Issue 6

Mainstream Social Safety Net Programs

In 2011, only one-quarter (25.0%) of all adults who exited transitional housing, permanent or supportive housing, rental assistance, and other programs earned income from full- or part-time employment.[1] With low levels of education, the jobs that homeless parents typically qualify for do not pay a living wage or provide health insurance or other benefits. As a result, homeless families depend on existing social safety net programs that serve all low-income families. However, complex application and eligibility requirements for mainstream programs coupled with the trauma, stress, and unique circumstances of homelessness act as barriers that prevent homeless families from enrolling.

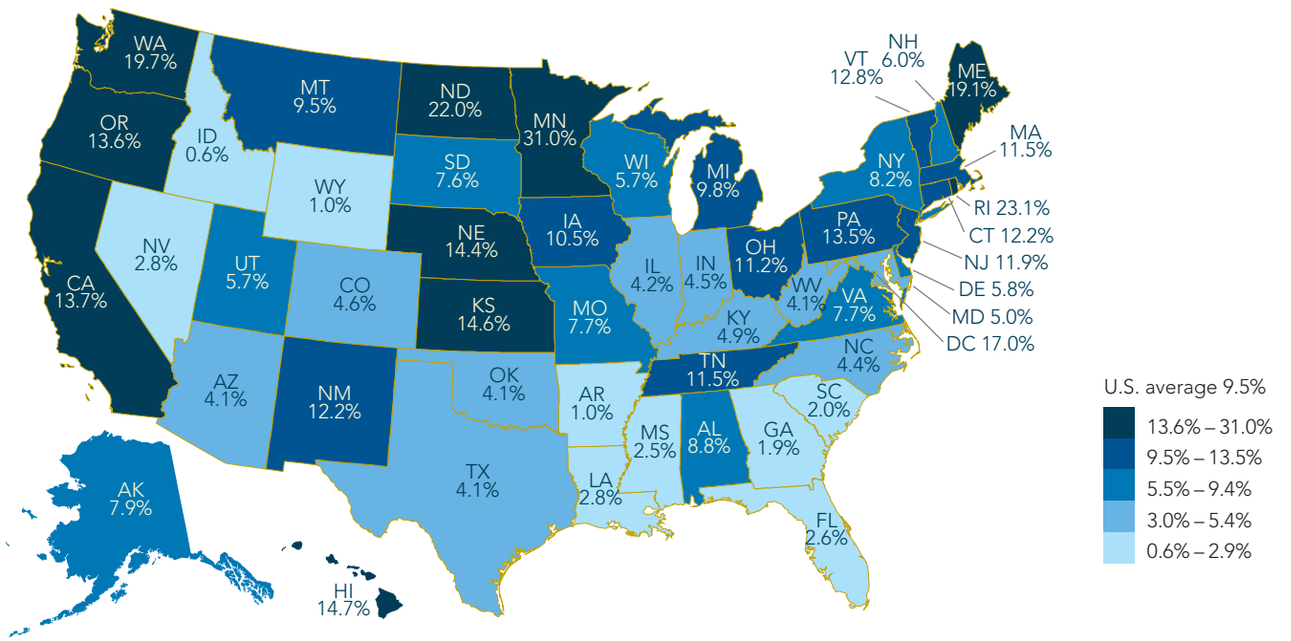
This section presents a detailed discussion of mainstream benefit programs that can both prevent and raise families out of homelessness by providing cash assistance through the Temporary Assistance for Needy Families (TANF) program; improving early childhood education outcomes through Head Start; providing child care subsidies to find and maintain employment through the Child Care and Development Fund (CCDF); combating food insecurity with the Supplemental Nutritional Assistance Program (SNAP, formerly the Food Stamp Program), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the National School Lunch Program (NSLP); improving access to health care through Medicaid and the Children's Health Insurance Program (CHIP); and providing disabled families with financial aid through Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). When available, the information is supplemented by ICPH state-by-state analysis of individual mainstream benefit programs using data reported on the U.S. Department of Housing and Urban Development's (HUD's) 2011 homelessness funding applications (see the *Almanac* State Dashboards for a single-page reference for each state). The chapter concludes with a review of where federal strategy and providers are failing homeless families: clients exiting programs without any financial assistance, neither through employment income nor benefits. Without the necessary resources, families are likely to continue to experience housing instability.

TANF

The U.S. Department of Health and Human Services (HHS) administers TANF, which provides cash assistance to low-

Figure 1

Percent of Adults Exiting SHP or S+C Enrolled in TANF, 2011



Note: The Supportive Housing Program (SHP) funds transitional housing, permanent housing, safe havens, innovative supportive housing, supportive services only, and homeless management information systems. Shelter Plus Care (S+C) includes tenant-, sponsor-, and project-based rental assistance and single room occupancy dwellings. Beginning in 2012, SHP, S+C, and the Section 8 Moderate Rehabilitation grants were consolidated into the Continuum of Care Program. Alaska is represented at half the scale of the other states. Data are classified by quintiles.

Source: U.S. Department of Housing and Urban Development, *HUD's 2011 Exhibit 1 Continuum of Care (CoC) Application.*

income pregnant mothers and families with children for up to five years under the condition that parents fulfill strict work requirements. Federal financial penalties reduce TANF grant allocations to states that do not meet required client work-participation thresholds, which discourages states from assisting the hardest to employ: homeless parents. Data collected by HUD in 2011 reveal that only 9.5% of all homeless adults exiting the former Supportive Housing Program (SHP) or Shelter Plus Care (S+C) program nationwide were enrolled in TANF (Figure 1).[2] However, data remain scarce on TANF enrollment among homeless parents or homelessness rates of TANF recipients. While 41 states include homelessness indicators or risk factors in their TANF documentation, only five states report conducting any analysis of the information. No state enrollment data are publicly available.[3]

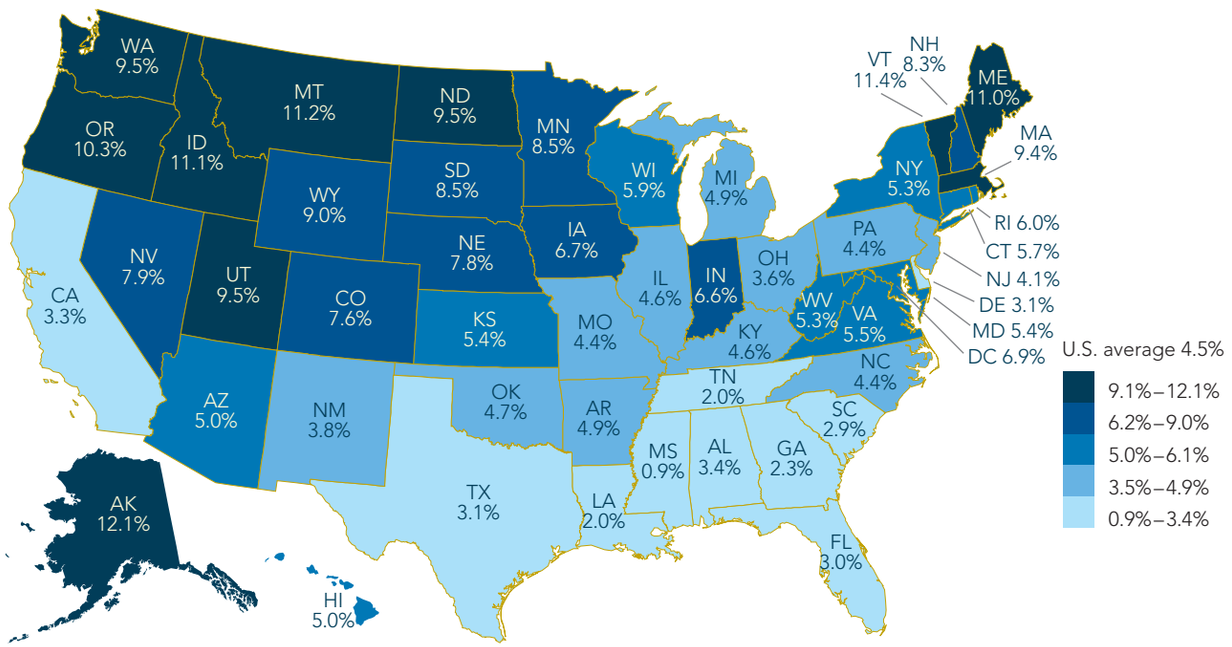
Low enrollment can be attributed, in part, to TANF regulations that fail to account for the specific needs of homeless families. Federal law requires that half of all single parents enrolled in TANF be engaged in a specified work-related activity for at least 30 hours per week (20 hours for those with children under age six) and that 90% of all two-parent families participate for a combined average of 35 hours a week. Homeless parents tend to have low levels of educational attainment and lack sufficient job skills, which hinder their ability to participate in program work requirements and later move from assistance to employment. Compared with 16% of single mothers nationwide, 39–65% of homeless mothers do not graduate high school or obtain an equivalency degree.[4] While education and job-skills training are permissible work activities, they count for only a limited number of hours and for a small proportion of eligible families. Exemptions from work requirements do exist for all parents with children under age one and those with children under age six to whom child care is unavailable, although this varies by state.[5]

