Springfield & Sangamon County's 2022-2028 Strategic Plan to Address Homelessness

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Heartland HOUSED:

CREATING HOUSING OPPORTUNITIES FOR UNDER-SERVED PERSONS THROUGH EQUITABLE DELIVERY

A commitment to do things differently

Leadership

The **City of Springfield**, **Sangamon County**, and the **Heartland Continuum of Care** have partnered with many agencies and members of this community to design a strategy to protect some of the most vulnerable members of our community and end their homelessness. All these partners have committed to work together to create the systems, housing, and resources needed to ensure our community can effectively support individuals and families to recover from homelessness and to improve our community. The strategies and actions proposed will require all of us, and all of us will benefit.

Committed Community Partners

Executive Summary

Heartland HOUSED: Springfield & Sangamon County's Strategic Plan to Address Homelessness

Big Goal: By 2028, our community will put everyone who becomes homeless back in suitable and safe housing within 30 days.

Strategies:

Strategy 1: Create More Housing

- Create **765 units of safe housing** that people who are homeless can afford.

Strategy 2: Improve the Homeless System

- Help **our neighbors that live outside** to get the help they need.
- Support the **programs that are best** at ending homelessness.

Strategy 3: Work with Health Care, Public Safety and Workforce Partners

- Partner to help people who are homeless **easily get what they need** like health care, safety, and jobs.

Strategy 4: Work Together to End Homelessness

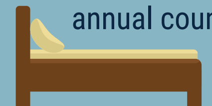
- Improve how we **collect, use, and share information** about people who are homeless.
- Make sure **people who have been homeless lead** our plan.

Why We Need a Plan:

264 people are homeless in our community on a given day

Each year, the number of people that are homeless grows by **155.4 people**

Only **58%** of shelter beds were full the night of our annual count



56% of people who are homeless need housing with supports to stay housed

and only

16% of people who live outside or in shelters in Sangamon County get into housing

Why 765 new housing units?

To house not only people who are homeless today, but those that will become homeless in the next five years.

This plan is a commitment to do things differently.

State of Homelessness in Springfield & Sangamon County

Overall

746.4
people make up the annual inflow to the local homeless system of care

155.4
Annual Growth in Homeless Population

591.2
people make up the annual outflow from local homeless system of care

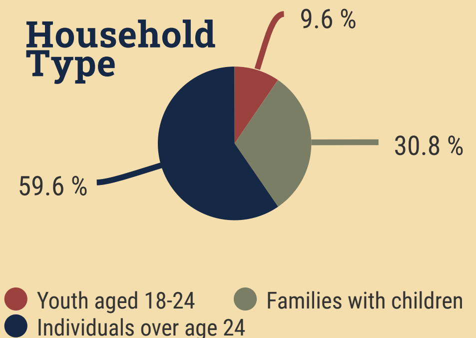
Who Experiences Homelessness Locally

264
people experience homelessness at a point-in-time

What is homelessness?

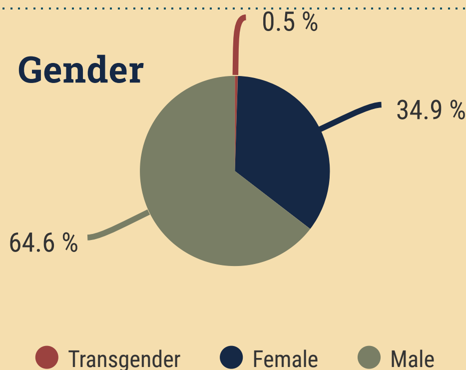
Homeless people live on the streets, in tents, in cars, in abandoned buildings, in shelters, in transitional housing, or have recently lost their housing and do not have any financial or social resources to access another home.

Household Type



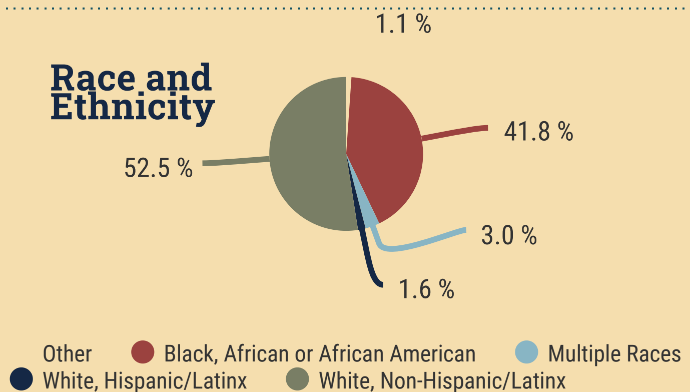
Youth aged 18-24 · Families with children · Individuals over age 24

Gender



Transgender · Female · Male

Race and Ethnicity



Other · Black, African or African American · Multiple Races · White, Hispanic/Latinx · White, Non-Hispanic/Latinx

