Rural Housing Toolkit
Money Follows the Person

MFP's Rural Housing Toolkit offers practical advice that can be used to help Medicaid-eligible people leave institutions and return to their rural and frontier homes.

Table of Contents: *Rural Housing Tool Kit*

EXECUTIVE SUMMARY

Money Follows the Person (MFP) Demonstration projects across the country say that the biggest obstacle to successful transition is the lack of affordable, accessible housing. When someone chooses to use self determination to return home to a tiny community out in the middle of nowhere, the problem can seem exponentially more difficult. Coupled with lack of housing, there is typically a lack of formal services and limited (if any) public transportation. This toolkit provides concrete resources that can help MFP providers, directors, outreach workers, and transition and housing coordinators identify and access the resources they need to help people leave institutional care and return to their rural communities.

If this sounds too good to be true, it isn't. Rural MFP practitioners all over the country are helping people move home to rural and frontier communities every day. They manage this by overcoming one obstacle at a time, transition by transition, and community by community. The strategies in this toolkit will become increasingly important as the MFP Demonstration project grows: 80 percent of America is still rural, a huge area that about one in five Americans call home. This toolkit was written for the MFP programs that are increasingly being called to help people return home to their rural homes. Each chapter of this toolkit provides strategies, tips, tools, resources, and examples of exactly how you can make these transitions happen.

EXECUTIVE SUMMARY

The Executive Summary provides a roadmap to this toolkit.

- Each chapter begins with an introduction, and includes a set of basic objectives.

- Practical explanations, nuggets of information, insights on how the information can be used, stories, and step-by-step instructions are clearly marked throughout the toolkit.

- You do not need to read and digest this toolkit from beginning to end: skip right to the parts you need today.

Chapter Summaries

Introduction: *How to use this Toolkit*

The Introduction provides a brief description of the toolkit and a key to the "what to watch for" icons that are used throughout the text. The icons are brightly colored and meant to draw the reader's attention to specific kinds of information. These include the *Learning Objectives* at the beginning of each chapter; *Takeaways* (practical nuggets, explanations, or implications); *So What?* (insights on why the information is important and how it can be used); *Theory into Practice* (opportunities to learn by doing and/or examples from the field); and *Additional Information* (resources, links, suggested or additional reading).

Chapter One: *Overview*

This chapter establishes a frame of reference for the terms "rural" and "frontier" as they are used in this toolkit, and articulates why it is useful to understand these settings in context with the MFP service area. This chapter also provides practical tools that can be used to determine how much of a state or county is considered rural or frontier. The "So What" section of this chapter explains what the implications are and articulates why it will be important for MFP providers to begin considering how to transition MFP participants to the rural areas of their states. For example, did you know that the rate of growth for seniors living in rural areas has tripled since the 1990s?

Chapter Two: *Home on the Range*

Becoming culturally competent is a critical component of success in rural and frontier transitions. This chapter provides insights into understanding the unique cultures of small communities and provides MFP practitioners with tools to determine whether or not a community could be a good fit for MFP. These tools can help you gain a basic understanding of an area that an MFP participant wishes to relocate to – without leaving your desk. This chapter shows you how to decode an area's demographics and where to begin looking for housing. There are also strategies for asset mapping that will help you identify resources at the community and individual levels.

Chapter Three: *MFP in Rural States*

Implementing MFP in rural and frontier states requires ingenuity and adaptation, which has led to creative strategies that vary from state to state. MFP directors and staff members have generously shared the ways they meet the needs of clients who wish to transition to rural communities. This chapter highlights some of the many ways rural MFP states have managed to ensure successful MFP transitions.

Chapter Four: *Rural Housing Solutions*

Housing resources for rural areas might be more readily available than you think. In fact, some opportunities are available *only* to rural areas. This chapter shares information about sources of funding for rehabilitation, repair, housing development, and capacity building, as well as some innovations that are working well in rural communities. Conventional housing resources such as the Department of Housing and Urban Development (HUD) HOME, Community Development Block Grant (CDBG) and the Low Income Housing Tax Credit (LIHTC) program are not included in great detail in this toolkit. Instead, these resources presented here are some you might be able to use to improve housing in the rural communities you serve.

Chapter Five: *Cross Pollination*

Have you ever considered looking across service sectors to see how other kinds of programs solve problems similar to the ones your MFP project is facing? Many creative, federal and non-federal strategies are being used to great effect in rural and frontier areas. Some are geared to increasing the supply of safe, accessible housing for people in poverty (including those with disabilities and the elderly). Others hinge on forming unique partnerships to ensure people can remain independent within their communities. We hope the ideas in this chapter will lead to at least one "*AHA"* moment for readers.

Sources Cited

This isn't your typical "Sources Cited" section. This section is chock full of links to the resources we used to create this toolkit. If you want to know more, these links are terrific jumping-off points.

Appendices

More tools are included as appendices. These include a sample self-sufficiency matrix, and a transportation decision tree. Use these tools as they are – or use them as a jumping off point to create your own. There is also a list of the contributors to the Rural Housing Tool Kit, with contact information for follow-up.

Acknowledgements

With gratitude:

- for the support and guidance of the New Editions Consulting, Inc. staff, including Ellen Speckman-Randall, Anna Lenhart, and Stephanie Mensh; and
- the generosity of all of the MFP directors, outreach staff, transition and housing staff, consultants, and direct service providers who shared their hard-won lessons.

INTRODUCTION: *How to use this Toolkit*

This toolkit was designed to be as useful as possible for a range of busy professionals, from state MFP directors and legislators to transition planners, housing coordinators, and outreach workers. The common theme is an interest in expanding the reach of the MFP program to rural and frontier areas. This is not a report, though it will include facts. This is not a narrative, though vignettes and stories will be used as illustrations from time to time.

MFP offers Medicaid-enrolled people real options to transition out of institutions, while retaining the Medicaid supports needed to remain independent. But what if someone is determined to return home to a small, rural community where there are few services, and even fewer options? The *Rural Housing Toolkit* was designed to provide the practical takeaways needed to make that happen.

The Toolkit offers tips on actualizing, implementing, and translating MFP to frontier and rural environments. There will be case examples from areas that have had success with implementing MFP in less populated areas, and a look at how different states have brought Medicaid to bear on the needs of people who wish to leave institutions and return to rural and frontier communities. This toolkit should not gather dust on a shelf. It is filled with practical tools that providers can use on the ground, including checklists, decision trees, and action steps that can be used at state, community, and individual levels.

What to watch for

Learning Objectives	*Learning Objectives* are front and center at the beginning of each chapter. They detail the skills a reader can expect to acquire from the chapter.
Takeaways	*Takeaways* offer nuggets of information, practical explanations, summaries, or inferences.
So What?	*So What* sections provide insight on how information can be used, or why it may be useful. These sections offer application suggestions, and tips from the field for transitioning MFP participants to their rural homes.
Theory into Practice	*Theory into Practice* sections provide opportunities to "learn by doing." These sections offer problem-solving opportunities, or step-by-step guides to application. They may take the form of checklists, decision trees, action steps, or exercises.
Additional Information	*Additional Information* is offered at the end of most chapters, and includes resources, links, suggested or additional reading.

CHAPTER ONE: *Overview*

Many people coming from isolated, sparsely populated areas have deep roots – strong connections to land, home, and community. Many have ties that span multiple generations, while others have recently moved to the country to enhance their quality of life. Living in rural America can be a dream come true … until something happens to undermine self-sufficiency. Then the very qualities that have been the biggest draws – privacy to enjoy the peaceful quiet, beautiful scenery, wildlife, and acres of land – can become formidable obstacles. The more isolated the community or the home, the more difficult it is to overcome these obstacles.

Understanding the Language: Frontier and Rural America

There are many definitions of "rural" and "frontier." These and other terms are used to delineate distinctions, and can hinge on such factors as population density or proximity to a population center. Ultimately, though, these are such inexact terms that people sometimes joke while "rural" is hard to define, like art, they know it when they see it. It might be more accurate to say that people know it when they *don't* see it – "it" being traffic, stores, hospitals, clinics, bus systems, and service providers. If population density is portrayed as a continuum, then dense urban centers would be to the far left, echoed by frontier (often defined as fewer than six persons per square mile) on the far right. Somewhere to the right of center, rurality starts, but the variations in what that means can be extreme.

CHAPTER ONE LEARNING OBJECTIVES

After reading Chapter One, readers will be able to:

- Identify basic distinctions between rural and frontier settings.

- Identify rural and frontier areas in their states or regions.

- Articulate why it is useful to understand rural and frontier settings in context with their state, region, or service area.

What might seem simple at first glance becomes complex very quickly. Trying to carve out common ground for definitions of "rural" and "frontier" is not easy. According to Ricketts, et. al., (1998), identifying areas as *urban*, *rural*, or *frontier* is an ongoing problem for policymakers. There are more than 15 federal definitions of "rural," used for a variety of purposes. The most widely used definitions come from the Department of the Census and the Office of Management and Budget (Coburn, et. al., 2007).

In general, the Census Bureau uses "rural" to describe areas with small populations or unincorporated areas with population densities of less than 1,000 persons per square mile. "Frontier" usually equates to fewer than six persons per square mile. Clearly, there is a lot of difference between the frontier on one hand, and a rural area that is home to 999 people per square mile on the other, with hundreds of variations between. Therein lie some of the difficulty in establishing clarity about the terms.

Takeaway There is no single, universally preferred definition of "rural" that serves all policy purposes (Coburn, et. al., 2007). Each definition has advantages and disadvantages, and combining definitions with key demographic, economic, or health care characteristics allows policymakers to target policies and programs to meet specific needs (Coburn et. al., 2007)

So What? Common misperceptions can lead policymakers and program directors to discount the importance of rural and frontier issues. Rural and frontier America is not limited to the far Northwest and Alaska, as many people think. There are rural and frontier areas in virtually every state. Many of the states that currently have MFP Programs include large stretches and isolated pockets of rural and frontier lands.

- The *frontier,* which is used in this toolkit to describe areas with extremely low population densities, are home to 4 percent of all Americans, and yet cover 56 percent of the United States (Rural Assistance Center, 2012).
- Approximately 62 million people – nearly one in five Americans – live in rural and frontier areas (American Journal of Clinical Medicine, 2012).
- Geographically, rural Americans reside in 80 percent of the U.S., but comprise only 20 percent of the U.S. population (American Journal of Clinical Medicine, 2012).

MFP could play a particularly important role in frontier and rural areas, given that rural and frontier residents tend to be older, poorer, and to have poorer health outcomes.

Urban ← → **Rural** **Frontier**

Theory into Practice

There are several ways to determine how much of your state or county is rural or if it meets the frontier definition of six or fewer persons per square mile.

- For Census information about your state, go to the U.S. Census Bureau's *State and County Quick Facts:* http://quickfacts.census.gov/qfd/. Select a state. Additional information is also available by county or city. Scroll to the bottom of the fact sheet to find data labeled, "Persons per Square Mile."

- Go to the Rural Health Research Center (RUCA) at http://depts.washington.edu/uwruca/.
  - *Data* makes ZIP code-level RUCA files available.
  - *Maps* provides access to two versions of ZIP code-level RUCA categorizations.
    - The four category classification aggregates 33 RUCA codes into four categories: *Urban, Large Rural, Small Rural,* and *Isolated*.
    - The seven category classification aggregates data into seven categories, including *Urban Core, Other Urban, Large Rural Core, Small Rural Core, Other Small Rural*, and *Isolated Rural.*

It is relatively simple to find the rural and isolated areas in a state. Go to: http://depts.washington.edu/uwruca/, and click on *Maps*. Choose the 7-catgegory classification, then a state.

| Urbanized | Other Urban | Large Rural Core | Other Large Rural | Small Rural Core | Other Small Rural | Isolated Rural |
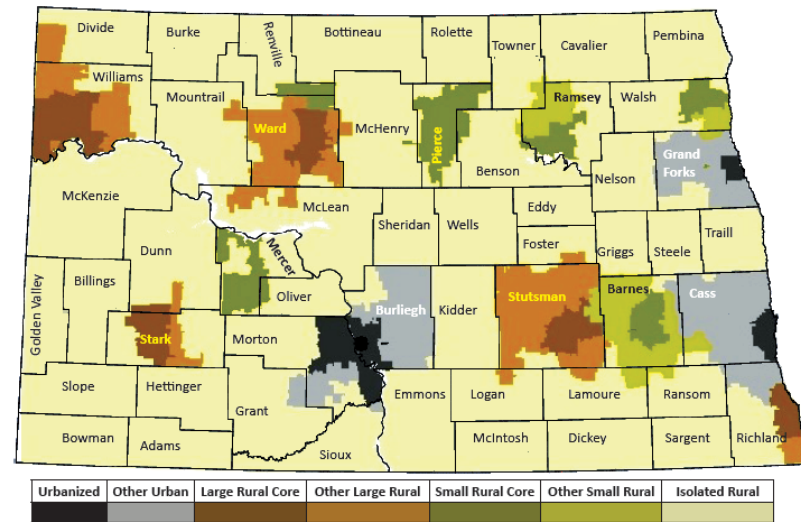
Above, as an example, is the population density map of North Dakota, taken from the Rural Health Research Center noted above. For this example, the RUCA map was overlaid with a county map. The pale beige areas represent isolated rural (synonymous with frontier). In this example, it is clear that while North Dakota is home to an *average* of 9.9 persons per square mile, the majority are clustered in three urbanized and other urban (black and grey) areas, large rural cores (dark brown), and other large rural areas (lighter brown). Many counties are isolated rural (or frontier), and have far lower population densities. This is consistent with the population distribution in many states.

Find your state at http://depts.washington.edu/uwruca/ and identify rural and isolated rural areas. How likely are you to transition your MFP clients to these areas?

Additional Information

Rural and frontier experts from around the nation developed a weighted matrix to define frontier areas that they dubbed the *Consensus Definition*, (1997, updated 2007). The matrix provides a simple way to determine frontier status based on three key factors: population density, distance in miles and travel time in minutes to the nearest service/market area. The matrix is available online at: www.frontierus.org/documents/consensus2007update.pdf

More Resources

- The *Rural Assistance Center* offers a range of information on rural health and human services. (http://www.raconline.org/)
- The *Rural Health Research Gateway* provides access to publications and projects funded through the federal Office of Rural Health Policy (ORHP) as part of the Rural Health Research Centers and Analysis Initiatives grant program. (http://www.ruralhealthresearch.org/)
  - The *Gateway* provides links to seven rural health research centers. All offer excellent and unduplicated resources. The centers are located in Maine, North Carolina, North Dakota, South Carolina, Minnesota, Iowa, and Washington, but their research, projects, and information are national in scope. All can be accessed at: http://www.ruralhealthresearch.org/centers.php.

So What?

According to the National Conference of State Legislators (2012):

- *The rate of growth for seniors living in rural areas has tripled since the 1990s,* and if the 80 million baby boomers living in the United States continue to follow these migration patterns, the rural population of people aged 55 to 75 will increase 30 percent between 2010 and 2020.
- The fastest growing segment of the population – aged 85+ – is expected to grow from 4 million in 2000 to 21 million by 2050. Based upon current migration patterns, much of the growth will be concentrated in rural areas.
- Approximately 15.4 percent of rural residents live in poverty compared with 11.9 percent of urban residents.
- As a result of the Affordable Care Act (ACA), an estimated five million *more* rural Americans (16 percent) will have health insurance coverage by 2019, either by way of a health insurance exchange or Medicaid.
- Rural elders are more often disabled and diagnosed with more severe occupation-related illnesses than those found among urban residents. Chronic conditions are more prevalent in rural areas.

CHAPTER TWO: *Home on the Range*

In rural and frontier areas, the nearest small town – and sometimes the nearest neighbor – can be miles away. Coverage for such services such as Meals on Wheels, when they are available, rarely extends beyond city limits. Quality home-based services can be hard to guarantee in sparsely populated areas because of the general lack of direct service providers. Service areas tend to be huge, with long distances between clients and providers. If there *is* public transportation – which is rare – it has limited routes or intermittent schedules. Seasonal conditions can make traveling treacherous or impossible. Many rural areas are Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs). By definition, these areas – in addition to meeting other criteria – are served by primary medical care professionals who are "over-utilized, distant, or inaccessible" (HRSA, 2012). Widespread, intergenerational poverty is common, as is the attitude of fierce independence.

Transition planners, housing coordinators, and program directors need to be clear about the obstacles that go hand-in-hand with transitioning someone to a rural area, where it often requires creative solutions to make the MFP program succeed. It also requires an understanding of the rural/frontier culture, flexibility, a willingness to negotiate, an ability to see beyond the veneer of poverty to possibilities, and a talent for building and maintaining relationships. A sense of humor and a wide stubborn streak can also be assets in this work.

CHAPTER TWO LEARNING OBJECTIVES

After reading Chapter Two, readers will be able to:

- Demonstrate cultural competence in rural and frontier communities.

- Articulate ways MFP could be an important resource for the frontier and rural areas in their states or regions.

- Identify pockets of potential need using demographic data.

- Identify housing issues using HUD data.

- Identify potential partners using asset mapping.

Cultural Competence

Rural cultures vary dramatically, based on history, ethnicity, geography, age of the population, whether the population is static or evolving, degree of isolation, level of poverty or affluence, predominant industries, and many other factors. While rural and frontier communities do share some commonalities, the reality is rarely consistent with the romantic ideal of rural America. The myths evoke Andy's Mayberry, replete with fresh air, clean streams, friendly neighbors, healthy eating, and a safe, pastoral life (Morgan and Reed, 2003). Living in an isolated area where the next home is three miles away would seem like an ironclad guarantee of privacy. Unfortunately, in many cases, these perceptions couldn't be further from the truth.

Rural and frontier communities experience virtually all of the maladies of urban areas, but can be even more insular and – in some cases – even more dangerous. Deep poverty can make communities vulnerable to undesirable sources of income, such as the manufacture of illegal drugs. High rates of untreated drug and alcohol disorders coupled with a culture that accepts gun ownership as the norm can lead to dangerously explosive situations. Many rural counties are largely comprised of federal lands, a situation that equates with a tax base insufficient to provide needed services. These realities, coupled with a lack of connection to statewide decision-makers, often culminate in a strong distrust of outsiders, especially those coming in from "the city" to make changes, issue demands, or apply policy.

To know one rural or frontier community is to know *one* rural or frontier community. Cultural norms, beliefs and values look very different in a rural West Virginia coal mining community where residents share a Scots-Irish or Welsh heritage than they do in a Pennsylvanian Dutch-German farming community. Isolation, rising from cultural and geographical remoteness, often creates and sustains fierce independence (Yellowlees, Marks, Hilty, and Shore, 2008). Many rural and frontier communities choose to limit their access to the broader world views that could lend perspective to their culture.

The most important components of cultural competence in rural and frontier communities rise from awareness of – and interest in – the unique history, values and culture specific to each community. It is also important to recognize that cultures can vary dramatically, even between communities that are just an hour apart. Critical to success are attitudes of respect, openness, willingness to listen, and awareness that it takes time to earn trust and respect.

So What? The unique culture of each frontier and rural community needs to be acknowledged and honored. It is singularly important for people going in from the "outside" to be aware of their *own* values and to maintain an attitude of humility and respect for the people who live there.