Head Start

Established in 1965, Head Start is a federally funded early childhood development program administered by HHS that serves low-income children from birth to age five and their families. Income-eligible families receive access to supportive social services in areas including education, health care, nutrition, and parenting. Head Start is primarily comprised of two components: Early Head Start (EHS), for children zero to three years of age and pregnant women, and Head Start (HS), for children ages three to five.[6] Head Start policies recognize that homeless children are more at risk than their housed peers for developmental delays; chronic and acute health problems; and behavioral, emotional, and mental health issues.[7] With the passage of the Improving Head Start for School Readiness Act of 2007, all homeless children were made automatically eligible for EHS and HS programs, and all states were directed to identify and prioritize homeless children for enrollment. Homelessness also became one of ten federally mandated service and priority areas to be overseen by Head Start State Collaboration Offices—bodies that coordinate services between Head Start grantees and other state and local entities.[8] In program year 2012–13, 46,800 homeless families (including 50,992 children) were registered in Head Start programs throughout the country, representing an 80.2% increase from 2008.[9]

In 2012–13, there were just under 3,000 Head Start programs (1,020 EHS, 1,777 HS, and 56 Migrant and Seasonal), serving 1,033,698 low-income families with 1,129,805 children.[10] Nearly five percent (4.53%, or 46,800) of Head Start families nationwide were homeless (Figure 2).[11] States that served the greatest percentage of homeless families were located in the Northwest and New England, with **Alaska, Vermont**, and **Montana** enrolling these households at the highest rates (12.1%, 11.4%, and 11.2%, respectively). Among most states

Figure 2
Percent of Head Start Families Who Are Homeless, 2013



Note: Alaska is represented at half the scale of the other states. Data are classified by quintiles.
Source: U.S. Department of Health and Human Services, *2012–13 Head Start Program Information Report, Family Information Report—State Level.*

in the Southeast, less than 3.0% of all families registered in Head Start were homeless.[12]

Research has shown that EHS and HS are beneficial for all children. Head Start participants demonstrate better cognitive, social, emotional, and educational outcomes than their nonparticipating low-income peers. Head Start parents have greater quality of life satisfaction, increased coping skills, and fewer health-related problems. Furthermore, every dollar spent on a child's participation in HS yields an economic return of seven dollars or more, through increased earnings and decreased costs associated with welfare receipt, grade repetition, and crime.[13]

Through EHS and HS families also have access to the housing assistance and emergency intervention services they need to gain shelter and stability. Head Start grantees partner with community agencies to place families in stable housing that best fits their needs. Head Start reported that in 2012–13, 33.5% of all enrolled homeless families acquired their own residences.[14] In three states—**Vermont** (60.9%), **Delaware** (55.8%), and **Wyoming** (53.1%)—50% or more of families secured housing. The **District of Columbia** saw the lowest housing rate, at 16.7%.[15]

While Head Start grantees have made great strides in enrolling homeless children and connecting their families to stable housing, there is still room for improvement. A combination of conflicting Head Start program requirements and collaboration deficiencies act as barriers to serving more homeless children. For example, grantees face possible funding cuts if participation falls below 97% and must maintain an average daily attendance rate of 85%. Simultaneously, programs must prioritize homeless children, who often experience frequent moves and unpredictable schedules that can make it difficult to maintain these attendance and enrollment levels. Furthermore, slots are often not available for children who become homeless after the start of the program year. In states with exceptional collaborative partnerships among Head Start programs, shelters, and government agencies, grantees have been able to overcome these obstacles by quickly enrolling homeless children if slots open during the year.[16]

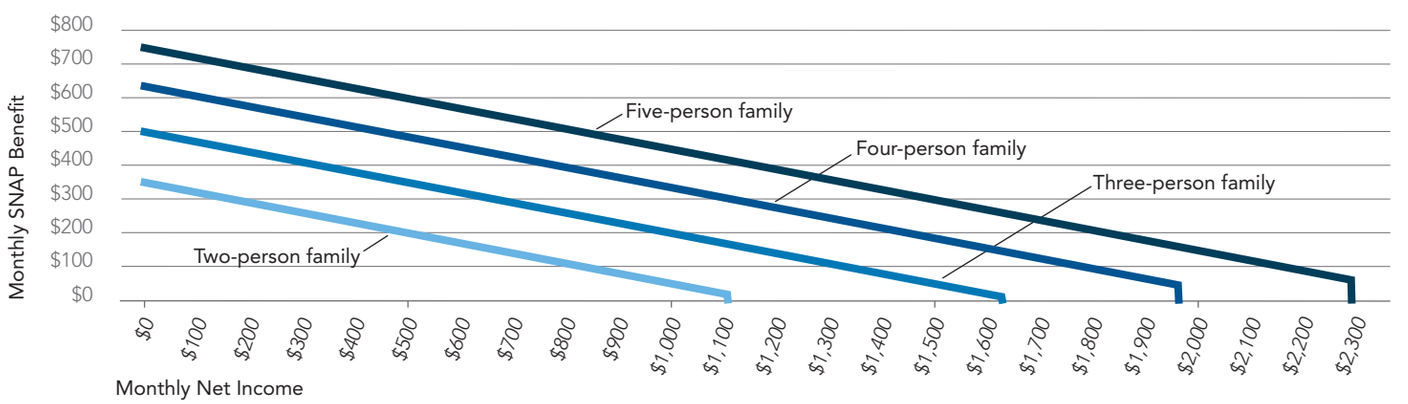
Other barriers include the difficulty of establishing working relationships with school district personnel and other publicly funded preschool programs, engaging school homeless liaisons in cross training and coordinated planning, and obtaining homelessness data.[17] In 2009, the most common strategies for improving services for homeless children involved conferences or workshops, meetings or joint planning sessions with educational personnel, and meetings of collaborative bodies such as homelessness coalitions.[18] In January 2013, HHS released guidance on increasing homeless children's access to early education services, including Head Start.[19]

