Comprehensive Housing Master Plan

September 21, 2011

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Background

Tri-City

Tri-City Mental Health Center was created in 1960 as the result of a Joint Powers Authority adopted by the cities of Claremont, La Verne and Pomona. It was and remains the mission of Tri-City to deliver comprehensive outpatient mental health services to those in need residing within the three cities.

Tri-City Mental Health Services is governed by a seven member board of Directors consisting of two City Councilmembers from Pomona, one Councilmember each from the cities of Claremont and La Verne, and three members appointed at-large.

Tri-City currently serves a population of 243,000 persons and has a current client base of 979 persons. In fiscal 2010-11 Tri-City served over 1,500 unduplicated clients. Tri-City has 124 full and part-time employees and an annual operating budget of $14 million dollars.

Tri-City provides services from a full service outpatient clinic in addition to services provided under its MHSA CSS programs, including Full Service Partnerships. In addition, Tri-City expects to open its new Wellness Center in October of 2011. The clinic and the soon to open Wellness Center are located on Garey Avenue in Pomona. Tri-City leases space from the City of Claremont to house its administrative offices.

Housing

Tri-City has long understood the important role of housing in the treatment of mental health clients. For many years, Tri-City has provided short term transitional housing for its clients through collaboration with other private and governmental partners, including services and housing provided under the AB 2034 homeless program that was discontinued by the State in July 1, 2007. Until recently, however, Tri-City has lacked the resources to undertake efforts in supplying long-term Permanent Supportive Housing.

It is generally held that successful treatment of mental illness is difficult if not impossible to attain unless the client has the security of stable, safe, and sanitary housing. It is further believed that providing the mentally ill with such housing can significantly reduce the cost of other services such as emergency room visits and incarceration.

Mental Health Services Act

In November of 2004 the voters of California passed Proposition 63 enacting the Mental Health Services act (MHSA) which took effect on January 1, 2005. The MHSA placed a one percent tax on all California individual taxable incomes in excess of $1 million dollars. It was anticipated that MHSA would generate approximately $1 billion dollars annually and that the majority of the funds would be used for outpatient treatment for mental illnesses such as schizophrenia, depression, bi-polar disorder and other psychiatric problems. The act requires that the vast majority of the funds would be apportioned to the State's 58 counties which include Tri-City Mental Health Center.

Although Proposition 63 made no specific provision for housing, in 2007 the State, in collaboration with all the County Directors of Mental Health, agreed that $400 million in MHSA funding would be set aside on a one time basis for Permanent Supportive Housing. It was further agreed that these housing funds were to be allocated to the counties on a per capita basis.

Permanent Supportive Housing

Permanent Supportive Housing, as the name implies, is a living space where the client who is homeless or at-risk of homelessness and suffers from one or more mental illness, may reside for as long as the person pays rent and abides by his or her tenant obligations. In addition to a living space, the tenant is provided the option of receiving a bundle of services designed to aid in his or her stabilization and recovery from their mental illness. Rents charged to eligible individuals are typically restricted to thirty percent of the tenant's income. This limitation on rents requires that a substantial portion of any Housing Project be paid by one or more *outside* funding Sources.

Homelessness

According to a recent report by the California State Senate Office of Oversight and Outcomes, the homeless population in California is estimated at 133,000 of which twenty-five percent are considered to be chronically homeless. Of the chronically homeless, approximately one-third (11,500) are thought to have significant mental illnesses.

Homelessness among the mentally ill is a vicious cycle where these persons lack the income to find suitable stable housing, the lack of which only exacerbates their mental condition, and so on, and so on. Although Tri-City has been successful in providing many clients with emergency

short-term housing, the uncertainty of their housing circumstances undermines their treatment, chances for recovery and ultimately independent living opportunities.

Cost of Permanent Supportive Housing

Although the provision of Permanent Supportive Housing is quite expensive, both from the perspective of capital construction and ongoing operating expenses, in reality it may not be as expensive as it appears. The State Senate Office of Oversight's report quotes various studies which show that most, if not all, of the expense of Permanent Supportive Housing is offset by savings in other public services. The report cites a New York City study which indicated that the per capita annual cost of Permanent Supportive Housing of $17,277 was offset by per capita savings in other public services of $16,281, for a net annual per capita supportive housing cost of only $995. The report also sites a 1999 California study which showed a seventy-two percent drop in hospital stays and an eighty-one percent drop in incarcerations. In addition to reduced demand for other public services the study showed a seventy-seven percent increase in full-time employment among the 951 people who participated in the study.

Mental Health Services Act

The Mental Health Services Act Provides directs funding in four Broad program funding Categories:

1. Community Services and Supports (CSS)
2. Prevention and Early Intervention (PEI)
3. Workforce Education and Training (WET)
4. Innovations

Funding for Permanent Supportive Housing is contained within the Community Services and Supports (hereinafter CSS) component of the MHSA. Tri-City has completed three-year plans and has begun receiving funds for the CSS and PEI components. Tri-City is in the process of preparing three-year plans for the WET and Innovations program areas.

Permanent Supportive Housing Loans

Pursuant to current rules enacted by the Department of Mental Health, all funds designated for Permanent Supportive Housing must be assigned to the California Housing and Finance Agency (CalHFA) where they are placed in a Tri-City Housing Sub-account. Tri-City Housing Funds are invested with the State Treasurer's investment pool, and investment proceeds are credited to Tri-City's Housing Account. Funds in the Housing Sub-account are thereafter used to make long-term, low and deferred interest loans for the development of Permanent Supportive Housing.

Loan Requirements

MHSA loans are underwritten by CalHFA pursuant to loan terms and requirements established by CalHFA. Some of the more important rules are:

- Only those organizations or non-profit developers with a successful track record in providing Permanent Supportive Housing will be approved for loans.
- MHSA loans cannot be made for more than one-third the cost of a Supportive Housing unit, or $112,486, whichever is less. Each year the loan limit increases by four percent.
- Loans are made for a term of up to 57 years. The interest rate of three percent simple interest is collected only from net operating receipts of the project.

- Interest collected from the project is placed in Tri-City's Housing Account at CalHFA.
- Unless otherwise determined by CalHFA, two-thirds of the funds in the Housing Sub-account must be used for new construction or rehabilitation of housing units, while only one-third may be used for rental subsidies.
- CalHFA has granted Tri-City the discretion of using any of its funds assigned to Housing over and above the core housing allocation (agency's share of the MSHA $400 million statewide allocation) for rent subsidy.

Tri-City's Decision to Implement Supportive Housing

Tri-City has long partnered with other agencies and organizations to provide short-term transitional housing to its clients. Until the advent of the Mental Health Services Act, Tri-City lacked the financial resources to facilitate Permanent Supportive Housing. Tri-City believes strongly that the provision of this Housing is an important step in its goal of providing a comprehensive mental health treatment program. Tri-City believes that Permanent Supportive Housing is important for the following reasons:

- Permanent Supportive Housing is an important tool to insure that Tri-City's target population can achieve stability and independent living.
- Permanent Supportive Housing is an important means toward eliminating chronic homelessness of the mentally ill population in the tri-cities and throughout the San Gabriel Valley.
- Permanent supportive Housing will reduce the pressure on, and cost of, other public services such as police calls, Emergency Room visits, incarcerations, etc.

The three year CSS Plan submitted to the Department of Mental Health makes the following references to the need for Permanent Supportive Housing:

- "The objective of assisting clients secure and/or maintain safe Housing."
- "A lack of appropriate housing options for people with mental issue in various stages of recovery."
- "Current estimates of homelessness in the three cities range in the thousands."

- "Data collected through this study reveals that thirty percent of adult clients in short-term housing programs in the San Gabriel Valley reported their previous residence to be another short-term housing program. Similarly, twenty-two percent of adult clients leaving short-term housing programs were discharged into another short-term housing program. The San Gabriel Valley lacks an adequate supply of Permanent Supportive Housing to meet the needs of this sub-population."

- "Housing is often a major barrier to support an individual or family's recovery. We anticipate having a substantial amount of non-recurring funding from FY 2009-10 due to lag times in start-up. Although delegates have not yet developed a plan for these dollars, they have already signaled an interest in devoting a substantial portion of these dollars to augmenting the $2.4 million dollars that is available to Tri-City through the MHSA Housing program."

- "Recommended Outcomes for Full Service Partnerships: Safe and adequate housing including helping them to secure and/or maintain safe housing."

Current Conditions

Tri-City Population and Client Base

According to the California Department of Finance, Tri-City's 2011 population is 215,449 as follows:

Claremont	35,053	16.3%
La Verne	31,153	14.4%
Pomona	149,243	69.3%

The Tri-City population ranks as the 28th most populous of the State's 58 MHSA counties.