Contributing Factors to Homelessness

Lack of Affordable Housing

Physical or Behavioral Health Challenges

Domestic Violence

History with Criminal Legal System or of Past Evictions

Lack of Income or Financial Emergencies

State of Homelessness in Springfield & Sangamon County

Unsheltered & Chronic Homelessness

193

people are chronically homeless annually, meaning an individual has been homeless longer than a year and has a disability

94%

of the unsheltered population is made up of individuals without children

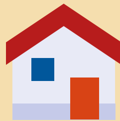
16% of the unsheltered population succeeds in accessing permanent housing

80% of those successful in accessing housing remain permanently housed

Homeless System of Care Effectiveness

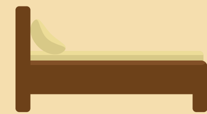
7%

of individuals who experience homelessness ever access homeless housing resources



12% of people served in shelters exit to permanent destinations

88% of people served in rapid rehousing exit to permanent destinations



58%

of shelter beds were in use the night of the Point-in-Time Count

Needs

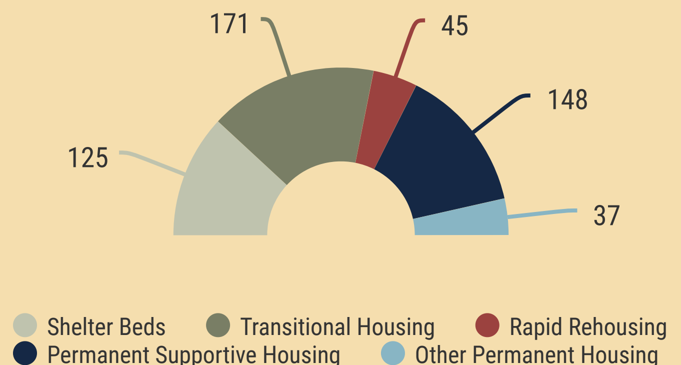
Of people assessed:

56% need permanent supportive housing

5% need transitional housing resources

38% need rapid rehousing

Number of Beds Available by Project Type



State of Homelessness in Springfield & Sangamon County

A Commitment To Do Things Differently

We are committing to do things differently, but what does that mean?

- It means a **diverse group of leaders** from sectors across the community and people with lived experience of homelessness will be at the table leading an effort to end homelessness in our community.
- It means we are committing to **equity**.
- It means we will **coordinate across the community** to determine priorities for resources, using **data to inform decisions**.
- It means we will leverage our local strengths to **build capacity in our community** to respond to homelessness. It means that we will share our progress or our lack of progress with the community.
- It means we will make better use of the resources we have and **find the funding** to make the resources we need.
- It means we will create programs using **evidence-based, best practices** that end to homelessness for the households they serve.
- **It means that five years from now, we will have a system of care that is addressing the needs of our unhoused neighbors**.

Where we have been...

Prior Efforts to Address Homelessness That Did Not Come to Fruition

- **2005:** A Salvation Army shelter J. David Jones Parkway near Oak Ridge Cemetery
- **2006:** A Salvation Army shelter on East Jefferson
- **2013:** A Helping Hands shelter on North Fourth Street
- **2015:** A Salvation Army shelter on Ninth Street
- **2019:** Helping Hands' Center for Health and Housing on 11th street

This pattern must change.

Commitment to Equity

While this Plan includes specific strategies to improve equity, we also want to confirm an overall commitment to equity in all our work.

This Plan's implementation bodies commit to equity and anti-racism throughout the local homeless system of care and in all partnership engagement, seamlessly at all points of practitioner and clinician service delivery, making this a priority for all people who experience homelessness in this community.

We acknowledge the past pains and root cause of inequities in our community, and we commit to doing things differently than we have done before. What we do, how we do it, who's at the table—that needs to change so that we can end homelessness efficiently, effectively, and equitably.

- The Strategy Board and the CoC Board that lead the Plan's implementation will use an anti-racist framework of operating, and all board members will receive training and support to be trauma-informed and anti-racist.
  - We are committed to making room for diverse voices.
  - We want to be held accountable, internally, and externally.
  - We understand that intent is not always the same as impact.
  - We acknowledge the power and control dynamics of our community and will engage them from a collective empower approach.
- Within our housing, shelter, and outreach plans, we will integrate plans to deconstruct structural racism, and racial and LGBTQIA+ disparities where they exist.
- We commit to reducing disparities in the experience of people experiencing homelessness, including by focusing resources on populations who have been impacted intersectionally by gaps in multiple systems of care, including criminal legal systems, education, and health care.

LathanHarris, Inc.

