HOMELESS SERVICES & HOUSING RESOURCES
RFP # 14026-2025

AGENCY APPLICATION

Instructions:

Each applicant agency (or group of collaborative partners) must submit one completed Agency Application. Program-specific information must be submitted separately in the appropriate Program Application(s).

Please limit the total length of your completed Agency Application – including the questions, tables and narrative responses – to no more than **7 pages**. Applications that exceed this limit may not be fully reviewed. This page limit does not include requirement attachments (e.g., financial audits or financial statements).

AGENCY INFORMATION

Applicant Organization:	Madison Area Care for the Homeless (MACH) OneHealth dba **Madison Street Medicine**
Contact Person Name and Title:	**Brenda K. Konkel, Executive Director**
Address:	**1202 Williamson St. #101 Madison, WI 53703**
E-Mail:	**brenda@madisonstreetmedicine.org**
Phone:	**608-676-7826**
Website:	**www.madisonstreetmedicine.org**
Federal Tax ID or EIN:	**81-2102647**
Unique Entity ID (UEI) Number:	**UBTGTY45V521**
Legal Status**:**	**XX** Corporation
Tax Exempt Status:	**XX** Non-profit: 501 (c)(3) since **2017**

AGENCY REQUEST SUMMARY

Program Type	**Request Amount**
Homeless Services	
A. Homelessness Prevention	$
B. Diversion	$
C. Emergency Shelter	$
D. Street Outreach	$ 350,00 $ 179,500
E. Extreme Weather Hotel for the Unsheltered	$
F. Rapid Rehousing (RRH)	$ 230,000
G. Permanent Supportive Housing (PSH)	$
H. Other Permanent Housing (OPH)	$
I. Other Programs that Promote Pathways to Stable Housing	$
Housing Resources	
J. Tenant Support	$

TOTAL REQUEST	$ 759,500

AUTHORIZATION TO SUBMIT PROPOSAL

This application is submitted with the knowledge and approval of the organization's governing body. To the best of the undersigned's knowledge, the information provided is accurate and complete. The undersigned also certifies that they have reviewed and accept the terms and conditions outlined in the Request for Proposals (RFP).

Brenda K Konkel — 6/26/25

Signature **Date**

AGENCY QUALIFICATION

1. AGENCY MISSION AND RELEVANT EXPERIENCE (10 POINTS)

1) **Mission Statement:** Provide your agency's mission statement.

Vision: We envision a community where individuals experiencing housing insecurity have housing and healthcare.
Mission: We are on a mission to develop programming and services to fill gaps in access to healthcare and housing in the Madison area.

2) **Relevant Experience:** Describe your agency's experience delivering the types of services proposed in this application.

Brenda Konkel, our Executive Director has over 30 years of experience in nonprofits, has served on over 20 non-profits Boards and has supervised a staff of up to 17 people and run or supervised three different extensive volunteer programs (Madison Street Medicine, Tenant Resource Center and Occupy Madison). She has extensive experience in housing and homelessness programs and supervising staff running those programs. She has administered federal (CoC, EHH/ESG, HUD & ARPA), State (DHS, DECHR) as well as City and County funds for the city-sanctioned campground, outreach programs as well as rapid rehousing & prevention (funds and services) programs. She has almost 15 years of experience in leadership at Occupy Madison tiny house villages. She keeps up to date on system changes through active participation in the Homeless Services Consortium and serves on multiple committees. She currently serves as the Vice Chair of the Homeless Services Consortium Membership. Our Executive Director is also very active in the community, has extensive knowledge of city and county government and has been a Madison resident for over 30 years.

She leads a team that comes from a wide range of backgrounds which is best equipped to help the diverse clients that we provide services to. This starts with having members of staff with lived experience of homelessness. Having staff with that lived experience is an important part of our ability to provide quality and responsive care. They help as mediators between our volunteers who provide medical assistance and other staff and our clients who may not have established trust with those physicians or case managers because of lack of trust in the medical and other systems. They also provide a wide body of expertise on areas around Madison where individuals living outside may choose to temporarily stay which allows our outreach team to better serve the population compared to if they did not have that knowledge. They serve as advocates for our clients in agency and community meetings and in discussions with city officials to make sure the voice of the

homeless population in Madison does not go unheard. Finally, they understand the realities of being homeless and know best how to meet the needs of our clients where they are.

We also pride ourselves on having staff on our team with experience of navigating substance use and mental health services so they have understanding for what our clients deal with. With this experience, they know how to best support our clients in navigating those same services to receive support. This is especially impactful in our harm reduction efforts to distribute safer use kits, testing kits, and treatments to reverse an opiate overdose.

Our agency been running the following programs with the following start dates:

- Footcare clinic (2016)
- Community Health Needs Assessment (2017)
- Medical street rounds (2017)
- Encampment Outreach (2020)
- Housing Focused Outreach (2020)
- Housing Focused Case Management (2020)
- Beacon Medical Clinic (2020)
- Nurse Care Coordination (2021)
- Men's Shelter Medical Clinic (2021)
- Dairy Drive Campground (2021)
- SOS Outreach Coordination (2023)
- Public Health Vending Machine (2024)

See below for organizational partners, case conferencing and HSC involvement.

2. ORGANIZATIONAL AND FISCAL MANAGEMENT (10 POINTS)

1) **Quality Improvement:** Describe your agency's internal quality improvement processes, including how you review program outcomes and incorporate feedback from program participants.

Quality Improvement: Continuous Quality Improvement and PDSA (Plan, Do, Study, Act) are principles we build our processes around. We may not technically perform PDSA analysis but we utilize the principles. This is baked into our organization through practicing Sociocracy as our governance model. As a group reviews proposals and develops policies and procedures, we assign a review date to make sure what we thought was "good enough for now and safe enough to try" is still working and to review and make improvements. Any group member can also call for an earlier review or make an alternative proposal.

Program Outcomes: With help from the Board of Directors, we are developing 3-5 "metrics" for each of our programs. The metrics will be both leading metrics and process measures. The program circle is to review them monthly and the board will review them quarterly. This will serve as a dashboard for our organization to measure our effectiveness and progress. The Outreach Circle, which has the most clients and moving pieces, also reviews data and information in its weekly meetings for various data quality aspects as well as housing outcomes for our clients.