As of June 30, 2011 Tri-City had a total of 979 clients as follows:

Claremont	60	6.1%
La Verne	63	6.4%
Pomona	801	81.8%
Other	55	5.1%

As of June 30, 2011 Tri-City's 979 clients fell into the following treatment population categories:

Children	220	22.5%
Transition Age Youth (16-25)	162	16.5%
Adults	509	52.0%
Older Adults (60+)	88	9.0%

Transitional Housing

Tri-City currently collaborates with the City of Pomona and the County of Los Angeles to provide short term housing for its homeless clients.

As a result of these collaborations, temporary transitional housing is provided to 25 clients at any given time. In addition to these efforts, Tri-City has a master lease arrangement with the owner of a five-unit apartment building in Pomona that provides temporary accommodations for an additional ten clients.

Permanent Supportive Housing Resources

Through the MHSA Housing Program Tri-City has received a core allocation of **$2,389,400.** In addition, Tri-City has allocated an additional **$4.5 million** in non-recurring CSS funds bringing Tri-City's commitment to **$6,889,400**. As previously stated, the majority of these funds are held by CalHFA to be used for Permanent Supportive Housing loans and/or rental subsidies. In addition to CSS funds, Tri-City owns a 25,000 square foot land parcel which it intends to utilize for Permanent Supportive Housing efforts.

Tri-City has been recognized by the State as one of the very few counties to supplement their core Housing allocations with discretionary funds. As a result of Tri-City's extraordinary commitment to Permanent Supportive Housing, CalHFA has rewarded it with expanded discretion as to how those funds can be utilized, i.e., for rental subsidies in lieu of capital expenditures.

In order to plan and utilize these Permanent Housing resources, Tri City has hired a part-time Housing Project Manager to coordinate the efforts of existing staff and future housing partners to plan and implement this Housing Master Plan.

The Comprehensive Housing Program

Goals and Objectives

The following represent the overall goals and objectives of the Tri-City Mental Health Center Comprehensive Housing Master Plan:

- To continue and increase the supply of short-term transitional housing units to accommodate new clients and those considered not ready to enter Permanent Supportive Housing.
- To facilitate the construction and/or rehabilitation of **100 units** of Permanent Supportive Housing.
- To provide housing and Supportive Services designed to enable eligible clients to achieve independent and productive living.
- To provide Permanent Supportive Housing to those unable to achieve the transition to living independently in the broader community context.
- To provide quality relevant mental health and other Supportive Services to persons at all stages of treatment.

Target Client Populations

It is the intent of the Comprehensive Housing program to provide Permanent Supportive Housing to the full range of the eligible tenants who are:

- Children who have a serious emotional disturbance and who are homeless or at-risk of being homeless, and their families.
- Transition Aged Youth who have a serious mental illness and who are homeless or at-risk of being homeless.
- Adults and older adults who have a serious mental illness and who are homeless or at-risk of being homeless.
- Veterans who have a serious mental illness and are homeless or at-risk of being homeless.

Desired Permanent Housing Characteristics

It is the goal of Tri-City's Comprehensive Housing program to provide Permanent Supportive Housing that:

- Will effectively serve as an important treatment tool for the maximum number of Tri-City's target population.
- Provides a safe and clean environment for tenants.
- Is attractive and instills a sense of pride in the tenants and portrays an asset to the community in which it is located.
- Is designed to meet the special needs of Tri-City targeted Clients.
- Is well located to meet the need of the tenants.
- Is supported by the appropriate mental health services.

Criteria for Locating Permanent Supportive Housing

The following criteria shall be considered when determining suitable locations for Permanent Supportive Housing:

- The Housing units should be proximate and/or easily accessible to existing Tri-City treatment facilities.
- The Housing units should be proximate and/or easily accessible to medical facilities.
- The Housing units should be proximate to public transportation services.
- The Housing units should be proximate or easily accessible to grocery and other retail shopping establishments.
- The Housing units should be proximate or easily accessible to recreational opportunities.

Housing Unit Types

There are a number of different types of housing that have been utilized in Permanent Supportive Housing programs including:

- Efficiency Units. A single room occupancy in which multiple units share bathroom facilities. These units may be suitable for single individuals, but have an institutional feel to them.
- Studio Apartments. Have a separate sleeping area but do have separate bathroom and kitchen facilities. These units are suitable for single individuals.
- One Bedroom Apartments. These units would be suitable for couples or single parent tenants.
- Two Bedroom Apartments. These units would be suitable for families or as shared units occupied by separate individual tenants.
- Single Family Homes. Single family homes would be appropriate for target families or as shared housing for two or more separate adult tenants.

Housing Unit Types to be Utilized in the Tri-City Housing Program

The County of Orange conducted a survey among various clients and stakeholders (when compiling its MHSA Housing Plan) concerning the features and amenities they considered important in designing Permanent Supportive Housing. The survey ranked seven desirable features of a Permanent Supportive Housing project in their order of importance:

1.	Independence (no roommate)	85%
2.	Freedom to come and go as they please	79%
3.	Privacy	79%
4.	Having one's own personal space	77%
5.	Having one's own bathroom	74%
6.	Having one's own kitchen	66%
7.	Having access to onsite services	55%

Supportive Services

The Orange County client and stakeholder's survey indicated housing linked services deemed desirable included:

- Accessibility to transportation services
- Educational assistance
- Employment training
- Medication assistance
- Housekeeping
- Crisis assistance

While services to be provided to tenants of Permanent Supportive Housing are central to the ultimate success of Tri-City's housing efforts, specific discussion concerning these services will be fully addressed in the Tri-City **Supportive Services Plan** (now under development) and will be a companion of this Comprehensive Housing Master Plan.

Housing Unit Composition

Based upon staff discussion, conversations with successful Permanent Supportive Housing developers, and review of other agency housing programs, it is recommended that:

- The majority of the Permanent Supportive Housing units provided should be one bedroom apartments to accommodate single adult, couples or single parents. It is felt that clients with severe mental illness are not usually good candidates for shared housing and may create a whole set of problems for apartment and support services managers to deal with
- That a smaller number of two bedroom units be developed to accommodate small families or as shared units for separate adults believed to be compatible. MHSA rules require that shared units have lockable bedroom doors.
- That up to six single-family homes be procured and rehabilitated for client families. These homes could also be used for shared housing among separate adults who are deemed advanced in their progress toward wellness and independent living. Again, MHSA regulations require that bedrooms have lockable doors. It is hoped that the

single family homes would be either gifted or acquired at deep discounts from the three member cities under the Neighborhood Stabilization program.

Housing Features and Amenities

Amenities to be included in the design of newly constructed or rehabilitated housing units are as follows:

- All units should have full kitchens.
- All units should have microwave ovens.
- All units must have full baths.
- All units should be air conditioned.
- All units should have cable television and internet access.
- All units must be compliant with the Americans with Disabilities Act requirements.
- All shared units must have lockable bedrooms for each tenant.
- Shared units must demonstrate that kitchens, baths, and personal space are adequate for the number of tenants residing in a unit.
- All units shall be served by on-site laundry facilities.
- All units will be located in accordance with the criteria outlined previously in this Plan.
- Project designs should be non-institutional in feel and blend with, and enhance, the community in which it is located.
- All projects should include security design features such as landscaping, fencing, lighting and security cameras.
- Depending on size and location, projects should contain common space for recreation and on-site provision of Supportive Services.

Unit Sizes

The City of Industry Funds Program establishes minimum unit sizes. Since Industry Funds **mirrors** many other funding source requirements and promises to be an important resource in Tri-City's future housing endeavors, the following **minimum unit sizes** are incorporated as part of this Plan:

- Studio Apartments 400 Square Feet
- One Bedroom Apartments 500 Square Feet
- Two Bedroom Apartments 750 Square Feet

General Affordable vs. MHSA Eligible Housing

It is quite likely that projects sponsored by Tri-City will be mixed projects containing less that 100% of the units occupied by MHSA eligible tenants. The mixed unit concept may not only be necessary from a financial perspective, but also from a clinical perspective.

In order to build a project it will be necessary to obtain funding from a number of governmental sources. Many of the State and Federal funding programs have conflicting goals and requirements. While the MHSA restricts its units to persons with mental illness, many Federal funding sources aimed at providing additional affordable housing units and reducing homelessness do not permit targeting a specific disability such as mental illness. In Permanent Supportive Housing projects which require a" layering" of funding sources, it is often necessary to designate specific units to specific funding sources.