In parallel to this Plan's development, LathanHarris, Inc. developed an Equity Analysis and a Need Assessment that have informed this plan's content and strategies, and which are available at https://heartlandhoused.org/equity-analysis/

Ending Homelessness

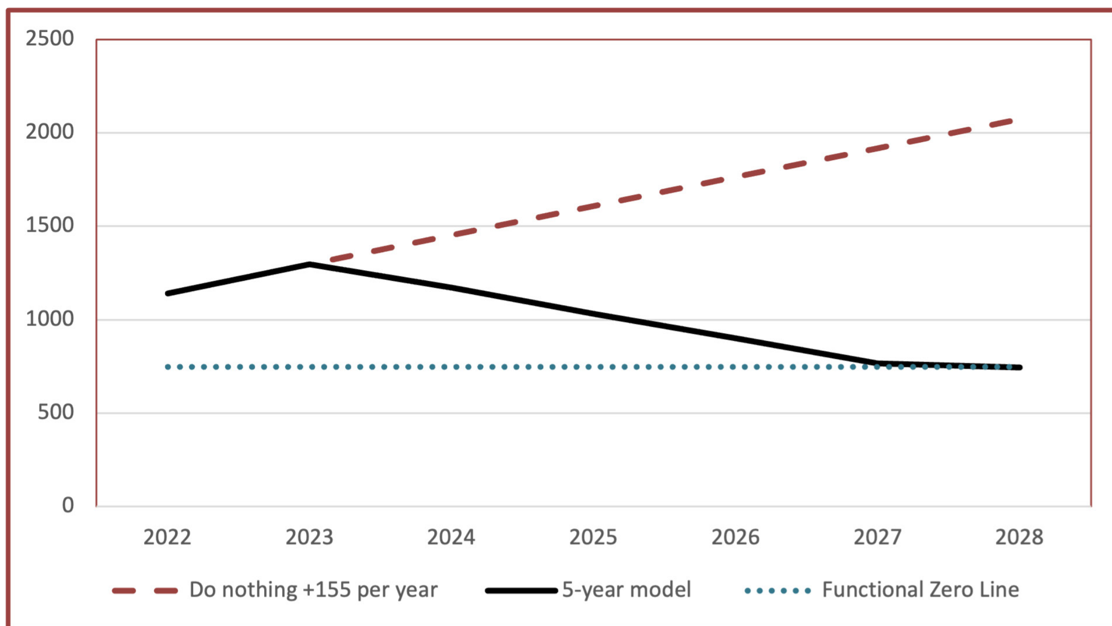
Strategic Plan Vision

Create a **collaborative, unified system** *that provides people experiencing homelessness an* **equitable, trauma-informed***, and* **coordinated community system** *where all can access the* **housing and support services that each person needs to thrive**.

Strategic Goal

- **Reduce homelessness to functional zero in five years**, which means that our community will have the housing and service resources to support all people that become homeless to exit homelessness within 30 days. By reaching this goal, our community will also:
  - Reach functional zero for chronic homelessness, and
  - End unsheltered homelessness.

Five Year Model of Total Number of People Experiencing Homelessness, 2022-2028



Driving Strategies

Strategy 1
Create safe, effective housing opportunities

Strategy 2
Improve the effectiveness of the homeless system

Strategy 3
Coordinate with other systems of care to reduce homelessness

Strategy 4
Community works collaboratively to address homelessness

Highest Priority Action Steps

1. Create **765 more permanent housing opportunities** for people experiencing homelessness and people at risk of becoming homeless through new construction, rehabilitation, or by accessing existing housing stock.
2. Develop practices to **identify and link unsheltered Sangamon County residents to crisis and permanent housing** and other needed resources.
3. Create **stable, effective, community-wide crisis housing** that serves all homeless subpopulations and supports movement into housing.
4. Create a **strategy board** that represents the whole Springfield & Sangamon County community to lead this plan's efforts using an inclusive framework and structure for operating.
5. Improve the **collection and use of data related to homelessness** to improve the performance of the system of care and to reduce inequity by identifying unmet needs and improving service delivery.
6. Create a strong, sustainable **Lived Experience Advisory Board** to ensure the voice of people with lived experience of homelessness is incorporated throughout the homeless system.

Strategic Plan Strategies

Strategy 1 — Create safe, effective housing opportunities

Goal

Increase the number of permanent affordable and supportive housing units available for people experiencing homelessness

Metric

- Create 765 permanent housing opportunities for people experiencing homelessness

Lead

Housing Task Force

Staffing

Housing Development Coordinator

Examples of Permanent Housing Opportunities

- New built units
- Rehabilitated or renovated units
- Housing subsidies to use in existing units in the community (may be short- or long-term)
- Shared housing
- Tiny homes, and
- Any other home where a person can live without a time limit.