Grantees must also contend with changes brought on by regulations following the passage of the Improving Head Start for School Readiness Act of 2007. In November 2011, HHS announced its plan to enhance program quality and accountability. For the first time since the program's inception, Head Start grantees that fail to meet new quality benchmarks will not have their grants automatically renewed. All grantees who do not address one or more of seven problem areas—such as deficiencies in on-site reviews, failure to establish and use school-readiness goals, and low performance in classroom quality evaluations—have to instead compete for funding. An estimated one-third of grantees will not meet these standards; in December 2011, the first Head Start agencies—132 in total—were informed that they had to compete for continued Head Start monies, and in January 2013, 122 agencies were designated for recompetition.[20]

Child Care Subsidies

Administered by HHS, CCDF is the primary source of child care subsidies for low-income families. In Fiscal Year 2013 (FY13), CCDF served nearly 1.5 million children and 900,000 families on average each month.[21] Federal guidelines state that to be eligible, a child must be under 13 years old (or under 19 and physically or mentally incapable of caring for himself or herself), and a family's income must not exceed 85% of the state median income. Parents must work or participate in an education or job training program, with the exception of families with children deemed to have a need for protective services and more immediate care.[22] Congress leaves it to HHS and states to determine the

Figure 3
Monthly SNAP Benefit in Fiscal Year 2014
(by family size and monthly net income)



Note: Net income is total income after allowable deductions, such as standard deductions based on household size and earned income, medical expenses, child support payments, and shelter costs.
Source: U.S. Department of Agriculture, "Supplemental Nutrition Assistance Program (SNAP)," http://www.fns.usda.gov/snap.

activities that fulfill work or education requirements and which vulnerable children have a protective-services need. As of 2013, six states included at least some homeless children in that latter definition. Only seven states include housing search as an eligible work-related activity.[23]

As CCDF is a block grant and not an entitlement program, states are not mandated to provide assistance to all eligible applicants. HHS estimates that only one in six eligible children actually receives assistance.[24] States have the flexibility to establish additional eligibility rules and, given the limited resources, to target subsidies to particularly at-risk families, including those experiencing homelessness. ICPH's analysis of states' CCDF state plans reveals that only nine states include homeless children as a priority population to serve. Only 18 states even mention homeless families in their CCDF plans. Seven state-level CCDF policies that reduce homeless families' barriers to accessing child care are included in the *Almanac's* State Family Homelessness Rankings.

The number of homeless children utilizing child care subsidies is currently unknown. However, the latest reauthorization of CCDF, the Child Care and Development Block Grant Act of 2014, requires that states begin to report homeless children's enrollment monthly. This information will provide a clearer picture of how many homeless families states' CCDF programs are reaching and what state-level CCDF policies may be correlated with higher participation among homeless families.

SNAP

Administered by the U.S. Department of Agriculture (USDA) nationwide since 1974, SNAP provides low-income participants with financial assistance for acquiring food and nutritional education. As an entitlement program, SNAP must aid all eligible applicants, with the level of cash assistance decreasing as income rises **(Figure 3)**. In addition to meeting income and asset qualifications, able-bodied adults between 18 and 50 years of age without dependents must be employed or participate in work programs to remain enrolled. Parents are exempt from the work requirement if they are pregnant or are responsible for the care of a child. In FY13, SNAP served an average of 47.6 million people per month.[25]

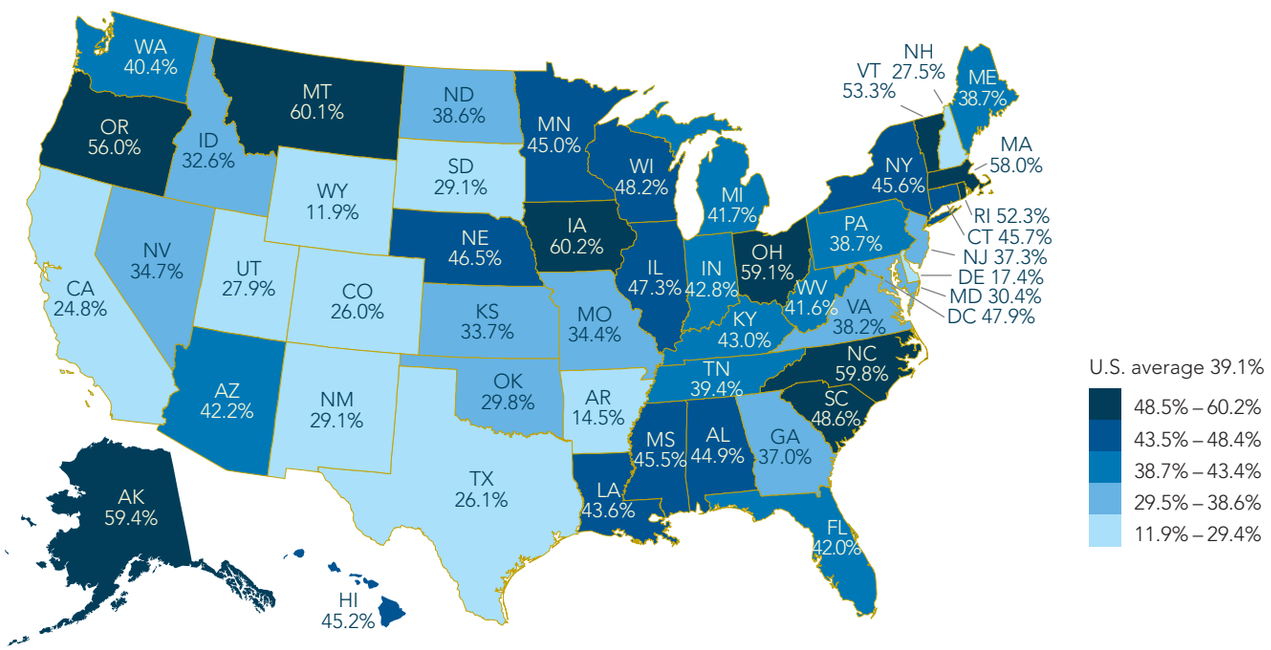
According to 2011 CoC funding application data submitted to HUD, two-fifths (39.1%) of all adults exiting the former SHP or S+C programs—which included transitional housing, permanent or supportive housing, rental assistance, and other programs—participated in SNAP, with enrollment generally higher in the North and lower in the South **(Figure 4)**.[26] Because SNAP exempts parents from work requirements if they are pregnant or are responsible for the care of a child, it is likely that the participation rate of parents differs from that of single adults.[27]

WIC

In 1974, the same year that SNAP started serving low-income individuals and families, the USDA began providing supplemental food; nutrition education; breastfeeding counseling and equipment; and referrals to other health, welfare, and social services through WIC. The program targets low-income pregnant, breastfeeding, and postpartum women as well as children ages zero through four who are at nutritional risk. As WIC is not an entitlement program, not all eligible applicants must be served. If state budget limitations create a waiting list, federal guidelines allow states to prioritize homeless mothers and children.[28] In FY13, WIC served 8.7 million clients per month.[29]

Figure 4

Percent of Adults Exiting SHP or S+C Receiving SNAP Benefits, 2011



Note: The Supportive Housing Program (SHP) funds transitional housing, permanent housing, safe havens, innovative supportive housing, supportive services only, and homeless management information systems. Shelter Plus Care (S+C) includes tenant-, sponsor-, and project-based rental assistance and single room occupancy dwellings. Beginning in 2012, SHP, S+C, and the Section 8 Moderate Rehabilitation grants were consolidated into the Continuum of Care Program. Alaska is represented at half the scale of the other states. Data are classified by quintiles.

