Department of Sociology)

Bruce Davis
Guilford County Commissioner

Osberry Diles
Central Carolina Construction Services

Jim Fealy
City of High Point Police Department

Rev. Mazie Ferguson
The Pulpit Forum

Cara Michele Forrest
Homeless Prevention Coalition of Guilford County

Cathy Gray
City of High Point Community Development and Housing

Rabbi Fred Guttman
Temple Emmanuel

Gail Haworth
The Servant Center

Darby Henley
Merrill Lynch

Rev. Cindy Higgins
Westminster Presbyterian Church

Gary Paul Kane
The Center to Create Housing Opportunities

Robert Kenner
Executive Director, High Point Housing Authority

Steve Key
Open Door Ministries

Anne Kimball
The Guilford Center

Ed Kitchen
Joseph M. Bryan Foundation

Robert O. Klepfer, Jr.
Action Greensboro

Mark E. Konen
Lincoln Financial Group

David Levy
Affordable Housing Management

Jackie Lucas
Homeless Prevention Coalition of Guilford County

Skip MacMillan
Community Volunteer

Pam McCollum
High Point Regional Health System

Mitch McGee
Triad Health Project

Beth Mckee-Huger
Greensboro Housing Coalition

Michael McNair
City of High Point Community Development and Housing

Michelle McNair
City of High Point Housing Coalition

Sandy Michael
NIA Community Action Center, Inc.

David Miller
D.S. Miller, Inc.

Susan Mills
Community Resource Board/Greensboro

Erica Moore
Greensboro Housing Authority

Donna Newton
Neighborhood Congress

Robert Newton
Moses Cone – Wesley Long Community Health Foundation

Greg Niles
Guilford County Planning Department

Kathleen Patterson
Greensboro Partnership

Raymond Payne
Rabbit Quarter Ministries

Dona Pickett
WFMY News 2

Billie Martin Pierce
Guilford County Area Mental Health, Developmental Disabilities & Substance Abuse Program

Hope Rife
Moses Cone Health System

Diane M. Robinson
Sickle Cell Disease Association of the Piedmont

Gladys Robinson
Sickle Cell Disease Association of the Piedmont

Jim Roskelly
Moses Cone Health System

Tara M. Sandercock
Community Foundation of Greater Greensboro

Marlene Sanford
Triad Real Estate & Building Industry Coalition (TREBIC)

Andrew Scott
City of Greensboro Housing and Community Development

Chris Shelton
Housing Authority of the City of High Point

James Shields
Guilford College
Jim Summey
West End Ministries

Timothy Tepedino
Greensboro Police Department

Rev. Scottie Torain
Mt. Zion Baptist Church

Chuck Wallington
American Express

Wes Ward
Westover Church

Mike Weaver
Mental Health Association in Greensboro

Jerri White
Community Clinic of High Point

Robert Ziegler
American Red Cross

Rev. Charlie Zimmerman
First Lutheran Church

Administrative Partners

Neil Belenky
United Way of Greater Greensboro

K. Jehan Benton
United Way of Greater Greensboro

Jackie Butler
Homeless Prevention Coalition of Guilford County

Bobby Smith
United Way of Greater High Point

Karen Thompson
United Way of Greater Greensboro

Desha Williams
United Way of Greater High Point

Research and Data Analysis Committee

Jim Roskelly, Chair
Hope Rife
Susan Mills
Mark Konen
Jerri White
Tim Tepedino
Ken Schultz
Robert Burchette
Anne Kimball
Steve Cureton
Mike Aiken
Steve Key
Cathy Gray
Cynthia Blue
Cara Michele Forrest
Beth Mckee-Huger

Housing Committee

Donna Newton, Chair
Jennifer Baptiste
Neil Belenky
K. Jehan Benton
Gary Paul Kane
Robert Kenner
David B. Levy
Skip MacMillan
Erica Moore
Greg Niles
Mitch McGee
Chris Shelton
James Shields
Wes Ward
Desha Williams
Vivian Clarke
Michelle McNair
Bob Ziegler
Diane M. Robinson

Prevention and Supportive Services Committee

Ed Kitchen, Co-Chair
Robert Newton, Co-Chair
Chuck Wallington
Susan Mills
Anne Kimball
Tom Blount
Pam McCollum
Karen Thompson
Jackie Lucas
Tania Castillero
Bobby Smith
Rev. Jim Summey
Gladys Robinson
Desha Williams