It's not what you say…it's *how* you say it

As stated, rural and frontier areas are *not* homogenous. Traditions, backgrounds, cultures, and ethnic identities vary dramatically. Each small community has its own cultural milieu that includes a shared context, set of perceptions and understandings and a view of "how we do things around here" (Alegria, Atkins, Farmer, Slaton, Stelk, 2010).

Helping someone transition back into a small community will require an attitude of cooperation and respect. Many people who have spent their lives in small towns and frontier communities have been forced to deal with people coming in with a take-charge, "big-city attitude." It is not necessarily *what* but rather *how* something is said that can cause offense.

Media often portrays people who live in the country as somehow less intelligent, educated, serious, or ambitious. This urban bias couldn't be further from the truth, but people can be very sensitive to perceived slights from outsiders. People may pull away from strangers at the first hint of condescension…for any language that smacks of *hayseed versus city slicker, or my new car versus your old truck.* Making demands and quoting law or policy are not only ineffective, they're the first step to creating adversarial relationships and permanently closing doors. It can be extremely difficult to "mend fences" once broken in these environments.

Takeaways

- It's best to go slowly, and to start from an attitude of cooperation. Find common ground. Ask, *"How can we make this happen?"*

- As in any culture, there are unwritten rules. The only way to learn them is to carefully listen and observe, build relationships, and learn local customs. When in doubt, *ask.*

- It can help to find the informal "town center" where everyone gathers. That might be a café or the post office, a certain coffee shop, or the senior center.

- Recognize your "outsider" status. It takes time to earn trust and to become part of the community.

- Gaining a sponsor or mentor who is a trusted insider can be very helpful.

- Be careful not to judge. Housing may not "look" the same as it does in a larger community. There may be fewer apartments, and people may own their homes. Some of those homes would not meet Housing Quality Standards (HQS) in a more urban environment.

Consider George.[1] *At 78, George was moved to a rural nursing home 40 miles from the only home he had ever known. Adult Protective Services had gotten involved when George fell on his porch and couldn't get up. When the ambulance arrived, George was confused and nearly incoherent. No one knew how long he'd been lying there, because no one had been checking in on him regularly.*

A combination of health issues had limited George's ability to care for himself. He struggled with Type II Diabetes, Parkinson's Disease, bladder incontinence, and bipolar disorder. The diabetes caused open, slow-healing sores on George's right foot. The Parkinson's left him with a tremor and sometimes made it difficult for him to keep his balance. But after spending a few months in the nursing home, his issues seemed to be under control and he started talking about going home.

Staying in a nursing home had been painfully difficult for George. Like many rural Americans, he is fiercely independent and distrustful of federal programs. George owned his home, and talked nonstop about it. He told about the things he missed there…pictures of his family, his comfortable old recliner, the sweater hanging where it always had, on the back of his favorite kitchen chair.

George viewed himself as the patriarch of his family, and fretted that they can't get along without him. Two of his adult grandchildren had moved in to George's house to care for it in his absence; his brother, Fred, lived next door. George managed Fred's money because – as George put it – Fred "drinks a bit."

Listening to George talk, the transition planner pictured a cozy little cottage. When she saw George's house, it took her breath away. The single-pane windows weren't sealed, and a few missing panes were patched with cardboard and duct tape. She tripped over a loose board as she climbed up to knock on the peeling door.

George's grandchildren welcomed her in. Inside, some of the linoleum had worn through to plywood. The pot-bellied woodstove in the corner appeared to have a shaky chimney. The cabin was dim and sparsely furnished. The grandchildren said the power had just been shut off, but that they had been in touch with the power company. They said they planned to stay on to help when George came home.

To complicate matters, local Adult Protective Services workers – those who initiated George's institutionalization in the first place – have vigorously protested the idea of letting George return home. They say the level of risk is unacceptable, that the house is a firetrap, and that George doesn't have the wherewithal to sustain independence if he does come home.

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[1] Although this situation is based on a real MFP participant, the name and identifying details have been changed.

What would you do?

Before proceeding with this transition, there are a number of factors that need to be examined and a number of questions that should be asked.

- What services would George need? Are they available? What help can the family provide?

- Even though the house doesn't meet traditional Housing Quality Standards (HQS), it is George's home and it's where he wants to be. How could you mitigate the risk? What might you consider doing to make the house safer?

- Are George's needs so great that it would be irresponsible to support his transition? Why or why not?

- What questions would you need to ask to determine whether George's adult grandchildren could be considered as service providers. Are other service providers available? How would you find out?

- What other questions would you want to ask or issues would you want to explore before moving forward?

What difference does MFP make? Ask Betty.
As told by Jeri Darby, R.N., MFP Case Manager

Complications from knee surgery at age 55 left Betty Staffney unable to walk. Her situation was further complicated by a diagnosis of Multiple Sclerosis (MS). Even so, after three weeks of therapy in a rural nursing home, Betty was looking forward to discharge. Unfortunately, her doctor told her that she shouldn't go home. "Not with all *your* problems," he said. After all, Betty required a Hoyer Lift and the assistance of one or two people just to transfer in and out of bed.

Betty cancelled the lease on her apartment. After that, she was depressed. She found herself crying easily, and snapping at the nursing home staff. Through good times and bad, the faith and support of her pastors sustained her, even as her hopes of ever leaving the nursing home faded.

Then one day, three and a half years later, a social worker told her about the MFP initiative. Hope rekindled and began to grow – this sounded like the answer to her prayers. She worked with a nurse and social worker who together assessed her medical and financial eligibility, then helped create a person-centered plan.

Betty celebrated the four-year anniversary of being in her own apartment in December 2012. Betty shares her story because she wants people to know there is hope. *"There is help if you want to go home. And if I can do it, then they can, too."*

Forewarned is forearmed

The idiom *forewarned is forearmed* is particularly apt when you are getting ready to transition MFP participants to rural and frontier communities. Beyond relationships and knowledge of the community culture, data is one of your most important assets. This section will highlight information that can help you paint a picture of rural and frontier areas in your state, and pinpoint communities that are likely to be home to potential MFP clients.

Many national databases make state- and county-level information available, much of which can be useful to MFP providers and state directors. These include the U.S. Census Bureau, the Behavioral Risk Factor Surveillance System (BRFSS), the Centers for Disease Control (CDC), Social Security, Health Resources and Services Administration (HRSA), and others. This section will provide step-by-step directions for accessing and interpreting data from these sites. The takeaway for this section will be giving you the tools you need to paint a realistic picture of the areas you choose to target.

Note: The Department of Housing and Urban Development (HUD) site also has data available, but that will be covered in a separate section on housing. More information on state Medicaid waivers and Medicaid state plan amendments will be covered in separate sections as well.

Starting with the Basics

Key eligibility components of the MFP Program as defined by the Centers for Medicare & Medicaid Services (CMS) provide an excellent starting place for knowing which data to collect from a veritable ocean of available information.

- States can assist older adults (aged 65+), and individuals with physical, intellectual/developmental, and/or psychiatric disabilities of any age, as detailed in the state's MFP Operational Protocol.
- Participants must be Medicaid eligible.
- Participants must have lived in an institution for at least 90 days (not counting Medicare short-term rehab days) prior to transitioning back to the community.

Given these criteria, it becomes clear that useful information will include data on demographics, including age, and disability. Medicaid enrollment by county will be useful information to access, as well as information about local and state institutions.

The Affordable Care Act (ACA) includes a provision that expanded the Medicaid program to cover non-elderly individuals with income up to 133 percent of the Federal Poverty Level by 2014. Currently, all persons living on incomes below the Federal Poverty Level (FPL) would meet financial eligibility criteria, so these tools will also include tips for accessing poverty data.
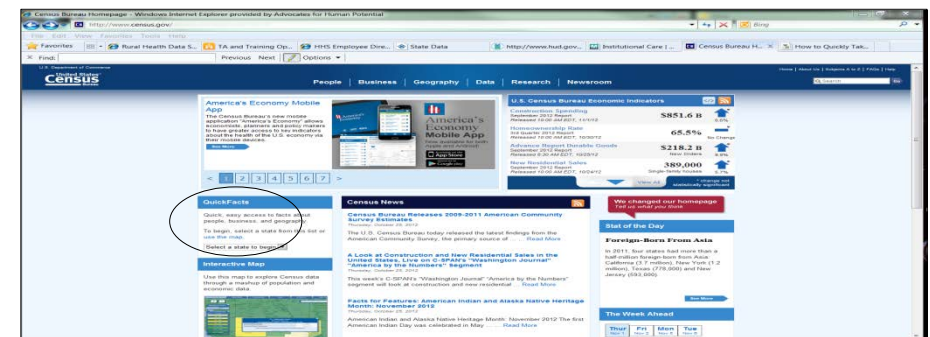
Why demographics?

Demographics are important because human service needs vary depending upon population. Young adults with serious physical or developmental disabilities who leave institutions will have different needs and preferences than the frail elderly. Similarly, demographics can reveal whether there are likely to be language barriers, high numbers of disabled veterans, or disproportionate numbers of persons with disabilities.

Demographic Needs Profile: a Step-by-Step Process

North Dakota has been used in the examples to this point, so we'll continue by looking at two North Dakota counties. Consider the map below. Ramsey County includes a mix of *isolated rural*, *other small rural* and *small rural core* areas. Find Bowman County in the far southwestern corner. Bowman is an *isolated rural* (frontier) county.
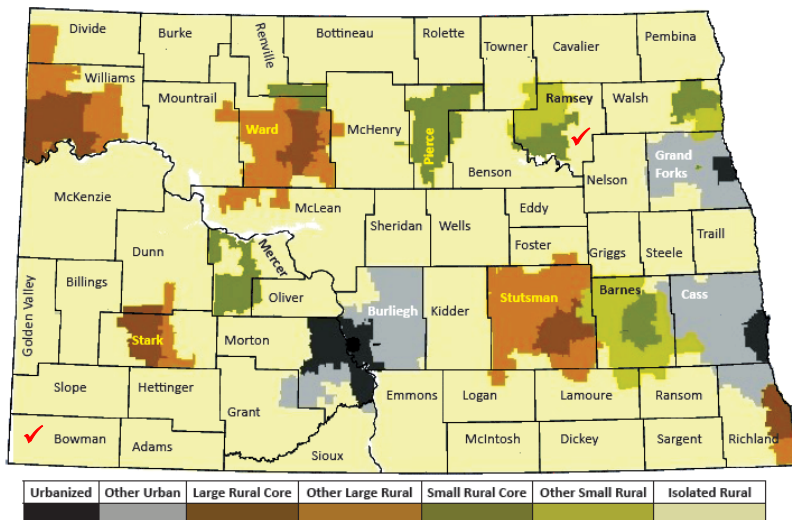
Quick Demographic Profile from *State & County QuickFacts*		
County	Ramsey	Your County
1. Population (2011 Estimate)	11,452	
2. Population Density (persons/square mile)	9.6	
3. % of Population over age 65	18%	
4. Number of People over 65 (Multiply #1 by #3)	2,061	
5. Living in same house 1 year+ (2006-2010)	88.6%	
6. Predominant races:		
• White	88.0%	
• American Indian/Alaskan Native	8.4%	
7. Foreign born persons	1.7%	
8. Language other than English spoken at home	4.4%	
9. High school graduates (age 25+)	86.4%	
10. Bachelor's degree or higher (age 25+)	20.9%	
11. Mean travel time to work (minutes) (age 16+)	11.0	
12. Housing units	5,593	
13. Homeownership rate	65.5%	
14. Housing units in multi-unit structures	30.3%	
15. Median value of owner-occupied units	$85,300	
16. Median household income (2006-2010)	$41,792	
17. Persons below poverty level (2006 – 2010)	11.5%	
Start at www.census.gov. *Choose North Dakota from QuickFacts.*		

The demographic profile is a fast way to get an immediate sense of the area's needs and capacity as they relate to MPF.

What can you extrapolate from the profile as it exists so far?

What we know: More than 2,000 people fall into the 65+ age bracket. The overwhelming majority of people in this area are stable members of the community: 88.6 percent have lived in the same house for at least a year. More than half of Ramsey County residents own their moderately priced homes (median value of $85,300).

- **What we can infer:** People from a community this stable will likely want to use self-determination to return home if they *are* institutionalized. With nearly one in five people over age 65, the likelihood is that a substantial number will end up in a nursing facility at some point.

What we know: Most people have finished high school: 86 percent of adults are high school graduates, and 21 percent have Bachelor's Degrees or more.

- **What we can infer:** This is an established community, and on the face of it, appears to have a good labor pool. Because the educational attainment level is relatively high, many people who are available to work may have the background or capacity to serve as trained caregivers, and/or to use technology to supplement in-person care.

What we know: The average commute time to work is 11 minutes, but wages are modest, as reflected by the median household income of $41,792. More than one in ten people (11.5 percent) live on incomes *below* the federal poverty level.

- **What we can infer:** With a high number of people in poverty, there will probably be a demand for MFP from Medicaid-qualified applicants. We can also infer that additional jobs will be welcome, particularly if they pay more than minimum wage.

What we know: Not quite a third of the local housing is in multi-unit structures.

- **What we can infer:** There may be rental units available for people wishing to leave institutions.

What we know: This is a relatively homogenous population. Most people speak English (just 4.4 percent speak a language other than English in the home). The majority are White (88 percent) or American Indian (8.4 percent).

- **What we can infer:** While there may be some demand for multi-lingual caregivers and MFP materials, the majority of potential workers and clients will speak English, but providers may need training in cultural competence strategies for persons coming from local tribes.

What else would you *want* to know?

There are several pieces of data it would be helpful to collect, including poverty and disability. But first, consider the county-level population density of 9.6 persons per square mile in context with the many remote areas in this county. So how do you figure out where Ramsey County's inhabitants reside?

Find a county's population centers

Go back to the front page of the www.Census.gov website. Below the QuickFacts menu, go to the *Population Finder* to begin. Select your state from the pull-down menu.

Once inside the 2010 Population Finder site, click the "Areas Within" button, which will take you to another pull-down option. Select *Counties*, then *Search*.

For purposes of our example, select *Ramsey County* from the new pull-down menu, click "*Areas Within*," and choose "*Minor Civil Divisions*." A new pull-down menu opens, with about three dozen townships, and nine cities. Click on the cities and population data will come up at the bottom of the screen.

A quick scan reveals just one city has a population greater than 200 people: Devils Lake has 7,141 residents – 64 percent of the county's population.

Return to the state QuickFacts page, and choose your city. The same set of information will appear that were available at the county level.

What jumps out in the Devils Lake example?

- The population density is relatively high for a rural area: 1,098 persons/square mile
- A large percentage of people live in poverty (16.2 percent)
- Median household income is lower than it is in the county as a whole ($32,493)
- The homeownership rate is *much* lower (49.8%)
- Almost half of the housing units are in multi-unit structures
- Mean travel time to work is just under 9 minutes

On the surface, it seems that Devil's Lake might be a good place to consider for rural MFP services. Digging deeper will mean looking at disability data, poverty data for seniors, and Medicaid recipients.

| **Takeaway** | **You can quickly get a sense of whether a community might be a good fit for MFP using readily available data. This step-by-step process can be accomplished relatively quickly, depending on the amount of information you wish to review.** |

Disability data

Some of the most recent disability data available at the county level can be found through the Social Security Administration website (www.ssa.gov). Select "*Our Agency*".
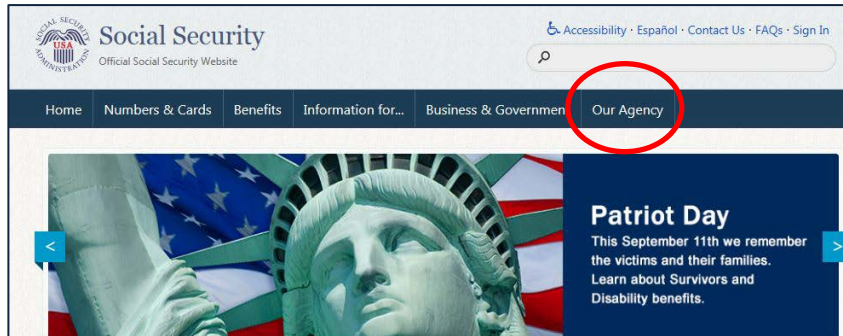
Select "*Research, Statistics & Policy Analysis*," then "*Publications List*."

- Under "*Links to Most Recent Issue*," choose "*OASDI Beneficiaries by State and ZIP Code*." The link will allow you to choose your state, and then to access data on disabled workers in a given Zip Code.

- Under "*SSI Recipients by State and County*" you can find information about your state and counties in an alphabetical list. This file will show the total number of people who are Aged, Blind and Disabled, recipient age categories, and the number of SSI (Supplemental Security Income) recipients who also receive OASDI.

OASDI: Old Age, Survivor, and Disability Insurance

Look up Devils Lake, North Dakota in the *"OASDI Beneficiaries by State and ZIP Code"* to find the number of retired workers (4,115), disabled workers (605), and beneficiaries who are aged 65+ (4,865).

Now check the *"SSI Recipients by State and County"* for North Dakota, and look at Ramsey County. In the continued Devils Lake example, there were 195 SSI recipients in 2011:

- 16 were Aged;
- 179 were Blind and Disabled;
- 20 were under age 18;
- 138 were between the ages of 18 and 64;
- 37 were aged 65+; and
- 78 also received OASDI.

SSI is the Social Security program that guarantees income to people who are age 65 or older, blind or disabled and who have limited income and resources. The payment standard for SSI recipients is much lower than the federal poverty rate, so in general, a person receiving SSI will be Medicaid eligible. If institutionalized, these folks could represent potential MFP clients.

In 2013, the maximum annual individual federal payment for SSI will be $8,520, and $12,792 for a couple (www.SSA.gov). The 2012 Federal Policy Guidelines are $11,170 for a single person, and $15,130 for a couple (www.aspe.hhs.gov).

Locating information about area nursing homes and hospitals

The final step of this process is to identify the nursing homes, hospitals, or home health services where persons from any given county or city are likely to be. This is an easy step! Go to: www.medicare.gov.

- Click *Find nursing homes.*
- A *Find a Nursing Home* box will pop up. Enter the location you wish to research by name or zip code.

Once again, let's use Devils Lake, North Dakota as an example. Once the location is entered, the tool shows 22 nursing homes available within 100 miles of town center. They are listed closest first, and move down to those further away.

Return to the main *Find doctors, providers, hospitals, & plans* menu, and repeat the process for hospitals, home health agencies, and dialysis facilities. Under *More quality, planning and compare tools,* it is also possible to pinpoint where covered medical items can be found.

- In the Devils Lake example, the site shows that 14 hospitals are available within 100 miles of the town center, starting with nearest first.
- Unfortunately, no home health agencies are available in the Devils Lake region.
- One dialysis facility is located in Devils Lake.

Gathering and evaluating key information provides a strong foundation as you begin to consider moving an MFP client into a rural or frontier area. The information can be encouraging, as in the case of Ramsey County/Devils Lake, or it can throw up red flags. Either way, forewarned is forearmed.