Source: U.S. Department of Housing and Urban Development, *HUD's 2011 Exhibit 1 Continuum of Care (CoC) Application.*

A Centers for Disease Control and Prevention (CDC) survey found that 4% of recent mothers were homeless and three-quarters (75.7%) of homeless mothers were enrolled in WIC. The researchers calculated enrollment rates by locality, allowing administrators to assess low-performing states—such as **Colorado** (63.8%), **Georgia** (64.1%), and **Mississippi** (65.6%)—to determine barriers to access and measures to improve outreach. Planners seeking to improve their states' WIC participation rates can look to high-performing states such as **Montana** (89.3%), **Vermont** (88.2%), or **West Virginia** (85.5%) for assistance in developing more effective enrollment strategies.[30]

WIC participation is associated with greater food security, healthier practices among mothers, and better physical health among newborns. In a study of low-income, pregnant, first-time clients in **California,** half of participants who were food insecure at program entry were food secure one year later.[31] Research by the CDC in 30 states and New York City found that among homeless mothers, WIC enrollment was associated with positive maternal health behaviors and infant health outcomes.[32]

School Nutrition Programs

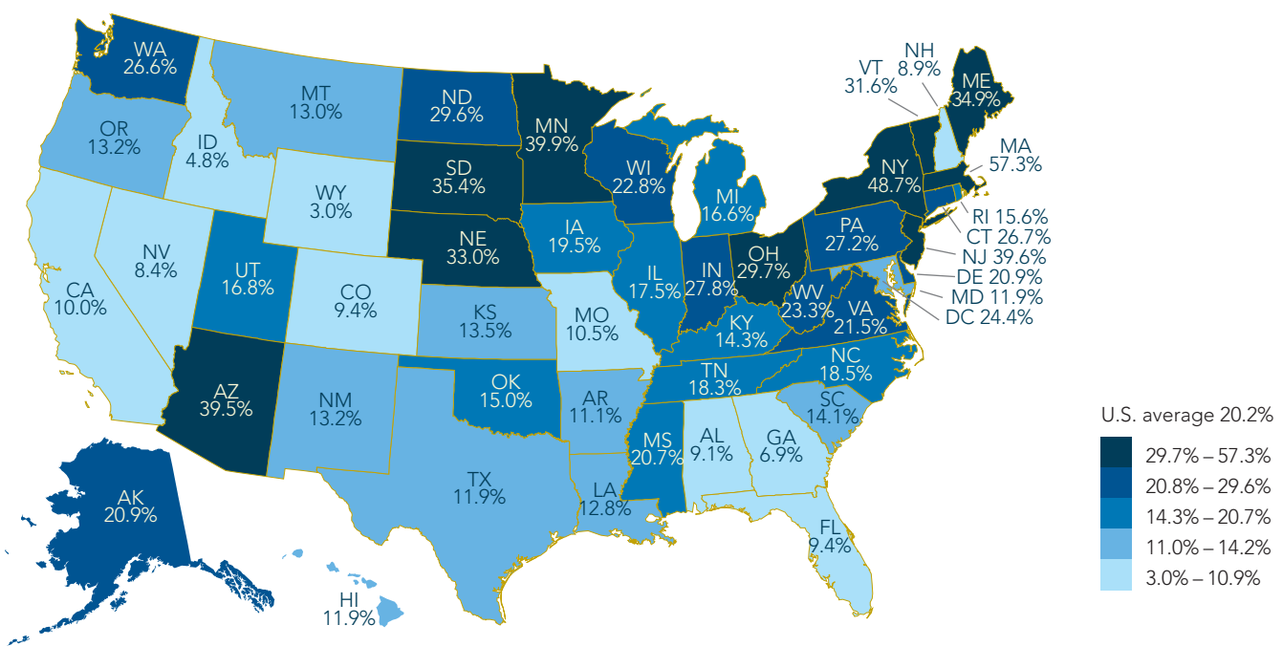
Administered by the USDA since 1946, NSLP provides cash subsidies and food to public and non-profit private schools and residential child care institutions, including those run by homeless service providers. These entities in turn offer nutritionally balanced, reduced-price or free lunches to students—over 31 million meals per day in 2013. Since 1998, NSLP has also included reimbursements for snacks served in after-school programs. NSLP is an entitlement program; all eligible schools can receive subsidies, and all students at participating institutions may take advantage of the program. The program cost a total of $12.2 billion in 2013.[33]

In addition to NSLP, the School Breakfast Program (SBP) and the Child and Adult Care Food Program (CACFP) also provide free meals to children from families with incomes at or below 130% of the federal poverty level and those whose families' incomes are between 130% and 185% can receive reduced-price meals. When school is not in session, the Summer Food Service Program (SFSP) reimburses community summer programs for free meals provided to all children who qualify for free or reduced-price meals during the school year. Homeless service providers can also receive funding through NSLP and SBP if they have child care or after-school programs and through SFSP if they run summer programs. Emergency shelters can get reimbursed for up to three meals a day for all residents age 18 and under through CACFP. Homeless children are categorically eligible for free meals, as are students in households that receive SNAP or TANF, foster care children, and Head Start participants.[34]

Participation in NSLP improves children's health and decreases food insecurity. One study found that NSLP reduces poor health by at least 24% and food insecurity by at least 6%. Another revealed that most of the reduction in food insecurity occurs in households at higher risk. For example, among households with children who experienced hunger over the course of a year, those that participated in NSLP were 33% less likely to be food insecure during the last 30 days of the year.[35]

Figure 5

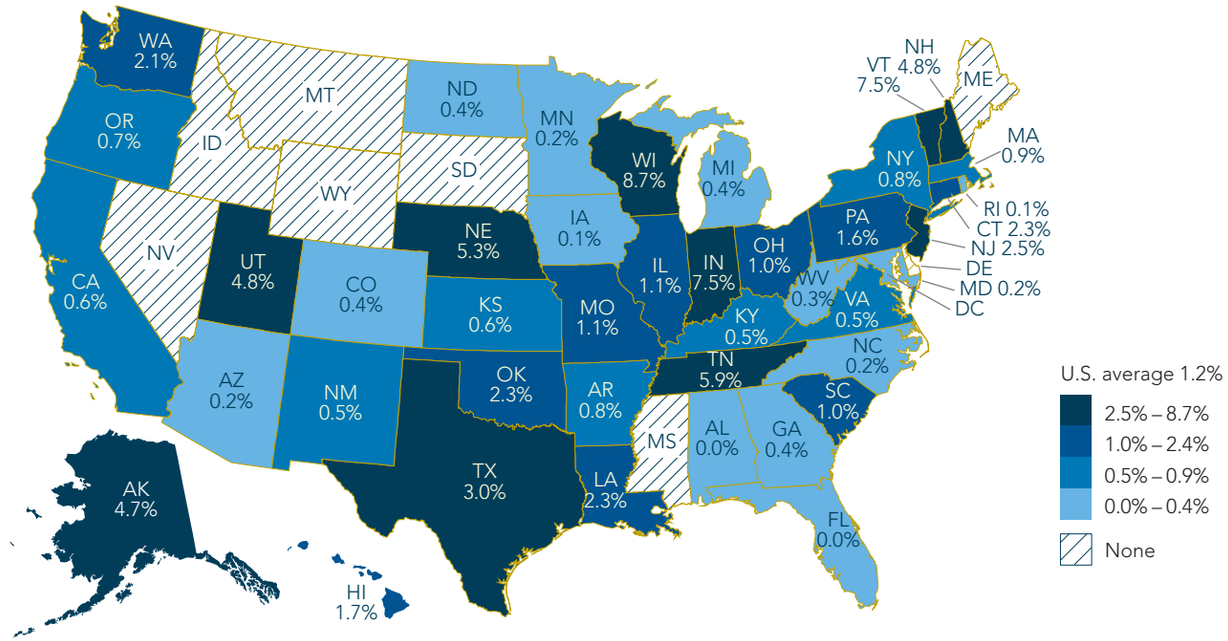
Percent of Adults Exiting SHP or S+C Receiving Medicaid Benefits, 2011



Note: The Supportive Housing Program (SHP) funds transitional housing, permanent housing, safe havens, innovative supportive housing, supportive services only, and homeless management information systems. Shelter Plus Care (S+C) includes tenant-, sponsor-, and project-based rental assistance and single room occupancy dwellings. Beginning in 2012, SHP, S+C, and the Section 8 Moderate Rehabilitation grants were consolidated into the Continuum of Care Program. Alaska is represented at half the scale of the other states. Data are classified by quintiles.