While multiple funding sources may require a mix of tenant types, there is a feeling by many mental health professionals that such a mix is beneficial for the treatment of mentally ill tenants. Many feel that concentrating mentally ill persons in a single complex may amplify and/or reinforce abnormal behavior.

It is therefore recommended as part of this Housing Master Plan that projects consisting of less than 100% MHSA eligible tenants be encouraged as long as the number of MHSA eligible units is proportional to Tri-City's available MHSA funding.

Plan Implementation

Plan Implementation Challenges

There will be many Challenges to implementation of this Housing Master Plan. Some of these challenges include:

- *Cost of Building Housing Units.* Permanent Supportive Housing units are expensive to build. Tri-City staff estimates that the cost of building a Permanent Supportive Housing unit, depending on the price of land, would be somewhere between $175,000 and $200,000. As stated elsewhere in this Plan, MHSA funds may only be used to fund up to one-third the cost of the unit. Therefore the MHSA funds must be heavily leveraged with other local, state or federal funds.

- *Cost of Maintaining and Operating the Projects* (exclusive of Supportive Services). MHSA requires that the maximum rent charged to a tenant cannot exceed thirty percent of income; therefore, the cost of maintenance and operation must be heavily subsidized. Often funding for the construction or rehabilitation of the project is easier to obtain than the ongoing subsidies required maintaining and operating a given project.

- *Site Selection and Potential Community Opposition.* Often special needs permanent housing carries a stigma. Often prime housing locations can arouse a strong fear among neighboring residents and businesses. Often this "not in my back yard" (NIMBY) sentiment can lead to strong political opposition, as well.

- *Reduced Funding for Capital and Operating Expenses.* Economic and political turmoil over the past three years has resulted in reduced funding for Permanent Supportive Housing. Budget problems at the State level have resulted in uncertainty for continued local redevelopment agency funding for housing of all types. The State Multi-Family Housing Program (MHP) funding under Proposition C has been exhausted. Recent budget battles in Washington D.C. threaten to reduce funding under the various Housing Programs offered through The Department of Housing and Community Development such as the Section 811, the Community Development Block Grant, and the Section 8 rent subsidy programs. The Federal Tax Credit Program is likely the primary source of funding for affordable housing and is also under economic and budget pressure.

Community Support and Outreach

Tri-City along with its partners and stakeholders will need to educate the public, as well as, local, state and federal elected officials of the benefits and critical need for an increase in the supply of Permanent Supportive Housing.

Tri-City should attempt to convince the three member Cities to financially support our efforts to increase the supply of Permanent Supportive Housing with contributions of Redevelopment Housing Funds, Community Development Block Grant allocations, and other available funding sources to assist with maintenance and operating expense shortfalls. Project based Section 8 rental subsidy vouchers would make a very significant contribution to the successful development of Permanent Supportive Housing. Similarly, convincing county, state and federal representatives will be necessary to attract the funding necessary to bring this Housing Master Plan to fruition.

In addition to Government funding, efforts should be made to seek funds from the private sector including private non-profit foundations and the local business community.

Drawing on support from Tri-City's partners and stakeholders, an education and outreach effort should be made to obtain the general acceptance of Permanent Supportive Housing and to overcome potential NIMBYs from obstructing project development even when responsible site design and selection criteria are employed.

Identification of Potential Housing Sites

In advancing its Housing Master Plan, Tri-City will definitely attempt to develop Permanent Supportive Housing on property it currently owns adjacent to its clinic. The property is a rectangular parcel and 25,000 square feet in size. It is anticipated that 15 to 20 housing units could be constructed on this site. The site meets all the site selection criteria outlined above and in particular its location immediately adjacent to its largest treatment facility. The current fair market value of the site is estimated to be $500,000 to $600,000.

Tri-City will attempt to gain control of other sites which meet this plans site location criteria. These sites can be either vacant or currently developed. Due to cost of acquisition and demolition, vacant property is preferred. The acquisition of developed property will also be considered if the existing improvements can be economically modified and incorporated into the planned Housing Project.

New Construction vs. Rehabilitation Projects

New housing construction will generally be considered the preferable mode of development since there would be no constraints to the type, number, and design elements desired in a Permanent Supportive Housing Project.

While new construction will generally be preferred, rehabilitation of existing housing projects such as motels or apartment buildings will be considered based upon the location of the facility, its current condition and suitability, as well as, the estimated cost of the rehabilitation work versus new construction costs.

The acquisition and rehabilitation of up to six single family homes for use by family clients and scattered site shared housing will be pursued. Attempts will be made to obtain these units from member cities through the Federal Neighborhood Stabilization Program (NSP) at either no cost or minimal cost.

Existing and Potential Project Funding

Three primary types of funding resources will be required to implement this Housing Master Plan, i.e., Capital, Maintenance and Operations, and Supportive Services. Capital funding will be required to plan and design the project, acquire the site, and construct the project. Maintenance and Operations funding will include lease up activities, project management, utilities, ongoing maintenance activities, as well as, necessary repairs and replacements.

Since tenants of Permanent Supportive Housing are required to pay no more than thirty percent of their incomes toward rent, significant rental subsidies will be needed to fund the gap between rental income and the ongoing cost of Project Maintenance and Operation. For example, the typical tenant will be receiving **Supplemental Security Income (SSI) which is $830.40 per month. resulting in a maximum rent payment of $249.12 per month.** The fair market rent for a one bedroom apartment in the Tri-City area is $1,173.00 per month, requiring a rental subsidy of up to $923.88 per month or $11,086.56 per year.

Existing and potential Capital funding sources include the following:

- MHSA housing fund either held by CalHFA in Tri-City's Housing Sub-account or otherwise allocated to Permanent Supportive Housing currently stands at $6,889,400. All of these funds plus any additional amounts placed in this Sub-account may be used to fund a portion not to exceed one-third the cost of each qualified housing unit created.

- Tri-City Property. The 25,000 square foot lot owned by Tri-City located adjacent to the Tri-City clinic. The estimated value of this property is between $500,000 and $600,000.

- City of Industry Program Funds administered by the Los Angeles County Community Development Commission may be applied for, and if approved, may provide as much as $2 million dollars to be used for Capital construction not to exceed $131,753 for a one bedroom unit.

- County discretionary funds set aside by Supervisors Molina and Antonovich may be used to assist in the construction or rehabilitation of Permanent Supportive Housing units. Approximately $1 million dollars is currently available on a competitive application basis.

- Federal Neighborhood Stabilization (NSP) funds offered through the Housing and Economic Recovery Act of 2008 are available to acquire and rehabilitate foreclosed single-family homes in selected neighborhoods. The City of Pomona has acquired and rehabilitated several of these properties and has an unobligated balance of $1 million dollars in NSP funds.

- Redevelopment Low and Moderate Income Housing funds may be available in an indeterminate amount from each of the three cities to assist in the construction of Permanent Supportive Housing projects. The availability of these funds depends on the outcome of current litigation between Redevelopment Agencies and the State of California. Availability also depends on the willingness of the three cities to allocate some portion of these funds to Tri-City's housing efforts.

- Federal HOME Funds administered through the Pomona Housing Authority could be made available to a Tri-City non-profit development partner also qualifying as a Community Housing Development Organization (CHDO).

- Flexible parking requirements granted by the City would be a valuable Capital resource in that reduced parking ratios would increase building density, reduce construction expenses, and lower the per unit costs of future Supportive Housing Projects.

- Federal and State Tax Credits are available through qualified, experienced non-profit developers of Permanent Supportive Housing. Tax credit financing has traditionally been an extremely important source of funding for affordable Housing Projects.

- Free or discounted and expedited zoning and building fees from the city of Pomona is another significant potential resource that can reduce the cost of developing future Tri-City Supportive Housing Projects.

- Free or discounted property owned by one of our cities is a significant potential Capital funding resource.

Existing and potential sources of funding for Project Maintenance and Operations include:

- MHSA Housing Funds. $5,298,060 of the $6,889,400 allocated to Housing may be used for rental subsidies.

- MHSA Full Service Partnership Program Flex Funds may be used in part to assist program participants with the cost of housing. It is possible that as much as $1 thousand dollars per year, per participant may be allocated to partial rent subsidies.

- HUD Section 8 Project Vouchers. The Section 8 program is the single largest source of rental subsidy funding. Most section 8 funds are granted to individual tenants who may take the funding to any housing that the tenant prefers. A minority portion of Section 8 Funds are issued on a *project basis* and provide rental subsidies to whatever tenants occupy a specific rental Project. Section 8 funds are distributed to tenants or project owners through public housing authorities. In Tri-City's' case, funds are distributed through either the Pomona Housing Authority or the Housing Authority of Los Angeles County. Pomona issues all of its section 8 funding on a tenant basis and currently with 984 vouchers outstanding and a waiting list of 2,000 persons. These vouchers would provide the landlord the difference between thirty percent of the tenant's income and the established fair market rent for the unit being rented.

