Housing, Health, and Independent Living Program (HHIL)

"GETTING HOUSED, STAYING HEALTHY"

AVAILABLE RESOURCES

- 40 Housing Units
- 2 Intensive Case Managers

PARTNER AGENCIES

- AIDS Foundation of Chicago (Lead agency)
- Christian Community Health Center
- Heartland Human Care Services

PARTNER PROGRAM

- Pediatric AIDS Chicago Prevention Initiative (PACPI) Housing Partnership Program

FUNDING SOURCES

- Chicago Department of Public Health (CDPH)
- Housing Opportunities for Persons with AIDS (HOPWA)
- Illinois Department of Human Services (IDHS)
- Various Private Funders

PROJECT DESIGN

The Housing, Health, and Independent Living Program, developed out of the national Department of Housing and Urban Development (HUD)/Center for Disease Control (CDC) Housing and Health study, is a collaboration developed to simultaneously care for the medical and housing needs of people who are HIV+ and homeless. The goal of the collaboration is to provide stable permanent housing to clients in order to improve their overall health.

INTERVENTIONS

The project partners believe that when homeless individuals with HIV are able to focus their energies on healing and maintaining their health, rather than coping with the challenging circumstances that arise from living on the streets and in shelters, their health will improve.

WHO Receives Services?

- Former Housing and Health study participants (HIV+) who:
  - are single with no income OR
  - a family unit.
- Pregnant, HIV+ women.

HOW Do Clients Get Connected?

- Through referrals from their PACPI case managers.

WHAT Services Do Clients Receive?

- Permanent Supportive Housing
- Case Management Services
- "Wrap around services" as needed for HIV+ individual and his or her family. Includes referrals to substance abuse treatment; counseling services; employment training; benefit acquisition, and health care.

THE MODEL
HOUSING FIRST

In this model, eligible individuals are referred to intensive housing case managers with the first goal being to obtain permanent housing. Research has shown that providing services in a permanent housing setting leads to improved health outcomes and is less expensive than habitual shelter-stays and emergency medical services that are often required by the chronically ill homeless.

This does not mean that participants do not need case management, substance abuse treatment, employment training or other supportive services. Even before participants are housed, they are linked to the "wrap around" services that best meet their immediate and long-term needs. The fundamental shift from previous paradigms is that services are transitional; housing is permanent.

"The fundamental shift is that services are transitional, housing is permanent."

The Chicago Continuum of Care

Pediatric AIDS Chicago Prevention Initiative (PACPI) Housing Partnership Program

"GETTING HOUSED, STAYING HEALTHY"

AVAILABLE RESOURCES

- 15 Housing Units
- 2 Intensive Case Managers

PARTNER AGENCIES

- AIDS Foundation of Chicago (Lead agency)
- Christian Community Health Center
- Housing Opportunities for Women

PARTNER PROGRAM

- Housing, Health, and Independent Living (HHIL)

FUNDING SOURCES

- Chicago Department of Public Health (CDPH)
- Housing Opportunities for Persons with AIDS (HOPWA)
- Illinois Department of Human Services (IDHS)
- Various Private Funders

PROJECT DESIGN

The Pediatric AIDS Chicago Prevention Initiative (PACPI) Housing Partnership Program is collaboration between the PACPI program and the Housing, Health, and Independent Living (HHIL) Housing program. The PACPI program provides intensive case management to HIV+ pregnant women with the goal of ensuring that their children are born HIV-free, and the partnership with HHIL increases success in this goal by enabling the program to provide housing for a homeless or unstably housed HIV+ pregnant woman in addition to case management services. The ultimate goal of the collaboration is to provide stable permanent housing to clients in order to improve their overall health.

INTERVENTIONS

The project partners believe that when homeless individuals with HIV are able to focus their energies on healing and maintaining their health, rather than coping with the challenging circumstances that arise from living on the streets and in shelters, their health will improve.

WHO Receives Services?

- Pregnant, HIV+ women

HOW Do Clients Get Connected?

- Through referrals from their PACPI case managers.

WHAT Services Do Clients Receive?

- Permanent Supportive Housing
- Case Management Services
- "Wrap around services" as needed for HIV+ individual and his or her family. Includes referrals to substance abuse treatment; counseling services; employment training; benefit acquisition, and health care.

THE MODEL
HOUSING FIRST

In this model, eligible individuals are referred to intensive housing case managers with the first goal being to obtain permanent housing. Research has shown that providing services in a permanent housing setting leads to improved health outcomes and is less expensive than habitual shelter-stays and emergency medical services that are often required by the chronically ill homeless.