Disability Rights

At times, it may be necessary to advocate for clients' civil rights as they attempt to move back to their rural and frontier communities. There is help available through the federally mandated *Protection and Advocacy (P&A) Systems and Client Assistance Programs (CAP)* for persons with disabilities, located in every state and territory. P&A/CAP agencies have the authority to provide legal representation and other advocacy services to people with disabilities. They maintain a presence in facilities that care for people with disabilities, and have the authority to monitor, investigate and attempt to remedy adverse conditions in those facilities. P&As also help ensure that people with disabilities have full access to inclusive educational programs, financial entitlements, healthcare, accessible housing and productive employment opportunities. This is an important connection to make: P&A/CAP agency staff members can be valuable allies.

Find help in your state. Go to the National Disability Rights Network (www.napas.org), and click on the interactive map. You will find information on the issues P&A/CAPs can assist with, links to state offices, contact information and other links.

What about housing?

Many rural/frontier residents own their own homes, but for those who do not, finding housing can be one of the most challenging components of a transition, particularly if the MFP participant needs accessible housing or has mobility challenges. Fortunately, the Department of Housing and Urban Development (HUD) offers tools that can help you begin the search for publicly subsidized, affordable, accessible housing in your state, county, or community. Start at www.HUD.gov.

There are three areas that may be useful in your search for affordable, accessible housing for MFP clients transitioning into rural or frontier communities.

- *Search for an Affordable Apartment*
  This link will take you to an area where you can search for low-cost apartments, by state, then city, county, zip code, apartment type, and number of bedrooms. The search will show all local affordable housing complexes, complete with contact information, target population, and number of bedrooms. The search does not tell whether apartments are available or not, but it offers a starting point in the search for housing.

- *Find Rental Assistance*
  This link will take you to an area where you can find additional information about HUD's subsidized housing programs, fair housing, tenant rights, and more. It also offers a link to "Rental help in your state." Click on this link and choose your state to find a state-specific HUD site.

- *Find my Local Public Housing Agency (PHA)*
  This link will take you to an area where you can access Housing Authority contact information by state. Also on the PHA page, under *Related Information,* is a link to HA Profiles. This link offers access to more detailed, up-to-date Housing Authority information, in addition to contact information for individual Public Housing agencies. The information available includes the location, and the number of low-cost rental units by city and county.

| Takeaway | In rural and frontier communities, a critical first step can be identifying local resources. The second is getting to know the housing manager or service provider. Relationships are key to success in rural and frontier communities. |

Census.gov Housing Profiles

A wide range of information is available through the American Community Survey (ACS) on the *American FactFinder* website. Information is available for all levels, all geography, down to the Census Tract level. Available information includes the physical characteristics of housing, the year a structure was built, the number of housing units in a structure, number of rooms, number of bedrooms, whether or not a unit has kitchen or plumbing facilities, whether telephone service is available, heating fuel, and the year a householder moved into the unit.

Go to: http://factfinder2.census.gov

Some very useful and comprehensive information is available on community-level housing characteristics. To view this information, go to the *"Community Facts"* area and type a state, county, city, town, or zip code.

From the list of topics that pops up, choose *"Housing,"* then the *"Occupancy and Structure, Housing Value and Costs, Utilities…"* link.

Using the Devils Lake example once more, you can learn that five-year estimates (2007-2011) reveal a rental vacancy rate of 13.9 percent, that 31.7 percent of homes were built before 1950, that the median rent is $484 and much more.

| So What? | In many rural and frontier communities, housing may not meet strict housing quality standards. |

The Census report data can provide information about what to expect. For example, if many units were built before 1950, accessibility issues or high heating costs may be the norm, but rents may be more affordable.

Housing Locator at SocialServe.com

Many states use www.SocialServe.com, a nonprofit dedicated to helping people access affordable housing and supportive services. This site provides a place where Public Housing Authorities, municipalities and other landlords can list housing, and where prospective tenants or case managers can search for properties that meet specific needs. After selecting a state, listings are offered by county, city, and metropolitan areas. The site notes whether units are available or when they will become available, if they are pet friendly, if Section 8 vouchers are welcome, if they are senior units, if units are accessible, and more. There are a number of ways to sort the search.

- Tip: Though just 33 states have listings, this is a resource worth checking.

Asset Mapping

If you're asking, *"What the heck is asset mapping?"* you've come to the right place!

Traditional community development models use a deficiency model that articulates needs, issues, lacks and problems. Asset mapping looks at the skills, capacities and resources within a given community. When using an asset-mapping model, the community is viewed as a treasure chest. Treasures vary by community, but individuals, structures, and organizations alike represent resources upon which to build. Connecting with assets or resources involves building (or rebuilding) relationships. This is an empowering approach that assumes the resources needed to solve a problem probably already exist within the community.

"Coming together is a beginning, staying together is progress, and working together is success."
– Henry Ford

Asset mapping can be viewed as creating an inventory of resources. Through this process, strengths are acknowledged and honored, and relationships are formed or strengthened. Identifying resources is particularly important in rural and frontier areas, where people must rely on their neighbors, families, and other community-based supports such as volunteers, and the faith community.

This section looks at two approaches to asset mapping for rural and frontier MFP communities – one is at the program level, and can be used by MFP professionals. This resource could be created at a statewide, community, or regional level and could take the form of a notebook, a spreadsheet, database, matrix, or an actual map. Assets can be people, physical structures or places, organizations, community services, businesses, locations, agencies…the list can go on and on. A program-level asset map will grow and evolve with time, as MFP becomes better established. It will also evolve as communities change to accommodate the MFP program. The program-level asset map is a tool that can be shared among transition planners, program directors, outreach workers, housing coordinators, state directors, and others.

Individual asset maps are person-centered and used in a completely different way. While the assets defined at the community level can and should be brought to bear on individual needs, the asset map built with and for an MFP participant is client-specific. It might include concrete assets or resources such as family relationships, church groups, long-term friendships, lodge memberships, income, car or home ownership, as well as intangible assets such as self-determination, cognitive or physical abilities, and the will to succeed. Individual asset maps can be structured in the form of a resource wheel, relationship chart, map or matrix. The results should be incorporated into a comprehensive and sustainable care plan.

Community Asset Mapping 1-2-3

Step 1: Begin to Identify Resources

Step 1 of the process is identifying resources. Assets or resources are anything (or anyone) that can be used to smooth the transition of an MFP participant into a rural or frontier community. These can include community members' abilities or capabilities, places or structures, businesses, associations, social or civic clubs, associations, institutions, volunteer organizations, the faith community, and more.

Step 2: Conduct Appreciative Inquiries

Appreciative inquiries, which are used to identify the best in people, organizations, and the community, lead to the discovery of assets available in a community. Appreciative inquiry is the art and practice of asking questions to identify community resources. Use of respectful, appreciative inquiry is the foundation of the community asset mapping process.

Step 3: Mapping

Resource mapping is useful when MFP is brought to a rural or frontier community. It is a time-intensive process that involves building relationships versus the relatively time-limited process of assessing a community using readily available data from existing resources such as the internet, telephone books or other directories.

- *Human Resources*

A roster of people with contact information, availability, resources, capabilities, or talents can be one of your most valuable resources. Some of the people you will want to add to the roster are obvious: health care providers, case managers, housing coordinators, Housing Authority representatives, transportation providers, and volunteer managers will all be helpful resources. But there are many others who might be able to help you make the transition easier for your clients.

Who can help you transition MFP clients into rural and frontier communities? Think outside the box. Maintenance agencies, repair technicians, and construction companies could all help in the event housing modifications are needed. Law enforcement personnel can be valuable partners, as can lawyers, city or county government representatives, bankers, church representatives, youth groups, and members of tribal government. The local librarian, sales personnel, and representatives of the local media can all play valuable roles.

> A community resource map is a valuable tool that helps portray relationships among assets.

Takeaway

Rural and frontier communities are tightly woven systems. Every connection you make on behalf of your MFP clients and the MFP program can lead to additional connections.

- *Association Resources*

Associations are organizations of people who share a common purpose and have a formal structure. Examples include civic clubs such as the Lions Club, Soroptimist International, Kiwanis, United Way, the Chamber of Commerce, 4-H, the American Association of Retired Persons (AARP), and many others. Most rely on voluntary commitments from their members. Many associations welcome speakers to their regular meetings. Making an opportunity to speak about the MFP program can be an excellent way to build awareness of (and interest in) your program…and ultimately, to gain support and assistance. Organizations like these can be rich sources for volunteers, and can provide information, assistance, and connections to other resources.

- *Institutional Resources*

Institutions are formal or structured entities. Examples include government agencies, some nonprofit entities, hospitals, community health centers, food banks, libraries, churches, synagogues and mosques. Institutions fill niches in the community, and are valuable additions to the resource map.

- *Business/Economic Resources*

Businesses can be important resources for inclusion in your asset map. It is important to know where to find needed supplies, and who to call for specific goods and services. For example, local pharmacies often work hard to accommodate their clients' needs, and may even fill medication dispensers and deliver medications.

Takeaway

Resource or asset mapping is about building relationships. Once you know the *what and who* of the community's resources, the next step is to identify *how* they are able and willing to assist with welcoming MFP clients back into the community.

Inventory and Action Tools

Theory into Practice

Start to build your community asset map. Involve your whole team to begin the conversation. Start by naming the people and institutions you already connect with, and expand from there. An asset form can be useful for completing individual inventories, which can then be compiled into a single spreadsheet that includes agencies, contact names, e-mails, telephone numbers, addresses, scope of services offered, hours, and more. For institutional resources, it is also important to understand eligibility criteria, and know the hours of operation, and process for accessing services.

Consider how valuable it would be to know who to call when you need someone to paint a house or fix a heating system. Think of the time it would save if you had a single resource that includes information about who could plow snow, help a client fill out forms, adapt a vehicle, get nutritional advice, help with housekeeping or yard work, or provide care for clients who have serious mental illnesses. The resource or asset map should be a living document that helps you piece together functional systems of care.

Individual or Client-Based Strengths Mapping

An individual client's resources can be compared to a pie sliced into a number of wedges. Each wedge represents a strength, resource or asset that the individual can draw on in order to create a satisfying and sustainable life in the community. The pieces in the pie will vary for each individual, but each person's "pie" will include tangible and intangible assets, as well as internal and external resources. Examples of internal resources might include determination to succeed, strong cultural identity, spirituality, stable health, and specific talents or abilities. External resources might include a supportive family, connection to a faith community, a home to return to, or access to transportation. Developing a clear understanding of each individual's strengths and resources can make all the difference between success and failure.

The MFP transition coordinator gathers information from the client about his/her strengths and resources, as well as his or her needs, values, beliefs and practices. This is a collaborative process that puts the MFP client squarely in the driver's seat.

Like the community asset or resource inventory, the individual asset mapping process begins with an initial identification of resources or strengths, developed through a process of appreciative inquiry. Approaching the individual using a strengths-based approach is empowering and helps instill hope. This process should be individualized, outcome-oriented, compassionate, culturally competent, and professionally responsible.

The more pieces an individual has in his or her personal "resource pie," the better the chances of success in the community. At the same time, a thorough and realistic understanding of the individual's strengths and resources can help the transition coordinator realistically assess gaps, needs, or deficiencies that must be addressed to avoid unnecessary or premature return to an institution. A strength assessment provides a snapshot of the client's resources, and forms the foundation for a sustainable service plan across multiple life domains. Using open-ended questions will help to elicit as much information as possible.
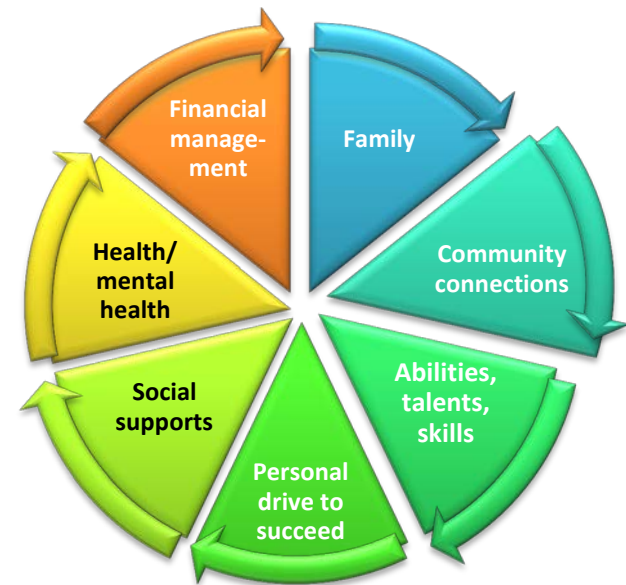
| Takeaway | View clients through a lens of their strengths by learning about their skills, abilities, knowledge, interests, relationships, resources and desires. |

Building Bridges to the Community

"To successfully support individuals transitioning from institutions, we have to build bridges from the institutional subculture back into the community." – Jodi Lamoreaux, MFP Housing Program Manager, Washington State

Culture, broadly interpreted, encompasses the core of an individual's identity. It defines communication patterns, beliefs, and values. MFP staff members often work with profoundly vulnerable individuals, many of whom have been overwhelmed by circumstances and events they have felt powerless to control. Working to understand who a person really is provides evidence of your respect for the individual, and your commitment to promoting self-determination. The key ingredient is communication.

Connecting with people like ourselves is a basic human need. It is important to remember that each MFP client is leaving an institutional culture where he or she developed friends, had opportunities to participate in activities, and had a settled routine in which many choices were already made. Many MFP clients experience loneliness and boredom once they leave, particularly if their social outlets are limited.

When doing the individual's strength or asset map, it is important to be sensitive to potential barriers, including a family's or individual's "can't do it" attitude.

Culture is to people as water is to fish. It is part of our identity, part of our very being. – Dr. Alf Bamblett

<table>
<tr><td>**Theory into Practice**</td><td>**A tool you can use: a Self-Sufficiency Matrix**</td></tr>
</table>

A self-sufficiency matrix is an individual assessment and measurement tool that can be used to monitor and evaluate client resources after return to the community. Many forms of the self-sufficiency matrix are available online, and though a sample matrix is provided in **Appendix A,** you should add domains as needed to fit your individual client base, as well as individual clients.

Tip: The self-sufficiency matrix can be used as a tool of engagement to help clients recognize or evaluate their own progress. Looking at the matrix prior to leaving the institution can also help the client – and MFP staff – identify potential resources and issues. Aggregate results can be used to demonstrate the difference the MFP program makes in the community. Aggregate data can also help you explain the program to a funder, potential volunteers, or the community.

Appropriate domains for an MFP client could include housing, access to services, access to food, functional ability, income, legal issues, life skills, relationships, activities of daily living, family support, physical health, behavioral health, transportation, and other individual support systems.

The self-sufficiency matrix looks at each dimension on a scale that ranges from thriving on one end to in crisis on the other. When the transition is a success, client status should be stable or improving across the various dimensions.

Rural Michigan's MFP Team: Collaboration in Action

Small towns take pride in taking care of their own, and this was never clearer than the night the Lakeside Apartments burned. At the time, seven MFP clients were living in the units. One gentleman weighed 700 pounds and first responders had no way to get him out of his apartment without special equipment. His life was in danger, and first responders were terrified that they wouldn't be able to get him out in time. After several telephone calls, a special ambulance with a bariatric stretcher was located in a neighboring county.

No lives were lost that night, but all seven MFP clients became homeless overnight. The program dispatched coordinators to find temporary housing and to arrange for staffing in other settings. They had one clear imperative: they needed to identify back-up resources so that everyone could be immediately stabilized within the community.

Michigan's MFP transition team agrees that relationships are the key to success. They say it's important to go in with a win/win attitude, to build bridges, and to form relationships. The Michigan team also offered up a few more hard-won tips.

- Tap into the mindset of the community. One of the core values is often "we take care of our own."
- It's important to talk with and be nice to *everyone*. Some of the Michigan transition planners make a point of starting conversations with nursing home janitors, housekeepers, and aides, because they know *everyone* in the facility.
- Visit. It helps when nursing home residents know your face.

Additional Information Center for Applied Rural Innovation (CARI) Institute of Agriculture and Natural Resources, University of Nebraska-Lincoln: http://utahlinks.org/rp/docs/VitalComm.pdf.

- The *Self*-Sufficiency *Matrix: an Assessment and Measurement Tool Created through a Collaborative Partnership of the Human Services Community in Snohomish County* can be accessed online at: http://performwell.org/. Choose: *"Find Surveys / Assessments,"* then *"Employment, Housing, and Self-Sufficiency."* Click on the *"Housing and Shelter"* link to reach a link to the Self-Sufficiency Matrix.

- The Community *Tool Box (2012). Identifying Community Assets and Resources* can be accessed online: http://ctb.ku.edu/en/tablecontents/sub_section_tools_1043.aspx#tools1.

- *Tools for Tenants,* part of the Substance Abuse and Mental Health Services (SAMHSA) Permanent Supportive Housing KIT offers tools that can be used to explore housing preferences, being a good tenant, and a client's support needs. Go to: http://store.samhsa.gov/home, and type "Tools for Tenants" in the search box.

CHAPTER THREE: *MFP in Rural States*

Implementing MFP in rural and frontier states requires a lot of ingenuity and adaptation, which has led to creative strategies that vary from state to state. MFP directors and staff members have generously shared the ways they are meeting the needs of clients who wish to transition to rural communities.

Finding safe, accessible housing in rural areas is challenging. The good news is that housing in rural America can be more affordable than it is in urban communities. Unfortunately, there is a dearth of subsidized and accessible units. Keeping people housed by ensuring that they receive appropriate services is another obstacle: there are limited numbers of service providers, and long distances between clients, sometimes over rutted, dirt roads. Rural providers call this "windshield time" and it's both costly and uncompensated.

Despite all of the obstacles, rural MFP states have managed to ensure successful MFP transitions to rural communities. Following are some of the highlights describing strategies in use by six states comprised of large rural and frontier areas – Michigan, North Carolina, North Dakota, Ohio, Oklahoma, Texas and Washington.

Thank you to all of the MFP directors, staff members, and contractors who participated in telephone calls, and so generously offered tools, tips, and stories.

CHAPTER THREE LEARNING OBJECTIVES

After reading Chapter Three, readers will be able to:

- Identify at least two promising approaches for overcoming common obstacles to rural transitions.
- Name at least three strategies that are working well for MFP programs in rural and frontier areas.
- Identify commonalities in states' rural housing strategies.

MICHIGAN

Michigan's MFP Program participants transition from nursing homes into the MI Choice Waiver Program, through which they receive the services they need to live in the community. A wide array of services are available under the waiver and include personal care, homemaking, chore and respite services, adult day care, transportation, and home delivered meals, among many other services.

In addition to services provided under the waiver, MFP supports enhanced outreach and assists participants in finding housing (Kaiser Family Foundation, 2013). After their year of MFP eligibly is up, enrollees continue to participate in the MI Choice Waiver as long as they meet eligibility criteria and continue to need services.

Michigan's MFP system was designed to allow flexibility to meet local needs and takes a singularly local approach to MFP placements. Leaning into local relationships has smoothed the path for identifying affordable housing options, accessing Housing Authority Resources, and creating sustainable relationships with local housing agencies and other organizations.