- Federal Shelter Plus Care Program is another HUD administered funding source. Under this program, permanent rental subsidy vouchers are issued to very low income individual who are homeless with disabilities and reside in supportive housing. Tri-City currently receives 54 tenant-based Shelter Plus Care vouchers through the Pomona Housing Authority. The Pomona Housing Authority has indicated that up to half (27) of these vouchers could be converted to Tri-City Project Based vouchers to be used in a future Permanent Supportive Housing Project. Just as in the section 8 program, the voucher would provide the landlord a payment equal to the difference between thirty percent of the tenant's income and the established fair market rent for the unit being rented.

- Veterans Affairs Supportive Housing Services (VASH) is administered through a partnership of the Housing Authority of the County of Los Angeles (HALCOLA) and the Veterans Affairs Medical Center. VASH vouchers are issued to Homeless veterans with disabilities to reside in Permanent Supportive Housing. Vouchers pay the landlord the difference between thirty percent of the tenant's income and the established fair market rent for the unit being rented.

- Federal Community Block Grant Funds. This is a grant program administered by HUD to fund a variety of community development and housing programs. Since Pomona has a population in excess of 50,000 persons it receives its funds directly from HUD, while funds flow to the cities of Claremont and La Verne through the Los Angeles County Department of Community Development. The three cities use their respective block grants to fund projects and local organizations by way of a competitive application process. Projects and programs are funded on an annual basis.

- The HUD Section 811 program provides Capital and rental subsidies for projects housing very low income person with disabilities. For FY 2010-11, nationally a total of $95.7 million has been fully committed. Funding levels for FY 2011-12 are as yet undetermined, though likely to be lower.

- Private Foundation Funding. Many private foundations and corporations provide funding for Permanent Supportive Housing. It is the intention of Tri-City to explore and apply for this type of funding.

- Local donations should be explored to assist with program development and operation. For example, local hospitals could be approached both on the basis of humanitarianism and on the basis that Permanent Supportive Housing can reduce uncompensated emergency room visits.

Supportive Services Funding

It is anticipated that all costs of Supportive Services to be provided to Permanent Housing tenants would be accommodated from existing Tri-City program funding sources.

Project Partnering

A requirement to securing MHSA housing fund loans is that the borrower must have prior successful experience in developing and managing Permanent and Supportive Housing. Prior development experience is also a requirement of most other funding sources. Since Tri-City

Mental Health Center has no track record in developing this or any other type of housing, it will be necessary that it partner with a non-profit developer(s) with extensive relevant experience.

While partnering will be required, there are several reasons why partnering will benefit Tri-City's Housing Program.

- Tri-City's mission is the delivery of mental health services to its clients. By partnering with an experienced developer, Tri-City can concentrate on its primary objectives without distractions of direct day-to-day involvement in the Housing development and operation.
- Bringing in a development partner increases the likelihood of success due to the partner's experience in the development process.
- A development partner can bring a project to fruition much quicker since the developer will bring with it an experienced development team including architects, engineers and building contractors, and project management.
- The development partner will ultimately take on the financial risk of the project.
- A non-profit developer with experience in creating Permanent Supportive Housing will have better access to certain types of project funding, namely Federal Tax credit financing and private foundation Funding.

Partner Selection

Partner selection process will be as follows:

- Tri-City staff prepares and distributes a Request for Qualification (RFQ).
- Tri-City staff will review RFQ submittals and narrow the responses to the top responders.
- The top RFQ responses will be submitted to a five-person interview panel which shall select the developer it deems to be the most qualified. The interview panel will consist of:
  - One member of the Board of Directors
  - One member from the Delegates Housing Sub-committee

  - One member of the Mental Health Commission
  - One member from NAMI
  - The Director of Clinical Program Services
- The Board of Directors will make the final developer selection.

Partnership Structure

The structure of the partnership and the business points shall be negotiated by Tri-City staff in the form of a memorandum of understanding (MOU) to be reviewed by Tri-City's attorney and approved by the Board of Directors. The MOU will establish the basic partnership structure, as well as, the following roles the perspective the parties will play:

- Establish Tri-City's right to review and approve site plans and building plans.
- Establish a mutually agreeable standard of maintenance and operation.
- Establish a framework for the post construction working relationship between the property manager and the Supportive Services manager.
- Establish Tri-City as the primary Supportive Services provider to the project's tenants.
- Establish Tri-City's right to be the tenant referral agency with regard to any and all MHSA financed/designated housing units, as well as, the maintenance of a tenant waiting list for these same units.
- Establish the extent to which Tri-City will be a financial participant in the project.
- Establish the level of Tri-City's cooperation that will be provided to the developer in obtaining outside funding and various governmental planning and building approvals.
- Establish the degree to which Tri-City will have the right to review project plans and amenities.
- Establish the right of Tri-City to review and approve any property management plan.

The role of the non-profit housing partner in bringing the Project to a reality will include but not necessarily limited to the following:

- Prepare a Project construction and post construction operating budget in sufficient detail to demonstrate the Project's long term financial viability. The budget must identify specific sources of funding. This budget will further specify the specific amount of Tri-City MHSA funding that will be required to make the Project feasible.
- Prepare a detailed Project development schedule.
- Assemble the development team.
- Obtain site control.
- Prepare site plans and building elevations subject to review and approval of Tri-City.
- Apply for all required city zoning entitlements and CEQA clearances. Prepare any special studies or exhibits required to obtain these clearances or entitlements.
- Obtain Article 34 exemption certification from the city.
- Apply for City of Industry Funds plus any rent subsidy vouchers offered in conjunction with this funding.
- Apply for any and all other available funding required to make the Project a reality. Provide any and all information required by the funding organization.
- Take title to the Project.
- Prepare final construction plans and specifications.
- Apply for and obtain all necessary construction permits.
- Commence and oversee Project construction.
- File a final Notification of Project completion.
- Prepare a Maintenance and Operation plan subject to the review and approval of Tri-City. This plan establishes clear standards of Maintenance and Operations and includes remedial measures should these standards not be maintained.
- Enter into a post construction agreement for the long-term Maintenance and Operation of the Project.

- Maintain and operate the Project in accordance with standards established jointly by the developer and Tri-City.

Tri-City's role in the partnership will generally be as follows:

- Provide reasonable assistance to developer in securing outside funding, various planning entitlements, and performance of community outreach activities.
- Develop a Supportive Services Plan acceptable to the Department of Mental Health, or such other state agency that may replace CA DMH, in regulating Permanent Supportive Housing. This Supportive Services Plan will be prepared and submitted in conjunction with this Housing Master Plan and be included in various Project funding applications.
- Undertake marketing of the Project to its clients or other eligible families or individuals.
- Establish and periodically update a tenant waiting list.
- Organize the appropriate mix of onsite and/or offsite Supportive Services to be provided to tenants.
- Appoint a Supportive Services manager/coordinator who maintains a close liaison with the property manager and clinical staff.
- Cooperate with developer in effecting tenant occupancy of the Project.
- Provide Supportive Services.
- Monitor property Maintenance and Operation. Take remedial action should Maintenance and Operation fall below agreed upon standards.

Annual Review of This Plan

This Comprehensive Housing Master Plan is a guide for future action and will undoubtedly require periodic revision to align it with future realities, which cannot with certainty be predicted. Tri-City Mental Health Center recognizes that Housing actually created may differ from that which is described herein. Challenges and/or opportunities may arise that are not currently anticipated. Given the fluid state of local, state and federal budgets, it is impossible to predict with absolute certainty the exact mix of project types, unit sizes, populations to be served, and development costs. The Plan is intended, however, to establish Project preferences and priorities for moving forward in Tri-City's future housing endeavors.

Tri-City's Board of Director, Delegates, Mental Health Commission, and staff will meet throughout the Plan's period of implementation. Periodically, and not less than annually, Tri-City will review the Plan and the housing units created, as well as, those under development. Based upon this review, Tri-City will revise the plan to align with realities of the period.

Attachments

1. Definitions
2. CA Cities Ranked by 01/01/2011 Total Population
3. CA Counties Population Listing
4. Tri-City Demographics Report Dated 07/13/2011
5. Final FY 2011 Fair Market Rents for Los Angeles County *(HUD)*
6. Supplemental Security Income (SSI) in CA – Facts *(Social Security Online)*
7. Article Entitled "Revolving door to gateway," Los Angeles Times 08/28/2011
8. National Coalition for the Homeless – Facts, Published 07/2009

Attachment 1. Definitions

Definitions

The following important terms and acronyms are used in this plan.

