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

F. RAPID REHOUSING

Instructions:
This Program Application form must be completed for each proposed **Rapid Rehousing** 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:	Singles Rapid Rehousing
CDD Funding Request:	$ $230,000

1. PROGRAM DESCRIPTION (30 POINTS)

1) Target population

Describe the population you expect to serve, including:

- **Projected annual number of unduplicated households without children (singles):**
- **Projected annual number of unduplicated households with children (families):**
- **Key characteristics of the target population**

We would like to use these funds to serve unsheltered people who rise to the top of the Coordinated Entry Rapid Rehousing list. However, we are open to working with people in the shelter as well, as we know it will be a high priority to clear shelter beds as quickly as possible. We would like to serve singles. Reimagining Coordinated Entry changes will prioritize people who are newer to homelessness, but homeless over 6 months. So this will be a slightly different population as we typically work with, chronically homeless individuals. We are expecting to serve 10 people. We are starting small as the Rapid Rehousing program is new to Madison Street Medicine but not new to our Executive Director who has run a Rapid Rehousing Program at another agency. We are hoping to apply to other funding sources and expand over the next four years. This grant funding will allow us to get started and develop procedures and policies around Rapid Rehousing so we can expand in the future. We would like to provide housing assistance up to 24 months, but we would like to use true progressive engagement in supporting the client and spending the funds. Budgeting for this type of program is unpredictable, so we will keep a very close eye on funds in the first year to develop our program in a way that best serves the community and the client.

2) **Coordinated Entry and Intake Process**
City-funded Rapid Rehousing programs providing rent or financial assistance must utilize the Dane CoC's Coordinated Entry system. This means informing the Coordinated Entry Manager (currently the Institute for Community Alliances) when there are program openings and accepting referrals from the Coordinated Entry list. Describe how your agency will receive and respond to Coordinated Entry referrals, and what the intake process will look like from the participant's perspective.

Once we get a referral from Coordinated Entry, we will look the client up in Clarity and see what agencies, if any, have worked with the client. We will reach out to any agency that may have worked with the client to get a warm hand off. The client will be introduced to our staff by the agency staff that has been working with them. The client will be told about the rapid rehousing program and given a choice of if they are interested. If they are agreeable, we will ask the client the most convenient way to be in touch with them and when and where would be a convenient place to meet with them. At the first meeting we will complete the elements of the EHH Rapid Rehousing Checklist that are required at that time. The client will be told we need to ask them questions to ensure they are eligible for the program. After determining they qualify, we will work on the initial assessment/housing plan with the client, asking them what they want in housing including location and client preferences for housing. We will also ask them about any concerns or barriers to housing they might be worried about. We will also ask if they expect anyone else to be living with them in the future. We will explore income and opportunities to increase income in the next two years. We will explain progressive engagement and expectations of being actively involved in case management. We will check in with the client periodically and see if they are getting overwhelmed or have questions and we will take breaks and if necessary, stop when needed and arrange for another meeting. Client choice and pace will be key in this interaction and we will check in often to make sure the client is comfortable continuing, however, we will meet with clients at least weekly in the beginning.

3) **Rent or Financial Assistance Provided**
If rental or financial assistance will be provided, describe:
- **The types of assistance (e.g., security deposit, first month rent, monthly rental assistance, monthly utility assistance, rental arears, utility arrears)**
- **Maximum length of financial assistance**
- **Expected average length of financial assistance**
- **Maximum amount of financial assistance, if any**
- **How assistance amounts will be determined using progressive engagement model described in the Dane CoC Written Standards; any proposed payment schedule, including participant and agency portion of rent**
- **Method used to adjust the payment schedule if needed**

We would work with 1915i if eligible for security deposit and move in costs. City funds would be prioritized for up to 24 months of rent and any payments for utility or rent arrears that are preventing a client from getting into housing or 1915i ineligible clients security deposit and move in costs. We will use progressive engagement to gradually pay less and less rent for our clients but be there to back them up if they need additional assistance in any given month. We expect most people will be able to be on their

own in 6 - 12 months. However, we want to reserve the opportunity to pay up to 24 months if needed. We would not have a maximum amount of assistance unless we are running out of funds for the year. Amounts of rent will be determined by talking with the client, assessing their budget and their ability to pay and increase their income. We would likely start with a plan to not be paying rent after 12 months, but we would explain this is plan that can be revisited monthly if needed but no less than quarterly. Rent adjustments will be made based on budget and other needs as well as income fluctuations.

4) **Services Provided**
Describe how the program will support participants in identifying and addressing specific barriers to obtaining and maintaining permanent housing, including housing navigation, connections to healthcare, behavioral health services, long-term case management, and other benefits. Include frequency and duration of services and how services will incorporate best or evidence-based practices.