"When you have more cornfields than people, you have to be innovative." – Michigan MFP Housing Coordinator

HOUSING COORDINATION

In 2010, nearly all (93.6 percent) of Michigan's land mass was rural or frontier, and was home to 25.4 percent of the population, or approximately 2.5 million people (U.S. Census, 2010). Because so much of Michigan is rural, MFP providers have had to come up with strategies that help ensure that program participants can transition home to their rural and frontier communities.

One hallmark of Michigan's MFP Program is that it works through networks of agencies at the community level. Twenty waiver agencies, including 16 Area Agencies on Aging (AAAs), serve all of Michigan's 83 counties by administering the MI Choice Waiver and providing transition services to local residents. One effective strategy has been hiring regional MFP Housing Coordinators who work through the state's 20 MI Choice Waiver agencies. Michigan's MFP program also covers the cost of outreach specialists who are employed by the statewide network of Centers for Independent Living (CILs).

Using staff from waiver agencies and CILs to facilitate transitions meant that more than 150 transition coordinators are providing transition services around the state. This enabled almost 1,700 Michiganians to transition back into community life in 2012.

OUTREACH STRATEGIES

Michigan's network of 14 Centers for Independent Living (CILs) are charged with providing outreach to nursing facility residents and staff, and with making referrals to waiver agencies for individuals interested in receiving waiver services and participating in MFP. Additionally, they provide advocacy, referrals for other community services, and training on independent living skills. The CILs also provide transition services, although in this capacity, they generally work with individuals who either do not wish to participate in MFP, or do not qualify for the MI Choice Waiver.

Michigan's Long-Term Care Ombudsman Program addresses quality issues among residents of licensed long-term care facilities. Because of this, staff members are knowledgeable about transition services, and often work with the CILs and MI Choice waiver personnel to help facilitate outreach.

Strong partnerships result in a greater number of accomplishments, at a greater speed. For example, in one rural 10-county area of Michigan, six two-person teams work with people who wish to transition. Each team includes a social worker and a nurse who do outreach, person-centered planning, and needs assessments. They also ensure that potential participants understand the MFP Program and the MI Choice waiver. Adding a Housing Coordinator to the mix provides further efficiency, freeing the teams to focus on discharge and transition.

HOUSING COORDINATORS

Housing coordinators are charged with finding community housing resources. They seek out low cost rentals, subsidized units, and vacant apartments, and build relationships with landlords who may be willing to negotiate lower rents or rent to people with less than stellar rental or credit histories. Housing coordinators also work with local Public Housing Authorities (PHAs) and others in the housing industry to increase the number of local housing options available to MFP participants. Finally, housing coordinators link MFP participants with housing. At times they may help people find roommates, enabling them to secure housing they could not otherwise afford, or they may assist homeowners with substandard housing with adding ramps or finding resources for other upgrades that make it possible for them to live in their homes.

Michigan's MFP transition coordinators enroll people at all levels of need. "We take the good, the bad, the hard and the easy. We never say *can't*. Even so, it's important to consider a safety net. For example, during one horrendous winter storm, we had to fund temporary caregivers to stay overnight with high-needs clients because they wouldn't have been able to get back again once they'd left."

The transition team follows MFP participants for up to six months, gradually transitioning the relationship to the MI Choice team. They are careful to ensure the community-based case manager knows which MFP participants need extra help.

STRATEGIES FOR SUCCESS

Placing people who have histories of active Serious Mental Illnesses (SMIs), felonies, or poor rental histories can be as challenging in rural areas as it is anywhere else. This is particularly true for those who have housing challenges that make it difficult or impossible for them to access subsidized housing. Following are tips gleaned from their experience.

- Good relationships are critical. Get to know the client and housing providers. If your reputation is on the line, people will trust your word.
- Ask clients to be honest from the beginning – it helps you build trust on both sides of the fence. Nothing is tougher than getting months into a transition and discovering the person has barriers you haven't addressed because you didn't know about them. Extenuating circumstances can be explained. Transition coordinators can write letters of recommendation based on what they know about a client.
- Eviction can be prevented through close follow-up with landlords and with the rest of the team. Give the landlord or property manager your card and ask to be contacted if problems occur and before a letter of eviction is issued.
- Rural Development may make allowances or have different approval processes. It never hurts to ask. There also may be a property management company willing to help with placement.

SUCCESS STORIES: THE UPCAP PARTNERSHIP

Michigan's MFP Program attributes some of its greatest successes to working with agencies that go the extra mile. UPCAP (Upper Peninsula Commission for Area Progress) is a regional organization that provides resources to 15 primarily rural counties in Michigan's Upper Peninsula. UPCAP is also a regional Area Agency on Aging, and administers the MI Choice Waiver and Michigan's MFP Program throughout the Upper Peninsula. UPCAP maintains a 2-1-1 call center that provides easy access to information and assistance provided by call specialists 24 hours a day, seven days a week. The MFP Program also uses a Guardian Alert 911 system – a two-way communication device that connects participants directly to trained operators. MFP staff tries the system out with transitioning clients when it is installed, to demonstrate and reassure the clients that it works.

Theory into Practice

What difference does it make? Ask Charlie. Charlie hadn't been in the community long when he started calling 911 in the middle of the night. The transition team knew he was calling because he was lonely, but the local sheriff got tired of the calls fast. Sadly, Charlie ended up back in the nursing home. Looking back, MFP staff says they might have been able to keep Charlie in the community if they'd had the Guardian Alert in place at that time.

NORTH CAROLINA

North Carolina's MFP Program has been in place since 2008, and the two biggest obstacles to transitions have been housing and transportation. This can be particularly true in rural areas. Almost 91 percent of North Carolina's landmass is rural and inhabited by about one third of all North Carolinians – about 3.2 million people (U.S. Census, 2010).

HOUSING

Moving people back to their own homes has been successful in North Carolina: 81 percent of NC MFP participants have returned to their own or a family member's home (MFP Roundtable Notes, 2012). Unfortunately, many who wish to transition to rural areas are returning to family homes that do not meet health and safety criteria. For example, some MFP participants wish to transition to places way up in the Appalachian Mountains where they own dilapidated mobile homes. MFP home modification funds aren't sufficient to address the rehabilitation needs, and although housing rehabilitation resources may be available at the county level, mobile homes typically aren't eligible for assistance.

That mobile home might be all the individual can afford, so transition staff members note that they've learned to step back and ask themselves if this is a home where people can live *safely*. Personal aesthetics should not be a reason to deny or delay a transition.

HOUSING INEQUITIES

North Carolina's far eastern and far western areas are very rural. Several pockets are extremely poor, while others are vacation and retirement areas for the very wealthy. There are counties where $1 million properties literally butt right up to dilapidated cabins where people are living without running water or electricity. Rentals that meet Housing Quality Standards (HQS) in such areas can be priced way beyond an MFP client's level of affordability.

"My agency got a referral to a rural county. Seven people (four generations) ranging in age from two to 87 were living in the family home. At one time, the house had been a chicken coop. It had two rooms, and no privy. They got water from the river 50 yards away. It didn't matter to the MFP participant because it was home." – a North Carolina transition planner

TIPS FOR GETTING PEOPLE INTO HOUSING

- Dig in to find and build relationships with landlords. Make cold calls, see if the family can help, don't be afraid to ask for lower rents.
- Churches are excellent resources. One recently built a ramp for a client. MFP just had to purchase materials.
- Small community colleges often have carpentry programs. Students may be looking for projects.

NORTH CAROLINA INNOVATIONS

North Carolina's MFP Program has a section on the state website (www.ncdhhs.gov/dma/MoneyFollows) that provides information about the program from a variety of perspectives. A showcase of participant stories with written and filmed narratives offers – in many cases – the dual perspectives of the participant and his or her family.

The website serves as an outreach strategy while clearly delineating the project purpose, history, benefits, and eligibility guidelines. The program goals, transition materials, and systems level information are readily available and transparent. There are separate sections for beneficiaries, county staff, and providers, as well as some statistics and reports. Under "CMS MFP Presentations," the website also lists housing models that could be incorporated into an MFP housing strategy, including accessible, integrated rental housing, cooperative homeownership, community land trusts, Permanent Supportive Housing, and adult family homes (Baldwin and Dressler, 2008).

The MFP Roundtable section of the website provides a clear way to get involved in the project, and links to notes from recent Roundtable sessions. Meetings are held three or four times a year in different locations around the state and provide a clear mechanism for informing and involving the community.

Theory into Practice

What difference does it make? Ask Brian[2].

Brian's family had a strong internal support system that had been put in place long before he had his stroke at age 40. Brian's daughter, Kalie, was in her 20s, but she'd had profound disabilities from birth. Though Brian had provided most of her care before the stroke, his girlfriend, Sarah, and his extended family were also involved.

After his stroke, singly or in groups, Sarah and his family showed up at the nursing facility every day. From day one, they'd said, "We'll be taking Brian home."

Brian's family lived on top of a mountain. They'd managed to get a triple-wide trailer up there, and retrofitted it with accessible doorways, bathrooms, and ramps. They also had a modified van that made transport possible.

The remote location concerned MFP transition staff at first, especially given the gravity of Brian's disabilities. But during a home visit a few weeks after the transition, they were elated. Brian was doing great. He'd needed a lot of expensive equipment. The MFP budget had quickly disappeared, but Sarah and his family had proved excellent advocates. If Brian needed something, they found a way to get it. MFP staff said Brian's family made them realize that no matter where someone is located, if they have family, a transition can work.

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[2] Although this situation is based on a real MFP participant, the name and identifying details have been changed.

NORTH DAKOTA

Most of North Dakota retains frontier status: 37 of its 53 counties are designated as frontier and just four counties are urban. North Dakota is home to fewer than 700,000 people, approximately 270,000 of whom live in rural areas (Census 2010). This sparse population coupled with miles of wide-open spaces makes aging in place complicated. Part of the problem is that there are critical gaps in housing, services, and transportation (UD E-World, 2012).

Jake Reuter, North Dakota's MFP Program Administrator, describes MFP participants who wish to transition to rural North Dakota as "stridently self-sufficient and private, with deep roots."

Decent, safe and affordable housing is in short supply throughout North Dakota. People qualified for MFP have had difficulty locating housing that meets their needs at a price they can afford. North Dakota has instituted several innovative solutions to ensure that MFP participants have safe, accessible, affordable housing.

The more rural the area, the more likely it is that the individual will be isolated. Even fire trucks and ambulances can't find homes if they're too remote. We lay the cards on the table. "There are no services. You might make it for a week or two, but then what?"

FINDING QUALIFIED SERVICE PROVIDERS

Significant obstacles to stable housing in North Dakota arise from the fact that services are widely scattered and less robust than they are in urban areas. Fewer services are available, and the cost of service delivery is higher. All of this is compounded by the difficulty of finding Qualified Service Providers (QSPs). In response, MFP staff identifies and recruits people who are part of the client's natural environment.

Under "Family Home Care", family members (including spouses) can enroll with the state as QSPs and be paid to provide care for qualified family members. Although the MFP Program cannot pay family members to perform normal household tasks, the program can compensate qualified family members for tasks that go above and beyond normal spousal or family duty. They can also pay someone to come in and provide respite for primary caregivers.

Most of the QSPs in rural and frontier North Dakota function as self-employed, independent contractors. QSPs have various skill sets, and can be enrolled to fulfill a broad range of tasks, from case management to home remodeling, and from extended personal care and education to homemaker services. They are enrolled by the state Department of Human Services and must demonstrate competency in the services they wish to provide.

What difference does it make? Ask Emily.[3]

At 82, Emily had been in a nursing home for a year after falling and breaking a hip. Staff said that Emily spent a lot of time at the nursing home looking out the window, hoping for visitors. The trouble was, her closest family members were 75 miles away. They all had busy, demanding lives, and little extra money for gas. She fretted constantly about the two great-grandchildren who had been born while she was in the nursing home. She hated missing the opportunity to see them grow up.

Even though she was frail, Emily was convinced that she could get along with MFP supports. A Transition Coordinator helped her relocate to an apartment in the heart of the tiny community where she'd spent most of her life and where her family still lived. She couldn't have been happier. Her son and his wife, three grandchildren, and four great-grandchildren all lived nearby and stopped in often.

Emily had been in the apartment for three months when she was diagnosed with terminal cancer. She was determined to remain at home. After Emily passed, the family got in touch with her Transition Coordinator. They said how grateful they were that Emily had been able to spend her final months surrounded by the people she loved and who loved her.

CONSUMER HOUSING RESOURCE SPECIALISTS

Consumer Housing Resource Specialists help MFP participants assess housing. They work at the community level to help eliminate barriers to finding and securing the units MFP participants want and need if they are going to live successfully in the community. Housing Resource Specialists also offer MFP participants assistance with accessing housing subsidies and other income supports, and with overcoming barriers that inhibit access to housing. One Consumer Housing Resource Specialist is stationed in each of the four designated service areas established by the four North Dakota Centers for Independent Living.

RISKS, CONSEQUENCES AND RISK MITIGATION

North Dakota's MFP Transition Coordinators adhere to the principle that the person transitioning is the primary decision maker. At the same time, it can be difficult to achieve a balance between safety and choice. There are hazards inherent to transitioning to isolated areas, so the MFP Program has protocols to gather information about risks that could result in reinstitutionalization, create contingency plans, and establish mitigation processes. If an individual wants to take risks that staff members are uncomfortable with, coordinators use a Participant Risk Mitigation Assessment and policies. These tools, among many others are available online: http://www.nd.gov/dhs/info/pubs/mfp/overview.html.

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[3] Although this situation is based on a real MFP participant, the name and identifying details have been changed.

NORTH DAKOTA HOUSING INNOVATIONS

State Tax Credit Program

The North Dakota Housing Incentive Fund was initially authorized by the 2011 Legislative Assembly to close the financing gap on affordable housing available to families living on low and moderate incomes, and to promote development in rural communities. This state tax credit program was increased to $20 million during the 2013 legislative session. It is capitalized by taxpayers in exchange for tax credits (North Dakota Housing Finance Agency, date unknown). Tax credit funds are used to finance new housing construction projects for people with low and moderate incomes, a housing registry, and facilitation of public–private development projects.

MFP Housing Program

The MFP Housing Program is the result of a collaborative effort between the MFP Program and the North Dakota Center for Persons with Disabilities at Minot State University. Staff includes a State Housing Facilitator and four Consumer Housing Resource Specialists, located in the four quadrants of the state. MFP administrative funds support these positions. The State Housing Facilitator works with agencies, landlords, and Public Housing Authorities to identify housing. Consumer Housing Resource Specialists help consumers locate housing, facilitate housing development, and educate property managers on client needs.

MFP Housing Database

The North Dakota MFP Housing Program has created a housing database comprised of a searchable online registry to link prospective tenants with rentals that meet their needs and wishes. The database provides listing details including location, contact information, and details about the housing unit. There is also information about subsidized, low-income and fair-market units, accessibility features, unit size, the application process, and contact information for landlords and property managers. Landlords can contact a Consumer Housing Resource Specialist or provide information online to add housing to the database.

- Visit the website at **www.ndcpd.org/mfp** and click on the Housing tab.

Additional Housing Strategies

- MFP works with North Dakota's PHAs by covering the cost of housing inspections to ensure that housing used by MFP participants meets Housing Quality Standards (HQS).
- North Dakota assists with one-time moving costs to support discharge from the State Hospital and nursing facilities.
- MFP transition coordinators consider the issues that led to institutionalization in the first place. If Adult Protective Services (APS) was involved, they begin working with the state's APS Coordinator and local APS representatives as soon as they receive a referral.

NORTH DAKOTA'S RENTAL GAP ASSISTANCE PROGRAM

People who can succeed in the community (if they have supports) generally prefer community-based housing. Because this strategy is also anticipated to yield long-term savings, Medicaid incentivizes MFP Demonstration states by paying a higher reimbursement rate for support services that help MFP participants transition to community-based care. States are required to invest these "rebalancing funds" in programs or initiatives that help shift the balance of long-term supports and services from institutional care and toward Home and Community Based Services (HCBS).

States have considerable flexibility in the ways they use their rebalancing funds. North Dakota is using some of its rebalancing funds to help get MFP participants into housing and sustain them until a traditional housing subsidy or appropriate subsidized housing unit becomes available.

Housing Choice Vouchers (HCVs) pay the difference between the cost of housing and 30 percent of the household's adjusted income, making housing affordable to people living on extremely low incomes. Unfortunately, they are generally over-subscribed. North Dakota has succeeded in using MFP rebalancing funds to temporarily bridge the affordable housing gap until a traditional subsidy becomes available. This allows participants to transition from institutions when they are ready, rather than forcing them to wait until a Housing Choice Voucher or Public Housing Authority unit becomes available.

Applicable Rents and Rent Payment Process

The ND MFP Rental Gap Assistance Program mirrors local Public Housing Authority (PHA) and HUD rules. Maximum rents are consistent with Fair Market Rents (FMRs) established by HUD, and participants pay 30 percent of their adjusted gross incomes for rent. Rental gap assistance is equal to the difference between the amount paid by the MFP participant and the cost of the rent. The program can provide assistance for up to six MFP participants per month. The number varies depending on amount of assistance needed by participants.

The North Dakota MFP Rental Gap Assistance Program pays the difference between market rent and the amount the tenant is responsible for. The program pays the Transition Coordinator or HCBS provider agency involved with the client, who then will make the rental gap payment on behalf of the MFP participant.

Application Process

The Transition Coordinator completes the MFP Rental Gap Assistance Program application form, and includes written evidence that the applicant has applied for local rental assistance and has been placed on a waiting list. The request is then submitted to the MFP Program Administrator, who establishes a wait list if need be. MFP Rental Assistance can continue until a Housing Choice Voucher or other assistance becomes available to assist with rental costs or until the participant discontinues participation in the MFP program.

Eligibility Criteria

Applicants must meet all of the minimum criteria established for the MFP program. The applicant must:

1. Be an active participant of the MPF program.

2. Meet financial and other eligibility criteria for the local Public Housing Authority (PHA) for a Housing Choice Voucher (HCV) or other rental assistance.

3. Have applied – and be on the waiting list – for an HCV through the local PHA or other local subsidy programs.

4. Provide written evidence that s/he has applied for rental assistance and is on the waiting list(s).

5. Have living arrangements that meet the housing standards established by the local rental assistance agency, PHA, and/or HUD regulations.

6. Be financially responsible for the rent or housing costs.

7. Have been discharged from a qualified institution to a MFP qualified housing arrangement, and continue to participate in the MFP program.

Takeaway

Well-defined protocols are in place for every step, with clear "wins" for landlords as well as clients. The Rental Gap Assistance Program protects clients as well as housing providers and the program itself, and plans are in place for almost every eventuality. This kind of planning is a good start toward success.

North Dakota MFP and Housing Inspections

The Rental Gap Assistance Program arranged to have housing inspections completed by the local PHA. The cost (from $30 - $40) is paid to the Housing Authority and funded through one-time moving costs and/or the MFP rebalancing fund. For more information go to: www.nd.gov/dhs/info/pubs/mfp.html.

Quality Control and Safe Housing

Chapter Four discusses rural housing resources, including funding for repair. While there can be tradeoffs between self-determination and housing quality, safety is paramount. Housing may be so substandard that transition is unsafe.

Theory into Practice

What difference does it make? Ask Erline[4].