Acronyms:

AHP: Affordable Housing Program – a program of the Federal Housing Finance Board to finance the development of affordable housing.

CalHFA: The California Housing Finance Agency.

CS&S: Community Services and Supports, a portion of the Mental Health Services Act funding and planning.

FSP: Full Services Partnership (see below).

GHI: Governor's Homeless Initiative – a program of the State of California to finance the development of affordable housing for persons who have been homeless.

HCA: Orange County Health Care Agency.

MHSA: Mental Health Services Act.

MOU: Memorandum of Understanding – an agreement to work together between two agencies.

MHP: Multi-family Housing Program – a program of the State of California to finance the development of affordable and special needs or supportive housing.

NIMBY: Not In My Back Yard – a term to describe community opposition to siting affordable or special needs housing projects.

NOFA: Notice of Funding Available – a method by which public agencies make funding available for applications from non-profit housing developers or service providers.

OCCS: OC Community Services.

SSI: Supplemental Security Income, a federal disability benefits program.

TAY: Transitional age youth – youth with mental illness between the ages of 16 and 25.

Key Terms (in alphabetical order):

At Risk of Homelessness:
At risk of becoming homeless due to one of the following situations:

(i) Transitional age youth exiting the child welfare or juvenile justice systems.

(ii) Discharge from crisis and transitional residential settings; a hospital, including acute psychiatric hospitals; psychiatric health facilities; skilled nursing facilities with a certified special treatment program for the mentally disordered; and mental health rehabilitation centers.

(iii) Release from city or county jails.

(iv) Temporary placement in a residential care facility upon discharge from (ii) or (iii) above.

(v) Certification by the county mental health director as an individual who has been assessed by and is receiving services from the county mental health department and who has been deemed to be at imminent risk of being homeless.

(Source: MHSA Housing Program Term Sheet)

Adult or Older Adult with Serious Mental Illness:
(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2). *[See definition below for Serious Mental Illness]*

(B) (i) As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.

(ii) For the purposes of this part, "functional impairment" means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.

(C) As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.
(Source: California Welfare and Institutions Code Section 5600.3, b, 3)

Chronically Homeless:
The definition of "chronically homeless" has very recently evolved at the federal level. The reauthorization of the federal homeless assistance programs provided under the McKinney-Vento Homeless Assistance Act of 1987 was signed into law on May 20, 2009 through the passage of the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act and will be implemented over the

next 12 – 18 months. The HEARTH Act expands the definition of "chronically homeless" to mean a homeless individual or family with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years.
(Source: SEC 401 (2): S. 896 - Helping Families Save Their Homes Act of 2009)

Full Service Partnerships:
A mental health program that enters into partnerships with clients, their families and their communities to provide, under client and family direction, whatever it takes to enable people to attain their goals. Under full service partnerships:

- The program agrees to working with the individual and his/her family, as appropriate, to provide all necessary and desired appropriate services and supports in order to assist that person/family in achieving the goals identified in their plan.
- Individuals have an individualized service plan that is person/child-centered, and individuals and their families will be given sufficient information to allow them to make informed choices about the services in which they participate.
- All fully served individuals have a single point of responsibility – Personal Service Coordinators (PSCs) for adults – case managers for children and youth – with a caseload that is low enough so that: (1) their availability to the individual and family is appropriate to their service needs, (2) they are able to provide intensive services and supports when needed, and (3) they can give the individual served and/or family member considerable personal attention. Services must include the ability of PSCs, children's case managers or team members known to the client or family member to respond to clients and family members 24 hours a day, 7 days a week. For transitional age youth, adults and older adults this service must include the ability to respond to landlords and or law enforcement. For children and youth it must include the ability to respond to persons in the community identified by a child's family.
- PSCs/case managers must be culturally competent, and know the community resources of the client's racial ethnic community.
- Services also include linkage to, or provision of, all needed services or benefits as defined by the client and or family in consultation with the PSC/case manager. This includes the capability of increasing or decreasing service intensity as needed
  (Source: California Department of Mental Health, Mental Health Services Act Community Services and Supports, Three Year Program and Expenditure Plan Requirements, August 1, 2005)

Homeless:
Living on the streets or lacking a fixed and regular nighttime residence. This includes living in a shelter, motel or other temporary living situation in which the individual has no tenant rights.
(Source: MHSA Housing Program Term Sheet)

MHSA housing-eligible:
Individuals who meet the following criteria:

(1) Adults or older adults with serious mental illness
(2) Children and youth with severe emotional disorders
(3) In addition to meeting either (1) or (2) above, the individual shall be either homeless or at risk of being homeless.

The county mental health department must certify the eligibility of individuals meeting target population criteria. Individuals who have been certified are MHSA-eligible residents.
(Source: MHSA Housing Program Term Sheet)

MHSA Housing Program:
A program jointly administered by the California Housing Finance Agency (CalHFA) and the Department of Mental Health (DMH) which offers permanent financing and capitalized operating subsidies for the development of permanent supportive housing, including both rental housing and shared housing, to serve persons with serious mental illness who are homeless, or at risk of homelessness.
(Source: MHSA Housing Program Term Sheet)

Serious Mental Illness (SMI):
A mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.
(Source: California Welfare and Institutions Code Section 5600.3, b, 2)

Seriously Emotional Disturbed (SED) Child or Adolescent:
Minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

(Source: California Welfare and Institutions Code Section 5600.3, a,1)

Attachment 2. CA Cities Ranked by 01/01/2011 Total Population

#2

California Cities Ranked by 1/1/2011 Total Population

Rank	City	County	Total Population
1	Los Angeles	Los Angeles	3,810,129
2	San Diego	San Diego	1,311,882
3	San Jose	Santa Clara	958,789
4	San Francisco	San Francisco	812,820
5	Fresno	Fresno	500,121
6	Sacramento	Sacramento	469,566
7	Long Beach	Los Angeles	463,894
8	Oakland	Alameda	392,932
9	Bakersfield	Kern	351,443
10	Anaheim	Orange	341,034
11	Santa Ana	Orange	325,228
12	Riverside	Riverside	306,779
13	Stockton	San Joaquin	293,515
14	Chula Vista	San Diego	246,496
15	Irvine	Orange	219,156
16	Fremont	Alameda	215,711
17	San Bernardino	San Bernardino	211,076
18	Modesto	Stanislaus	202,290
19	Oxnard	Ventura	199,722
20	Fontana	San Bernardino	198,456
21	Moreno Valley	Riverside	195,216
22	Glendale	Los Angeles	192,473
23	Huntington Beach	Orange	190,377
24	Santa Clarita	Los Angeles	176,971
25	Garden Grove	Orange	171,327
26	Santa Rosa	Sonoma	168,856
27	Rancho Cucamonga	San Bernardino	168,181
28	Oceanside	San Diego	168,173
29	Ontario	San Bernardino	165,392
30	Lancaster	Los Angeles	157,795
31	Elk Grove	Sacramento	154,594
32	Corona	Riverside	153,649
33	Palmdale	Los Angeles	153,334
34	Salinas	Monterey	151,219
35	Pomona	Los Angeles	149,243
36	Torrance	Los Angeles	145,927
37	Hayward	Alameda	145,839
38	Escondido	San Diego	145,196
39	Sunnyvale	Santa Clara	141,099
40	Pasadena	Los Angeles	138,915
41	Orange	Orange	136,995
42	Fullerton	Orange	135,574
43	Thousand Oaks	Ventura	127,557
44	Visalia	Tulare	125,770
45	Simi Valley	Ventura	125,026
46	Concord	Contra Costa	122,676
47	Roseville	Placer	120,593
48	Santa Clara	Santa Clara	118,169