Best or evidence based practices - Generally speaking, we will incorporate the following principles into this program:

- **Housing First** - our case management will be housing focused, with housing being the primary goal. We center client choice, make sure our services are low barrier and client centered.
- **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.
- **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 this work.
- **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 to understand various cultures.
- **Continuous Improvement through data** - Plan, Do, Study, Act (PDSA) principles from the healthcare field were taught to our HSC community through Built for Zero and Continuous Quality Improvement through data analysis is a principle our board is helping us to 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. This is an example of the type of

work we do. 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.
- **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. We will carry this over into our Rapid Rehousing program and continue with strong harm reduction services, using our Street Medicine principles of meeting people where they are at literally and figuratively and use our healthcare resources to support clients as needed.

Identifying and addressing barriers - As we develop a relationship with the client we will learn more about their background. Through the initial housing plan and participant interest questions we will identify issues the client is concerned about when getting into housing. We will help them walk through typical landlord requirements and see where they might have concerns and match them with landlords that are more likely to accept them initially or through appeal. We will also begin working on the Housing Stability Plan to ensure that we are finding housing where they are more likely to be successful. Once barriers are identified, our case manager will consult with our Executive Director who has nearly 30 years of experience working at the Tenant Resource Center and determine how we can help mitigate those barriers. We will come up with ideas to be explored with the client.

Connections to healthcare - As we are assessing the client and building plans and discussing their goals with the client, if healthcare issues are part of the concerns, we will connect them with our nurse or volunteers to get any immediate needs addressed, connect people to a primary care provider and be an advocate for them as needed. Our nurse can provide care coordination, medication management and more if needed or get them connected to someone who can provide that service for them.

Connections to behavioral health and long-term case management and benefits - We have been building relationships with behavioral health providers and programs. We would use the connections to help connect the client as needed. We would also explore if CCS would be an appropriate fit for them. We also expect if federal proposals pass, we may need to spend time keeping our clients eligible for Medicaid.

Housing Navigation - We are starting small so we can build strong housing navigation skills and resources within our organization. Our Executive Director has nearly 30 years experience working at the

Tenant Resource Center and will help us build expertise in working with landlords and various affordable housing programs. We are also tracking which landlords are renting to our clients and building a database of landlords who we have relationships with. We will rely on our Executive Directors experience to review leases and ensure landlords are not taking advantage of our clients. We would prefer that this work was done collaboratively with other organization and our Executive Director has been trying to work on that for over 10 years, but progress alludes us.

Maintaining permanent housing - We will create a housing stability plan for the client through assessing their past, identifying their strengths and concerns and breaking down large goals to manageable pieces. We will also provide some light tenant education around their lease and expectations. We will emphasize the importance of following landlord rules to get a good reference in the future. If issues arise, we will intervene between the landlord and tenant and provide advocacy and mediation. We also are reserving the right to pay rent up to 24 months in case they fall behind on rent.

5) Staff Training

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

This will be a new program, so we will be able to borrow some from our training for outreach and Dairy Drive, but we will need to develop a new Guide and Wiki for Rapid Rehousing. Our current training does already cover many things that will also transfer to this program. 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, Coordinated Entry, 1915i, finding housing, affordable housing types (PSH, RRH, Section 8, public housing, Section 42, VASH, GPD), case file requirements and why the data is important. We will need to develop case file requirements, written standards, funding source requirements and other items for this program.

For on-going support we have the new guide and "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. We will likely start having case manager meetings for our programs in addition to our Clarity and Housing meetings. Each staff member meets with our Executive Director for a half hour every two weeks to have individual questions answered. While there is only one staff person who will likely be new to Rapid Rehousing, those meetings will likely be extended to an hour. We also plan to do some motivational interviewing training for the entire staff.

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.

6) 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
Rapid Rehousing Case Manager	New	1	1	$28.84	Intakes/Eligibility, Housing Plans, Housing Search and Placement, Housing Stabilization Case Management, Progressive Engagement with Clients, Landlord mediation and advocacy, connections to mainstream resources and financial counseling
Executive Director	Current	.15	.15	$48.07	Program Management, Supervision, Financial Management, Technical Expertise

7) **Implementation Plan** *(for new or expanded programs only)*

Milestone	Target Date
Program staff hired	Jan 1
Program staff onboarding/training completed	Feb 1
First client served	Feb 28
Full-service operation capacity reached	June 30

2. OUTCOME AND PERFORMANCE (20 POINTS)

Select one and complete the appropriate section below:

XX C. New Program With No Past Outcome Data

New Program With No Past Outcome Data

Complete this section if the proposed program is new and does not have historical performance data.

1) **Proposed Outcome**

Proposed outcomes should be ambitious but realistic based on population, service model, and timeline.

Performance Measure	CDD Target	Proposed Outcome
% of Leavers Exiting to Permanent Destinations	90%	90%

% of Leavers Who Exited to PH Returning to Homelessness in Less than 6 Month	≤ 5%	≤ 5%
% of Participants (Stayers and Leavers) Increasing Total Income	60%	60%

2) **Anticipated Challenges and Mitigation Strategies**
   Describe any anticipated challenges in implementing the program or achieving the proposed outcomes. Include how your agency plans to address or mitigate these challenges.