This does not mean that participants do not need case management, substance abuse treatment, employment training or other supportive services. Even before participants are housed, they are linked to the "wrap around" services that best meet their immediate and long-term needs. The fundamental shift from previous paradigms is that services are transitional; housing is permanent.

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The Chicago Continuum of Care

Renaissance Care Network(RCN)Housing Program

"GETTING HOUSED, STAYING HEALTHY"

AVAILABLE RESOURCES

- 28 Housing Units
- 2 Intensive Case Managers

PARTNER AGENCIES

- AIDS Foundation of Chicago (Lead agency)
- Christian Community Health Center
- Other community partners

FUNDING SOURCES

- Housing for Persons with AIDS (HOPWA)/ Special Projects of National Significance (SPNS)
- Various Private Funders

PROJECT DESIGN

The Renaissance Care Network (RCN) is collaboration in the greater Roseland community on the far-Southside of Chicago that identified a need for housing units for HIV+ community members. In coordination with AFC and other partners, they are now able to offer housing to support HIV+ individuals and their families. The goal of the collaboration is to provide stable permanent housing to clients in order to improve their overall health.

INTERVENTIONS

The project partners believe that when homeless individuals with HIV are able to focus their energies on healing and maintaining their health, rather than coping with the challenging circumstances that arise from living on the streets and in shelters, their overall health will improve.

WHO Receives Services?

- Homeless or unstably housed individuals or families who are:
  - HIV+ (at least one person in family)
  - Willing to live in the greater Roseland area

HOW Do Clients Get Connected?

- Clients are identified and referred through Christian Community Health Center.

WHAT Services Do Clients Receive?

- Permanent Supportive Housing
- Case Management Services
- "Wrap around services" as needed for HIV+ individual and his or her family. Includes referrals to substance abuse treatment; counseling services; employment training; benefit acquisition, and health care.

THE MODEL
HOUSING FIRST

In this model, eligible individuals are referred to intensive housing case managers with the first goal being to obtain permanent housing. Research has shown that providing services in a permanent housing setting leads to improved health outcomes and is less expensive than habitual shelter-stays and emergency medical services that are often required by the chronically ill homeless.

This does not mean that participants do not need case management, substance abuse treatment, employment training or other supportive services. Even before participants are housed, they are linked to the "wrap around" services that best meet their immediate and long-term needs. The fundamental shift from previous paradigms is that services are transitional; housing is permanent.

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The Chicago Continuum of Care

Re-Entry Housing for Health Partnership (RHHP)

"GETTING HOUSED, STAYING HEALTHY"

AVAILABLE RESOURCES

- 42 Housing Units
- 3 Intensive Case Managers

FUNDED AGENCIES

- AIDS Foundation of Chicago (Lead agency)
- Christian Community Health Center
- Interfaith House

Community Partners:

- Austin Health Center
- Chicago House and Social Services Agency
- CORE Center
- F.A.I.T.H. Inc.
- Haymarket
- New Beginnings
- Southside Help Center
- Men and Women in Prison Ministries
- Prentice Place (transitional housing)
- Elite Houses (transitional housing)

FUNDING SOURCES

- Housing Opportunities for Persons with AIDS (HOPWA)/ Special Projects of National Significance (SPNS)
- Various Private Funders

PROJECT DESIGN

The Re-Entry Housing for Health Partnership (RHHP) is a collaboration developed to care for the medical and Housing needs of HIV+ men who would be homeless upon their release. The Re-Entry for Housing and Health Partnership (RHHP) is a collaboration developed to care for the medical and housing needs of HIV+ men who would be homeless upon release from a correctional facility. The program's steps ensure continuity of care for each participant - "in-reach" to correctional facilities by program manager; a brief three to four week stay in transitional housing/shelters or treatment center allowing the participant time to work with his case manager to identify a private market housing situation that fits best with his unique needs; and finally connection to permanent housing. The ultimate goal of the partnership is to provide stable permanent housing and to improve clients' overall health.

INTERVENTIONS

The project partners believe that when HIV+ individuals in correctional facilities re-enter civic life and are faced with providing for their medical and housing needs without support, the probability of repeated incarceration, transmission of the HIV infection, and an overall decrease in health all have increased likelihood. With housing and case management support, however, they are able to focus their energies on healing and maintaining their health, rather than coping with the challenging circumstances that arise from living on the streets and in shelters, and their health and rehabilitation will improve.

WHO Receives Services?

- Unaccompanied men aged 18 or older who:
  - are released from a State Correctional Center or Cook county jail,
  - would be homeless upon release,
  - are HIV+,
  - Willing to live in the City of Chicago.

HOW Do Clients Get Connected?