Erline wanted to leave the nursing facility, but was adamant that she'd only return to her home, which she and her husband had finishing paying for not long before he died. There were obstacles. Not only was the house in a state of terrible disrepair, Erline was morbidly obese and needed help with all aspects of personal care. There was a huge hole in the bathroom floor and structural problems with the foundation. It wasn't safe for Erline to return. Her transition coordinator gently offered other options. Ultimately, after trying to maneuver through the house, Erline sadly acknowledged the reality of her situation and opted to move into an apartment.

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[4] Although this situation is based on a real MFP participant, the name and identifying details have been changed.

OHIO HOME CHOICE

More than 89 percent of Ohio's geographic area is rural, inhabited by just 22 percent of the state's population – about 2.6 million people (U.S. Census, 2010). Ohio's MFP program, HOME Choice (Helping Ohioans Move, Expanding Choice) has transitioned MFP participants into all 88 Ohio counties (HOME Choice, 2013). More than half (48) of those counties are rural (Ohio Department of Job and Family Services, 2012), and some are very isolated.

One unique component of Ohio's program lies in its partnership with the Ohio Department of Mental Health (ODMH). Though HOME Choice serves people with all types of disabilities, since 2011 there has been a focus on people with Serious and Persistent Mental Illness (SPMI). The ODMH has a liaison position within its Pre-Admission Screening and Resident Reviews Office (ODMH, 2012). Cumulative data demonstrates resounding success. The program estimated that 692 people with SPMI would be served through December 2013, but 892 people with SPMI had already been enrolled by April 23, 2013. (HOME Choice, 2013).

Kim Donica, Ohio's MFP Director, credits the high numbers of MFP participants who have SPMIs to effective outreach and education, as well as the partnership with the ODMH. Ohio has also made effective use of the Minimum Data Set (MDS) Section Q tools to identify potential participants.

HOUSING INNOVATIONS

- The Ohio Housing Finance Agency approved Housing Development Gap Financing that awards points to developers who include at least one unit that is affordable for people living at 18 percent of Area Median Income or below. People whose only source of income is Supplemental Security Income (SSI) could afford these units without a housing voucher (HOME Choice, 2013).

- One barrier to transition was removed by a short-term Home Modification Cooperative that funds temporary and permanent ramp construction. The funds are dispersed through Centers for Independent Living and Area Agencies on Aging. Primarily geared to HOME Choice participants, this program can be used to provide a temporary ramp until a permanent ramp can be provided through a Medicaid Waiver (HOME Choice, 2013).

Ohio HOME Choice Fast Facts

- HOME Choice had enrolled 3,282 participants by April 23, 2013, from a pool of 8,192 applicants. The program relies on a pool of 140 Transition Coordinators and 560 providers.

- Enrollment by population includes 1,470 people with physical disabilities, 862 people with Serious Mental Illnesses (SMIs), 659 elderly and 374 people with developmental disabilities (HOME Choice, 2013).

RURAL TRANSITIONS AND HOUSING

Younger generations are highly mobile, but the MFP Program works with many seniors who don't want to leave the areas they consider home. Many have spent their entire lives in the foothills of the Appalachian Mountains. Frequently, their philosophy is, "Don't trust strangers, and don't leave home."

In Ohio as everywhere, housing is hard to find. Rural communities typically have few apartments or senior housing units. Single-family rental housing can mean dealing with lack of accessibility, big yards that are difficult to maintain, and houses that are too big to manage.

Ohio's transition coordinators have adopted several creative strategies for finding housing. They watch for "For Rent" signs, check newspapers, and build relationships with landlords and Realtors. Many have received housing leads through their churches or neighbors.

"When someone goes into an apartment and says, 'I never thought I'd see this again,' it makes it all worthwhile."

— Ohio HOME Choice Transition Coordinator

INTEGRATION TIPS

- HOME Choice Transition Coordinators remind potential MFP participants that the nursing home provides a highly social environment, but after transition, they could be alone for hours at a time. Additionally, if the person has been in an institution or away from the community for a significant time, the community may have changed dramatically. The individual's memories may be filtered through rose-colored glasses, reflecting times when they were younger, healthier, or more mobile. The guys at the coffee shop probably aren't there anymore and the bridge club may have broken up.

- Is there a local Area Agency on Aging or Council on Aging? Ask if volunteers are available to help the MFP participant begin building or rebuilding a social network.

- If the individual has been affiliated with a church, synagogue or other religious or fraternal organization in the past, help him or her reconnect.

- There may be few organized activities in small towns. Sharing Sunday dinners, attending religious service or club meetings, grocery shopping, playing Bingo, going to the Senior Center or the American Legion are common social outlets. Helping people make these connections is critical.

HOME Choice publishes a biannual newsletter available at: http://jfs.ohio.gov/OHP/consumers/HCnewsletter.stm.

OKLAHOMA LIVING CHOICE

Nearly *all* of Oklahoma (98.1 percent) is classified as rural, and is home to just over one-third of the state's population or about 1.3 million people (U.S. Census, 2010).

The Living Choice Money Follows the Person Program began transitioning people into the community in 2009. The lead agency is the Oklahoma Department of Human Services Developmental Disabilities Services Division. Partners include three federally funded Centers for Independent Living and eight case management agencies working under ADvantage Waiver contracts. Collectively, these agencies coordinate statewide transitions. The Oklahoma Health Care Authority (OHCA) is responsible for supervising, monitoring, and administering the Living Choice Project, as well as contracting and arranging service delivery (Mecham, 2013).

PAYMENT FOR RURAL TRANSITION COORDINATION

The Living Choice Project recognizes that more time is needed to transition MFP participants to very rural areas. In support of that reality, it pays a higher rate for these services. Areas that carry a "*very rural*" designation are harder to staff and consume more staff resources in the course of an MFP transition than are typically required in more populated areas (Mecham, 2013b).

Theory into Practice

What difference does it make? Ask Donald.[5]

David was 53 when he joined Living Choice. He'd spent seven years in nursing facilities after sustaining a Traumatic Brain Injury in a motorcycle accident. Once he got back to his rural community, David had formal support from the MFP program, and a lot of informal support from his mother and sister. It wasn't long before he began managing all of his personal needs independently.

Before the accident, David had worked in restaurant management, so he was able to draw on that knowledge to help with meal planning, budgeting, and money management. After a year in the My Life, My Choice waiver, he asked to be discharged. By then, he'd been managing his household, personal, medical and financial needs for over a year. David has remained happily independent and is still thriving in the community.

"Once you're outside major metropolitan areas in Oklahoma, housing is hard to find. If you see a trailer with a "For Rent" sign, even if it's on an acre of land out in the middle of nowhere, slow down and get the number." – Joseph Mecham, Director

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[5] Although this situation is based on a real MFP participant, the name and identifying details have been changed.

TEXAS MONEY FOLLOWS THE PERSON DEMONSTRATION

According to U.S. Census data (U.S. Census, 2010), nearly all of Texas's huge land mass is rural (96.7 percent). That vast area is home to 15.3 percent of the state's population or approximately 3.9 million people.

Texas was one of the originators of the Money Follows the Person concept, which was implemented by the Texas Department of Human Services in 2001 as the Promoting Independence Initiative. Texas was in the first cohort of states that received Money Follows the Person Rebalancing Demonstration funds. The project, seated in the Health and Human Services Commission (HHSC) and the Texas Department of Aging and Disability Services (DADS), has led the nation in transitions from institutional care.

Community Transition Teams (CTTs) have been developed in each of eleven multi-county regions. Members include the Relocation Contractor, managed care staff, nursing facilities, PHA representatives, adult protective services, state agencies and others as appropriate.

Texas works with relocation contractors who employ relocation specialists to assist with outreach, identification, and relocation services for individuals who wish to participate in the MFP program (Texas Health and Human Services Commission, Texas department of Aging and Disability Services and State Health Services, 2010).

RURAL RELOCATION ISSUES

Rural service areas in Texas are so immense that participants can be 250 miles apart and still live within the same region. Contractors have the right to refuse a referral for any reason, including geography. This can make it challenging to find providers, particularly in an area where it can take up to six hours of uncompensated "windshield" time for the provider to reach a single client.

Texas's relocation program targets those with very high needs, but it can be difficult to find a willing relocation specialist for really tough cases. Even in situations where the relocation is approved, the community of choice may not have good access to providers who offer acute services or long-term supports. Care agencies also have the right of refusal if they don't believe they can meet a consumer's care needs. Many people have been approved only to learn that none of the local doctors are willing to accept the liability implicit in their care. If the relocation goes forward, the MFP participant may need to travel out of the county to see a specialty care provider or primary care physician. Though Medicaid will provide medical transportation, the long distances involved are problematic.

One recent MFP participant wanted to transition to an extremely small, isolated community. Although the Public Housing Authority did not have a wait list, there wasn't a local grocery store, and the only transportation provider charged $25 for a ride to the nearest store.

RURAL HOUSING

There are trade-offs when MFP participants want to transition home to small towns. Though housing availability varies by community, in general, finding housing with a subsidy attached can be easier in rural America than it is in urban areas. Rent may be cheaper in rural areas as well, though still too high to be affordable to MFP participants. Apartments are scarce, and though a duplex or single-family unit may be larger, it can be much more difficult to manage, and may be further away from services and other accommodations.

If the MFP participant is returning to a rural home that he or she owns, it may very likely be substandard. Since MFP is a consumer-directed program, transition coordinators will work with the individual, but the $7,500 lifetime cap on the residential repair through the waiver may not be sufficient if there are holes in the floor and the roof is falling in.

MFP staff members may suggest alternative housing options, and encourage potential participants to tour available units before accepting them. It's important to make sure any unit under consideration meets the client's needs, no matter how badly the individual wants to transition. Staff have found that rentals in rural areas are often older units that do not have accessible doors or bathrooms, and that repairs or modifications are often needed.

RURAL RELOCATION TIPS

- Get creative. Volunteer labor can make MFP relocation funds stretch. Church and civic groups are a good place to start: they are often willing to donate services.
- Some relocation contractors have hired volunteer coordinators to support the local MFP Program.
- Use social media, including Twitter and Facebook to help educate the community about the MFP Program. Recruit housing and care providers as well as volunteers. Make sure any information provided is clear.

Theory into Practice

What difference does it make? Ask Jane.[6]

Before Jane's car accident, she lived in a rental home "300 miles from anything but cactus and cattle." She desperately wanted to return. Her transition coordinator finally helped Jane find the perfect cottage close enough to family to offer a degree of security, and far enough away from town that Jane could enjoy her solitude. Unfortunately, the place did not have air conditioning, a potentially life-threatening omission in the sweltering Texas heat. The MFP transition coordinator purchased an air conditioner and hauled it to Jane's new home in the back of a borrowed truck only to find that it didn't work. The second unit worked, but this "easy fix" cost hours of work. The good news? Jane is still enjoying the silence two years later.

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[6] Although this situation is based on a real MFP participant, the name and identifying details have been changed.

WASHINGTON'S ROADS TO COMMUNITY LIVING

Washington State's land area is 96.4 percent rural, an area that is home to approximately 1,073,000 people or 16 percent of the state's population (U.S. Census, 2010). The Roads to Community Living (RCL) Project, which started in 2008, has been very successful in terms of achieving transitions from institutions into the community, largely through the use of dedicated housing staff.

The MFP RCL Program has three levels of housing staff in place. These include a state housing coordinator who reports directly to the Washington Department of Social and Health Services (DSHS) Assistant Secretary for Planning, Performance and Accountability. For DSHS program purposes, the state is divided into three regions, each of which has an RCL Regional Housing Specialist – the second level of housing staff. Case managers can refer MFP participants to local Community Choice Guides – the third level of housing staff. These guides help participants find the housing and services that can ease transition to the community (Mensh, 2012).

> *"We hear a lot about this idea that housing people in rural areas is more difficult and more challenging than it is in urban areas. There are some unique cases, but I've actually had an easier time housing people in rural communities."*
> *— Jodi Lamoreaux, RCL Housing Program Manager*

CUTTING THE RED TAPE: RCL AND RURAL HOUSING

Housing is often more available in rural Washington communities than it appears, and through relationships with landlords and Housing Authorities, it may be possible to expedite housing access. Wait lists for subsidized housing may appear long, but can be artificially inflated with the names of people who have found housing or left the area. In many cases, getting people housed comes down to building good relationships with clients, case workers, and housing providers.

All housing providers have had bad experiences with tenants who damaged property, didn't meet the terms of the lease, or disturbed other residents. The case management available to MFP participants can help ensure a level of accountability that is not usually available. Once housing providers know that RCL clients have ongoing support and that if something happens, the program can make it right, they are often more open to taking a chance.

Washington's front-line transition coordinators say that in some rural communities, they have – at times – been able to get someone in the next day. Coordinators have formed excellent relationships based largely on being able to ensure accountability. An additional savings to the MFP program is in the time and effort saved when case managers or transition coordinators don't have to help people fill out applications at multiple housing projects.

RURAL PARTNERSHIPS

- RCL services were purposely designed to be broad, because services that are too narrowly defined can become a barrier to care, particularly in rural areas where resources are sometimes limited (Washington State's Money Follows the Person Demonstration Project, 2010).

- Transportation is an issue. Community Choice Guides (CCGs) cannot afford to purchase insurance that allows them to transport RCL clients. Medicaid will pay for gas for medical transportation, but non-medical transportation is another story. Rural communities often look to volunteers who can transport MFP clients to appointments, grocery shopping, or the pharmacy. Mission-driven churches can be especially helpful in finding volunteers. Community members often go above and beyond the call of duty. There are many examples of pharmacists willing to drop medications off on their way home, and neighbors who take RCL participants to the driving range to hit golf balls or to the senior center for quilting classes.

*Volunteers are such a critical resource that Washington State has formalized a process for registering volunteers. This way, volunteers can be covered by state insurance so they can drive state cars. Sample volunteer application, registration, and authorization forms have been compiled into a PDF document available at **WA Volunteer Forms** on the www.MFP-TAC.COM technical assistance website.*

WASHINGTON'S HOUSING BRIDGE SUBSIDY PILOT

Washington State's MFP program is called Roads to Community Living (RCL); RCL rebalancing funds are used to support the Housing Bridge Subsidy Pilot Program. Like North Dakota's program, this pilot provides an opportunity for MFP participants to obtain a time-limited rental subsidy for the time between moving from an institution to affordable community housing and the time a permanent subsidy becomes available. Eligible MFP clients are those who are otherwise capable of discharge, but have no other affordable housing options while they wait for a permanent subsidy.

This program funds the difference between an MFP participant's rent and 30 percent of the client's current income. The numbers served vary, depending on the amount of support needed by participants and the length of time each client needs the subsidy. Current estimates suggest that approximately 100 persons will be served per year. Most will need assistance for less than a year. The total annual cost of approximately $500,000 depends on the types of subsidies needed and where the housing is located. MFP participants cannot receive the bridge subsidy for more than two years.

- **Cost Effectiveness**

From a fiscal perspective, RCL staff believes that they can provide a year of rental subsidy for clients for less than it would cost for them to remain in a skilled nursing facility for two months *or less.*

WASHINGTON'S HOUSING BRIDGE SUBSIDY PILOT, *continued*

Time-limited rental subsidies are paid one month at a time, until the MFP participant can access a mainstream subsidy, or until it becomes apparent that affordability is not achievable within the maximum time frame.

If the pilot project is successful, additional funding will be requested on an annual basis until one year before the MFP Demonstration is scheduled to end. At that point, the program will not accept new clients but will continue to fund existing clients in need of the assistance.

- **Managing and Reporting the Bridge Subsidy**

The housing bridge subsidy is a pilot project that is being very carefully and deliberately implemented. The feasibility of bridge subsidies for MFP participants will depend on a complex set of variables that vary on a case-by-case basis and collective evaluation. Applicants will be screened by a special committee that considers individual information, including strengths, needs, functionality, and more.

Before a client is accepted into the pilot, s/he is required to review and sign a service agreement outlining the requirements for participation and clearly explains that funding is available for just one year at a time. The service agreement will also outline the expectation for compliance with lease agreements. Each case will be reviewed at least every six months.

- **Accessing the Housing Bridge Pilot**

To begin the process, an MFP social worker completes an assessment, which is followed up with an email to the Project Director that includes basic information about the client and his/her needs and desires. At that point, the Housing Program Manager (HPM) completes the initial screening and contacts the social worker with the results. Afterward, the client is assisted with completing at least three subsidized housing applications. The client views and completes applications at each of the subsidized sites and must agree to accept the first unit that becomes available.

In the meantime, the HPM completes the following tasks:

- Arranges for the pilot committee to review the client's application;
- Ensures that the client has signed the Participant Agreement after acceptance into the pilot;
- Ensures that the contract with the housing provider is complete and authorizes the rental subsidy.

After the client has been accepted into the program, the HPM reviews each case on a six-month basis, to check progress, and to reauthorize the subsidy if necessary.

WASHINGTON'S HOUSING BRIDGE SUBSIDY PILOT, *continued*

- **The Goal is Client Success**

It must be very likely that clients accepted into the program will be able to obtain a permanent subsidy within two years, and each individual's plan must include at least two back-up options. If a year passes without a permanent subsidy, the Housing Program Manager works with the client to begin developing alternative housing options. During the last six months of participation in the pilot, the HPM works intensively with the client to obtain alternative housing.

- **Basic Rules**

  o Housing must be independently affordable once the subsidy is awarded.
  o The client must apply for a minimum of three subsidized units and accept the first subsidy offered.
  o Those accepted into the pilot are likely to be able to access a permanent subsidy within the two-year timeframe.
  o The client must remain functionally and financially eligible for services throughout the time s/he participates in the pilot.
  o Continued funding of the bridge voucher is contingent on funding availability.

For more information, go to:

http://www.altsa.dshs.wa.gov/professional/hcs/roads/.

Takeaways

RURAL MFP PROGRAMS: COMMON THEMES

Although the language varies from state to state, common themes emerged from the many conversations held with MFP directors, staff members, and contractors.

- Flexibility is particularly important in ensuring that rural programs can meet local needs. Roles may not be as clear-cut and care providers may need to take on multiple roles.
- Strong community-level relationships are essential to program success. Many MFP Programs are working through established local organizations including Area Agencies on Aging, Centers for Independent Living, and Long-Term Care or Senior Ombudsman agencies that have already established a trusted local presence.
- Identifying housing is a creative process, and though there may have to be some give and take between quality and self-determination, safety is a key consideration.
- Volunteer service can be an effective and important part of the MFP Program in rural areas, and can make all the difference in whether a placement is successful or not. Churches and civic organizations should not be overlooked as partners.
- Social media can be valuable for getting the message out to rural communities.

CHAPTER FOUR: *Rural Housing Solutions*

MFP staff members from rural states almost universally note that finding decent, accessible, safe housing for clients who wish to transition to rural communities is one of their biggest challenges for a number of reasons.

Many rural areas experience high poverty rates and are home to aging populations. Many rural seniors own their own homes, but are less able to maintain them as they age. These factors are often coupled with declining populations in frontier and rural communities as younger people leave to seek work. Absentee homeownership becomes more common. Collectively, these factors lead to declines in home values, which in turn make it more difficult to obtain mortgages or home rehabilitation loans. Rural areas also have fewer rentals, and the rentals that do exist are more likely to be substandard (Housing Assistance Council, 2012).