It is difficult to identify what challenges we will have given the reimagined coordinated entry and new population for us. However, we know there will be challenges. The way we address challenges within our organization is to discuss the issues, develop a theory, create a proposal to address it, try it for a period of time and re-evaluate, make changes and repeat. This continuous quality improvement technique has served us well to continue to grow as an organization.

Our biggest concern currently is the unpredictability of the funding needed for the program because we will be fully using progressive engagement. We will develop tracking methodologies and keep a close eye on spending and perform projections to ensure that we are housing the maximum number of people and yet being conservative enough to ensure that we have the funds necessary to keep people in their housing. We are confident that with the help of Common Good Bookkeeping we will be able to build strong financial management tools for the organization so the fluctuations in budget due to progressive engagement are not a deterrent to a strong Rapid Rehousing program.

3) **Additional Outcome Measures**
   List any additional outcomes your agency tracks or proposes to measure.

As mentioned above, we are working on the metrics and we will begin tracking them after 6 - 12 months. Up until that point we will be looking at data monthly to help build our program.

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, yet, but we are exploring doing that in the next two-three years.

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 will bring that experience to this program. At this point we are unable to predict how much we will be able to use this program, but if we can reliably use that to pay for staffing costs, we may ask for a budget amendment to use staffing funds to house additional people. At this point, we don't feel we can rely on that but this grant will help us explore our options.

We are a bit concerned about the national political picture and what it will mean for our clients qualifying for the 1915i program. 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 for Medicaid. 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 enrolled with other agencies. We may end up spending more time getting people their Medicaid benefits restored.

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): City GPR funds and possibly 1915i funds
- Maximum estimated annual match your agency can provide: $ Up to the amount of GPR funds

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).

This is our first foray into the Rapid Rehousing program and we are hoping that we can grow this program over time and these funds will be used to develop the program, policies and procedures. Our Board of Directors has made this one of our priorities at this point. Over the next 4 years we will seek additional funding based on our experience this year. We also need a year to determine if 1915i funds are a good fit with this program. We believe they will be if our clients remain eligible. That may be one of our tasks, to help our clients remain eligible for medicare.

5) ***(New Programs Only)*** **Minimum Viable Funding**

It may not be possible for the City to provide the requested amount of funding. What is the smallest amount of City support that would allow your program to proceed? How would a reduced level of City funding affect operations (e.g., reduced capacity, scope of services, staffing). Be as specific as possible, that is, to what extent would program capacity or staffing levels be affected by lower funding.

The smallest amount of funding we could accept is $115,000. We would be willing to start the program with a half time case manager and serving 5 clients. Again, we just need to get the program started and develop the expertise so we can apply for additional funding and see if the 1915i program is compatible and at what level. We will only know that with experience and more time with the new coordinated entry process.

Agency & Program: **Madison Street Medicine - Singles Rapid Rehousing**

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	75,000		75,000	see descirption in table ->
Taxes/Benefits	10,800		10,800	taxes, health, dental, vision insurance
Subtotal A.	85,800	0	85,800	
B. OTHER OPERATING				
Insurance			0	
Professional Fees	6,000		6,000	bookeeping and CPA serrvices
Audit	5,000		5,000	annual audit
Postage/Office and Program Supplies	500		500	printing, paper, basic supplies
Equipment/Furnishings/Depreciation			0	
Telephone	700		700	cellphone
Training/Conferences	500		500	motivational interviewing training
Food				
Household Supplies	1,000		1,000	for incidental move in costs
Auto Allowance/Travel	5,100		5,100	mileage for staff
Vehicle Costs/Depreciation			0	
Other (Specify):			0	
Subtotal B.	18,800	0	18,800	
C. SPACE				
Office or Facility Rent	3,000		3,000	office rent
Utilities			0	
Maintenance			0	
Mortgage Principal/Interest/Depreciation			0	
Property Taxes			0	
Subtotal C.	3,000	0	3,000	
D. SPECIAL COSTS				
Assistance to Individuals - Rent (monthly rent and rent arrears)	120,000		120,000	Average of $1000/mo for 12 month for 10 clients with more being spent in the
Assistance to Individuals - Other Financial Assistance (security deposit, application fee, bus passes, etc.)	2,400	9,600		$2400 is for bus passes and client security deposits if they don't qualify for 1915i
Program Subcontracts (Specify):			0	
Other (Specify):				
Other (Specify):			0	
Subtotal D.	122,400	9,600	120,000	
TOTAL (A.-D.)	230,000	9,600	227,600	

NOTES:

STAFFING: Include ALL staff working for the program

Staff Position Title	City-Funded FTE	Total FTE, including Non City Sources	Roles and Responsibilities
Rapid Rehousing Case Mar	1	1	Engagement with Clients, Landlord mediation and advocacy, connections to mainstream resources and financial counseling
Executive Director	0.15	0.15	Program Management, Supervision, Financial Managemetn, Technical Expertise