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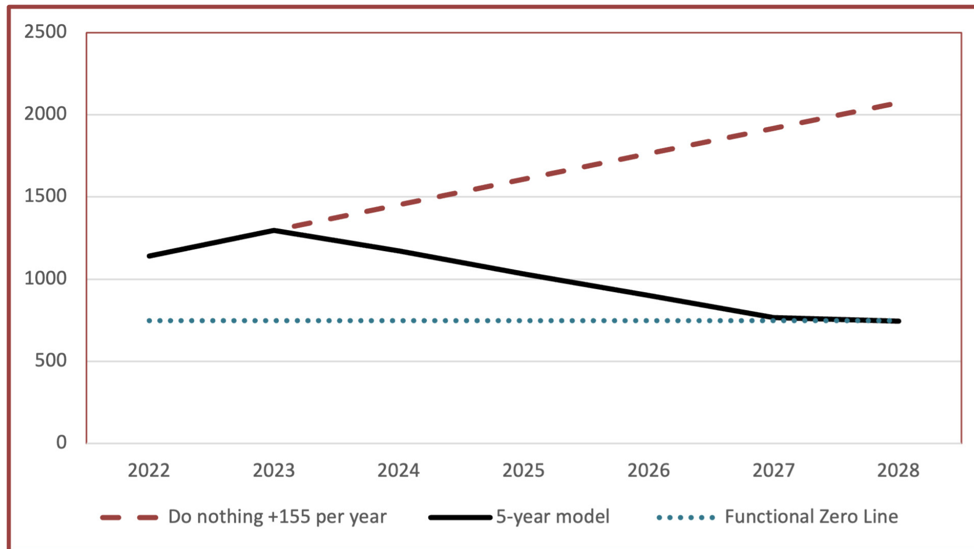
Five Year Model of Total Number of People Experiencing Homelessness, 2022-2028



Looking at data from recent years, the number of people who are served by local homeless housing and service providers in our community is **increasing by 155 people each year**. To increase the system to meet demand, not only for **today's** homeless population, ***but also the people that are forecasted to become homeless in the next five years***, requires:

- 365 units of rapid rehousing (short term housing subsidy and services to support household stability) and,
- 400 units of permanent supportive housing (non-time-limited housing with services to ensure people with disabilities maintain housing).

The Details		
Current Inflow	747	Ideally, this average number will come down over time – but is not included in the model.
Current Outflow	591	To reach Functional Zero, this average number needs to match the inflow number and is included in the model
Unmet Need	155	With no action, this is the projected addition to the population each year. This is the number we are reducing to zero to meet Functional Zero.
Total Active Homeless in HMIS	1142	This is current number served annually. To reach Functional Zero, it needs to match the new outflow number (747).

	2022	2023	2024	2025	2026	2027	2028
Total Homeless Population if No Changes Are Made (red dashed line)	1142*	1297	1453	1608	1764	1919	2074
Proposed 5-year Model for Total Homeless Population (black solid line)	1142	1297	1171	1030	899	765	744

*1142 is the unduplicated number of people served in homeless programs (not permanent supportive housing) in calendar year 2022.

Additional Units Per Year						
	2023	2024	2025	2026	2027	Total
Annual Housing Resources						
Short-Term Rapid Rehousing	25	25	50	45	15	160
Long-Term Rapid Rehousing	75	75	25	20	10	205
Units Aggregate and Are Maintained Going Forward						
Permanent Supportive Housing	100	100	100	100	0	400

Notes:

- There will be an initial period of intense investment followed by a softening and sustaining period. For example, the rapid rehousing numbers increase to 100 each year in early years to address backlog, but Functional Zero will be sustainable with only 25 total annual units in addition to the current units available today going forward. In addition, the plan calls for 400 units of new permanent supportive housing in the first four years that will need to be maintained post-plan, but after the plan period, turnover in permanent supportive housing will serve all new people becoming homeless who need permanent supportive housing.
- This model assumes short-term rapid rehousing will serve a household for a year or less, long-term rapid rehousing will serve a household for up to two years, and permanent supportive housing will have a 15% turnover rate.
- The unit allocation was determined based on current coordinated entry assessments and may change as coordinated entry changes practices.
- This model assumes no current units will be defunded.
- By implementing diversion and ramping up prevention, potentially less units will be needed.

Action Steps

1. Create a **Housing Task Force** that meets quarterly to align funding and other development processes cross-community. Membership will include housing-focused representatives from the city, county, Springfield Housing Authority, people of lived experience, developers, landlords, and community stakeholders:
    a. To develop and implement a strategy for creating homeless housing that will meet the goals of this plan
    b. To influence and align existing processes
    c. To oversee and advocate for funding for housing (e.g., CDBG, General Revenue, ARPA, CoC, health care resources, and philanthropy); and
    d. Be responsible for needs assessment, strategic planning, and proposals to government funding sources related to housing for persons experiencing homelessness.

2. Create **765 more permanent housing opportunities** for people experiencing homelessness and people at risk of becoming homeless through new construction, rehabilitation, or by accessing existing housing stock.
    a. To increase access to community-based units and use of available government subsidies for housing, develop a **landlord engagement and support program** to recruit landlords and provide education, specialized supports, and financial supports to landlords.
    b. Create and maintain permanent **housing with wraparound services on-site** for those with serious mental illness, substance use disorders, and other health needs.
    c. **Work alongside developers and landlords** to identify strategies to create housing opportunities, which may include financial or other incentives or leveraging properties owned by the County and/or the City of Springfield.
    d. Support development of an **affordable housing plan** to support homelessness prevention and reduce returns to homelessness.