Source: U.S. Department of Housing and Urban Development, *HUD's 2011 Exhibit 1 Continuum of Care (CoC) Application.*

Figure 6
Percent of Adults Exiting SHP or S+C Receiving CHIP Benefits for Children, 2011



Note: The Supportive Housing Program (SHP) funds transitional housing, permanent housing, safe havens, innovative supportive housing, supportive services only, and homeless management information systems. Shelter Plus Care (S+C) includes tenant-, sponsor-, and project-based rental assistance and single room occupancy dwellings. Beginning in 2012, SHP, S+C, and the Section 8 Moderate Rehabilitation grants were consolidated into the Continuum of Care Program. Alaska is represented at half the scale of the other states. Data are classified by quartiles.

Source: U.S. Department of Housing and Urban Development, *HUD's 2011 Exhibit 1 Continuum of Care (CoC) Application.*

About three-quarters of households with eligible children receive free or reduced-price lunches through NSLP.[36] One study found that predictors of NSLP participation are broader than those of food insecurity. Both NSLP participation and food insecurity are related to low paternal educational attainment and economic factors such as family income and SNAP receipt. However, for NSLP enrollment, race is also a noteworthy predictor; black children are almost five times more likely to participate in NSLP than students of other races. The researchers describe this finding as an indication of the importance of culture in NSLP enrollment. They speculate that, for example, black children may attend schools with higher rates of NSLP participation and therefore less stigma is attached to free and reduced-price lunches.[37]

Studies have shown that the risk of food insecurity is lower in states with higher rates of participation in NSLP and SFSP. The one study that also included SBP found that the program had no significant effect on food insecurity.[38] Little research has been done to look at the outcomes of CACFP participation, but a 2013 study found that children attending CACFP-enrolled daycare centers consume more milk and vegetables and show a slight decrease in food insecurity.[39]

In FY13, 18.9 million NSLP participants, 10.16 million SBP students, and 2.43 million SFSP children ate free meals, an increase of 22.7%, 35.8%, and 14.0%, respectively, since FY08. CACFP served free and reduced-price meals to 3.68 million clients, with participation relatively steady since FY08.[40] Data on enrollment rates among homeless children are not available.

Medicaid and CHIP

Established in 1965 pursuant to the Title XIX amendments to the Social Security Act, Medicaid is a joint federal-state program that provides health insurance coverage to certain low-income families and persons with disabilities. The Centers for Medicare and Medicaid Services provides oversight while states control program eligibility requirements. Created in 1997 as part of the Balanced Budget Act, CHIP provides matching funds for state health insurance programs serving uninsured children and pregnant women in families who do not qualify for Medicaid but are unable to afford private insurance.[41] Due to the expansion of federal programs including Medicaid and CHIP prior to the Patient Protection and Affordable Care Act of 2010, fewer children were uninsured in 2012 (8.9%) than in 2007 (11.0%).[42] Together, Medicaid and CHIP currently cover approximately 33.7 million children.[43]

Despite the expansion of Medicaid and CHIP, homeless participation rates are low. Only one-fifth (20.2%) of adults exiting shelter nationwide in 2011 received Medicaid benefits **(Figure 5).** Participation was generally higher in the Midwest, Mid-Atlantic, and Northeast, with **Massachusetts** (57.3%) enrolling the greatest percentage of adults and **Wyoming** (3.0%) the least. Enrollment in CHIP was even lower than Medicaid at 1.2% in 2011 **(Figure 6).** Homeless parents in **Wisconsin** (8.7%), **Indiana** (7.5%), **Vermont** (7.5%), **Tennessee** (5.9%), and **Nebraska** (5.3%) utilized CHIP at the highest rates. In eight states and the **District of Columbia,** no homeless families participated in CHIP.[44]

In addition to the lack of health care insurance in many low-income households, homeless families face further

obstacles to accessing health care. Transportation is a significant problem for families living in rural or suburban areas where clinics are typically far apart. School-based health centers work to decrease transit barriers for rural families and have been found to reduce asthma hospitalizations among children by 75%.[45] Families with language barriers or limited education may be deterred by complicated registration procedures, while restricted clinic hours and lack of child care can prevent working families from seeking medical care. Nearly one-third (31.8%) of homeless women in Massachusetts listed not having child care as a major barrier to accessing medical services.[46]

Health Care for the Homeless

In addition to Medicaid and CHIP, federally funded Health Care for the Homeless (HCH) programs specifically serve homeless families and individuals unable to access or afford health services on their own. HCH is one of the few programs targeted to exclusively serve homeless persons, even though the mainstream programs of Medicaid and CHIP are also available. Founded in 1985, HCH was created with the goal of using health care to address a broader range of problems affecting homeless persons. At community-based centers throughout the country, health workers provide free comprehensive medical and dental care to homeless families. Social workers link participants to services related to shelter, jobs, and permanent housing. In 2013, 250 federally funded HCH projects served 851,641 persons (including 818,882 homeless patients), more than half (57.0%) of whom were uninsured. **California** accounted for 224,932 or over one in four (27.5%) of all patients served **(Figure 7).**[47] Separate data for homeless families with children are not available.

Unfortunately, HCH centers reach less than one-third of the three to four million homeless persons in need of care annually.[48] A 2006 study on the availability of health services for homeless families and individuals revealed that due to a lack of resources, one quarter (25%) of persons requesting primary health care were turned away and approximately one third of programs were unable to provide dental care.[49] Families unable to access care at HCH centers often endure significant wait times before receiving services from other health providers, which can exacerbate their illnesses.