Through:

- Discharge planners or nurses in the correctional facility
- AFC Corrections Case Mangers
- Community Calls

WHAT Services Do Clients Receive?

- Permanent Supportive Housing
- Case Management Services
- "Wrap around services" as needed – referrals to substance abuse treatment; counseling services; employment training; benefit acquisition, and health care.

THE MODEL
HOUSING FIRST

In this model, eligible individuals are referred to intensive housing case managers with the first goal being to obtain permanent housing. Research has shown that providing services in a permanent housing setting leads to improved health outcomes and is less expensive than habitual shelter-stays and emergency medical services that are often required by the chronically ill homeless.

This does not mean that participants do not need case management, substance abuse treatment, employment training or other supportive services. Even before participants are housed, they are linked to the "wrap around" services that best meet their immediate and long-term needs. The fundamental shift from previous paradigms is that services are transitional; housing is permanent.

"The fundamental shift is that services are Transitional, housing is permanent."

The Chicago Continuum of Care

Safe Start/CHHP Program
"GETTING HOUSED, STAYING HEALTHY"

AVAILABLE RESOURCES

- 171 Housing Units
- 11 Intensive Case Managers

PARTNERS AGENCIES

Housing Partners:
- AIDS Foundation of Chicago (Lead agency)
- Chicago House and Social Services Agency
- Christian Community Health Center
- Heartland Health Outreach
- Heartland Human Care Services
- Housing Opportunities for Women
- Mercy Housing – Lakefront

Hospital Partners:
- Mt. Sinai Hospital
- Stroger Hospital
- Jesse Brown Veteran's Administration (VA)

FUNDING SOURCES

- Department of Housing and Urban Development (HUD): Supportive Housing Programs (SHP)
- Housing Opportunities for Persons with AIDS (HOPWA)/ Special Projects of National Significance (SPNS)
- Various Private Funders

PROJECT DESIGN

The Safe Start Program, developed out of the Chicago Housing for Health Partnership, is a collaboration developed to simultaneously care for the medical and housing needs of people who are chronically ill and homeless. The goal of the collaboration is to provide stable long-term housing to clients in order to improve their overall health.

INTERVENTIONS

The project partners believe that when homeless individuals with chronic medical conditions are able to focus their energies on healing and maintaining their health, rather than coping with the challenging circumstances that arise from living on the streets and in shelters, their health outcomes will improve.

WHO Receives Services?
- Homeless adults who:
  - Have a chronic medical condition
  - Have a disability
  - Live in the City of Chicago

HOW Do Clients Get Connected?
- The city of Chicago's Central Referral System (CRS) www.chicagocrs.org**.** The Safe Start Program primarily uses the CRS to recruit program participants.
  - Hospital referrals from Stroger, Mt. Sinai, and VA Hospital social workers

WHAT Services Do Clients Receive?
- "Housing First**" –** Permanent Supportive Housing *first*
- Specialized Case Management Services – delivered through a Systems Integration Team (SIT), an interagency collaboration used to share information and coordinate services
- "Wrap around services" as needed – referrals to substance abuse treatment; counseling services; employment training; benefit acquisition, and health care.

THE MODEL
HOUSING FIRST

In this model, eligible individuals are referred to intensive housing case managers with the first goal being to obtain permanent housing. Research has shown that providing services in a permanent housing setting leads to improved health outcomes and is less expensive than habitual shelter-stays and emergency medical services that are often required by the chronically ill homeless.

This does not mean that participants do not need case management, substance abuse treatment, employment training or other supportive services. Even before participants are housed, they are linked to the "wrap around" services that best meet their immediate and long-term needs. The fundamental shift from previous paradigms is that services are transitional; housing is permanent.

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The Chicago Continuum of Care

Chronic Homeless Samaritan Supportive Housing Program

"GETTING HOUSED, STAYING HEALTHY"

AVAILABLE RESOURCES

- 225 Housing Units
- 14 Intensive Case Managers

PARTNER AGENCIES

Housing Partners

- AIDS Foundation of Chicago (Lead agency)
- Alexian Brothers Housing & Health Alliance
- Chicago House and Social Services Agency
- Heartland Human Care Services
- Housing Opportunities for Women
- Interfaith House
- Mercy Housing - Lakefront
- North Side Housing and Supportive Services

Hospital Partners

- Stroger Hospital
- Mt. Sinai Hospital
- Jesse Brown Veteran's Administration (VA)

FUNDING SOURCES

- Department of Housing and Urban Development (HUD): Supportive Housing Programs (SHP)
- Chicago Department of Public Health (CDPH)/ Housing Opportunities for Persons with AIDS (HOPWA)
- Illinois Department of Human Services (IDHS)
- Various Private Funders

PROJECT DESIGN

The Chronic Homeless Samaritan Supportive Housing Program, based on the Chicago Housing for Health Partnership model, is a collaboration developed to simultaneously care for the medical and housing needs of people who are chronically ill and homeless. The goal of the collaboration is to provide stable permanent housing to clients in order to improve their overall health.