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3. **Build capacity** in the community to build, rehabilitate and provide housing to homeless and at-risk populations.
    a. Develop the **infrastructure and experience** to respond to housing opportunities and develop new housing, which includes identifying opportunities, funding, resources, and partners and investing in organizational capacity-building with existing providers.
    b. Identify, recruit, and support **property management companies** to administer affordable and subsidized housing.
4. Ensure permanent housing projects are **fully and sustainably funded**, including funding for operations and supportive services that support people experiencing homelessness to maintain housing.
    a. Capitalize on short-term and long-term funding to create and sustain permanent housing such as County CSBG, ARPA, HOME, and CDBG.
    b. Build new public-private partnerships to develop permanent housing.
    c. Build new partnerships with health care to develop permanent housing and services.
    d. Develop a strategy and mechanism to monitor and apply for available federal, state, and private funding for housing and services (e.g., apply for IDHA funding annually for the next 5 years).

Strategy 2 Improve the effectiveness of the homeless system

Goal

The homeless system of care is effectively and efficiently meeting the needs of people experiencing homelessness and speeding their recovery from homelessness.

Metric

- Maintain communitywide housing retention rate of at least 95%.
- Increase rate of people who access shelter or outreach that exit homelessness into permanent housing from approximately 16% to 40%.

Lead

Heartland CoC Board

Staffing

Implementation & Crisis Response Coordinator

Permanent Housing Retention Performance

Permanent housing retention was 99% in federal fiscal years 2020 and 2021, a strong increase from 82% in 2018.

Action Steps

1. Develop practices to **identify and link unsheltered Sangamon County residents to crisis and permanent housing** and other needed resources.
   a. Create a **By Name List of unsheltered persons** to help coordinate strategy and approach to housing each individual experiencing unsheltered homelessness.
   b. Revise **Coordinated Entry system prioritization** to prioritize unsheltered persons and integrate equity principles.
   c. **Coordinate, align & target outreach working and housing navigators** to reduce duplication and ensure housing-focused approach, including creating **community-wide outreach standards** to improve safety, housing outcomes and equity.
2. Build **diversion strategies and resources** and link to existing programs to support returning households to housing immediately.
3. Create **stable, effective, community-wide crisis housing** that serves all homeless subpopulations and supports movement into housing.
   a. Annually, **review data and identify current resources and community need** to inform allocation of emergency shelter and transitional housing resources, including strategies to

serve underserved populations and to flex units to serve different populations as needs arise.

b. Create and stabilize **low-barrier, housing-focused shelter(s)**, that accepts all people experiencing homelessness, aligns with public health priorities, operates 24/7, and prioritizes placement for people who are unsheltered.

c. Expand access to **flexible funding** for housing-focused needs (e.g., utility arrears, car repair, getting identification, transportation, relocation to friends or family, employment needs) to support diversion and rapid exit from homelessness.

4. Ensure sufficient **day services to ensure safety, protection from inclement weather, and access to referrals, services, and support** to exit homelessness, including for people who are aging, have limited mobility, and/or chronic illness. Partner with Lived Experience Advisory board to ensure resources available remain responsive to community needs.

5. Develop **community wide standards for providing individualized supportive services at and operating shelters, day services, transitional housing, rapid rehousing, and permanent supportive housing** that include training requirements; equitable assessment, service and case conferencing expectations; strategies to expand consideration of representation and culture in hiring and engagement; support for peer- based services; and other guidance and tools to ensure success of agencies of to serve broader populations, to implement best practices, to improve equity, to expand diversity, and to expand access to housing. Standards should include regular review of program level performance and resources to improve outcomes at program level.

6. Community wide, **strategically focus and prioritize supports for recently housed** individuals to ensure housing stability.

Case Managers & Supportive Services

Case managers and other service providers support people experiencing homelessness to:

- Plan their path to housing,
- Access resources like health care and job training,
- Complete applications for benefits,
- Create personal budgets, and
- Solve problems.

Without these providers, recovery from homelessness can be much longer and more difficult. By supporting these providers to learn and use the most effective practices, homelessness can be ended more quickly with less trauma.

Strategy 3

Coordinate with other systems of care to reduce homelessness

Goal

Create a county-wide, coordinated response to homelessness to minimize duplication of effort and improve system effectiveness to reduce homelessness.

Metric

- Reduce the system's length of time people experience homelessness to less than 60 days on average.
- System-wide, reduce rate of returns to homelessness from 28% to 15%.

Lead

Heartland HOUSED

Staffing

Implementation & Crisis Response Coordinator

Action Steps

Cross System

1. Create systems to support **cross-system data sharing** including expanding HMIS usage, data exchange, and easily accessible dashboard to reduce duplication of services across full community, while protecting individual privacy.
2. Improve and expand **cross-system service coordination and referrals** to be more transparent and effective and to reduce duplication through strategies that include cross training, appropriate referrals (e.g., leveraging primary care providers or specialty outreach), case conferencing, discharge planning, cross-siting, expanded on-site services, expanded service hours, expand adjacent supports (i.e., legal, child welfare, employment, etc.) and real time data sharing.
3. **Improve access to treatment and services system-wide** by restructuring access and program requirements to reduce barriers (including transportation), implement best practices, and ensure welcoming, culturally specific, trauma-informed services.