Feedback from Program Participants: When Madison Street Medicine was first founded in 2016 we developed a Community Health Needs Assessment that would serve over the years to guide our programming to fill gaps. Survey developers, administrators, and respondents worked with people with lived experience of houselessness to develop the survey. Our first survey in 2016 led to the inception of our Foot Care Clinics and our medical street outreach. Those programs were developed in response to the greatest barriers to healthcare being identified as cost, transportation, and not knowing where to go. Our CHNA has continued to serve as a valued resource as it gives us insight into issues facing the houseless community. Having a robust CHNA with as many respondents as possible is also crucial for gathering representative data that we can use in our advocacy efforts. It gives us the ability to compare the assessments we do every three years and allows

us to bring research-backed claims to the local healthcare systems in Madison (UW Health, Meriter, SSM) and to our systems work in the Homeless Services Consortium in developing solutions and system change. Finally, it also allows our organization to evaluate the effectiveness of our programming and identify where gaps in services present themselves so that we can shift our priorities if the community needs calls for change.

2) **Financial Management:** Describe how agency ensures sound financial accountability and sustainability.

Financial Accountability: We have developed Finance Policies at the Board and Resource Development and Finance Circle levels that the Executive Director used to guide day to day activities. We review these policies every two years and make changes if there are any recommendations during our annual audit. We also work with Common Good Bookkeeping who provides meticulous bookkeeping services and we work with two CPAs for grants tracking and reporting purposes. Our Executive Director has over 30 years of nonprofit finance experience in multiple organizations. Our primary CPA worked with Wegner CPAs for a few years doing audits and is extremely knowledgeable about compliance issues. They provide detailed monthly financial reports and checklists for checks and balances to the Treasurer of the Board and the Executive Director. The monthly reports to the Treasurer include reports to be passed on to the Board of Directors for review. Every spring our organization works with Wegner CPAs to complete a financial audit and 990s. We work to be transparent with the community by posting our financial reports on our website as well as digestible financial information such as our budget in our annual report.

Sustainability: We initially had a 5 year grant that covered the vast majority of our Executive Director's pay. That grant has ended and we are working to distribute her time to grant projects as well as seeking general operating support from various foundations. We have been fortunate to have had unrestricted funding from Roots and Wings over the past few years that helps us fill gaps between grants. We have started billing 1915i and are hopeful that the program will continue, but do have some concerns that our clients may qualify at decreasing rates with increased work requirements and reviews that are difficult for people without homes to navigate. If 1915i continues to go well, we are planning to also explore CCS funding but we have a few hurdles to qualify to do that work.

The other part of sustainability we are working on is as our organization matures and our Executive Director nears retirement age, we are focusing our efforts on building experience of our team and middle management to ensure long term sustainability and knowledge transfer. We also have developed a series of wikis and guides that provide policy, procedure and technical guidance for our programs and staff to preserve institutional knowledge.

3) **Financial Audit:**

Does your agency complete annual certified financial audits? **XX** Yes ☐ No

If yes, were there any significant deficiencies or material weaknesses identified in the most recent audit?

☐ Yes **XX** No

If **yes**, summarize the findings and describe how they are being addressed.

4) **2025 Agency Operating Budget**

AGENCY REVENUE

Source	2025 Budget

AGENCY EXPENSES

Category	2025 Projected Expenditure

City of Madison	652,400
Dane County	none direct
State of Wisconsin	81,361
HUD	281,280
Other Government	
United Way of Dane County	
Other Foundations	130,000
Fundraising	83,000
User Fee	
Other (Specify: carry over savings*)	269,000*
TOTAL REVENUE	1,497,041

Personnel	$1,242,368
Operating	183,875
Space	48,194
Special Cost	19,500
TOTAL EXPENDITURE	$1,493,937

	2025 Projected
Surplus or (Deficit)	$3,104

*We have already decreased this amount to be carried over to subsequent years through multiple small grants for operating costs at about $50,000 and expect this number to continue to decrease throughout the year.

3. SYSTEM COORDINATION (10 POINTS)

1) **Collaboration with Other Providers:** Describe how your agency collaborates with other providers in the homeless services and housing systems. Include examples such as referrals, case conferencing, shared service planning and delivery.

Referrals: Our agency runs the referral process for people experiencing unsheltered homelessness to get connected to a housing case manager. We call it the SOS line and people can contact us through walk-ins, phone, email, website form or we may contact people in the field. Our coordinator evaluates the caller's needs and pairs them with the outreach organization that may meet their specific needs (Youth - Briarpatch, Vets - VA, severe and persistent mental illness - Tellurian, etc.) or refers them to Urban Triage, Catalyst for Change or Madison Street Medicine. He also makes referrals to other community agencies as needed.

Case Conferencing: Our SOS coordinator also runs the case conferencing meetings of the outreach organizations where we talk about any clients we have concerns about, review 10-15 of the people who have been on the list the longest, review people who are new as well as people who are on Tier 2 but don't have their paperwork completed. We also developed a system where agencies will be entering case notes for the group and then designating a time to next review the client as a group. This is still work in progress but beginning to work better. In addition to internal case conferencing, we also do case conferencing with Kabba for our clients at Dairy Drive and some case conferencing with the Dane County Behavioral Health Group.

Shared service planning and delivery: We collaborate with many organizations for multiple reasons, here are some of the primary ones related to these grants.

- **Housing Coordination** - At Dairy Drive we currently are working closely with Urban Triage, CDA, and the HSC Coordinator with 10 Section 8 vouchers and 5 Rapid Rehousing slots. We also work with all the HSC nonprofit housing providers and Rapid Rehousing Programs. We take referrals from Coordinated Entry as people move into Tier 2 and coordinate with outreach groups and shelters to make sure the VISPDAT and paperwork are completed. We also work with private landlords and other affordable housing providers like Enso, Stonehouse, Gorman & Company and other WHEDA tax credit programs.