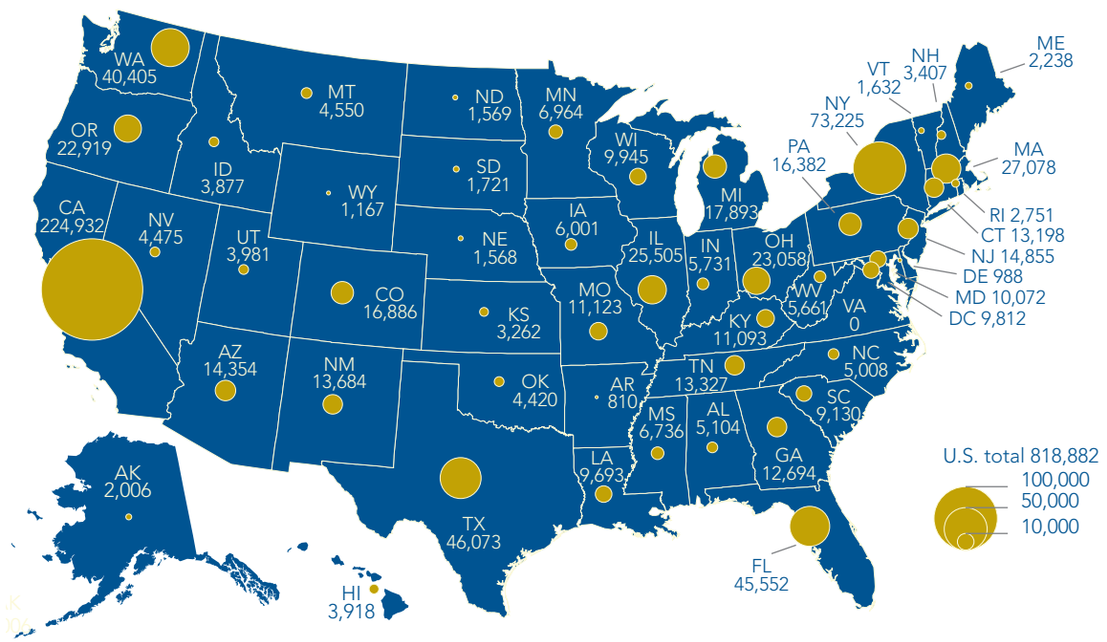
SSI/SSDI

Homeless families experience disproportionally high rates of disability; 18.6% of sheltered adult family members had a disability in 2012 compared with 8.1% of adults in families nationwide.[50] SSI and SSDI are disability benefit programs that are not time-limited. Managed by the Social Security Administration (SSA), they provide monthly cash assistance to eligible low-income adults and children.[51] Increasing SSI and SSDI enrollment reduces expenditures from state-funded general assistance programs and state-only medical or mental health services and lowers the rate of uncompensated emergency care.[52] Launched in 2005, the federally funded SSI/SSDI Outreach, Access and Recovery (SOAR) initiative helps states and localities increase eligible homeless persons' enrollment in SSA disability benefits. Although chronically homeless singles are the primary recipient group for benefits among homeless persons, SSI and SSDI are also crucial supports for homeless and at-risk families, providing better access to income and health insurance.[53]

One-fifth (19.7%) of all adults exiting SHP or S+C received SSA disability benefits in 2011, with 13.4% enrolled in SSI and 6.3% obtaining SSDI **(Figure 8).** **Delaware** had the greatest proportion of homeless persons enrolled in disability benefit programs (52.3%). Northeastern states, along with **Alabama** (33.4%), **Alaska** (32.7%), **Minnesota** (26.3%),

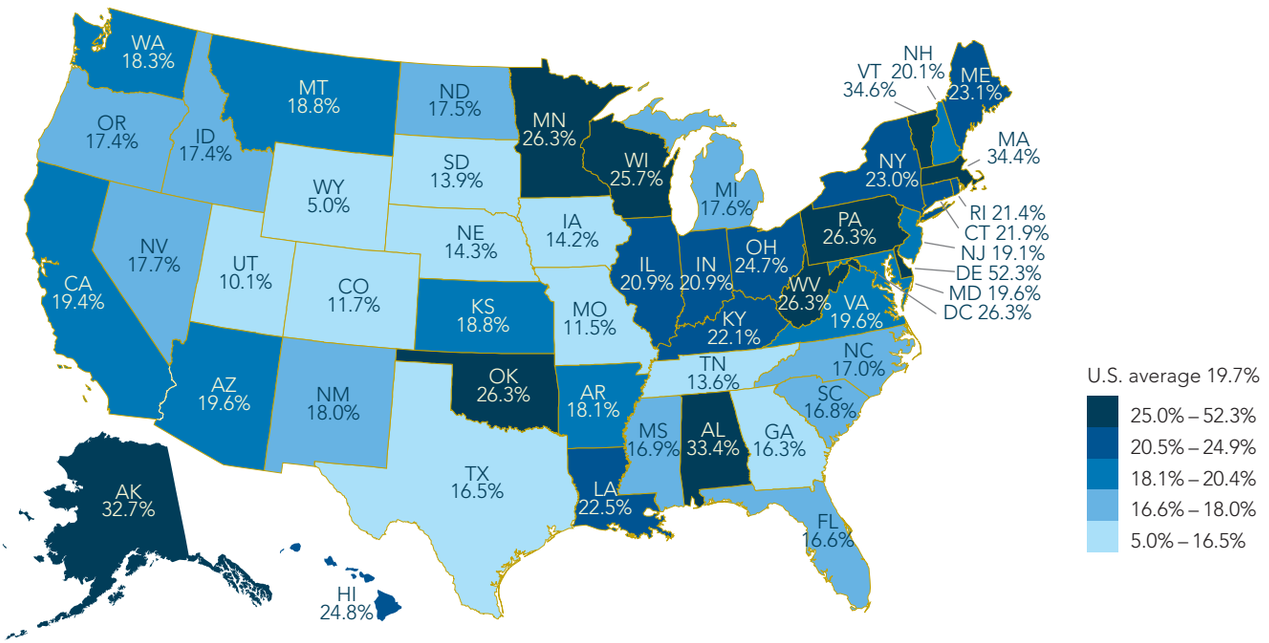
Figure 7

Number of Homeless Patients Served by Health Care for the Homeless Grantees, 2013



Note: Alaska is represented at half the scale of the other states.
Source: Health Resources and Services Administration, *2013 Uniform Reporting System.*

Figure 8
Percent of Adults Exiting SHP or S+C Receiving SSI or SSDI Benefits, 2011



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Source: U.S. Department of Housing and Urban Development, *HUD's 2011 Exhibit 1 Continuum of Care (CoC) Application.*

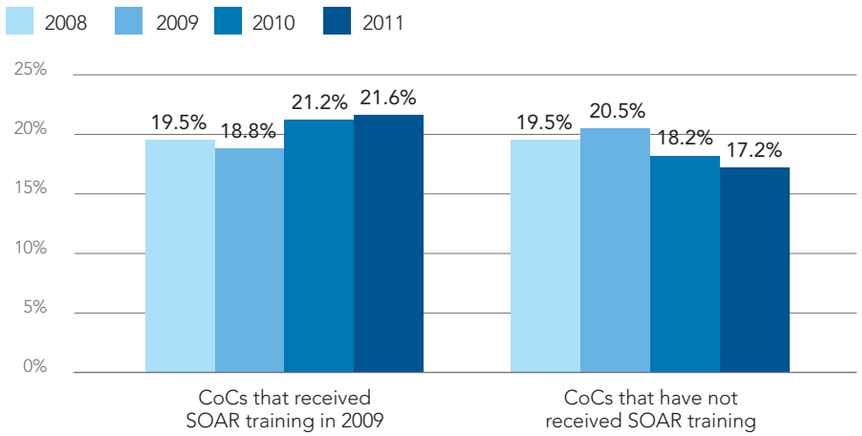
Oklahoma (26.3%), and **Wisconsin** (25.7%), also had high participation rates. States in the Midwest, West, and Southeast regions had the lowest percentage of recipients, with **Wyoming** (5.0%) having the lowest rate.[54]

Nationally, about 29% of SSI or SSDI applications are approved after the first submission. However, for homeless persons without guidance during the application process, the approval rate is roughly 10–15%.[55] Homeless persons also face a number of barriers to accessing benefits, including disability evaluators inexperienced with homelessness, a lack of medical history documentation, and a lack of transportation to application offices. While homeless families and individuals frequently meet SSA disability criteria, they are often unaware of their eligibility.[56]