California Department of Finance
Demographic Research Unit
Phone: 916-323-4086

2011 City Population Rankings

California Cities Ranked by 1/1/2011 Total Population

Rank	City	County	Total Population
193	San Bruno	San Mateo	41,842
194	Rancho Palos Verdes	Los Angeles	41,766
195	Coachella	Riverside	41,502
196	Rohnert Park	Sonoma	41,194
197	Brea	Orange	40,065
198	La Puente	Los Angeles	39,930
199	San Gabriel	Los Angeles	39,839
200	Campbell	Santa Clara	39,664
201	Calexico	Imperial	39,077
202	Culver City	Los Angeles	38,973
203	Stanton	Orange	38,317
204	Morgan Hill	Santa Clara	38,309
205	Beaumont	Riverside	38,195
206	La Quinta	Riverside	37,836
207	Pacifica	San Mateo	37,526
208	Montclair	San Bernardino	37,031
209	Monrovia	Los Angeles	36,686
210	Los Banos	Merced	36,525
211	Oakley	Contra Costa	35,997
212	Martinez	Contra Costa	35,958
213	Temple City	Los Angeles	35,673
214	Bell	Los Angeles	35,577
215	Manhattan Beach	Los Angeles	35,248
216	Hollister	San Benito	35,165
217	Claremont	Los Angeles	35,053
218	San Juan Capistrano	Orange	34,734
219	Moorpark	Ventura	34,710
220	West Hollywood	Los Angeles	34,636
221	Beverly Hills	Los Angeles	34,210
222	San Dimas	Los Angeles	33,465
223	Dana Point	Orange	33,429
224	Pleasant Hill	Contra Costa	33,279
225	Seaside	Monterey	33,075
226	Lawndale	Los Angeles	32,860
227	Wildomar	Riverside	32,543
228	Menlo Park	San Mateo	32,319
229	Adelanto	San Bernardino	31,671
230	La Verne	Los Angeles	31,153
231	Foster City	San Mateo	30,790
232	Laguna Hills	Orange	30,410
233	Saratoga	Santa Clara	30,195
234	Goleta	Santa Barbara	30,032
235	El Paso De Robles	San Luis Obispo	30,022
236	Banning	Riverside	29,844
237	Los Gatos	Santa Clara	29,651
238	Santa Paula	Ventura	29,531
239	Monterey	Monterey	29,440
240	Walnut	Los Angeles	29,439

California Department of Finance
Demographic Research Unit
Phone: 916-323-4086

Attachment 3. CA Counties Population Listing

CA County Population

Updated 2010

By County		*By Population*	
Alameda	1,574,857	Los Angeles	10,441,080
Alpine	1,189	San Diego	3,224,432
Amador	38,022	Orange	3,166,461
Butte	221,768	Riverside	2,139,535
Calaveras	45,870	San Bernardino	2,073,149
Colusa	22,206	Santa Clara	1,880,876
Contra Costa	1,073,055	Alameda	1,574,857
Del Norte	29,673	Sacramento	1,445,327
El Dorado	182,019	Contra Costa	1,073,055
Fresno	953,761	Fresno	953,761
Glenn	29,434	San Francisco	856,095
Humboldt	133,400	Ventura	844,713
Imperial	183,029	Kern	839,587
Inyo	18,110	San Mateo	754,285
Kern	839,587	San Joaquin	694,293
Kings	156,289	Stanislaus	530,584
Lake	64,053	Sonoma	493,285
Lassen	35,889	Tulare	447,814
Los Angeles	10,441,080	Monterey	435,878
Madera	153,655	Santa Barbara	434,481
Marin	260,651	Solano	427,837
Mariposa	18,192	Placer	347,102
Mendocino	90,289	San Luis Obispo	273,231
Merced	258,495	Santa Cruz	272,201
Modoc	9,777	Marin	260,652
Mono	13,617	Merced	258,495
Monterey	435,878	Butte	221,786
Napa	138,917	Yolo	202,953
Nevada	98,680	Shasta	184,247
Orange	3,166,461	Imperial	183,029
Placer	347,102	El Dorado	182,019

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National Association of Counties

Riverside	2,139,535	Madera	153,655
Sacramento	1,445,327	Napa	138,917
San Benito	58,388	Humboldt	133,400
San Bernardino	2,073,149	Sutter	99,154
San Diego	3,224,432	Nevada	98,680
San Francisco	856,095	Mendocino	90,289
San Joaquin	694,293	Yuba	72,900
San Luis Obispo	273,231	Lake	64,053
San Mateo	754,285	Tehama	63,100
Santa Barbara	434,481	San Benito	58,388
Santa Clara	1,880,876	Tuolumne	56,086
Santa Cruz	272,201	Siskiyou	46,010
Shasta	183,095	Calaveras	45,870
Sierra	3,303	Amador	38,022
Siskiyou	46,010	Lassen	35,889
Solano	427,837	Del Norte	29,673
Sonoma	493,285	Glenn	29,434
Stanislaus	530,584	Colusa	22,206
Sutter	99,154	Plumas	20,428
Tehama	62,100	Mariposa	18,192
Trinity	13,898	Inyo	18,110
Tulare	447,814	Trinity	13,898
Tuolumne	56,086	Mono	13,617
Ventura	844,713	Modoc	9,777
Yolo	202,953	Sierra	3,303
Yuba	73,380	Alpine	1,189

Source: CA Department of Finance

	Black	Mexican Hispanic White	Other	Other Asian	White	Filipino	American Indian	Chinese	Total
CLAREMONT	10 16.7% 4.7%	21 35% 4.3%	2 3.3% 6.5%	3 5% 15.8%	24 40% 11.5%				60 100%
LA VERNE	4 6.3% 1.9%	25 39.7% 5.2%	2 3.2% 6.5%		31 49.2% 14.9%	1 1.6% 12.5%			63 100%
OTHER	16 29.1% 7.4%	15 27.3% 3.1%	4 7.3% 12.9%	1 1.8% 5.3%	15 27.3% 7.2%	1 1.8% 12.5%	2 3.6% 25%	1 1.8% 16.7%	55 100%
POMONA	185 23.1% 86%	423 52.8% 87.4%	23 2.9% 74.2%	15 1.9% 78.9%	138 17.2% 66.3%	6 .7% 75%	6 .7% 75%	5 .6% 83.3%	801 100%
Total	215 22% 100%	484 49.4% 100%	31 3.2% 100%	19 1.9% 100%	208 21.2% 100%	8 .8% 100%	8 .8% 100%	6 .6% 100%	979

Key: Cell Value, Row Percent, Column Percent

Gender By City*

	Female	Male	Total
CLAREMONT	31 51.7% 5.8%	29 48.3% 6.5%	60 100%
LA VERNE	36 57.1% 6.8%	27 42.9% 6%	63 100%
OTHER	21 38.2% 4%	34 61.8% 7.6%	55 100%
POMONA	443 55.3% 83.4%	358 44.7% 79.9%	801 100%
Total	531 54.2% 100%	448 45.8% 100%	979

Key: Cell Value, Row Percent, Column Percent

Age Group By City*

	Adult	Child	Older Adult	Transition Age Youth	Total
CLAREMONT	29 48.3% 5.7%	9 15% 4.1%	12 20% 13.6%	10 16.7% 6.2%	60 100%
LA VERNE	38 60.3% 7.5%	8 12.7% 3.6%	11 17.5% 12.5%	6 9.5% 3.7%	63 100%
OTHER	24 43.6% 4.7%	13 23.6% 5.9%	4 7.3% 4.5%	14 25.5% 8.6%	55 100%
POMONA	418 52.2% 82.1%	190 23.7% 86.4%	61 7.6% 69.3%	132 16.5% 81.5%	801 100%
Total	509 52% 100%	220 22.5% 100%	88 9% 100%	162 16.5% 100%	979

Key: Cell Value, Row Percent, Column Percent

Payor by Cities - Medi-Cal*

	Adult	Child	Older Adult	Transition Age Youth	Total
CLAREMONT	26 51% 6%	9 17.6% 4.5%	6 11.8% 9.2%	10 19.6% 7.1%	51 100%
LA VERNE	32 65.3% 7.4%	8 16.3% 4%	4 8.2% 6.2%	5 10.2% 3.6%	49 100%
OTHER	19 47.5% 4.4%	9 22.5% 4.5%	1 2.5% 1.5%	11 27.5% 7.9%	40 100%
POMONA	356 50.9% 82.2%	176 25.1% 87.1%	54 7.7% 83.1%	114 16.3% 81.4%	700 100%
Total	433 51.5% 100%	202 24% 100%	65 7.7% 100%	140 16.7% 100%	840

**Key: Cell Value, Row Percent, Column Percent*

Payor by Cities - Medicare*

	Adult	Older Adult	Transition Age Youth	Total
CLAREMONT	8 80% 9.5%	2 20% 7.4%		10 100%
LA VERNE	14 82.4% 16.7%	3 17.6% 11.1%		17 100%
OTHER	5 83.3% 6%		1 16.7% 100%	6 100%
POMONA	57 72.2% 67.9%	22 27.8% 81.5%		79 100%
Total	84 75% 100%	27 24.1% 100%	1 .9% 100%	112

**Key: Cell Value, Row Percent, Column Percent*

Payor by Cities - Indigent*

	Adult	Child	Transition Age Youth	Total
OTHER	2 40% 25%	2 40% 25%	1 20% 50%	5 100%
POMONA	6 46.2% 75%	6 46.2% 75%	1 7.7% 50%	13 100%
Total	8 44.4% 100%	8 44.4% 100%	2 11.1% 100%	18

**Key: Cell Value, Row Percent, Column Percent*

Attachment 5. Final FY 2011 Fair Market Rents for Los Angeles County (HUD)

The Final FY 2011 Rents for All Bedroom Sizes

The following table shows the Final FY 2011 FMRs by unit bedrooms. The FMRs for units with different numbers of bedrooms are computed from the ratio of the 2005 Revised Final FMRs (based on 2000 Decennial Census Data) for the different unit sizes to the 2005 2-Bedroom Revised Final FMRs. These Rent Ratios are applied to the Final FY 2011 2-Bedroom FMR to determine the Final FY 2011 FMRs for the different size units.