- **Basic Needs Coordination -** We work with several groups to ensure basic needs of our clients are met. We are located in the Social Justice Center which provides computers, phones, personal essentials, food, phone charging and other services which lightens the load of what we need to provide. We regularly visit and work with First United Methodist Church (community breakfast), Bethel Church, Off the Square Club and the Beacon to locate our clients and connect them to services. We coordinate food through Second Harvest Food Bank for both outreach and Dairy Drive. We take Dairy Drive campers to multiple food pantries and community meal sites. We regularly work with Friends of the State Street Family to coordinate needs. We also have a staff member that is great and we have coordinate donations through shoe drives at the three Willy St. Coop locations, food drives at various stores, donations from individuals, churches and community groups. Many UW student groups also do donation drives for things we need. UW Athletics donates shoes, Bombas donates socks, a local pharmacy donates meds for our approved medications lists and this list continues to grow.
- **Behavioral Health Coordination** - We work with many CCS providers, particularly for our folks at Dairy Drive. We also work with the Dane County group that brings together Outreach Providers and Behavioral Health programs funded by the county. We have brought multiple clients with a signed ROI to that group for care coordination. Our nurse on staff also helps to coordinate behavioral health services and medications for our clients. At Dairy Drive we work with Kabba Inc. for substance use services for our campers.
- **Health Care Coordination & Harm Reduction** - We have strong working relationships and collaborate on multiple levels with UW Health, Meriter, Access Community Health, Vivent Health, and Public Health Madison & Dane County. Read-only access to the Epic EHR systems at UW Health and Meriter has significantly improved our ability to coordinate care across providers. We also participate in the Public Health Vending Machine Roundtable and meet quarterly with the Narcan Direct program to align efforts around overdose prevention.Our team maintains ongoing partnerships with Porchlight through the Men's Shelter Clinic every Monday, and with The Beacon, where we provide a weekly Tuesday morning clinic and monthly foot care clinics.
- **Systems Change Work** - For systems change work our staff are founding members of the Affordable Housing Action Alliance and HSC Education and Advocacy Committee. We have also started working with ABC for Health around healthcare needs of our clients.
- **Organizational Capacity** - We are members of the Wisconsin and National Free and Charitable Clinics organizations as well as the International Madison Street Medicine Institute. We also work with several UW departments (School of Nursing, Emergency Medicine, Family Medicine and Public Health) as well as the MEDiC students. Our Americorp volunteers have also been restored.

2) **Integration into the System of Care:** Describe strategies your agency uses to ensure alignment with the broader local system of care such as Homeless Services Consortium (HSC). Include strategies such as supporting staff or participants in system-level planning, participating in HSC committees or workgroups, providing staff training aligned with system priorities or best practices.

Strategies to Ensure alignment with broader systems of care - See Case Conferencing section above. We also were active in the Community Plan to Prevent and End Homelessness Dane Forward process. For the unsheltered SNOFO we helped develop the 15 page plan to address unsheltered homelessness and continue to work on various aspects of that work. See also HSC involvement above.

HSC Committee participation: Our Executive Director is the Vice Chair of the Homeless Services Consortium Membership. She has served on the Board of Directors, was President of the Board and has served on the following committees: Community Plan Committee, Core Committee, Reimagine Coordinated Entry Workgroup, Data Committee, Education and Advocacy Committee, Funders Committee, Nominating and Governance Committee, Outreach Committee, Point in Time Committee and attended the Shelter Services Committee along with many other ad hoc committees or committees that no longer exist. Our outreach staff actively participate in multiple committees including Outreach Committee, Education and Advocacy,

Point-in-Time and Reimagine Coordinated Entry Committee. Team members are encouraged to engage in any HSC committee that aligns with their interests and areas of passion.

Staff training aligned with system priorities or best practices: New staff go through a two week training period that includes not only standard agency onboarding, but training for Clarity, HIPAA compliance, Housing First, an overview of the Homeless Services Consortium, Written Standards, Coordinated Entry and case file requirements. While we talk about the importance of data, we have found focusing on why the data matters is more motivating for our staff. Our training focuses on elements of best practices including Housing First, Trauma Informed Care, Harm Reduction, Motivational Interviewing, Peer Support/Lived Experience, Cultural Competency, the importance of Interdisciplinary Teams, Continuous Quality Improvement, Collaboration and Self-Care.

We also have built in training opportunities throughout the year. We have full staff meetings every two weeks that have a training element to them. Our outreach and Dairy Drive teams meet weekly to address issues and learn from each other. Dairy Drive also has a meeting with Kabba every two weeks where additional training is provided. We also have one Clarity and one Housing meeting each month to answer questions and provide additional training as needed. Both the Dairy Drive and Outreach teams have case conferencing meetings that focus on skill building for staff as well as our clients. Each staff member meets with our Executive Director for a half hour every two weeks to have individual questions answered. We are currently doing training on the 1915i program. We also continue to work with Abha Thakkar from Mosaic who consults on various issues as needed.

Additional training support includes the Ryan Dowd Homeless Training series that we use as needed. It includes over 50 videos that include practical tips for working with homeless individuals as well as the science behind how people act and react to things. There are also educational elements on a variety of issues including mental illness, substance use, addressing behavioral issues, backing up coworkers, de-escalation, safely breaking up fights, addressing prejudicial comments, traumatic brain injuries and more.

HOMELESS SERVICES & HOUSING RESOURCES
RFP #14026-2025

PROGRAM APPLICATION
D. STREET OUTREACH

Instructions:

This Program Application form must be completed for each proposed **street outreach** program. Applicants may submit multiple program applications if applying for more than one program area under the RFP.

Please limit the total length of your completed Program Application – including the questions, tables and narrative responses, to no more than **12 pages**. Applications that exceed this limit may not be fully reviewed. This page limit does not include requirement attachments (e.g., HMIS reports, agency outcome reports).

Agency Name:	Madison Street Medicine
Program Name:	Housing Focused Street Outreach
CDD Funding Request:	$ 350,000

1. PROGRAM DESCRIPTION (30 POINTS)

1) **Target population - Describe the population you expect to serve, including:**
   - **Projected annual number of unduplicated participants with outreach contacts (enrollment)** 200+ (2022 = 163, 2023 = 95*, 2024 = 181, 2025 = 216 to date, *for a portion of the year we were only enrolling people with a date of engagement, but then changed back to enrolling everyone.)
   - **Projected annual number of unduplicated participants with agreed-upon service plans (HMIS date of engagement)** 75 (2022 = 44, 2023 = 43, 2024 = 75, 2025 = 28 to date)
   - **Key characteristics of the target population (e.g., age, household type, length of homelessness, special needs, shelter use)**

We work with any person sleeping in a place not meant for human habitation. However, we primarily work with unsheltered chronically homeless (47-58%) singles and couples (over 99%). We serve relatively few youth (1-4%), vets (2-4%) and trans/non-binary persons (3-4%). Our clients are more likely to be men (52-79%) than women (20-45%). Race fluctuates but is about 50/50 white (46-64%) and people of color (47-59%). 26% are over 55 years old. Clients report that 61% have mental health challenges, 41% report substance use challenges, 38% have chronic health issues, 34% have a physical disability and 16% have a developmental disability. Most of our clients use shelter on occasion but primarily sleep outside except during the worst weather. % ranges are data from the past 3.5 years with errors for data not collected/refused to answer. See EHH Data Quality Reports for further information.