Social service providers receive SOAR training based on the Substance Abuse and Mental Health Services Administration's Stepping Stones to Recovery curriculum, which provides an in-depth, step-by-step model for identifying eligible homeless persons and offering guidance on SSI and SSDI applications.[57] When homeless clients received assistance during the submission process, the approval rate on initial requests averaged 65.0% between 2006 and 2013 (up from 10–15% without guidance).[58]

SOAR has been implemented in all 50 states and the District of Columbia making SOAR training available nationwide.[59] According to data taken from the annual competitive applications for HUD homelessness funding, 77.3% of Continua of Care (CoCs) had participated in SOAR training by 2011. Analysis of this data from 2008 to 2011 indicates that CoCs trained in SOAR have more adults exiting SHP or S+C with SSA disability benefits. The 51 CoCs that received SOAR training in 2009 improved their participation rates from 19.5% in 2008 to 21.2% in 2010 and 21.6% in 2011 **(Figure 9).**

Figure 9
Percent of Adults Exiting SHP or S+C Receiving SSI or SSDI Benefits
(by year and CoC participation in SOAR training)



Note: A paired samples t-test was conducted to examine the differences among 2008, 2009, 2010, and 2011 disability benefit enrollment rates for homeless adults exiting the Supportive Housing Program or Shelter Plus Care. Four effects were significant for the experimental group that received SOAR training in 2009: 2009–10, $t(50) = -2.52$, $p = .015$; 2008–10, $t(50) = -1.96$, $p = .056$; 2008–11, $t(50) = -2.75$, $p = .008$; 2009–11, $t(50) = -2.81$, $p = .007$.
Source: U.S. Department of Housing and Urban Development, *HUD's Exhibit 1 Continuum of Care (CoC) Application,* 2008–11.

There was no statistical difference among rates for the 90 CoCs that did not receive training by 2011.[60]

SOAR implementation after the initial training period remains crucial. Despite informative in-state SOAR trainings, a 2009 study found that case managers rarely put what they learn into practice. Rather than discrediting program effectiveness, the lack of follow-through highlights the importance of additional support. States with the greatest success in connecting eligible homeless persons to benefits have had consistent leadership from qualified trainers, strong organization-level commitment, and significant levels of engagement, interagency communication, targeted implementation, and outcome-data collection. In-state SOAR trainers already familiar with the SSI/SSDI application process are more effective in training case managers on the SOAR curriculum. States that piloted the initiative and systematically tracked outcome data were able to troubleshoot problems and overcome initial barriers.[61]

No Cash Income or Non-cash Benefits

Federal policy has emphasized using mainstream resources to fill gaps in targeted funding and services for homeless families. However, due to access barriers ranging from transportation to documentation to eligibility, homeless families are connected to mainstream services at low rates. Once enrolled, homeless families have difficulty maintaining their benefits. As a result of low enrollment and poor retention, over one-fifth (22.5%) of adults nationwide exiting SHP and S+C in 2011 had no source of income. Homeless persons are least likely to exit these programs without income in **Mississippi** (2.1%), **Alaska** (3.9%) and **New Jersey** (7.2%), and most likely to do so in **Rhode Island** (42.3%), **Arizona** (35.1%), and **Florida** (34.8%) **(Figure 10)**.[62]

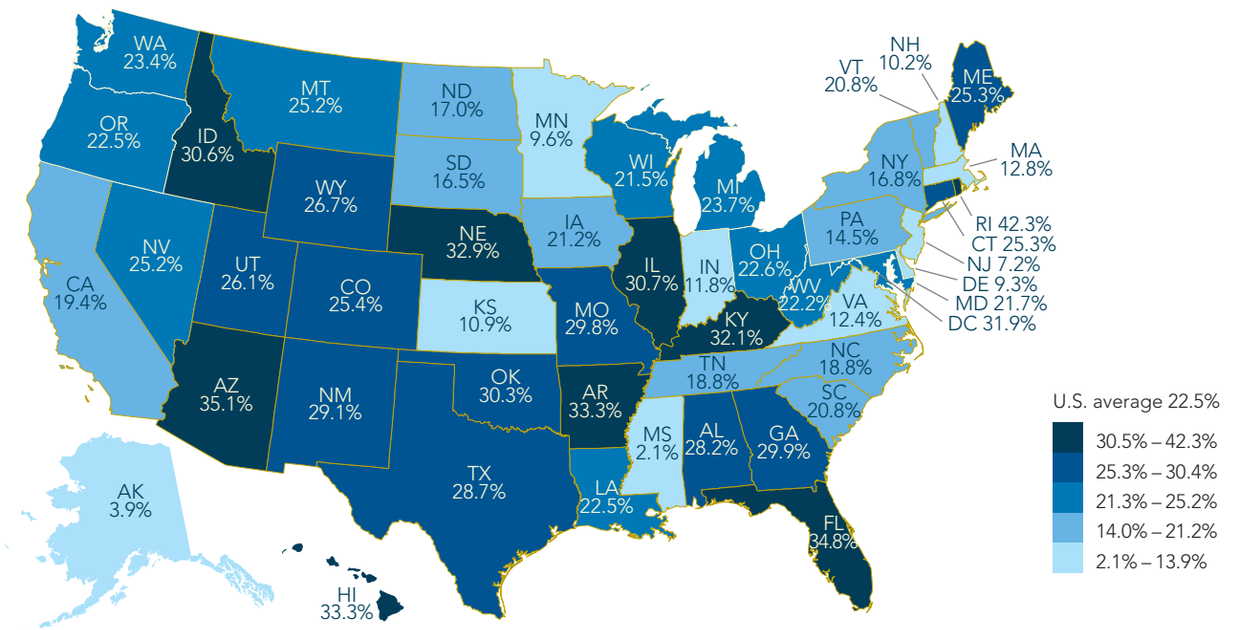
Federal Strategy and Local Performance

The 2010 federal strategic plan to prevent and end homelessness, *Opening Doors,* calls for homeless families to be connected to mainstream benefits in order to maximize targeted homelessness funds for housing; the 2013 plan update reiterates this goal.[63] Utilizing these existing social safety net programs instead of creating homelessness-specific programs avoids duplication of services. HUD has enforced this policy by requiring that local homelessness coordinating and planning bodies, organized as CoCs, demonstrate how they intend to systematically connect homeless families to mainstream benefits as a condition to receive funding.[64]

Before a homelessness service provider within a CoC can receive federal funding, HUD requires that a specific plan be established to ensure that homeless clients will be individually assisted by specialized staff to obtain the mainstream health, social service, and employment benefits for which they are eligible. CoCs have to provide training to its members on how to determine eligibility and communicate with provider staff any changes to mainstream program requirements. CoCs must also analyze Homeless Management Information Systems (HMIS) data collected in shelters in order to monitor and improve access to mainstream programs. CoCs must have active planning committees focused on this goal that meet at least three times per year and collaborate with the state's interagency council on homelessness.[65]

Figure 10

Percent of Adults Exiting SHP or S+C with No Financial Resources, 2011



Note: The Supportive Housing Program (SHP) funds transitional housing, permanent housing, safe havens, innovative supportive housing, supportive services only, and homeless management information systems. Shelter Plus Care (S+C) includes tenant-, sponsor-, and project-based rental assistance and single room occupancy dwellings. Beginning in 2012, SHP, S+C, and the Section 8 Moderate Rehabilitation grants were consolidated into the Continuum of Care Program. Alaska is represented at half the scale of the other states.
Data are classified by quintiles.