Final FY 2011 FMRs By Unit Bedrooms					
	Efficiency	One-Bedroom	Two-Bedroom	Three-Bedroom	Four-Bedroom
Final FY 2011 FMR	$973	$1,173	$1,465	$1,967	$2,367

The FMRs for unit sizes larger than four bedrooms are calculated by adding 15 percent to the four bedroom FMR, for each extra bedroom. For example, the FMR for a five bedroom unit is 1.15 times the four bedroom FMR, and the FMR for a six bedroom unit is 1.30 times the four bedroom FMR. FMRs for single-room occupancy units are 0.75 times the zero bedroom (efficiency) FMR.

Data file last updated **Mon., Dec 27, 2010.**

Attachment 6.Supplemental Security Income (SSI) in CA – Facts *(Social Security Online)*

Electronic Fact Sheets

#6

Supplemental Security Income (SSI) In California

SSA Publication No. 05-11125, July 2011 [View .pdf] (En Español)

Contents

What is SSI?

SSI, or Supplemental Security Income, is a federal program that provides monthly cash payments to people in need. SSI is for people who are 65 or older, as well as for blind or disabled people of any age, including children.

To qualify you also must have little or no income and few resources. This means that the value of the things you own must be less than $2,000 if you are single or less than $3,000 if you are married. The value of your home does not count. Usually, the value of your car does not count. And the value of certain other resources, such as a burial plot, may not count either.

To get SSI, you also must apply for any other cash benefits you may be able to get.

You must live in the United States or the Northern Mariana Islands to get SSI. If you are not a U.S. citizen, but you are a resident, you still may be able to get SSI. For more information, ask for *Supplemental Security Income (SSI) For Noncitizens* (Publication No. 05-11051).

The state of California adds money to the federal payment. The single payment you get in the beginning of each month includes both the federal SSI payment and your supplement from California.

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Medical assistance

If you get SSI, you usually can get medical assistance (Medi-Cal) automatically. A separate Medi-Cal application

is not necessary. If you have questions about Medi-Cal, contact your local county welfare office.

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Food stamps

People who get SSI in California **cannot get food stamps** because the state adds money to the federal SSI payment instead.

However, you may be able to get food stamps:

- While you are waiting for a decision on your SSI application;
- If your application for SSI is denied; or
- If you move to another state.

For more information, contact your local county welfare office.

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Other social services

Other services you may be able to get throughyour local county welfare office include:

- A special allowance for assistance dogs for people who are blind or have a disability;
- Certain domestic and personal care services are provided to eligible aged, blind, and disabled persons who cannot perform the services themselves and who cannot safely remain in their own homes unless such services are provided; and
- Protective services.

For more information, contact your local county welfare office.

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Monthly SSI payment amounts

The amounts include both federal and state payments combined. Not all SSI recipients receive the maximum amount. Your payment may be lower if you have other income.

Category	Total monthly payment effective July 2011		
Single people	***Aged***	***Disabled***	***Blind***
Independent living status	$830.40	$830.40	$885.40
	$1,086.00	$1,086.00	$1,086.00

Category	Federal monthly payment effective July 2011		
Single people	***Aged***	***Disabled***	***Blind***
Non-medical out-of-home care			
Independent living status, no cooking facilities	$914.40	$914.40	$674.00
Living in the household of someone else	$609.17	$609.17	$664.17
Disabled minor child		$737.40	
Disabled minor child in household of another		$516.17	
Aged or disabled couples			
Independent living status	$1,407.20		
Non-medical out-of-home care	$2,172.00		
Independent living status, no cooking facilities	$1,575.20		
Living in the household of someone else	$1,075.33		
Blind couples			
Independent living status			$1,554.20
Living in the household of someone else			$1,222.33
Blind person with an aged or disabled spouse			
Independent living status			$1,498.20
Living in the household of someone else			$1,166.33

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Contacting Social Security

Our website is a valuable resource for information about all of Social Security's programs. There are a number of things you can do online.

In addition to using our website, you can call us toll-free at **1-800-772-1213**. We treat all calls confidentially. We can answer specific questions from 7 a.m. to 7 p.m., Monday through Friday. We can provide information by automated phone service 24 hours a day. (You can use our automated response system to tell us a new address or request a replacement Medicare card.) If you are deaf or hard of hearing, you may call our TTY number, **1-800-325-0778**.

Attachment 7. Article Entitled "Revolving door to gateway," Los Angeles Times 08/28/2011

Revolving door to gateway

#7

Agency tries to break the jail-to-street cycle for the mentally ill

STEVE LOPEZ

James Coley can't save all his clients. He can't slay their demons or change the world they live in.

But he goes to work every day and gives it a shot.

On a recent morning in a downtown Los Angeles courtroom, his to-do list was growing fast, the day's challenges lined up bumper to bumper.

The client he was supposed to meet was running late, and he needed to get over to County Jail to check on another client who had threatened to drink Clorox. Then there was a third client he was supposed to take from jail to a housing and treatment program in Pasadena. And he also had to deal with the call he'd just gotten about a fourth client who drank vodka for breakfast and was in trouble at a board-and-care facility.

I had hooked up with Coley because of something the father of Kelly Thomas said to me a few weeks ago. Ron Thomas had said that his 37-year-old son, who died violently in July after a run-in with Fullerton police, was in and out of treatment facilities after being diagnosed with schizophrenia 15 years earlier.

I hear that all the time — in and out of treatment. Thousands of people who fit that description wander the streets of Southern California.

But Marsha Temple, who runs the nonprofit Integrated Recovery Network, says it doesn't have to be that way. A few years ago, Temple, an attorney who once represented hospitals, zeroed in on what she calls the "revolving door between Twin Towers and skid row."

People would land in Los Angeles County Jail because of a crime committed due in large part to a mental illness, hang there for a while, then go back on the street, get into trouble again and land back in jail or prison.

IRFAN KHAN Los Angeles Times

HOPE: James Coley is a caseworker for Integrated Recovery Network, which connects with clients in jail and steers them into therapy, medication and housing.

There was little chance of breaking the cycle because they were pretty much on their own, with no treatment plan and no one looking after them.

"It was shameful," Temple said.

With public and private funding, her agency began connecting with clients while they were still in jail, steering them into therapy, medication and housing and then assigning caseworkers like Coley to check in with them regularly.

Temple's staff now handles nearly 100 clients at a time. Since she began, she said, only 20% have gone back to jail — a success rate three or four times greater than estimates for those who get no such monitoring. The cost works out to roughly $10,000 per client per year, which is far less than the cost of churning people through hospitals and the criminal justice system.

Los Angeles County Supervisor Mark Ridley-Thomas called the recovery network a model program.

"It provides intensive wraparound services, helping with substance abuse issues, mental illness, employment and social skills training, walking people through the system and seeing to it that they do not fail. And they don't let go. They don't cut their clients loose once a program is complete or a problem appears to be solved," Ridley-Thomas said.

No one can say whether Kelly Thomas might be alive if he had been a client in such a program.

As his father told me, Thomas often resisted help, and it can be difficult for family or even professionals to break through to someone who doesn't want treatment, medication or even housing.

But you just keep going back to people like that, Coley told me, and try to develop a trust that will pay off eventually.

The Orange County Board of Supervisors should take note. They responded to the Kelly Thomas tragedy by vowing to look into implementing a controversial state provision, known as Laura's Law, that allows for forced outpatient treatment.

There's no doubt some people need to be ordered by the courts into treatment for their own health and safety, and Los Angeles County makes some use of Laura's Law. But there wouldn't be as great a need for forced treatment — which is no sure-fire approach, and can be as traumatic as it is helpful — if there were adequate intervention, supportive housing and other services to keep people from deteriorating in the first place.