2) **Outreach Geography - Describe the geographical areas where outreach will occur, including high-priority locations. Discuss your rationale for choosing, or modifying, these areas.**

Our geographic areas are primarily in the City of Madison with some people in the immediate surrounding municipalities. High priority locations include Downtown (esp. State St. and Capitol Square),

the Isthmus and East Side of Madison. We do outreach South, North and West at least once a week, depending upon need.
We attempt to have a mixture of

- some “same faces, same places” same times outreach (Wednesday morning and Thursday evening State Street and Capital Square) and most mornings
- regular times (9:30-11:30am & 4pm - 8pm) where we rotate location
- at least one per week exploratory outreach where we are looking for new camps and following up on city recommended locations (unless CFC is) and SOS contacts

It is increasingly more difficult to predict where we will go long term due to people moving frequently. We frequently change our locations depending upon where we find people or they tell us they are camping. Our rationale is - we “go to the people” where we can find them. Due to people being increasingly protective of their camping locations, we also have walk-ins Monday - Friday 9 - 3, so people can also come to us if they are unwilling to disclose their exact campsite.

3) **Intake Process - From the perspective of a participant, describe the intake process that will be used. What is the number of new intakes you expect on a weekly basis?**

Intake for Enrollment - This is very informal and we seek permission at each step.

- Typically they are approached by someone identifying as being from MSM who introduces themselves and asks if they need anything. They may receive things like water, handwarmers, referrals, answer questions, etc.
- They may also chat with us and be asked if they are interested in services and we ask if they would like to share their name if they haven’t already.
- If they say yes, we seek their permission to enter information into the HMIS system. If people are reluctant, they will hear about the 6 additional questions needed to be on the housing list.
- If they agree, they will be asked basic (enrollment) questions, but sometimes intrusive questions about themselves..
- They will then hear information about when we will be back out on outreach, let them know about our office hours and ask them if they would like to be connected to a case manager to help them find housing. If a case manager is on outreach, they will be introduced to the case manager.

Intake for Date of Engagement - Intake for a date of engagement is typically done in the office, but can be done in the field. Clients arrive in our office or we visit them at their camp. We try to complete the entire intake packet at the same time, but that is can be overwhelming. From the client’s perspective we ask a lot of intrusive questions and make them sign things, hopefully with enough explanation that they understand what they are signing. We follow the EHH checklist for each intake, we start with the Service Plan and Agreement talking about what goals and strengths and they sign that they agree to receive services and work towards those goals. Together, we break the goal into smaller steps we will go through to meet those goals. They are also asked about other goals they might have, typically thost goals address barriers to housing. They then are asked about potential income and programs (mainstream resources checklist) to see what benefits they are getting and where we might work together to get them additional benefits. Sometimes the Service Plan will be modified at this point. They hear about our termination policy and sign it. Staff asks about their unsheltered homelessness and about using shelter services and checks the services they will be provided. The staff then enter a date of engagement in Clarity that matches the dates on the paperwork.

It is very difficult to predict how many intakes we will have over the next 4 years as much depends upon shelter capacity limits, what other outreach groups are doing, national increases in homelessness and the housing market. We expect a minimum of 2-4 new enrollments and 1-2 dates of engagements per week. However, we are exceeding those numbers at this time.

4) Services Provided

Describe how you will incorporate best or evidence-based practices in delivering the following services:

Generally speaking, the work we do incorporates the following core principles, many of which have common elements to them:

- **Housing First** - our outreach is housing focused, with housing being the primary goal. We center client choice, make sure our services are low barrier and client centered, focus on the questions at enrollment that get people more points on the tier system and aggressively seek out people who are in tier 2 to get their VISPDATs and paperwork completed.
- **Social Determinants of Health/Housing is Healthcare** - the whole premise of our organization is to holistically, through interdisciplinary teams, address all factors that impact health. 70-80% of health outcomes are driven by social determinants of health. Housing is one of the key determinants and therefore we strongly believe Housing is Healthcare and approach housing through that lens. Data shows that people experiencing homelessness die 20-30 years earlier than the average American due to a combination of poverty, exposure, untreated health conditions, violence and lack of healthcare access. We are seeking to end that.
- **Trauma informed** - during our interactions we understand that people may respond based on past trauma, and that houselessness itself creates more trauma. We focus on safety for the clients by respecting their spaces and being predictable. We work on building trust, following through on promises and giving clients choices, always respecting if they say they do not want services, but continuing to offer. We work with people where they are at from a strengths based perspective. We work hard to avoid retraumatization and making people re-tell their stories. However, if they are sharing with us, we listen with patience and free of judgement. We seek to understand when people have trauma responses to the work we do.
- **Harm Reduction** - which we provide in many forms - water, narcan, sun screen, cold weather gear (hats, gloves, blankets, hand warmers, etc), hygiene items, healthcare items (condoms, electrolytes, snacks, etc), etc. is a big element of our outreach. We focus on reducing harm, not changing people's behaviors while providing education as appropriate. We also have a strong substance use harm reduction approach distributing narcan, testing strips and safe use kits in person and through our public health vending machine thanks to our partnerships with Narcan Direct, Vivent Health & PHMDC.
- **Street Medicine principles** - Street Medicine is a healthcare delivery model that brings medical care directly to people experiencing unsheltered homelessness, where they are, both physically and emotionally, often building relationships and trust over time with individuals who are disconnected from traditional healthcare systems. It is strongly based on building relationships.
- **Motivational interviewing principles** - We work compassionately and in partnership with our clients drawing out their own motivations, strengths and reasons for change, accepting them as they are and exploring choices and honoring them. We work to ask open ended questions, recognize strengths and efforts, mirroring back what people say to show understanding and summarize key points. All of this is to help the person see they are capable of change.