INTERVENTIONS

The project partners believe that when homeless individuals with chronic medical conditions are able to focus their energies on healing and maintaining their health, rather than coping with the challenging circumstances that arise from living on the streets and in shelters, their health will improve.

WHO Receives Services?

- Chronically Homeless unaccompanied adults
  - -Living in the streets or shelters continuously for 12 months
  - OR
  - -4 episodes of homelessness in 3 years (totaling a minimum of 120 days in the last 13 months to 3 years)
  - Who have a:
    - o Disability or a diagnosis of HIV
  - And who live in the City of Chicago.

HOW Do Clients Get Connected?

- The city of Chicago's Central Referral System (CRS) www.chicagocrs.org**.** The Chronic Homeless Samaritan Supportive Housing Program primarily uses the CRS to recruit program participants.
  - o Hospital referrals from Stroger, Mt. Sinai, and VA Hospital social workers
  - o Other shelter providers

WHAT Services Do Clients Receive?

- "Housing First**" –** Permanent Supportive Housing
- Specialized Case Management Services – delivered through a Systems Integration Team (SIT), an interagency collaboration used to share information and coordinate services
- "Wrap around services" as needed – referrals to substance abuse treatment; counseling services; employment training; benefit acquisition, and health care.

THE MODEL
HOUSING FIRST

In this model, eligible individuals are referred to intensive housing case managers with the first goal being to obtain permanent housing. Research has shown that providing services in a permanent housing setting leads to improved health outcomes and is less expensive than habitual shelter-stays and emergency medical services that are often required by the chronically ill homeless.

This does not mean that participants do not need case management, substance abuse treatment, employment training or other supportive services. Even before participants are housed, they are linked to the "wrap around" services that best meet their immediate and long-term needs. The fundamental shift from previous paradigms is that services are transitional; housing is permanent.

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The Chicago Continuum of Care

Transitional to Permanent Housing Program

"GETTING HOUSED, STAYING HEALTHY"

AVAILABLE RESOURCES

- 21 Housing Units
- 2 Intensive Case Managers

PARTNER AGENCIES

- AIDS Foundation of Chicago (lead agency)
- Alexian Brothers Housing & Health Alliance
- Interfaith House

FUNDING SOURCES

- Chicago Dept. of Public Health (CDPH) – Housing Opportunities for Persons with AIDS (HOPWA)
- Illinois Department of Human Services (IDHS)
- Various Private Funders

PROJECT DESIGN

The Transitional to Permanent Housing Program began when a need was identified for more housing units for HIV+ individuals approaching the maximum period for transitional housing. Often clients in transitional housing settings do not have access to the limited number of permanent supportive housing units and housing case manager services. The program increases access by collaborating with transitional housing partners to provide a stable transition from transitional housing to permanent housing for clients in order to improve their overall health.

INTERVENTIONS

The project partners believe that when homeless individuals are able to move from homelessness to transitional housing to permanent housing, working with the same agency and case managers, they will have greater success of staying in housing. In housing, HIV+ individuals are able to focus their energies on healing and maintaining their health, rather than coping with the challenging circumstances that arise from living on the streets and in shelters, their health will improve.

WHO Receives Services?

- HIV+, unaccompanied adults who are:
  - Enrolled in a partner transitional housing facility.

HOW Do Clients Get Connected?

- Clients are identified for eligibility while staying in transitional housing at one of two partner agencies, Bonaventure House and Interfaith House.

WHAT Services Do Clients Receive?

- Permanent Supportive Housing
- Case Management Services
- "Wrap around services" as needed for HIV+ individual and his or her family. Includes referrals to substance abuse treatment; counseling services; employment training; benefit acquisition, and health care.

THE MODEL
HOUSING FIRST

In this model, eligible individuals are referred to intensive housing case managers with the first goal being to obtain permanent housing. Research has shown that providing services in a permanent housing setting leads to improved health outcomes and is less expensive than habitual shelter-stays and emergency medical services that are often required by the chronically ill homeless.

This does not mean that participants do not need case management, substance abuse treatment, employment training or other supportive services. Even before participants are housed, they are linked to the "wrap around" services that best meet their immediate and long-term needs. The fundamental shift from previous paradigms is that services are transitional; housing is permanent.

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