The supervisors would be better off investigating why, despite having the second-highest population of chronically homeless people in California, Orange County has fallen way behind on its 2009 plan to use available Proposition 63 funds for the construction of 185 supportive housing units by 2012.

Or they could take a close look at Temple's program and try the same thing in Orange County.

The day I spent with Coley was typical for him. He was so busy that the transfer of the woman from jail to housing would have to wait.

And after a long delay at the County Jail, it turned out that Coley's desperately ill client had been moved to another facility.

In the courtroom where the day began, his 19-year-old client, a woman with bipolar disorder, showed up and was congratulated by Coley, the city attorney and the commissioner.

She had completed a 120-day stretch in transitional housing and therapy, rather than jail, for a minor crime.

Coley did not let her leave until she told him her plans, and he promised to make a follow-up visit within a week.

The guy who had been drunk was still tipsy when we arrived at the board-and-care home where he lives.

"Why were you drinking?" Coley asked the man, who has multiple mental disorders and has made several suicide attempts.

"Because I'm alone and my life is sad," said the client, who wrapped his arms around Coley and thanked his caseworker for being his savior.

steve.lopez@latimes.com

LOS ANGELES TIMES AUGUST 28 2011

Attachment 8. National Coalition for the Homeless – Facts, Published 07/2009

Mental Illness and Homelessness

Published by the National Coalition for the Homeless, July 2009

PREVALENCE

According to the Substance Abuse and Mental Health Services Administration, 20 to 25% of the homeless population in the United States suffers from some form of severe mental illness. In comparison, only 6% of Americans are severely mentally ill (National Institute of Mental Health, 2009). In a 2008 survey performed by the U.S. Conference of Mayors, 25 cities were asked for the three largest causes of homelessness in their communities. Mental illness was the third largest cause of homelessness for single adults (mentioned by 48% of cities). For homeless families, mental illness was mentioned by 12% of cities as one of the top 3 causes of homelessness.

RELATIONSHIP TO HOMELESSNESS

Serious mental illnesses disrupt people's ability to carry out essential aspects of daily life, such as self care and household management. Mental illnesses may also prevent people from forming and maintaining stable relationships or cause people to misinterpret others' guidance and react irrationally. This often results in pushing away caregivers, family, and friends who may be the force keeping that person from becoming homeless. As a result of these factors and the stresses of living with a mental disorder, people with mentally illnesses are much more likely to become homeless than the general population (Library Index, 2009). A study of people with serious mental illnesses seen by California's public mental health system found that 15% were homeless at least once in a one-year period (Folsom et al., 2005). Patients with schizophrenia or bipolar disorder are particularly vulnerable.

Poor mental health may also affect physical health, especially for people who are homeless. Mental illness may cause people to neglect taking the necessary precautions against disease. When combined with inadequate hygiene due to homelessness, this may lead to physical problems such as respiratory infections, skin diseases, or exposure to tuberculosis or HIV. In addition, half of the mentally ill homeless population in the United States also suffers from substance abuse and dependence (Substance Abuse and Mental Health Services Administration). Minorities, especially African Americans, are over-represented in this group. Some mentally ill people self-medicate using street drugs, which can lead not only to addictions, but also to disease transmission from injection drug use. This combination of mental illness, substance abuse, and poor physical health makes it very difficult for people to obtain employment and residential stability.

POLICY ISSUES

Better mental health services would combat not only mental illness, but homelessness as well. In a survey by the United States Conference of Mayors (2008), 20% of cities listed better coordination with mental health service providers as one of the top three items needed to combat homelessness. Contrary to popular belief, many homeless people with severe mental illnesses are willing to accept treatment and services. Outreach programs are more successful when workers establish a trusting relationship through continued contact with the people they are trying to help.

Even if homeless individuals with mental illnesses are provided with housing, they are unlikely to achieve residential stability and remain off the streets unless they have access to continued treatment and services. Research has shown that supported housing is effective for people with mental illnesses (National Mental

Health Association, 2006). In addition to housing, supported housing programs offer services such as mental health treatment, physical health care, education and employment opportunities, peer support, and daily living and money management skills training. Successful supported housing programs include outreach and engagement workers, a variety of flexible treatment options to choose from, and services to help people reintegrate into their communities (National Mental Health Association, 2006). Homeless people with mental illnesses are more likely to recover and achieve residential stability if they have access to supported housing programs.

Unfortunately, lack of funding is a significant barrier to the successful implementation of supported housing programs. Funding is available from various programs run by the United States Department of Housing and Urban Development, as well as from the Projects for Assistance in Transition from Homelessness (PATH). Additionally, the United States Congress passed the American Recovery and Reinvestment Act (ARRA) in February 2009, which includes $1.5 billion for homelessness prevention and re-housing (National Alliance to End Homelessness, 2009). However, there are still not enough resources to provide adequate services to the homeless population and those at risk for homelessness. Efforts need to be made to ensure that these funds are used appropriately, efficiently, and in ways that will most effectively help the mentally ill homeless population.

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Supportive Services Plan

Overview

In Conjunction With

Comprehensive Housing Master Plan

September 21, 2011

Tri-City's Comprehensive Housing Master Plan proposes to bring Permanent Supportive Housing to those tri-cities residents who are homeless or at risk of homelessness, and are suffering from one or more mental health conditions. The main goal of the Supportive Services portion of the Housing Master Plan is to help clients retain long term housing.

In November of 2010, a Housing Sub-committee comprised of MHSA delegates and Tri-City Clinical Staff met twice and designed a framework to support this goal. The Sub-committee agreed that in order to be successful, the Housing and Supportive Services Plan must be founded upon the principles of the Recovery Model. Specifically, the Sub-committee decided that the Housing options and Supportive Services designed must be flexible enough to accommodate an individualized approach that aims to eliminate those barriers that historically interferes in the retention of stable housing for persons suffering with mental illness, and their families. Moreover, they agreed that the long term goal of retaining housing over time will only be achieved through adherence to the Recovery principle that "recovery is possible" and the conscientious planning of services to ultimately promote self-sufficiency, not just emotional and behavioral stability.

The Sub-committee further decided that while Permanent Supportive Housing programs for the mentally ill most often target single young adults, adults, and older adults, the Tri-City's Permanent Supportive Housing should include Housing options for the growing number of families who are homeless or repeatedly at-risk of homelessness as a result of the significant challenges presented by living with a loved one struggling with mental illness. Therefore, the target populations to be served in Tri-City's Permanent Supportive Housing will be individuals of any age suffering with a diagnosed mental illness that is significantly impairing functioning in some manner, including the ability to obtain or sustain stable housing.

Potential tenants will be identified for participation based upon referrals from persons accessing our Walk-In / Inquiry services, the Community Navigators, NAMI and other community partners. Persons may be seeking outpatient or the more intensive Full-Service Partnership services, or accessing the support and programs offered at the Tri-City Wellness Center. The purpose of the MHSA Housing Program is to address Housing first, which means that while persons applying for tenancy must meet the criteria to be enrolled in our mental health services including having one or more mental health diagnoses and experiencing some functional impairment in their lives, they are not required to actively participate in any of the Supportive Services offered.

Additionally, in keeping with Tri-City's vision to build a system of care, Permanent Supportive Housing will also be available to persons receiving mental health services from agency partners in our local area.

The barriers to long term stable housing includes the lack of access to appropriate mental health treatment, substance abuse/addiction, complex and untreated medical issues, incomplete education, deficient vocational skills and/or job experience, and the lack of a positive social support network. Given the wide range of barriers to be addressed, Tri-City will seek to actively engage and collaborate with a variety of community partners in order to meet all of the needs of those clients placed in Permanent Supportive Housing. Such partners will include the:

- Primary care community
- Substance abuse treatment community
- Local schools / colleges / technical training programs
- Local businesses
- Local landlords and property management companies
- Other locally operating mental health service providers

Tri-City will seek to address these barriers through an array of Supportive Services offered through the Full-Service Partnerships, the Outpatient Treatment Clinics and the Wellness Center. Services that Tri-City will directly provide include:

- Clinical assessment
- Individual, group and family therapy
- Rehabilitation services / skills building
- Case management
- Medication support
- Informal support groups
- Socialization activities

- Employment services
- Benefit services
- Housing assistance

The services provided to those residing in Tri-City's Permanent Supportive Housing will be offered on-site, as well as, off-site. Contacts may be one-to-one in conjunction with significant others in the resident's life or, group learning situations.

While the exact nature of the service to be provided and the frequency with which services will be provided will be determined by the individual needs of each resident, contact will occur at least once a week. Recognizing that some residents may be slow to trust and accept services aside from housing, one-to-one engagement may simply begin with the use of a telephone call or providing transportation.

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