- **Peer Support/Led by people who have experienced houselessness** - At the moment, our 3 case managers and 3 part-time outreach workers have lived experience of houselessness as well as staff members with lived experience of substance use and mental health challenges. 2 of our outreach workers are Peer Support Specialists and a 3rd is signing up for the training. Being a Peer Specialist and having lived experience in the field is very beneficial as it helps build trust and rapport with the client because staff has "been there". They are able to reduce barriers by supporting the clients navigate complex systems and translate jargon.
- **Cultural Competence & Equity** - We have staff who speak Spanish as well as Urdu and Hindi, or we use the language line, we identify and talk openly about systemic barriers and inequities. We also have non-binary staff and respect people's pronouns and identities. We advocate for change in systemic barriers and we try to always remain humble, stay curious and open to learning. Adapting as we learn and understand various cultures.
- **Interdisciplinary Teams** - Our ideal outreach team includes a person with lived experience of houselessness to lead the team, a housing focused case manager, someone with mental health background and a medical professional.
- **Continuous Improvement through data** - Plan, Do, Study, Act (PDSA) principles from the healthcare field were taught to our HSC community through Built for Zero. Continuous Quality Improvement through data analysis is a principle our board is helping us work on as we develop metrics for each of our programs. The concept of quality improvement and using the PDSA cycle are concepts that are baked into our organization through our governance model of Sociocracy and constant work in progress in our organization.
- **Collaboration -** Our organization sees a great value in collaboration with our community. Specific to outreach we wrote a grant to HUD to hire a community outreach programs coordinator to help unsheltered people get connected to case managers. We are strong partners in the Homeless Services Consortium (Our Executive Director is the Vice Chair of Homeless Services Consortium Membership and has been an active member of the Core Committee and several subcommittees, Community Plan Committee, Reimagine CE Workgroup, Education & Advocacy Committee and Outreach Committee) and coordinate with many homeless services organizations including we hold weekly medical clinics at the Beacon and Porchlight Men's Shelter. Beyond that we work in collaboration with healthcare partners (Access, UW Hospitals, Meriter, UW School of Medicine and Public Health, MEDiC UW healthcare students, UW School of Nursing, Public Health, Vivent Health, Wisconsin Association of Free and Charitable Clinics, Hoey Pharmacy), obtain food for clients from Second Harvest Food Bank, River Food Pantry and numerous other community meal sites and pantries as well as receive donations from many organizations.
- **Self-care and staff development** - In the past year we have spent much time on staff development and balancing self-care with the difficult work we do. We have opportunities to debrief difficult situations and work on improving staff wellness.

More specifically, we will incorporate these practices as follows:

a. Meeting basic health and safety needs of individual participants, especially during periods when individuals experiencing unsheltered homelessness are particularly vulnerable (e.g., extreme weather, public health emergencies)

Daily, we incorporate all of the principles above - but in extreme weather and public health emergencies we specifically employ harm reduction, collaboration with healthcare and homeless services providers,

utilizing interdisciplinary teams to do our work, street medicine principles and working with people with lived experience to develop our services. In the heat we will distribute water, electrolytes, ice packs, frozen treats and focus on getting people to cooler spaces. In the extreme cold we will focus on hand warmers, sleeping gear, long johns, dry socks, weather appropriate footwear, hats, gloves, etc and using skills above to help people make good choices to stay in the shelter instead of risking frostbite. We have also set up tornado shelter options in the past and would like to do so again in the future. For bad air quality we can give out masks and encourage people to be indoors. Last year we received a grant from Public Health where we worked on plans for emergency weather. We were able to purchase 20 cots, 2 generators and other supplies to run an emergency shelter in an emergency. During COVID we hosted covid shot clinics, did contact tracing, coordinated getting people into the COVID hotels and more. With our volunteer doctors and nurses, we are also able to coordinate medical assistance if needed. We also have a staff nurse that does targeted outreach if people need medical assistance and are not seeking it. Of course after these emergencies, we will debrief to learn and make improvements for next time.

b. Connecting participants to shelter or other immediate housing options

Sometimes the city goals to get people off the street conflict with client goals and many of the best practices above centering client choice and autonomy. We agree with City goals *and* it's complicated when trying to build relationships and trust. Truthfully, sometimes we struggle. The easy answer for housing is that we are all in on Housing First and coordinating through Coordinated Entry processes. We work hard to get the new questions answered in Clarity and complete VISPDATs and paperwork for Tier 2 clients. However, the Coordinated Entry process is not immediate and works for very few people. With over 1000 singles on the list and only 7% of them getting into housing through Coordinated Entry, we need to be creative. That is where developing a housing plan comes in and gives us the opportunity to explore other options that may not be renting a one-bedroom apartment. However, we also realize that some immediate housing options can retraumatize people and may be unsafe for them. In these cases trauma informed care and harm reduction conflict with immediate housing and shelter goals.

Connecting participants to shelter is equally challenging to do while being trauma informed. In many cases we are risking retraumatizing people who have experienced trauma in shelters and other similar settings. This is where building relationships in the street medicine philosophy is very important so we know what triggers impact people. Not being with their partner, going to shelter alone, leaving their pets and other similar circumstances are difficult for people and complicated when you layer on mental health and substance use issues. We understand the goal is to get participants to use shelter but it takes strong motivational interviewing skills, relationship building and time to do that while also being trauma informed and centering client choice. It's a very delicate balance we have to strike to meet the city's goals and still use all the best practices above.

c. Supporting participants in identifying and addressing specific barriers to housing, including housing navigation, connections to healthcare, behavioral health services, long-term case management, and other benefits

This is less complicated, but not much easier than above. While doing the housing plan with clients we identify barriers to housing and make a plan. However, that is typically done early on in the relationship and often needs to be revised as the relationship develops. When doing this work we focus on strength based approaches and client choice. It can sometimes take strong motivational interviewing skills to help clients understand the reality of some of their choices and to help them re-evaluate what they really need

vs. want. As we identify barriers to housing we often discover the need for connections to healthcare, behavioral health services and longer term case management. Our staff nurse is available to consult and provide comprehensive support, including guiding clients through healthcare complexities, accessing healthcare system records through UW and Meriter as well as educating clients on health and behavioral health issues. Strong cultural competency is needed particularly around healthcare, as well using a trauma informed lens and strong motivational interviewing to help the client make informed choices. With behavioral health issues, once a relationship is built, often through harm reduction efforts, we find people are much more engaged. We are able to have honest and meaningful conversations with people about their behavioral health needs. However, navigating behavioral health systems is challenging and frustrating for someone who is interested in addressing these needs. We are active participants in Dane County's efforts to bring the homeless services and behavioral health silos closer together and we have found success for our clients through that work. We recently also had Catalyst for Change come in and educate us about how to connect our clients to CCS. At Dairy Drive, we have found success in partnering with some CCS providers. Those providers are able to support with other services while we focus on housing. We have discovered that this makes the transition to housing easier for many of our clients as they have continued supports once we are no longer providing services. Housing Navigation continues to be our biggest challenge. Our Executive Director has 27 years experience with the Tenant Resource Center and is a good resource for our staff, but we struggle to build housing navigation expertise within our staff without more resources. We are continuously looking to build relationships with landlords and discover new ways to be creative in housing people outside of the coordinated entry system.