Healthcare

4. Build on **coordinated entry system to improve navigation and coordination of the homeless and health care systems of care by individuals experiencing homelessness**, including those with behavioral health issues, which may include improving equity in assessment, providing additional information to coordinated entry access points about eligibility and availability, adding additional screening tools or processes to intake, improving culturally-specific service provision, or may include more streamlined, integrated referral processes.
5. Improve access to **dental health care services** for people experiencing homelessness.
6. **Improve discharge planning** practices, ensuring access to medicine and appropriate supports for people experiencing homelessness, and specifically, create 10 units **bridge housing with integrated case management for those discharged from hospitals and treatment facilities** to ensure stability during transition to housing.

Public Safety System

7. Engaging all facets of the criminal legal system and community supports, **improve discharge planning** to ensure people exiting public safety system have housing access and support.
8. Continue to provide **clinical services for persons experiencing homelessness that coordinate with law enforcement and court services** to increase engagement and collaboration with new and existing partners.
9. Improve access to **criminal legal system diversion court programs** for people experiencing homelessness, including by expanding programs, destigmatizing programs, and focusing engagement on underserved populations.
10. Improve access to **detox beds** and other community resources to avoid criminal legal system involvement.

Workforce Development

11. Identify and engage **employers** to hire and train people experiencing homelessness.
12. Create resources to address system gaps for **populations that experience economic disparities** in this community, including people who have disabilities, who are Black, or who are seniors.
13. Provide **case management support to employers and employees** who are currently or formerly homeless to improve relationships and placement success.
14. Leverage **supported employment programs** and resources designed for the specific challenges people experiencing homelessness may experience, which may include, for example, shelter or housing, identification document access, transportation, childcare, tools/uniform stipends, literacy education, and GED programs.
15. Create **Individualized Placement Support (IPS)** for employment for individuals with high needs or barriers.

Strategy 4: Community works collaboratively to address homelessness

Goal

Share information, share responsibility, and improve success of ending homelessness in Sangamon County and Springfield.

Metric

- Increase funding from federal, state, and private sources by 50% from current levels.
- Design and maintain a two-way community communications strategy about homelessness and plan implementation throughout the plan timeline.

Lead

Heartland HOUSED

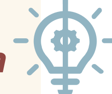
Staffing

Executive Director of Heartland HOUSED

Action Steps

1. Create a strategy board that represents the whole Springfield & Sangamon County community to lead this plan's efforts using an inclusive framework and structure for operating. The strategy board will give strategic direction to the Heartland Continuum of Care Board. The board will include members from the public and private sectors, including representatives of hospital systems, philanthropy, and advocacy organizations, and at least 1/3 of the board must be people who are Black, Indigenous or other People of Color.

"This strategy creates the permanent infrastructure necessary to solve this problem in our community."



Heartland HOUSED Strategy Board Membership	
How will the Heartland HOUSED Strategy Board & Heartland CoC Board partner?	
Heartland HOUSED Strategy Board	**Heartland CoC Board**
The new strategy board will be a public-private, cross-sector, decision-making and leadership body that will guide policy and oversee strategic plan implementation. **Key Roles** of the strategy board will include: • Decision making and oversight of policy for the homeless system and the strategic plan • Alignment and creation of resources for the homeless system • Monitoring and communicating on progress in addressing homeless.	The Heartland Continuum of Care Board will continue in its current roles, including meeting HUD requirements, and will also be responsible for implementation of the plan's strategies. **Key Roles** of the Heartland CoC Board would include: • Implementation of the strategic plan strategies • Utilization of funding towards strategic plan goals • Implementation of HUD mandates

2. Using hiring strategies to expand representation, increase staffing for homeless system to 6.0 FTE to coordinate system of care community-wide and ensure support for implementation of plan strategies.

Plan Staffing Structure

Heartland HOUSED staff will be responsible for coordinating efforts and activities across the community to improve outcomes for the homeless system of care.

Core Staff

- **Executive Director** (1.0 FTE) to staff the Strategy Board and CoC Board, lead public relations and communications, generate funding, and track, guide, and support strategy implementation.
- **Implementation & Crisis Response Coordinator** (1.0 FTE) to lead crisis response system, trainings, technical assistance, and respond to HUD mandates
- **Housing Development Coordinator** (1.0 FTE) to drive housing creation, including providing technical assistance to agencies to develop housing, coordinating community support, and identifying and braiding funding for housing.
- **HMIS Administrator** (1.0 FTE) to administer data system and undertake data analysis.

Additional Staff

- **Housing Navigation & Lived Experience Coordinator** (1.0 FTE) to support Lived Experience Board and unsheltered housing efforts.
- **Administrative & Communications Assistant** (1.0 FTE) to support team and public relations efforts.