Source: U.S. Department of Housing and Urban Development, *HUD's 2011 Exhibit 1 Continuum of Care (CoC) Application.*

Since FY08, HUD has used its annual competitive funding application process to measure CoC progress on connecting homeless households to mainstream benefits. Specifically, HUD requires CoCs to report on the percentage of service providers who are implementing four specific performance indicators. Case managers should help clients complete applications for mainstream benefits; provide transportation assistance to benefit appointments, employment training, and jobs; use a single application form for four or more mainstream programs; and systematically follow up with clients to ensure mainstream benefits are received.[66]

ICPH analysis of FY11 CoC applications for HUD funding finds that the majority of service providers are performing well on these four indicators. Out of 427 CoCs, over two-thirds (68.9%, or 294) reported that all providers in the CoC systematically assist clients in completing mainstream benefit applications, while just 2.1% noted that less than 50% of providers met this requirement **(Figure 11)**. Nearly half (46.1%, or 197) of CoCs reported that all providers supply transportation assistance to clients in order to attend mainstream benefit appointments, employment training, and jobs **(Figure 12)**. CoCs demonstrated mixed results in streamlining the application process by consolidating forms for four or more mainstream programs into a single application **(Figure 13)**. Although 38.6%, or 165, CoCs indicated that all of their providers simplified the benefit application process in FY11, nearly an equivalent number, 31.1%, or 133, reported that no providers in their CoC did so. Nearly two-thirds (62.1%, or 265) of CoCs indicated in FY11 that all providers have staff who systematically follow up with clients to ensure that they received the mainstream benefits for which they applied **(Figure 14)**. Only 4.0%, or 17 CoCs reported that less than 50% of providers have staff verify that clients received their mainstream benefits.[67]

In FY05–11, CoCs were also required to report the number of adults exiting homelessness programs who received specific mainstream benefits. In the FY12 competitive application process, HUD began including the increased use of mainstream benefits as one of six national policy priorities. CoCs are now required to indicate the percent of clients enrolled in social safety net programs and propose future target benchmarks to achieve. In FY12, HUD also expanded the number of benefit programs for which CoCs must help clients apply. A complete list of the programs is provided in **Table 1** (see on next page), separating sources of cash income from non-cash benefits. Although increasing the number of programs should improve accountability, discerning participation rates for family-only benefits, such as TANF, WIC, and CHIP, will continue to be a challenge since the total number of adults exiting programs are not distinguished by household composition.[68]

Figure 11

Number of CoCs that have Case Managers Systematically Assist Clients in Completing Benefit Applications, Fiscal Year 2011

(by percent of providers in the CoC)

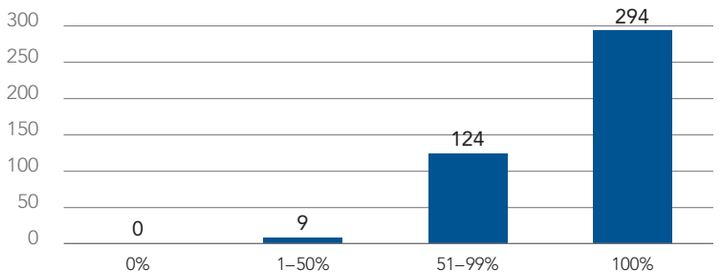


Figure 12

Number of CoCs that Supply Transportation Assistance to Attend Benefit Appointments, Employment Training, or Jobs, Fiscal Year 2011

(by percent of providers in the CoC)

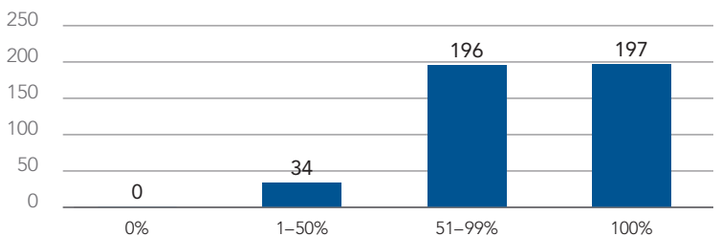


Figure 13

Number of CoCs that Use a Single Application Form for Four or More Mainstream Programs, Fiscal Year 2011

(by percent of providers in the CoC)

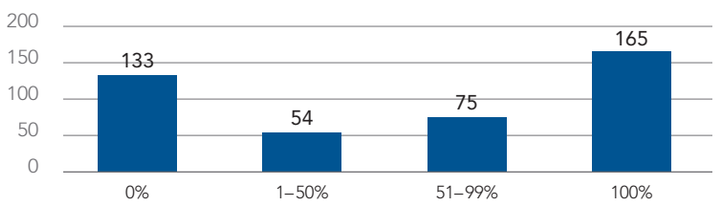
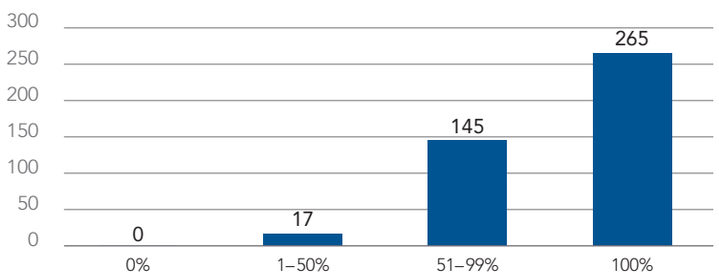


Figure 14

Number of CoCs that have Staff Systematically Follow up to Ensure Mainstream Benefits are Received, Fiscal Year 2011

(by percent of providers in the CoC)



Source for Figures 11–14: U.S. Department of Housing and Urban Development, *HUD's 2011 Exhibit 1 Continuum of Care (CoC) Application.*

Table 1

Reported Sources of Income and Benefits for Adults Exiting the Continuum of Care Program*

(by fiscal year funding application)

Sources of cash income	FY05–11	FY12–13
Earned income	✔	✔
Unemployment insurance	✔**	✔
Worker's compensation		✔
Social Security	✔	✔
Pension		✔
Veteran's pension	✔**	✔
Veteran's disability		✔
Private disability insurance		✔
Supplemental Security Income (SSI)	✔	✔
Social Security Disability Insurance (SSDI)	✔	✔
Temporary Assistance for Needy Families (TANF)	✔	✔
General assistance	✔	✔
Child support	✔**	✔
Alimony		✔
Other	✔**	✔
No cash income	✔**	✔
Sources of non-cash benefits	**FY05–11**	**FY12–13**
Supplemental Nutritional Assistance Program (SNAP)	✔	✔
Medicaid	✔	✔
Medicare		✔
State Children's Health Insurance Program (CHIP)	✔	✔
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)		✔
Veteran's Administration (VA) medical services	✔	✔
TANF child care services		✔
TANF transportation services		✔
Other TANF-funded services		✔
Temporary rental assistance		✔
Section 8, public housing, or rental assistance		✔
Other	✔**	✔
No non-cash benefits	✔**	✔

*Beginning in Fiscal Year 2012, the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 consolidated the Supportive Housing Program, Shelter Plus Care, and Section 8 Moderate Rehabilitation grants into the Continuum of Care Program; U.S. Department of Housing and Urban Development, "Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program Interim Rule," *Federal Register* 77, no. 147 (July 2012).

**Categories were combined in FY05–11 as unemployment benefits, veteran's benefits, and child support/alimony, while the other and no income or benefits categories were not separated by cash income and non-cash benefits.

Source: U.S. Department of Housing and Urban Development, *HUD's Exhibit 1 Continuum of Care (CoC) Application*, 2005–13.