5) **Encampment Response**

City-supported street outreach teams will be expected to collaborate with various City agencies, including Community Development, Public Health, Engineering, Parks, Streets and Police, in addressing issues related to encampments. This includes:

- **Responding to referrals from City agencies for street outreach support;**
- **Engaging with individuals and providing timely information before encampment closures or cleanups;**
- **Mediating situations to reduce the need for law enforcement involvement and prevent involuntary displacement**

Describe your agency's approach to encampment response, including:

- **How your team will coordinate with the City to reduce harm, while connecting individuals to services and housing options.**

- **How your team will engage with individuals who view camping in unauthorized/prohibited areas as a medium- to long-term solution, including strategies for understanding their experiences and challenges and how you will support their transition to stable housing.**

Our approach to encampments is to educate, educate, educate, educate. Sometimes the clients, sometimes the neighbors, sometimes the City or others. Again, it's complicated given all the best practices we try to incorporate. We regularly talk to campers about the risks of camping where they are, give out tents on a very limited basis and try our best to help people make informed choices. We try to

help people manage their garbage and keep their sites clean but trash pickup has remained a challenge for us. Some of this is easier right now because if someone does have to move a camp, going to the shelter for a night until they figure out their next step is an option. In the future with limited shelter beds, that likely will not be an option for folks.

We also coordinate with the City through meeting bi-weekly, responding to emails and coordinating through the SOS referral form. When we get referrals we try to follow up by the following day either through our scheduled outreach or by staff members coordinating to go separately. We also coordinate with Catalyst for Change if they may be in the area. When we connect with people who may be in an area of concern, we educate people about the concerns, give them information so they know what to expect, talk to them about their options and assist with things we can such as - helping clean up, providing transportation or sometimes just listening.

Again, this is a difficult area, because we can't be seen as coordinating with the police or "the City", because we will lose the trust of our clients. We try to just be agents of reality and have honest conversations about what is going to happen. If we have prior relationships with people they may already be working with our case managers on housing, it just takes time. If they aren't yet working with a case manager, this may be a motivating factor for them to start working with a case manager, in this case it is an opportunity for us. It also gives us the opportunity to verify that the additional CE questions are answered in Clarity if we did not have a prior relationship with the persons involved.

Conversations about camping as a medium- to long-term solution are more difficult in the summertime, but it is important to start them as soon as we can. They obviously get easier as the weather gets colder. For a large percentage of people it's overwhelming to try to figure out how to have enough money to rent an apartment and find a landlord to rent to them. We try to break down that process into manageable pieces for people and encourage people to get on waiting lists as soon as possible and pursue plan A, B, C, D and more. Being on the Coordinated Entry list alone is not enough and we try to educate people about that process and the likelihood of getting housing through that process. When developing the housing plan we do try to help the camper "think outside the box". We use our strong relationships we build through outreach, active listening and motivational interviewing to understand our client needs. We try to provide choices for our clients and help them navigate through the process, letting them know we will be by their side as they take this journey, however long or hard it might be. That is where that trust becomes so important what is so challenging about encampment responses.

6) Staff Training

Describe your agency's plan for staff training. Include both new staff and ongoing training plans.

New staff go through a two week training period that includes not only standard agency onboarding, but training for Clarity, HIPAA compliance, reviewing the Guide to Housing Focused Outreach and our wiki, Housing First, an overview of the Homeless Services Consortium, Written Standards, Coordinated Entry, funding source requirements, 1915i, finding housing, affordable housing types (PSH, RRH, Section 8, public housing, Section 42, VASH, GPD), case file requirements, why the data is important, driving our box truck and more. It also includes shadowing current staff for walk-ins, outreach and case management workflows and being shadowed by current staff once ready to do the work. It also includes some of the Ryan Dowd videos mentioned below.

For on-going support we have the “Guide to Housing Focused Outreach” document that includes many of our agreed-upon policies for doing this work as well as our “wiki” that has workflow steps and linked to the documents needed to do the work. We are also developing a step by step guide for Clarity specific to outreach requirements. We have full staff meetings every two weeks that have a training element to them. Our outreach team meets weekly to address issues and learn from each other. We also have one Clarity and one Housing meeting each month to answer questions and provide additional training as needed. On Fridays opposite the City meetings, we do case conferencing about our clients. Each staff member meets with our Executive Director for a half hour every two weeks to have individual questions answered. We are currently doing training on the 1915i program. We also continue to work with Abha Thakkar from Mosaic who consults on various issues as needed.

Additional training support includes the Ryan Dowd Homeless Training series that we use as needed. It includes over 50 videos that include practical tips for working with homeless individuals as well as the science behind how people act and react to things. There are also educational elements on a variety of issues including mental illness, substance use, addressing behavioral issues, backing up coworkers, de-escalation, safely breaking up fights, addressing prejudicial comments, traumatic brain injuries and more.

7) Staffing Structure

Describe the proposed staffing plan. Fill out the table below.

Staff Position Title	Hiring Plan (Current/ New/ Expanded)	Total Program FTE	City-Funded FTE	Proposed Hourly Wage	Responsibilities
Housing Focused Outreach Case Manager (full-time)	Current	2	2	$ 26.44	Outreach/Engagement Housing Focused Case Management Care Coordination Housing Search/Placement Referral and Connections to Services
Outreach Support Workers (part-time)	Current	1.75	.75	$22-24	Outreach/Engagement Connection to Case Management
Lead Case Manager	new/ previously existing	1	1	$28.84	Light middle management for program coordination and co-supervision Outreach/Engagement Housing Focused Case Management Care Coordination Housing Search/Placement Referral and Connections to Services
Office Manager	Current	.25	.25	$ 26.44	Donation Management Program Logistics Coordination Walk-ins assistance

Executive Director	Current	.15	.15	$ 48.07	Program Management Supervision Technical Expertise Financial Management

8) Outreach Schedule

Provided a detailed schedule of the proposed outreach activities, specifying the location and activities for each staff member proposed to be funded by the City grant. Include all planned activity types (e.g., 4-8pm downtown outreach, 10-2pm encampment outreach, 9am-11am in-reach at the Beacon, 2-5pm outreach follow-up work in the office, 10am-2pm admin work in the office). While it is understood that outreach schedule may change daily based on emerging needs, please provide the envisioned typical schedule for summer months.