3. Expand funding dedicated to housing and services that reduce homelessness in this community.

Selected Annual Costs for Plan Efforts

Expected Costs	Expected Annual Expenditures	Potential Sources
System Building Activities, including staff	$625,000	County, City, Township, CoC, private sources
Permanent Housing Subsidies & Landlord Supports	$2,250,000	Public Housing Authority, CoC, HOME-ARP, Other HUD, State, private sources
Housing and Service Provider Capacity Building	$635,000	HOME-ARP, County, City health care, private sources
Crisis Response System, including shelter, prevention, & diversion	$900,000	HOME-ARP, City, County, Township, health care, private sources

4. Improve the **collection and use of data related to homelessness** to improve the performance of the system of care and to reduce inequity by identifying unmet needs and improving service delivery, including by:
   a. Creating a **web-based community dashboard** to share progress on homelessness (broken out by demographics) and strategic planning efforts, including training opportunities.
   b. Annually, conducting a gaps analysis and equity-centered evaluation plan to ensure equitable service models system-wide, to focus resources to underserved populations and to support the annual implementation plan.
5. Coordinate a two-way community **communications strategy** to both inform and gather information regarding:
   a. The challenges and successes of this plan's implementation
   b. The results of data analyses
   c. How community members can help end homelessness and
   d. How to connect people in need to resources.

6. Respond to **citizen concerns about homelessness and siting housing** throughout Springfield and Sangamon County through information sharing, community building activities, and community engagement.
    a. Create **strategies to combat Not In My Backyard (NIMBY)** community responses.
    b. Increase engagement, openness, information sharing, safety, awareness, and partnership with **neighborhood associations** and communities, particularly those that have been directly impacted by homelessness.
    c. Develop a **Good Neighbor practice and policy**, providing extra support to communities with existing or new homeless housing projects, which may include keeping the neighborhood clean, managing noise, or adding additional security staff or structures, to ensure community harmony and safety.

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7. Create a strong, sustainable **Lived Experience Advisory Board** to ensure the voice of people with lived experience of homelessness is incorporated throughout the homeless system.

Appendix - Strategy Board Membership

Membership: The board may have up to 20 members. These members must include:

1. Mayor of Springfield
2. County Board Chairman
3. Key Leader from Continuum of Care
4. At least one Person(s) with Lived Experience of Homelessness (within the last 7 years)
5. Key leader from Springfield Housing Authority
6. Key leader from Springfield Memorial Hospital
7. Key leader from HSHS St. John's Hospital

The board must also include key leaders from at least 5 of the 8 entities listed below on the board:

8. Capitol Township
9. Urban League
10. NAACP
11. The Springfield Project
12. Community Foundation for Land of Lincoln
13. United Way
14. SIU School of Medicine
15. An impacted neighborhood association (designated by Mayor)

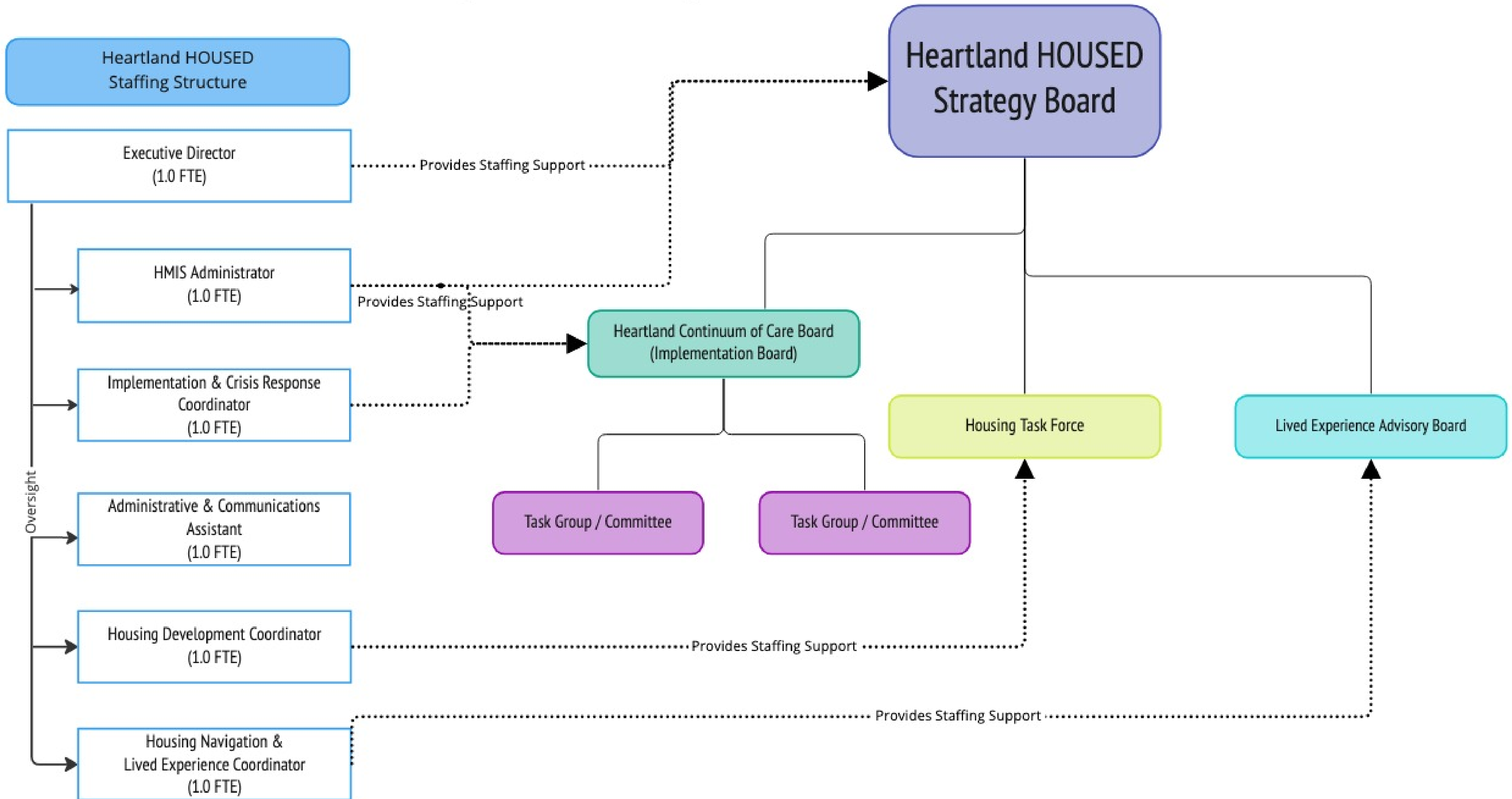
Additional at-large members may be invited by the board or through a public application process organized by the board to improve representation including:

16. At least one representative of a Faith Community
17. At least one DEIB professional

Other at large members may also represent additional homeless housing/shelter/service providers, business/commerce, philanthropy, or other community members. Members may represent more than one role.

At least 1/3 of the board must be people who are Black, Indigenous, or other People of Color (BIPOC). In selecting board members, the board should also consider representatives of groups that are overrepresented in the homeless system of care, which includes **people who are LGBTQIA+, who are immigrants, who have experience with the criminal legal system, or who have behavioral health disorders**.

Appendix - Implementation Structure



Glossary of Terms

Bridge Housing – Interim housing that provides a temporary, stable experience that can facilitate placement into permanent housing. Often thought of as the missing link between the shelter system and permanent housing.

Community Development Block Grant (CDBG) – Federal funding supporting local community development.

Chronic Homelessness – People who have experienced homelessness for at least a year — or repeatedly — while struggling with a disabling condition such as a serious mental illness, substance use disorder, or physical disability.

Continuum of Care (CoC) – A network of stakeholders that coordinates efforts to end homelessness locally and applies for HUD CoC funding through a consolidated application.

Crisis Housing – Housing that provides a safe and adequate nighttime residence for homeless individuals and families during their transition to permanent housing. Shelter and bridge housing are types of crisis housing.

Diversion – A strategy for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing.

Functional Zero – The point when a community's homeless system of care can prevent homelessness whenever possible and ensure that when homelessness does occur, it is rare, brief, and one-time

Homeless Management Information System (HMIS) – The data tracking system for client-level data on homelessness.

Homelessness – The state of people who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or exiting an institution where they temporarily resided. People who will lose their housing within 14 days or are fleeing from domestic violence, don't have a place to go, and don't have the resources to find a place to go are also considered homeless. This is the definition used in the strategic plan and to track data.

HUD – The U. S. Department of Housing and Urban Development, primary federal funder of homeless resources.

Permanent Housing – Community-based housing without a designated length of stay where formerly homeless individuals and families live as independently as possible.

Permanent Supportive Housing (PSH) – Programs providing permanent housing with supportive services (e.g., case management, health services, financial services), usually for chronically homeless people.

Point-In-Time Count (PIT) – Annual sheltered and unsheltered count in January of all homeless persons in the area.

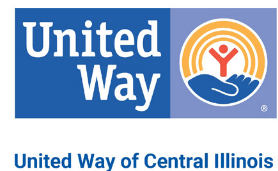
Rapid Re-Housing (RRH) – Programs provide rental and financial assistance and services to quickly house homeless households in the community.

Trauma-informed Services – Services that recognize that most people have a history of trauma, are attuned to symptoms of trauma, and acknowledge the role that trauma may play in an individual's life.

Unsheltered Homelessness – The state of people who spend most nights in places not meant to be used as a regular sleeping place for human beings, such as the streets, makeshift shelters (tents, boxes) or vehicles.

Thank you

This planning process would not have been possible without the financial support of:



This plan benefited from the leadership of its Steering Committee:

Amy Voils	MERCY Communities
Andy Van Meter	Sangamon County Board
Becky Gabany	Memorial Medical System
Dominic Watson	Springfield Black Chamber of Commerce
Jackie L. Newman	Springfield Housing Authority
Jilnita Johnson	Helping Hands
Jim Langfelder	Mayor of Springfield
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Vea Crawford	Community Member

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Homebase and LathanHarris, Inc. are contributing authors to this strategic plan.

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