While most MFP programs have resources that can be used to help ensure that the housing people transition into is habitable, safe, and/or accessible, those funds are limited. Fortunately, there are housing resources and technical support opportunities available specifically to rural areas. This chapter will explore some of those resources with an eye to rehabilitation, housing development, and capacity building. The chapter will also explore some innovations that are working well in rural communities.

CHAPTER FOUR LEARNING OBJECTIVES

After reading Chapter Four, readers will be able to:

- List at least five resources where they can find information about funding to rehabilitate or develop rural housing.
- Describe at least three strategies for rehabilitating or developing affordable housing in rural or frontier area.
- Give at least three examples of partnerships that have resulted in affordable housing in rural and frontier communities.

RURAL HOUSING

Common low-income housing issues in rural areas include lack of capacity, funding gaps, and high rates of substandard housing. The resources in this chapter have been designed to serve as a starting place for MFP transition coordinators who need housing rehabilitation funds, and agencies that have identified the need to develop more affordable housing. These resources include the following.

Home Improvement, Rehabilitation, and Purchase
- U.S. Department of Agriculture Rural Development
- Low Income Home Energy Assistance and Weatherization programs
- Veterans Assistance for Home Modification Grants
- Rebuilding Together
- NeighborWorks
- HOME Tenant Based Rental Assistance (TBRA) Vouchers

Housing Development
- U.S. Department of Housing and Urban Development (HUD) 811 Program
- HUD 202 Program
- HUD Rural Housing and Economic Development Gateway

Housing Access
- HUD HOME Tenant-Based Rental Assistance (TBRA)

Rural Capacity-building Assistance
- The Housing Assistance Council (HAC)
- Center for Rural Strategies

USDA RESOURCES

The United States Department of Agriculture (USDA) is often associated with food and nutrition assistance, but its Rural Development Agency also provides housing resources. In fact, USDA Rural Development (RD) is one of the best federal resources available for rural housing assistance. This support is also accessible: local Rural Development Service Centers are a familiar presence in rural counties. These centers provide a single local contact point where people can go to access USDA Farm Services, Rural Development assistance, Cooperative Extension Offices, and more.

Funding is available for housing and community assistance that can be accessed by individuals, non-profit agencies, municipalities, American Indian Tribes and other entities. Following are some of the resources that could be useful for MFP program participants.

USDA Housing and Community Facilities Programs (HCFPs)

The USDA Rural Development Agency provides technical assistance and financial backing through its Housing and Community Facilities Programs (HCFPs). These programs help rural communities – and individuals – by providing loans and grants that can be applied to single family homes, housing rehabilitation, apartments for low-income, elderly, and disabled persons, housing for farm laborers, and public facilities. These resources are available through mechanisms described below.

This section focuses on programs that may be able to offer assistance to MFP clients. Though few transitioning MFP participants are likely to purchase homes, many who leave institutions with the intent of returning to their small communities already own their homes. The Rural Development Agency offers low-interest loan programs for persons living on very low incomes that assist with rural home purchases, building, repairing, renovating, or relocating a home.

- **Rural Repair and Rehabilitation Loans and Grants**

The **Housing Preservation Grant (HPG) Program** provides grants to sponsoring organizations for use in repairing or rehabilitating low- and very low-income housing. These competitive grants are available in high-need areas. Property owners who are eligible to receive assistance include homeowners, landlords, or members of a cooperative. Eligible sponsors for these grant programs include state agencies, units of local government, American Indian Tribes, and nonprofit organizations. HPG funds can be used as loans, grants, or subsidies for recipient households. The purpose of the funds will vary based on the plan described by the grant application. The common criterion is that the assistance must be used on homes for households living on very low or low incomes*.

The **Very Low-Income Housing Repair Program** provides direct loans and grants to very low-income homeowners for use in repairing, improving, or modernizing their dwellings, or to remove health and safety hazards. To obtain a loan, homeowner-occupants must:

- be unable to obtain affordable credit elsewhere;
- have very low incomes (below 50 percent of the area median income); and
- need repairs to make improvements to remove health and safety hazards.

Grants are only available to homeowners who are 62+ years old and who do not have the resources to repay a Section 504 loan. Eligibility criteria as well as areas eligible for assistance are available online. To find out if the area you are serving is eligible, go to: http://eligibility.sc.egov.usda.gov/

- **Rural Housing Direct Loans**

Single Family Housing Programs provide homeownership opportunities to low- and moderate-income rural Americans through loan, grant, and loan guarantee programs. *The programs also make funding available to individuals so that they can make the improvements necessary to bring their homes into decent, safe, and sanitary condition.*

- For more information, see www.rurdev.usda.gov/HAD-Direct_Housing_Loans.html.

Note: *Very low income is defined as below 50 percent of the area median income (AMI); low income is between 50 and 80 percent of AMI.*

The **USDA Rental Assistance Program** can be used in existing and newly constructed Housing and Community Facilities Program (HCPF) projects financed through Rural Rental Housing (Section 515) or Farm Labor Housing (Section 514). Eligible tenants are elderly, disabled, and living on low and very low incomes.

The Rural Rental Assistance program provides an additional source of support for households with incomes too low to pay the USDA Rural Development subsidized rent. This operates like the Department of Housing and Rural Development's (HUD's) Housing Choice Vouchers: USDA Rural Development will pay the owner of a multi-family housing complex the difference between the tenant's contribution (30 percent of adjusted income) and the monthly rental rate.

Traditional housing subsidies through Public Housing Authorities or Housing Choice Voucher programs can be very difficult to procure for MFP clients who wish to transition into rural communities. Rural Rental Assistance subsidies may be available. These program can also provide grants or low-interest loans to landlords in order to assist with repairs or renovations needed to make units safe, decent and accessible.

- To learn if there is **rural rental housing** in your community, go to: http://rdmfhrentals.sc.egov.usda.gov.

From this site, select your state, then your county. Multi-family housing rentals are detailed by community, and include hot links to rental properties and property information.

The **USDA Service Center Locator** is a robust website that includes interactive maps. The site provides addresses and contact information for local USDA Rural Development Service Centers. Go to http://offices.sc.egov.usda.gov.

So What? Even though you may not be in a position to develop rural housing or to sponsor a program that assists low and very low-income renters or property owners, staff at the USDA Service Centers will know what is available within the community, which nonprofit or other agencies are providing funding for housing repairs, who is managing subsidies and whether they are available. Service Centers can also assist with matching client needs to available resources.

Takeaway Rural families living on low incomes are more likely than their urban counterparts to own their homes, but many live in substandard – and sometimes deeply substandard – housing (Rural Assistance Center, 2013). The difference between success and failure in a rural transition can hinge on finding a way to fund accommodations, shore up substandard housing, or find a rent subsidy. USDA Rural Development may have the means to help. Local service centers in rural counties throughout the nation can be valuable allies.

USING USDA RURAL REPAIR AND REHABILITATION GRANTS TO MAKE HOME MODIFICATIONS FOR THE ELDERLY

USDA Rural Repair and Rehabilitation Grants are available to low-income, rural homeowners unable to repay a loan. There are geographic and age requirements for this grant program: homeowners must be 62+ years old, and must live in a rural area with a population of fewer than 10,000 persons. A state-by-state and county-by-county list of eligible areas is available online: http://eligibility.sc.egov.usda.gov.

Those who are eligible for this program must have income at such a level that they cannot obtain loans elsewhere. The program typically defines this as an annual income of less than 50 percent of the area median. Clients eligible for the Money Follows the Person Program would likely be categorically eligible by virtue of the fact that they qualify for Medicaid.

The maximum USDA Rural Development grant is $7,500. The funds can only be used for repairs and improvements that enhance the health and safety of occupants. To apply, contact the local USDA Service Center.

Note: The USDA Rural Development Program is also referred to as the: Section 504 Program, Very Low-Income Housing Repair Program, and the RD 504 Loan Program.

Not sure where to start? Check with your local USDA Service Center to see if any nearby tax-exempt public agencies or private non-profit organizations are managing **USDA Housing Application Packaging Grants.**

These grants reimburse eligible organizations for part or all of the costs of conducting, administering, and coordinating an effective housing application packaging program in colonias and designated rural counties. Grantee organizations help rural individuals and families living on very low and low incomes obtain assistance from federal, state, and local housing programs. Assistance can include prescreening, preliminary eligibility determinations, ensuring applications are complete, and helping applicants understand the programs.

Theory into Practice

Consider Marty. At 68, he just wanted to move home to the small community where he'd spent his life. Unfortunately, he couldn't get to the door without a ramp, and between lack of insulation and an aging furnace, his heating bills were more than he could afford. His MFP Transition Coordinator called the local USDA Service Center and learned that Marty met the criteria for a Rural Rehabilitation grant. With help from his transition coordinator and local RD staff, Marty applied for – and received – a $7,500 grant, enough to accomplish everything he needed. He spent the next four years safely and comfortably in his home.

Additional Information

"Paying for Senior Care: a Resource Locator" is a web-based tool that opens with a short online survey. After answering a series of health-related and demographic questions, the survey participant is provided with a list of links to resources specific to his or her circumstances. Resources run the gamut from healthcare and durable medical equipment to veteran benefits. The list includes a section of links to home modification resources.

A sample survey completed for a senior with disabilities in rural Fruita, Colorado revealed eight distinct resources for home modifications alone. These included USDA Rural Repair Grants, Medicaid waivers in place in Colorado, non-profit resources, community building projects, *Rebuilding Together*, veteran resources, and HUD improvement loans. To try the tool, go to:

- **www.payingforseniorcare.com/.** Toward the middle of the page, select "Find Financial Assistance for Elder Care," then "Resource Locator Search Tool."
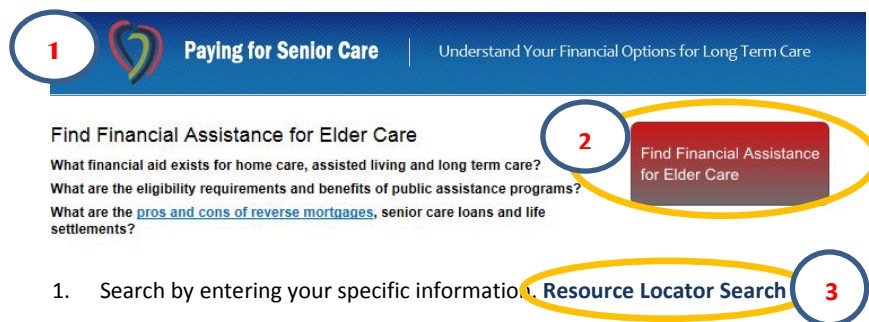
REBUILDING TOGETHER COMMUNITY BUILDING PROJECTS

Rebuilding Together is a national organization with local affiliates. Though not specific to rural communities, their programs help low-income families, veterans, and the elderly continue living at home by providing free home modifications.

The **Safe at Home Program** helps seniors living on low incomes and families who need assistance maintaining their homes, as well as those who have disabilities that require modifications. Volunteers make safety improvements such as installing ramps, handrails, or special lighting.

The **Heroes at Home Veterans Housing Program** helps veterans, their families, caregivers, and/or widows/widowers. The program modifies homes so that they are accessible to wheelchairs. Projects include constructing ramps, remodeling bathrooms, hallways and kitchens. The program is open to honorably discharged veterans (and/or their families) that own their homes and need modifications to maintain their independence.

On **National Rebuilding Day/Christmas in April,** thousands of volunteers make home modifications for low-income families and seniors with disabilities. Improvements are limited to those that volunteers can complete in a single day.

Applications for assistance are accepted and reviewed by local Rebuilding Together chapters and criteria are determined locally. Find local affiliates:

- http://rebuildingtogether.org/affiliates/.

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

According to an AARP Public Policy Institute report (Jackson and Walters, 2012), home heating costs have been increasing since the mid-1990s. Energy cost increases during this period have outpaced the ability of many low-income consumers to adequately heat their homes. The Low Income Home Energy Assistance Program (LIHEAP) provides block grant funding to all 50 states and other jurisdictions to provide heating and cooling bill assistance to eligible low-income households.

The LIHEAP program can help families stay safe and healthy by assisting with home energy bills, energy crises, and weatherization and energy-related minor home repairs. Although this resource is available to households throughout the country, benefit levels can vary greatly state-to-state. A list of state and territory LIHEAP contact listings is available at the Administration for Children and Families Office of Community Services website at:

- http://www.acf.hhs.gov/programs/ocs/liheap-state-and-territory-contact-listing.

Additional Information The LIHEAP Action Center provides state-by-state and county-by-county information on LIHEAP funding history, demographics, and county-level impact. This advocacy organization also put together state-specific fact sheets. Go to: http://liheap.org/.

WEATHERIZATION ASSISTANCE PROGRAM

The Weatherization Assistance Program (WAP) provides means to make homes more energy-efficient for households living on low incomes. The U.S. Department of Energy (DOE) provides funding to states, territories and tribal governments. In turn, the grantees fund local organizations such as community action agencies to manage the resource locally.

Once approved, actual weatherization services are determined on a residence-by-residence basis. Both single- and multi-family housing units are eligible, rented or owned. Efficiency measures can include improving heating and cooling systems, electrical systems, and electricity-consuming appliances. Services to consumers are free, and though the amount of money available per household is limited, the average expenditure is $6,500 (US Department of Energy, 2013). WAP also does global safety checks because many of the homes served are in substandard condition.

How does the Weatherization Assistance Program (WAP) work?

1. Get contact information for your state: www1.eere.energy.gov/wip/project_map/. Get information about the weatherization provider agency in the client's county.
2. Contact the local agency, then go in and apply. The application form takes about 20 minutes. The program will need proof of income for the year prior to application.
3. If the applicant is eligible, s/he will be put on a waiting list. People who are most in need are moved to the top of the wait list in many states. If the client is renting, s/he will have to gain permission to participate from the landlord.
4. A professional energy consultant will analyze the applicant's energy bills, test the infiltration of outside air, inspect for health and safety issues, and list the most cost-effective energy conservation measures for the home. All work must be energy related: it will not include, for example, new siding.
5. The local weatherization agency will schedule the work, which is typically completed within a day or two. The resident signs off on the final inspection.

To start the process, visit the Weatherization and Intergovernmental Program website Apply for Weatherization Assistance page: www1.eere.energy.gov/wip/wap_apply.html.

Making the Transition

According to several transition coordinators, many people are working hard just to survive in rural areas. Even in places where people are few and far between, most of the housing that MFP clients can afford is substandard. The trouble is, even when the rent is affordable, energy costs are often so high that the housing is unsustainable. That may not become apparent right away.

The Low Income Home Energy Assistance (LIHEAP) and Weatherization programs can help. In many places, the application process opens on October 1, and once a client is approved for LIHEAP, the home is automatically eligible for Weatherization services.

One transition coordinator interviewed for this toolkit talked about working with a client to get her approved for LIHEAP and Weatherization assistance. "We knew she was going to have a hard time making a go of it without that help. Heat in our area can be really expensive. The floors in her farmhouse weren't well insulated, and her water heater had conked out right before she went to the nursing home. Making her home safe and comfortable was going to cost a lot more than the program allowed. Community Action Agencies (CAAs) manage the LIHEAP and Weatherization programs for our area, and we make a point of reaching out when it seems like a good fit. Our philosophy is that we should use all of the MFP grant funds available, and access any other resources we can."

VETERANS' ASSISTANCE GRANTS FOR HOME MODIFICATIONS

The Veterans' Administration (VA) offers three types of grants that can help enable veterans to make home modifications needed to accommodate disabilities: the Home Improvement and Structural Alteration (HISA) Grant, the Specially Adapted Housing (SAH) Grant, and the Special Home Adaptation (SHA) Grant. Veterans can also access assistance through the Veterans-Directed Home and Community-Based Services and the Aid and Attendance programs.

The **Home Improvement and Structural Alteration (HISA) Grant** provides financial assistance that allows disabled veterans to make home modifications designed to improve access, mobility, and bathroom facilities. The disability does not have to be related to military service, although service-connected disabilities can lead to larger grant amounts. In order to access this assistance, veterans must have a doctor's prescription stating the diagnosis and medical reason for the home modification. The veteran doesn't have to own the home, so long as they have permission from the owner to make modifications. The maximum grant amount for veterans with non-service related disabilities is $2,000, and the veteran must be registered with the VA healthcare system. Veterans with service-related disabilities can access home improvement benefits of up to $6,800. More information is available online at: http://www.prosthetics.va.gov/HISA2.asp.

The **Specially Adapted Housing (SAH) Grant** (also referred to as 2010(a) Grants), provides financial assistance for home modifications to make veterans' residences wheelchair accessible. Assistance is only available to veterans with service-connected disabilities that include loss of or loss of function in at least one leg. There is no time limit on this resource. If a military-related disability has become progressively worse with age, to the point that the veteran requires a wheelchair, this may be a place to turn for assistance. The goal is to provide a barrier-free living environment that allows independent living. The maximum allowable benefit for the SAH grant is $50,000.

The **Special Home Adaptation (SHA) Grant** provides funds for veterans with specific service-connected disabilities to modify an existing home to meet adaptive needs rising from blindness or anatomical loss of – or loss of use of – both hands or extremities. This grant is generally used to assist veterans achieve mobility within their homes. The maximum benefit is currently $10,000.

MFP transition coordinators who think a client might be eligible for a SAH or SHA grant can help the client complete a VA Form 26-4555, Veterans Application in Acquiring Specially Adapted Housing or Special Home Adaptation Grant, and submit it to the local VA regional office. If the veteran is potentially eligible for a HISA grant, s/he should complete VA Form 10-0103, Veterans Application for Assistance in Acquiring Home Improvement and Structural Alterations, and submit it to the local VA medical center.

NEIGHBORWORKS

NeighborWorks America delivers community-focused programs and services through a national network comprised of 235 independent, community-based nonprofits that collectively serve more than 4,500 American communities. More than half serve rural communities. NeighborWorks takes a leadership role in affordable housing and community development, and works to create opportunities for lower-income people to live in safe, sustainable, affordable homes using a variety of mechanisms. The organization is headquartered in Washington, DC, and operates through the national office, two regional offices and seven district offices.

The NeighborWorks Rural Initiative is focused on rural community development. This initiative has generated more than $1 billion in direct investments in rural communities and has directly assisted more than 32,000 rural families with financial counseling, new home purchases, home repairs, economic development and job creation, new and improved units of affordable rental housing, and community facilities (NeighborWorks America, 2013).

In Fiscal Year 2011, NeighborWorks organizations generated nearly $4.2 billion in direct community investments, and assisted more than 261,500 low-and moderate-income families (NeighborWorks America, 2013). *To discover where the NeighborWorks resources are in your state or area, go to www.nw.org/network/Utilities/NWOLookup.asp, then choose your state or type in a Zip Code.*

SUPPORT FOR INNOVATIONS IN MANUFACTURED HOUSING

NeighborWorks America collaborates with the Innovations in Manufactured Homes program (I'M HOME), and two social enterprises, ROC USA and NEXT STEP LLC. Their goals include expanding opportunities for residents to own their manufactured homes and replacing pre-1976 mobile homes with Energy Star rated manufactured housing. By 2011, NeighborWorks America had made $1.55 million in capital grants for this purpose in eleven states (NeighborWorks America, 2011).