	Staff 1 City FTE: Case Manager	Staff 2 City FTE: Case Manager	Staff 3 City FTE: Case Manager	Staff 4 City FTE: Part-time Outreach Support Workers
Monday CM = case management* OR = outreach	9:30-11:30 encamp OR 1 hr admin/data entry 1 hr meeting/training 1 hr HSC meeting 3-4 hr CM/client mtgs	1 hr admin/data entry 1 hr meeting/training 1 hr HSC meeting 1 - 2 hr CM/client mtgs 4-8pm encamp OR	9 - noon walkins 1 hr admin/data entry 1 hr meeting/training 1 hr HSC meeting 2 -3 hr CM/client mtgs	9:30-11:30 & 4-8pm encamp OR noon - 3 walk-ins
Tuesday	9 - noon walk-ins 1 hr admin/data entry 4 hr CM/client mtgs	9:30-11:30 encamp OR 1 hr admin/data entry 5 hr CM/client mtgs	1 hr admin/data entry 3 hr CM/client mtgs 4-8pm encamp OR	9:30-11:30 & 4-8pm encamp OR noon - 3 walk-ins
Wednesday	1 hr admin/data entry 3 hr CM/client mtgs 4-8pm encamp OR	noon - 3 walk-ins 1 hr admin/data entry 4 hr CM/client mtgs	9:30-11:30 (State St and Capital Square OR) 1 hr admin/data entry 5 hr CM/client mtgs	9:30-11:30 & 4-8pm encamp OR 9 - noon walk-ins
Thursday	9:30-11:30 encamp OR 1 hr admin/data entry 1 hr mtg/training 4 hr CM/client mtgs	1 hr admin/data entry 1 hr mtg/training 2 hr CM/client mtgs 4-8pm (State St and Capital Square OR)	noon - 3 walk-ins 1 hr admin/data entry 4 hr CM/client mtgs	9:30-11:30 & 4-8pm encamp OR 9 - noon walk-ins
Friday	noon - 3 walk-ins 1 hr admin/data entry 1 hr mtg/training 3 hr CM/client mtgs	9:30-11:30 encamp OR 1 hr admin/data entry 1 hr mtg/training 4 hr CM/client mtgs	9 - noon walkins 1 hr admin/data entry 1 hr mtg/training 3 hr CM/client mtgs	9:30-11:30 encamp OR
Saturday	as needed	as needed	as needed	as needed
Sunday	as needed	as needed	as needed	as needed

*This schedule includes HUD matching funds, CM time may be in or out of the office depending upon the client, including visiting encampments and partner agencies (Beacon, Off the Square Club, Bethel, etc.) or taking clients to housing, medical or other appointments and getting housing documents

2. OUTCOME AND PERFORMANCE (20 POINTS)

Select one and complete the appropriate section below:

XX A. Existing Program with HMIS Data

A. **Existing Program with HMIS Data**

Use HMIS-reported data for past outcome fields. Refer to RFP **Appendix C** for instructions on generating the required reports. The HMIS report must be submitted with your application.

1) **Data Standards**
   The Wisconsin HMIS data quality standards for street outreach require: 90% for data completeness and 6 calendar days for data entry for participants with date of engagement.

   Please complete the following:
   - **2024 data completeness score:** 96.21%
   - **2024 average days to data entry for new entries:** 5.8 days
   - **2024 average days to data entry for exits:** 76 days

   Describe your agency's current practices to meet these standards and any planned improvements.

We encourage our staff to spend one hour in the morning or one hour before they leave catching up on any data entry they need to do. It is not always possible, so we tell them they have to have it caught up at the end of the week. On Friday afternoons the Executive Director spot checks data entries for the week and sends reminder emails to staff about the amount of data they entered for the week. Monthly HMIS reports are shared at the weekly outreach meeting for review and as a reminder to do timely and complete data entry. We are currently working on improving the number of Current Living Situations (CLS) we enter for our clients, we tend to be better at entering services than the CLS.

2) **Use of Data for Performance Improvement**
   Describe how your agency uses data to evaluate and improve outcomes. Include the key data points or reports that are reviewed, who reviews them, and how the data are used to inform program changes.

Currently we have on our agenda to review our CAPER, services provided, data quality, SOS referrals, CE referrals and program rosters from Clarity at our meetings. We also review Electronic Health Record note completion from rounds, it includes the number of people we see on outreach. The board has requested that we develop 5 "metrics", including leading and process measures for each of our programs. The program circle is to review them monthly and the board will review them quarterly. Our current proposed metrics for this program include clients housed, encounters on outreach, clients with a date of engagement, client services provided and current living situations. Program changes are proposed at our weekly circle meetings as we review the reports. Changes are based on data and observations and tend to be primarily tweaks in process and workflow or changes to locations we do outreach.

3) **Performance Outcomes**

Performance Measure	CDD Target	2022 Outcome	2023 Outcome	2024 Outcome	Proposed Outcome

% of Leavers Exiting to Permanent Destinations	30%	50%	21%	32%	30%
% of Leavers Exiting to Positive Destinations (including shelter and temporary destinations)	60%	41%	32%	22%	Realistically with higher enrollment rates it will be difficult to reach 60%. 40% is probably more realistic, but we will strive for 60%

4) Outcome Analysis

Compare your agency's past performance to CDD targets. Discuss trends and what you think explains your successes or challenges. What changes/strategies do you think could help improve outcomes?

Our leavers exiting to permanent destinations is roughly on track. In 2023 we had some data entry errors due to misunderstanding when people should have a date of engagement. We have since corrected that and in 2024 met the performance measure goals.

For the % of leavers exiting to positive destinations we clearly have work to do. Based on the CAPER and EHH Data Quality report, it seems as we get better at ensuring people are enrolled in our program, the worse our % is, even though we are housing roughly the same amount of people (20-25). Some people exited our program to homelessness because they were accepted at Dairy Drive, which seems like it should be a positive destination, but it wasn't. We could have left them enrolled in both programs but we did not. Some of this also seems related to exiting people because we didn't see them and didn't do an exit interview and then re-enrolling them when they returned to unsheltered homelessness. Some of the lack of follow up also likely occurred due to staff turnover. We will add the exit destination review to our monthly reviews of data. This will be especially important given the change to the 60 day auto-exit.