Implementation Committee

Carole Bruce, Chair
Rev. Cindy Higgins
Desha Williams
Greg Niles
Jim Roskelly
Donna Newton
Ed Kitchen
Jackie Butler
Bobby Smith
Neil Belenky
K. Jehan Benton
Andrew Scott
Michael McNair
Tara Sandercock
Darby Henley
Mark E. Konen
Chuck Wallington
David Miller
Karen Bridges
Mike Weaver

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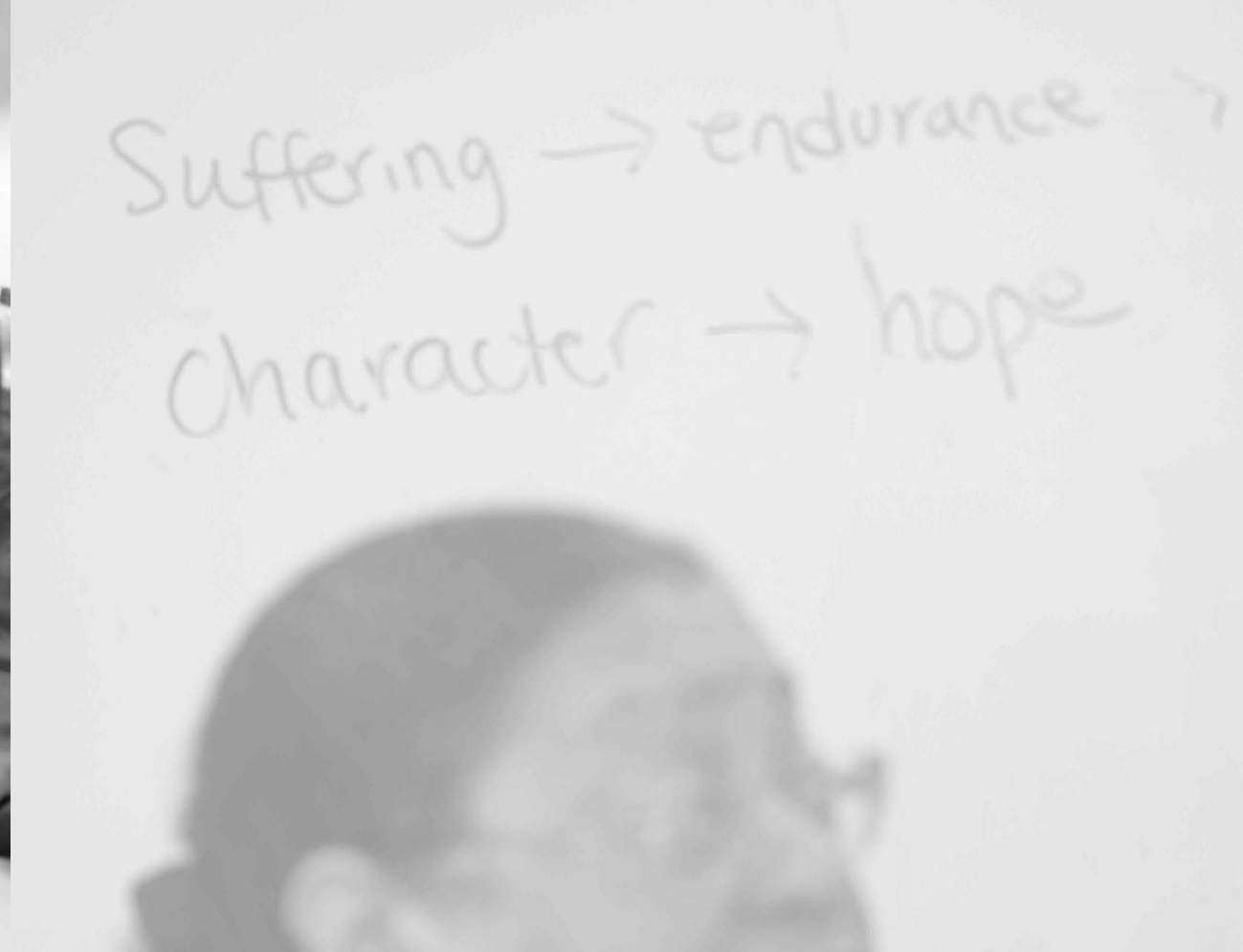
Suffering → endurance →
character → hope