Theory into Practice

MOUNTAIN SPRING VILLA

Mountain Springs Villa is a resident-owned community (ROC) in Red Lodge, Montana. In this resort area, residential lots sell for around $120,000; housing affordable for families on very low incomes was unavailable. In traditional mobile home parks, families that own manufactured homes rent the lot the home sits on. Living on rented land denies these homeowners many of the financial benefits and security that conventional homeowners enjoy. On the other hand, manufactured homes on permanent foundations are considered a good use for Section 8 Voucher-to-Homeownership programs. The homeowners of Mountain Springs Villa used the ROC model to form a cooperative that they used to purchase their community. By creating the ROC, residents ensured that their park was free from the threat of redevelopment and displacement.

- For more information, visit NeighborWorks Montana at: http://nwmt.org.

HOUSING DEVELOPMENT

Housing development is not easy anywhere, but rural and frontier areas often face steeper obstacles than their urban counterparts when it comes to developing decent, safe, accessible and affordable housing for families living on low incomes. There are many reasons for this, not the least of which is lack of capacity among non-profit agencies, developers, and small municipalities.

Developing housing for individuals and families living on low and very low incomes can mean creating complex packages comprised of funding from several different federal sources (e.g., Community Development Block Grant, HOME Investments Partnership Program, and Low Income Housing Tax Credits), setting up private financing, accessing grants from foundations, and managing capital campaigns. Completing this puzzle requires a sophisticated understanding of the housing development system within the state, a healthy network that includes the State Housing Finance Agency, and the institutional knowledge to generate a cohesive package of applications. All told, developing housing for persons living on very low incomes is daunting, even for agencies with plenty of experience, staff, and institutional knowledge.

Cost is another prohibiting factor. Not only is it expensive to put together a series of complicated grant applications, there is no guarantee they will be funded. Even when these grants *are* awarded, meeting the complex regulations involved in using them can present significant barriers to small agencies.

Rural areas generally have higher poverty rates and lower area median incomes than their urban counterparts. Since rents for publicly funded housing are predicated on Area Median Income (AMI), allowable rents in rural areas are lower than they are in areas with higher AMIs. At the same time, building costs are at least as high as they are in urban areas, and often higher due to shipping and other costs. This combination of high costs and low end-user rents make it extremely difficult to fund new housing in a way that makes it affordable for people living on low incomes. Partially for this reason, rentals may be few and far between in rural areas.

So What? *So what does this have to do with MFP programs?* A lot. At least 29 MFP states have developed relationships with their State Housing Finance Agencies (HFAs), seven have developed relationships with housing funders, and at least 15 have developed relationships with housing developers. The efforts involved vary among states, but demonstrate recognition of the fact that simply tapping into existing housing resources is not enough to address the housing needs of a growing MFP population.

HUD HOUSING DEVELOPMENT OPPORTUNITIES

- **SECTION 811**

The Section 811 Supportive Housing for Persons with Disabilities Program is a Department of Housing and Urban Development (HUD) mechanism that funds development and subsidization of rental housing with voluntary supportive services. The housing is geared to meeting the needs of very low-income adults who have significant, long-term disabilities. Section 811 allows people with disabilities to live as independently as possible in the community by subsidizing rental housing with access to services.

The Section 811 program is part of the Frank Melville Supportive Housing Investment Act (2010), which includes reforms to stimulate the annual creation of integrated permanent supportive housing units. The Melville Act reinvigorated the Section 811 program in order to assist states in developing new policies and systematic approaches to housing people who may be living unnecessarily in institutional settings, are homeless, or are at risk of either condition. For more information, go to the Section 811 Portal: http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/grants/section811ptl

811 Project Rental Assistance units are available to individuals who are at least 18 and less than 62 years of age, are living on extremely low incomes, and can benefit from supportive services offered with housing.

The Melville Act incentivizes creation of integrated housing using two options:

- Project rental assistance provides funding to state housing agencies working with state human services/Medicaid agencies to create integrated supportive housing. Under this approach, up to 25 percent of the units in Section 811 assisted properties can be set aside for people with disabilities.
- The Section 811 Capital Advance and Project Rental Assistance Contract (PRAC) funds nonprofit organizations that create integrated supportive housing. Under the multifamily option, up to 25 percent of the units in a project can be set aside for people with disabilities.

Project rental assistance provided under Section 811 is project-based assistance that helps governments create integrated, cost-effective supportive housing units within affordable rental housing developments. HUD awards Section 811 project-based rental assistance funds on a competitive basis to state housing agencies working in partnership with state human services/Medicaid agencies. Funded Section 811 PRA units must accept 30-year use restrictions as a condition of receiving funds.

Takeaway Contact your state's Housing Finance Agency to find out how to get involved in collaborative housing workgroups. Nonprofit developers and state agencies (e.g., housing, health and human services) are receptive to input and foster active collaboration. You can help with the housing development process through active advocacy.

- **SECTION 202: SUPPORTIVE HOUSING FOR THE ELDERLY**

The Section 202 Supportive Housing for the Elderly Program is a HUD mechanism that provides capital advances to help finance the construction, rehabilitation, or acquisition of structures that will serve as supportive housing for elderly persons living on very low incomes. These programs also make rent subsidies available so that the housing units are affordable to those they are designed to serve. The intent of the Section 202 Program is to expand the supply of affordable supportive housing for persons who are 62+ years old and living on very low incomes.

Through Section 202, HUD provides interest-free capital advances that allow private, nonprofit sponsors to develop supportive housing for elderly persons. As long as the project serves this population for 40 years or more, the capital advance does not have to be repaid. Project rental assistance funds are provided to cover the difference between the HUD-approved operating cost for the project and tenants' contributions towards rent. The Section 202 allows residents – including the frail elderly – to live independently in places where they can access support for the normal activities of daily living. The program is similar to the Section 811 Supportive Housing for Persons with Disabilities Program.

For more information, go to: http://portal.hud.gov/ and choose Program Offices, Housing, then Multifamily Housing. From there, choose Descriptions of Multifamily Programs, followed by Section 202 Supportive Housing for the Elderly.

- **RURAL HOUSING & ECONOMIC DEVELOPMENT GATEWAY**

If your program is interested in pursuing housing development, technical assistance is available. HUD's Rural Housing and Economic Development Gateway clearinghouse provides support for rural housing developers and community development practitioners.

Rural Gateway Services
- *One-on-One Technical Assistance:* Call 1-877-RURAL-26 (1-877-787-2526) or e-mail rhed@hud.gov. The Rural Gateway technical assistance line will be answered by a live staff person between 9 a.m. and 5 p.m. Eastern Standard Time, Monday through Friday.
- *Local Training Sessions* are offered by trainers with experience in rural housing, infrastructure, and economic development.
- *Peer-to-Peer Exchanges* provide opportunities to network with their peers across the country.
- *Listservs* on rural housing and economic development and infrastructure.
- *Conference Calls* focusing on rural housing, infrastructure, or economic development issues.
- *Rural Funding Summaries* provide information on federal programs that fund rural housing, infrastructure, and economic development.
- Visit: http://portal.hud.gov/, then go to *Program Offices*. Select *Community Planning and Development*, then *Economic Development*, and under *Economic Development Programs,* choose *Rural Housing and Economic Development (RHED)*.

STRATEGIC MFP HOUSING DEVELOPMENT PARTNERSHIPS

State	Relationships			Tactics
	State HFA*	Housing Funders	Housing Developers	
Colorado	✓	✓	✓	Helps develop statewide housing strategy; applies for HUD NOFAs
Hawaii	✓		✓	Takes the lead on housing funding applications; builds relationships with local developers; attends housing conferences
Illinois	✓	✓	✓	Helps coordinate state housing policy
Massachusetts	✓	✓	✓	Collaborates on submission of HUD grants
Michigan	✓		✓	Participates in community planning efforts to increase housing options
North Dakota	✓		✓	Assists in developing and expanding safe, affordable housing options
Pennsylvania	✓	✓	✓	Project manager for 811 activities
*HFA: Housing Finance Agency				

HUD SECTION 811 PROJECT RENTAL ASSISTANCE AND MFP

Theory into Practice

In 2013, 13 states were awarded $97.8 million through HUD's Section 811 Project Rental Assistance Demonstration (PRAD). Through these demonstrations, state housing agencies work closely with their Medicaid and health and human service counterparts to identify, refer, and conduct outreach to persons with disabilities who require long-term services and supports to live independently ((Sullivan, 2013).

With its award of nearly $5.6 million over a five-year period, Washington State will provide project-based rental assistance for up to 275 units of housing for income-eligible people with disabilities. Referrals will come from Washington's Department of Social and Health Services Aging and Disabilities Services Administration social workers and case managers, who will identify and screen clients within their caseloads. As envisioned, Washington's 811 PRAD Program and Roads to Community will work hand-in-hand to develop housing opportunities that help people access the services and housing they need to live successfully outside an institution.

MORE HUD SECTION 811 RURAL STATE SUCCESS STORIES

- **California Housing Finance Agency (HFA)**

Funds will be used to provide long-term, project-based rental assistance for 335 units reserved for extremely low-income people with disabilities. The target population includes Medicaid beneficiaries with disabilities who are transitioning from institutional settings as well as persons at serious risk of institutionalization. The demonstration will be available in all 58 California counties.

- **Minnesota Housing Finance Agency (MHFA)**

Funds will be used to create 95 units of integrated housing for persons with significant vulnerabilities, including those exiting institutional care. To implement the demonstration, MHFA invited proposals from owners of existing mainstream affordable housing, and will award the proposed units across ten multifamily projects.

- **Montana Department of Commerce**

This program will couple affordable, accessible rentals with the full range of Medicaid waiver services to support independent living for extremely low-income individuals with disabilities who would otherwise be at very high risk of institutionalization or homelessness. Target populations are individuals between the ages of 18 and 62 who qualify for Medicaid waiver programs because of physical disabilities or mental illness. Four counties will pilot the program, which will fund 82 existing units.

- **North Carolina Housing Finance Agency (HFA)**

North Carolina's Section 811 PRA Demo program will be modeled after its existing Targeting and Key Programs, which provide housing assistance for persons with disabilities. Under the Targeting Program, the state requires that ten percent of the units in Low Income Housing Tax Credit (LIHTC) properties to be set aside to serve people with disabilities. Disabled individuals are referred to the units via a state managed referral network. The Key Program provides a rent subsidy that bridges the gap between what the tenant can pay and the rent necessary to operate the unit. The PRA Demonstration will fund 562 units of integrated housing for persons with disabilities. People transitioning out of a licensed facility or who are at high risk of institutionalization are included as priority populations.

- **Texas Department of Housing and Community Affairs**

Texas will use 811 funds to create 385 units of integrated housing for people who have disabilities who are living in institutions, people with serious mental illnesses, and youth with disabilities who are transitioning out of the custody of the state's abuse and neglect system. The Section 811 PRA Demo units will be identified in existing and pipeline units managed by programs with the demonstrated ability to provide housing for people with disabilities.

For more information, access the original press release at http://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2013/HUDNo.13-024.

GET INVOLVED

There are several ways that MFP program staff members can begin to make a difference in the way housing development funds are allocated in their states. One of the most important devices is to get involved in the state's Consolidated Planning process.

THE CONSOLIDATED PLAN

HUD requires its grantees to create a Consolidated Plan that includes an affordable housing/community development needs assessment, market analysis, and strategic plan for addressing priority needs over a multi-year period. Grantees are required to draft Annual Action Plans that provide detail about how Community Planning and Development (CPD) funds are used. The planning process is the framework for a communitywide dialogue used to identify housing and community development priorities. The priorities are then used to align and focus the use of four CPD formula block grant programs: the Community Development Block Grant (CDBG), the HOME Investment Partnership (HOME), the Emergency Solutions Grant (ESG) program, and the Housing Opportunities for Persons with AIDS (HOPWA) program.

Participating jurisdictions are *required* to solicit public input on needs, priority populations, and to use that input to help inform the decision-making process when allocating funds. Getting involved in this process is an excellent opportunity to advocate for the MFP service population and the housing they need.

MORE ABOUT CONSOLIDATED PLANS

Many cities, counties, and states have posted their Consolidated Plans and reports online. The plans provide information about identified needs, strategies to address those needs, and the way to get involved. Rural and frontier areas will probably be included in the state's Con Plan because they are not large enough for direct block grant allocations.

- Go to: http://portal.hud.gov, then to *Program Offices.* Choose *Community Planning and Development.* Under *Resources,* choose *Consolidated Planning,* then under *I am looking for:* choose *Approved State and Local Plans* and click on your state.

- This resource links to additional tools, including *eCon Planning Suite: Mapping* (CPD Maps). This interactive resource provides access to large amounts of information including details about CDBG, HOME, HOPWA, and other grants, as well as grantee information summaries.
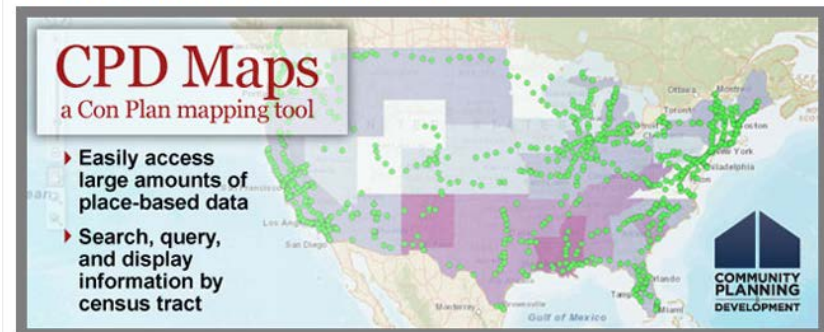
http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/about/conplan/cpdmaps

THE PUBLIC HOUSING AUTHORITY (PHA) PLAN

Public Housing Authorities (PHAs) submit five-year plans on behalf of the tenant-based assistance and public housing programs they manage. PHA Plans cover a number of issues, and can set priority populations for admission. PHAs must also assess the needs of those who are disabled, whether their needs are being met and – if not – plan how to do so.

So What? PHAs *must* hold at least one public hearing regarding the Annual Plan each year. The hearing is an excellent opportunity to advocate on behalf of the MFP population.

ADVOCACY TO HOUSING: AN INTERVIEW WITH DAVID LAYNE

- David Layne is a Housing Coordinator for the Money Follows the Person Program in Michigan. Partially because of strong relationships among MFP staff, the Michigan State Housing Development Authority (MSHDA), developers, funders, and others, his advocacy for housing has been successful.

I am proud to say that Michigan has more than 4,000 residents who were in nursing homes but now live in their communities with Medicaid in-home services. We would not have this many successes without the long- standing commitment of our partners at MSHDA, but we still have a long way to go. Solving the housing needs of people who are disabled, elderly, and living on very low incomes cannot be solved in a vacuum. These needs must be considered part of a comprehensive plan that leads to real solutions.

Good data is critical to making your case, so one of our strategies has been to perform needs analyses that can pave the way to successful grant applications. For example, 2012 surveys of Medicaid MI-Choice Waiver agencies, Area Agencies on Aging, and Centers for Independent Living revealed widespread shortages of subsidized units for non-elderly persons with disabilities and wait lists up to four years long.

Even in these times of polarized opinions on budgets and entitlements, folks rarely begrudge helping people who are elderly and disabled, but more housing is needed. In the beginning, I felt like I was screaming for help from a mountaintop. HUD mandates that its grantees get feedback on the Con Plans and Housing Authority plans. Every year, that means a fresh opportunity to speak up. Collaborations start with going to a meeting.

You don't have to be a developer, funder, or property manager to help create new housing. Start with being the advocate. If you're good at that, and if you let the developers know you're a partner who can bring service dollars to the table, you'll begin to find yourself in the loop when major housing decisions get made. These days I get invited to the meetings that count.

My advice? Dive in with good intention – you have the ability to help bring people, tenants, and dollars to the table. And not only can you bring tenants, you can bring good tenants who have lots of support. Developers and funders really hear that. And it's amazing how one thing leads to the next. As Martin Luther King said, "Faith is taking the first step even when you don't see the whole staircase."

HOUSING ACCESS

HOME TENANT-BASED RENTAL ASSISTANCE (TBRA)

HUD's Home Investment Partnership Program provides formula grants to states and localities that are used to fund activities that allow for building, buying, and/or rehabilitating affordable housing for rent or homeownership, or to provide direct rental assistance for persons living on low incomes.

HOME is the largest federal block grant supporting affordable housing for households living on low incomes. This flexible block grant encourages states and communities to design and implement housing strategies that meet their particular needs. It emphasizes consolidated planning, and some of it can be used for capacity-building. Using the funds requires local buy-in, so Participating Jurisdictions (PJs) must match every federal dollar with 25 cents of local funding. Because the program is flexible, PJs can use it to provide grants, loans, loan guarantees, rental assistance, or security deposits. This can be particularly valuable to MFP Programs. For basic program information, go to the Home website: www.hud.gov/offices/cpd/affordablehousing/programs/home

HOME's Tenant Based Rental Assistance (TBRA) program is used by a number of MFP Programs nationwide. This program gives PJs the flexibility to assist renters living on low incomes. Eligible tenants under this program receive direct rental subsidies that allow them to live in rental units of their choosing, provided that they meet Section 8 Housing Quality Standards (HQS).

TBRA BASICS

- TBRA is a rental subsidy PJs can use to provide help to households with basic housing costs, including rent, utilities, security deposits, and/or utility deposits. TBRA can be targeted to specific populations.

- TBRA assistance is limited to tenants with incomes at or below 80 percent of the area median, but the PJ can set tenant selection policies and criteria consistent with housing people living on very low and low incomes.

- Most commonly, TBRA is used to establish vouchers similar in purpose and execution to Housing Choice Vouchers. In this case, the tenant would pay 30 percent of his or her adjusted monthly income, and the program would pay the balance up to the Fair Market Rent for the area.

- Contracts with individual households cannot exceed two years, but can be renewable. HOME Program rules also establish a maximum TBRA payment, and require the PJ to establish a payment standard that puts an upper limit on the amount of assistance that can be provided to a tenant.

- **Potential Drawback:** HOME funds may be used to pay the cost of providing TBRA to households, but there are stringent limits on the amount that can be charged for administrative costs such as management, coordination, staff time, and indirect costs. Because administering these vouchers can require a significant amount of staff time, the program cost can be prohibitive.

TBRA AND MFP

Like Housing Choice Vouchers, TBRA vouchers can fill the gap between 30 percent of the participant's income and the cost of Fair Market Rent, which is set annually by HUD based on local markets. In order to implement this program, the need for TBRA must be articulated in the Participating Jurisdiction's Consolidated Plan. TBRA can be an exceptionally good fit for MFP in rural areas, many of which do not have Public housing Authorities or Housing Choice Vouchers specifically tied to the community. TBRA also allows housing vouchers to be targeted to specific audiences. MFP participants certainly meet the low-income criteria tied to program eligibility, and an individual subsidy can last for two years. This should provide sufficient time for the individual to "bridge" to a traditional housing subsidy or subsidized housing.