I am unclear why the EHH report does not match our CAPER which reports this for 2024.

TOTAL	**142**
Total persons exiting to positive housing destinations	35
Total persons exiting to destinations that excluded them from the calculation	1
Percentage of persons exiting to positive housing destinations	24.82%

5) Additional Outcome Measures

List any additional outcomes your agency tracks or proposes to measure.

We have other measurements we track, but they are services based and not outcomes. See question 2.

3. PROGRAM BUDGET (20 POINTS)

1) **Leveraging Medicaid Resources**
   Describe how your agency will utilize Medicaid 1915(i) and/or Comprehensive Community Services (CCS) to support the proposed program. Include:
   - **Specific services or costs for which you expect to seek Medicaid 1915(i) or CCS funding**
   - **A realistic estimate of revenue you expect these sources to generate**
   - **Steps, if any, your agency has already taken to access these funding sources and/or a timeline for securing necessary certifications and training**
   - **Any preparation or infrastructure you think your agency will need to support billing and compliance**

   Note: City-funded emergency shelters and outreach programs selected through this RFP will be required to utilize Medicaid 1915(i) to support eligible services and/or move-in cost assistance. Other program types are not required, but are strongly encouraged to incorporate Medicaid funding strategies where feasible.

Our agency doesn't have the staff qualifications to manage a CCS program, but we are exploring doing that in the next two-three years and currently assist clients through that application process.

We are currently charging 1915i for Dairy Drive Services. We started charging in May ($1500) and have not yet billed for June. We have charged for Consultation and Transition services in May. In June will include Relocation (security deposit, basic home furnishings). In July we will begin charging 1915i for our outreach program. We expect to charge the following in a year for outreach for Consultation and Relocation costs.

	# Clients	Charge	Total
Consultations	60	$84	$5,062
Relocation - Security Deposits	20	$1,282	$25,640
Relocation - Move in Costs	20	$718	$14,360
			$45,062

Relocation costs are reimbursements, so there would be no additional funds for the agency. The Consultations would likely result in about $4,500 for our agency.

Calculating Transition charges is much more difficult. First, because we have limited experience with it. This is our best estimate, if we have 75 clients who have a date of engagement, at this point we would predict that at least 60 would qualify for Medicaid. If we spent one hour a week for half of the 60 clients we would charge approximately $87,000 annually. This would be 10 hours per case manager. When we charge 1915i we then have additional funds for part-time outreach workers.

The second issue is more concerning. Right now, about 85% of our clients qualify for Medicaid and 1915i, but if Trump's work requirements and 6 month redeterminations pass, it could significantly reduce the number of people who qualify. Additionally, we were one of the first agencies to do 1915i but as more agencies start charging 1915i it is likely that we cannot enroll some of our clients because they are already enrolled with other agencies.

2) **Use of Emergency Solutions Grant (ESG) Funds**

Can your agency accept federal ESG funding for this program, either in full or in part? ESG-funded programs must comply with all applicable federal regulations.

XX Yes ☐ No

If yes, identify:

- **Source(s) of required 100% matching funds (cash or in-kind):** We use City GPR dollars as matching funds. We can also use our medical professionals volunteer time as matching dollars.
- **Maximum estimated annual match your agency can provide:** We have about 1700 volunteer hours each year as well as what grants funds would be awarded through this RFP, so it should not be an issue..

3) **Program Budget Form**

Complete the **Program Budget Form (Excel)** for a full program year. Only expenses listed as eligible in Appendix B of the RFP may be included in the funding request to the City of Madison.

4) **Budget Narrative and Clarifications**

Use this section to explain any assumptions, nuances or clarifications needed to fully understand your budget proposal as presented in the Program Budget Form (Excel).

None.

Agency & Program: **Madison Street Medicine - Housing Focused Street Outreach**

ACCOUNT CATEGORY	City of Madison Request Amount	Non-City Sources	Total Program Budget	Budget Details (e.g., Case manager and supervisor wages; $1,000 for application fee; $3,000 for bus passes)
A. PERSONNEL				
Salary	245,000	66,800	311,800	see staffing box ->
Taxes/Benefits	35,000	6,000	41,000	08 taxes and health, dental, vision costs
Subtotal A.	280,000	72,800	352,800	
B. OTHER OPERATING				
Insurance	1,200		1,200	General Liability
Professional Fees	10,000		10,000	Accounting fees
Audit	5,000		5,000	Annual Audit
Postage/Office and Program Supplies			0	
Equipment/Furnishings/Depreciation			0	
Telephone	4,000		4,000	Cell phone costs
Training/Conferences	2,000		2,000	Ryan Dowd Training Fees, Misc. Conferences
Food				
Household Supplies			0	
Auto Allowance/Travel	7,800		7,800	Staff mileage reimbursement
Vehicle Costs/Depreciation	3,000		3,000	Gas and insurance for Box Truck
Other (Specify): HUD 10% Admin costs		22,440	22,440	
Subtotal B.	33,000	22,440	55,440	
C. SPACE				
Office or Facility Rent	20,000		20,000	Office Rent
Utilities			0	
Maintenance			0	
Mortgage Principal/Interest/Depreciation			0	
Property Taxes			0	
Subtotal C.	20,000	0	20,000	
D. SPECIAL COSTS				
Assistance to Individuals - Rent (monthly rent and rent arrears)			0	
Assistance to Individuals - Other Financial Assistance (security deposit, application fee, bus passes, etc.)	17,000			$6,000 cabs, $2,000 bus passes, $2,000 supplies, $5,000 move in costs for non-1915(i) clients, $2,000 application fees and housing documents
Program Subcontracts (Specify):			0	
Other (Specify):				
Other (Specify):			0	
Subtotal D.	17,000	0	0	
TOTAL (A.-D.)	350,000	95,240	428,240	

NOTES:

STAFFING: Include ALL staff working for the program

Staff Position Title	City-Funded FTE	Total FTE, including Non-City	Roles and Responsibilities
Case Managers	2	2	Outreach/Engagement, Case Management/Care Coordination, Housing Search/Placement
Part-time outreach workers	1	2	Outreach/Engagement & Connection to Case Management
Lead Case Manager	1.00	1.00	Co-program management and supervision + case management duties above
Office Manager	0.25	0.25	Donations management, program coordination (schedules, logistics, etc), walk-ins assistance
Executive Director	0.15	0.15	Program Management, Supervision, Financial Management, Technical Expertise