TBRA SUCCESS STORIES

ARKANSAS: The Arkansas Development Finance Authority (ADFA) developed TBRA vouchers to provide rental assistance for up to two years for an individual wishing to divert or transition from an institution. The funds are contracted to community service providers, who in turn assist individuals with completing the application and applying to the local Public Housing Authority. www.mfp.ar.gov/mfpmore.html

COLORADO: Colorado Choice Transitions (CCT), the MFP Program, provides access to bridge subsidies with TBRA funds targeted to persons with disabilities, seniors, and those transitioning from nursing facilities. This provides a structured link to a permanent subsidy. www.Colorado.gov.

GEORGIA: The Georgia Department of Community Affairs (DCA) has developed a new TBRA Program funded through DCA's HOME allocation that is specifically designed for individuals participating in the Money Follows the Persons Demonstration Grant. DCA anticipates program start up by the summer of 2013 and has committed $1,000,000 in resources. The TBRA Program will operate statewide and allow participants to select neighborhoods and communities of their choosing. This program will be primarily for persons leaving nursing home care for community-based housing.

Takeaway The HOME Tenant Based Rental Assistance Program can provide bridge subsidies for Money Follows the Person. Not only does that facilitate leaving the institution more quickly, the subsidy can provide the time necessary for the individual to access a mainstream Housing Choice Voucher. If your state is *not* using HOME TBRA funds for bridge subsidies, open a conversation with your state's Housing Finance Agency and participate in the Consolidated Plan process to advocate for adding TBRA vouchers for MFP participants to the plan.

RURAL CAPACITY-BUILDING

HOUSING ASSISTANCE COUNCIL

The **Housing Assistance Council (HAC)** is a national nonprofit corporation headquartered in Washington D.C. Its mission is to improve housing conditions for the rural poor, with an emphasis on the poorest of the poor in the most rural places. HAC provides technical assistance, and helps local organizations build affordable homes (single- and multi-family) in rural America. HAC services include the following.

- **Direct Technical Assistance and Training** is available to organizations helping "the poorest of the poor." HAC helps build capacity through formal training, one-on-one technical assistance, and connection to resources. HAC has five regional offices throughout the nation, each of which serves a multi-state region. HAC also convenes the National Rural Housing Conference approximately every other year.
- Through its **Research and Information Division**, HAC provides a wide range of resources. Click on the *Technical Reports* link, then *Federal Funding Programs* to find easy-to-understand information about resources available through HUD, USDA, and more.

For a complete list of HAC services and publications, visit www.ruralhome.org.

- HAC is certified as a **Community Development Financial Institution** by the U.S. Treasury, and has offered low-cost rural housing development loans for the past 40 years. HAC operates several loan funds that provide seed money to rural housing developers. Funding is used to improve housing and living standards for rural low and very low-income households through the creation of new single- or multi-unit housing, rehabilitation of existing units, and improved water/waste water systems. The loan fund provides low-cost financing at deeply discounted rates.

| So What? | HAC does not offer direct assistance to individuals, but its singular focus on rural housing for people in poverty is unique to the field. Technical assistance and training resources, research and data, accessible through regional coordinators are valuable resources for rural communities that have begun considering housing development. Access to email listservs, links, and publications are all readily available. |

RURAL ASSISTANCE CENTER (WWW.RACONLINE.ORG)

The **Rural Assistance Center (RAC)** is a one-stop rural health and human services information portal where information is arranged intuitively by category, topic, state, partners, funders, and locale. The RAC website links rural stakeholders with a range of programs, funding sources, and research, all geared to helping them increase rural capacity around quality health and human services. All of RAC's services – including customized assistance by information specialists – are provided *free of charge*. Through its customized assistance portal, RAC will help you connect with organizations, experts, and colleagues who can provide the information you need. This resource can also put you in touch with appropriate U.S. Department of Health and Human Services (HHS) personnel, functioning as a single point of entry to HHS.

Web-based Services

- **RAC's Online Library** provides access to thousands of resources, including funding and opportunities, news, events, organizations, maps, and publications.
- The **Topics and States** page provides state-specific resources and information about 80+ topics of interest to rural health and human services projects and providers. **Housing and Homelessness** is one of more than 80 topics, each of which broaden into a rich pool of resources, contacts, organizations, publications, maps, funding opportunities, and more.

- The **Tools for Success** page includes resources that range from access to tools for promotion, development, and capacity building. There is also a success story and lesson-learned section by state, topic, and source.
- The **Publications and Updates** page provides links to content designed to support rural communities. The page includes listservs, the *Rural Monitor* (RAC's quarterly newsletter), and a directory of rural health contacts by group, organization, name, and state. This page also includes customizable maps on 37 key rural topics – a great resource for grant writing, presentations, and reports.

Theory into Practice

Local, non-profit organizations provide much of the housing assistance in rural areas throughout the nation. Scott and Eric Saunders benefited from that kind of assistance. They recently moved into a new fully accessible, ADA-compliant duplex after Interfaith Housing Services (IHS) came to their rescue in rural Hutchinson, Kansas. The brothers, who suffer from a degenerative neurological disorder, couldn't afford housing that accommodated their disabilities. IHS secured grant funds for the cost of the housing, and then engaged students from the local community college's building trades program to provide volunteer labor.

- **Source:** Helseth, C. *The Rural Monitor* (Winter 2013). Accessed online 5.13.2013: www.raconline.org/newsletter/winter13/.

CHAPTER FIVE: *Cross Pollination*

Finding housing and establishing accessible services in rural and frontier communities can be difficult. Compounding the problem is the fact that anyone can become entrenched in existing practices and solutions that have always (or usually) worked. And yet, looking across sectors to see how others are solving similar problems might be the beginning of a brand new solution: social innovation can rise from such cross-pollination. Many creative, non-federal strategies are being used to great effect in rural and frontier areas. Some are geared to increasing the supply of safe, accessible housing for people in poverty (including those with disabilities and the elderly). Others include unique partnerships to ensure people can remain independent within their communities. Some of these strategies will be examined in this chapter.

The practice of pulling ideas from other programs and fields has been dubbed "cross pollination" for purposes of this chapter. The following pages will provide information about programs, projects, strategies and solutions that others are using to improve access to housing and services in rural areas. The hope is that at least one will inspire an *"Ah-Ha!"* moment.

CHAPTER FIVE LEARNING OBJECTIVES

After reading Chapter Five, readers will be able to:

- Name and discuss at least four strategies from other human services and housing sectors that could enhance MFP programs' ability to house participants in rural communities.

- Describe at least two ideas for further exploration or potential application to rural and frontier MFP programs.

INNOVATIONS

Housing vulnerable people is one of the greatest challenges human services providers face. The issue crosses boundaries between fields, and touches virtually every community. In response, emerging practices and promising strategies are bubbling to the surface in communities across the nation. This chapter will discuss some ideas that have potential for rural and frontier communities and potential cross-pollination to MFP programs.

Housing and Housing Stability Practices
- Adult Foster Care
- Adult Day Care

Housing Development
- Tennessee's Creating Homes Initiative
- Kentucky's Build Corps
- Corporation for National and Community Service AmeriCorps Programs
- Straw-bale housing for rural elders by nonprofit Red Feather Development Corporation

Access to Services
- Department of Veterans Affairs Mobile Vet Centers
- Telemedicine and Telehealth
- National Health Service Corps
- Senior Centers

HOUSING PRACTICES: ADULT FOSTER CARE

Adult foster care is the practice of providing long-term services and supports in homelike settings. Adult foster care can provide an alternative to institutional care when living alone isn't a good choice or the individual prefers a family-like setting. This practice is variously called adult family care, adult family-care homes, foster companion care homes, and domiciliary care (AARP, 2009). Residents gain regular opportunities for social involvement, assistance with personal care, health-related activities, and activities of daily living such as money management, housekeeping and transportation.

Services in adult foster care homes are covered by Medicaid in many states through provisions set forth in Section 1915(c) of the Social Security Act. They can also be integrated into Section 1115 Medicaid Waivers. This can be a cost-effective alternative to institutional care as well as an integrated service and support delivery strategy. Residents of adult family care homes gain the opportunity to participate more fully in the life of the community. Many states allow MFP participants to transition into adult foster care homes that comply with the MFP definition for qualified group residences, which holds the number of residents to four or fewer unrelated individuals.

So What? Encouraging residents to open their homes to MFP participants can be a useful rural housing development strategy. These homes can provide an excellent housing alternative for the right person, particularly in rural communities where appropriate, accessible, rental housing is not readily available. Check to see if your state's MFP plan allows Adult Foster Care Homes.

HOUSING STABILITY PRACTICES: ADULT DAY CARE

Adult day care homes can provide an important adjunct to in-home care services in rural areas. These programs provide services in supportive social settings for those who have functional and/or cognitive impairments and whose primary caregivers cannot be present for 24-hour care because of other commitments. Adult day care centers can provide such services as health monitoring, meals and snacks, assistance with medications and the activities of daily living, social activities, and transportation. They also serve as respite centers that provide temporary relief to caregivers. These centers improve outcomes by providing families with the safe, dependable care options that prevent burn-out and premature reinstitutionalization (Division for the Aging, 2007). This can be a particularly valuable service in rural and frontier areas where there are often long distances between homes, and where assistance is not readily available when primary caretakers are absent.

VERMONT ADULT FAMILY CARE HOMES

A new choice in Home and Community Based Services became available to Vermont residents participating in the Choices for Care (CFC) Program in May 2013. CFC is Vermont's Money Follows the Person Demonstration Program. The Adult Family Care (AFC) Home Program is available to people who meet specific financial and clinical criteria, and who wish to transition back to their communities. AFC Homes are private homes approved to provide continuous individualized supports in a safe, family-style environment. The AFCs are an addition to Vermont's current menu of services, and are expected to enable more participants to return to community settings (Vermontbiz.com, 2013). MFP Program staff may recruit for prospective home providers and will conduct interviews and reference checks before approving transitions into each home. Providers receive appropriate training, including at least one session on the implications of being a person-directed home provider.

MICHIGAN: Adult day care is covered by the Medicaid Waiver that Michigan uses to serve MFP participants. Adult Day Care allows individuals who cannot be left alone but live with family members who cannot be home during the day to transition into community life.

HOUSING DEVELOPMENT

THE CREATING HOMES INITIATIVE

In 2001, the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) strategized partnering with individual communities to develop housing for people with mental illnesses and co-occurring disorders. The Creative Homes Initiative (CHI) was the result. The initial goal set by CHI was ambitious: create 2,005 new or improved permanent supportive housing options for people with serious mental illnesses and co-occurring disorders by 2005. That goal was achieved in the fall of 2002. The subsequent goal was to create 4,010 homes by 2005. They met that, too. Now the initiative has set an annual goal of 1,100 new or improved permanent housing options a year (MDMHSAS, 2013).

The state originally contracted with seven agencies statewide to hire Regional Housing Facilitators who were trained on housing development with a focus on Permanent Supportive Housing. Five of the seven serve rural multi-county regions that range from the coal mines of Appalachia to the cotton fields of the Mississippi Delta. Housing Facilitators were tasked with initiating and facilitating local CHI task forces.

In the beginning, the Housing Facilitators identified local cross-sector representatives, who were invited to participate in the CHI Task Forces by the Commissioner of the Tennessee Department of Mental Health and Developmental Disabilities.

Task forces assessed local housing needs, set housing development priorities, identified support services providers, and leveraged funds in support of creating supportive housing.

Housing Within Reach, a parallel consumer-directed project working with CHI, is funded by a grant from the Centers for Medicare and Medicaid Services. Housing Within Reach employs Consumer Housing Specialists who promote access to housing. This group maintains a robust website that includes local information on access to housing, services, recovery, transportation, and more (www.recoverywithinreach.org).

State support and involvement decreased as housing development processes evolved to meet local need, but the state continues to fund Regional Housing Facilitators. In many cases, the task forces evolved into – or combined with – the local HUD Continua of Care, which have similar functions.

CHI SUCCESSES

CHI has leveraged more than $100 million in federal, state, local, public, and private funding, and has created permanent, safe, affordable housing for more than 4,600 people at risk of institutionalization.

- For more information, visit:
  http://tn.gov/mental/recovery/CHIpage.html.

AMERICORPS

AmeriCorps is one of three core programs that comprise the Corporation for National and Community Service (CNCS) roster: AmeriCorps, Senior Corps, and the Social Innovation Fund. Each CNCS program offers a network of opportunities for volunteer service.

The program most useful to MFP housing efforts would probably be AmeriCorps, which includes AmeriCorps State and National, Volunteers in Service To America (VISTA), and the National Civilian Community Corps (NCCC). State-level or local organizations can sponsor AmeriCorps programs, which are responsible for stationing volunteers at the local agencies that apply for volunteers. There is usually a commitment to match part of the resources, but in exchange, a host agency gains a full-time team member committed to providing a year of service. State and National and NCCC members can provide direct service; VISTA members build capacity by creating and expanding anti-poverty programs.

So What? Could your agency host an AmeriCorps volunteer? If so, this can be an exceptional way to build housing capacity. A VISTA volunteer, for example, could start a housing task force; AmeriCorps members could help build, renovate or repair homes.
- *For more information about CNCS, visit:* http://cncs.gov.

KENTUCKY BUILD CORPS PROJECT

The Homeless and Housing Coalition of Kentucky sponsors Build Corps, an AmeriCorps Program that expands affordable housing opportunities for homeless and economically disadvantaged Kentuckians. Members serve at nonprofits that work on housing issues around the state. Their tasks include building, renovating, and weatherizing affordable housing, assisting with housing placement and case management. The Build Corps Program manages the statewide AmeriCorps Program. In that capacity, they accept applications for service sites, and place AmeriCorps members for their year of service.

Build Corps members assist in providing 1,800 people who are economically disadvantaged and/or homeless with housing. This is accomplished through direct housing services and home construction, as well as volunteer recruitment, training, and retention. Volunteers are placed with such organizations as Habitat for Humanity, housing agencies, housing development organizations, shelters, and crisis centers.
- *For more information, visit the Homeless and Housing Coalition of Kentucky:* http://www.hhck.org/.

So What? Staff can be one of the most crucial missing pieces when trying to piece together safe, affordable housing in rural communities. AmeriCorps service members can fill this gap.

THE RED FEATHER DEVELOPMENT GROUP

The Red Feather Development Group (Red Feather) is an inspirational example of a creative win-win solution to the lack of rural community housing. Red Feather partners with American Indian nations to implement sustainable solutions to urgent local needs for safe housing. Red Feather trains and uses local volunteers to help build energy efficient, low-cost straw-bale housing on American Indian Reservations, as well as to renovate existing homes in urgent need of repair. This is a win-win model that teaches transferrable job skills while meeting urgent local needs for safe housing.

Robert Young founded Red Feather in 1995 after learning that elders living in severely inadequate housing were freezing to death on the Pine Ridge Reservation in South Dakota. Red Feather's first project was a new home at Pine Ridge for Lakota elder, Katherine Red Feather.

Homes are constructed of straw bales, a readily available and sustainable resource. The use of volunteer labor contributes to a relative cost savings of as much as 60 percent when compared to a traditional starter home. Savings are ongoing: structures built with straw bales have very high insulation values, remaining cool is summer and warm in winter months.

- *For more information, visit:* www.redfeather.org

INDIANA'S HOME AGAIN MFP PROGRAM

Developing affordable housing can be a lengthy and difficult process that requires a specialized skill set. Indiana developed the Home Again demonstration project in response to this challenge. Indiana's Family and Social Services Administration, Division of Aging partnered with the Indiana Housing and Community Development Authority (IHCDA) to implement a pilot program that facilitates and enhances transitions from nursing facilities into home and community-based settings.

The Home Again program uses state dollars to subsidize housing for individuals transitioning from institutional care. The state also targets private multi-family housing properties funded by IHCDA in areas where housing is needed for MFP participants. In effect, the state "buys down" the rent for selected units for a period of five years or the period of the MFP participant's residency in the unit. Some of the dollars dedicated to this project may be used to make accessibility modifications to the unit receiving rental assistance. Funds for accessibility modifications are also offered to individuals within the MFP program.

- *For more information, contact Juman Bruce, MFP Program Director at* Juman.Bruce@fssa.in.gov *or 317-234-5715.*

ACCESS TO SERVICES

DEPARTMENT OF VETERANS AFFAIRS MOBILE VET CENTERS

Rather than expecting veterans who live in rural and frontier areas to find their way to community Vet Centers, the U.S. Department of Veterans Affairs (VA) is taking its services on the road with Rural Mobile Health Clinics and Mobile Vet Centers (MVCs). Like community-based centers, the MVCs focus on providing services that help veterans transition to civilian life. These vehicles include space for outreach, counseling, and VA health care enrollment. They can also be used for preventive health screenings and mental health medical support. These mobile clinics have reached veterans in some of the most remote counties in the nation. This strategy reflects a paradigm shift in the way the VA is serving veterans, and provides rural veterans with unprecedented opportunities to engage with services.

MVCs resemble well-equipped recreational vehicles. Each has a satellite dish that connects to communications and audio-visual equipment, multiple phone lines, a fax line, notebook computers, encrypted computer lines, and WiFi connections. Dividers separate the coach into private counseling rooms that allow for individual and small group counseling. Vehicles also have a medical exam table, a defibrillator, first aid kit, beds, a shower, refrigerator, microwave, and a long list of other amenities (Tyson, 2008 and VA, 2012).

As of 2012, there were approximately 70 MVCs in service throughout the country.

CHEYENNE WYOMING's VA MOBILE TELEHEALTH CLINIC

The Cheyenne VA's mobile Telehealth Clinic delivers high quality healthcare services closer to veterans' homes. The Mobile Telehealth Clinic regularly schedules primary care and mental health clinics in rural Sterling, Colorado, as well as Wheatland, Torrington, and Laramie, Wyoming. Some of the services offered through the Mobile Telehealth Clinic include: medical care; wellness promotion and immunizations; health screenings; chronic illness management; referrals to specialty clinics; mental health exams; counseling; and some lab tests.

Theory into Practice

Is your state VA Medical Center operating Mobile Vet Centers? If so, they could be a resource for MFP clients who are also veterans, and who need access to services in their rural or frontier communities.

TELEMEDICINE

The three pillars of health care reform are improved access, improved quality, and reduced costs. Advances in wireless broadband networks, mobile phone service, and data compression technologies have provided mechanisms for efficiencies in medical practice and patient access to care. Telemedicine is increasingly offering practical solutions to the lack of medical capacity in rural areas.

Many terms are being used to define this practice, including: *telemedicine, telehealth, e-Health, e-Consults,* and *e-Care* are some of the more common terms (Vita Advisors, LLC, date unknown). The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) describes telehealth, in part, as using electronic information and telecommunications technologies to support long-distance clinical health care. HRSA makes a distinction between telehealth and telemedicine, which they define as the use of medical information exchanged via electronic communication mechanisms to improve a patient's clinical health status (HHS HRSA, no date).

Rural populations can benefit dramatically from telemedicine and telehealth applications. People who lack access to medical care by virtue of geography, mobility, or cost can all benefit from this strategy. Telemedicine and telehealth technologies present win-win solutions by improving access without the cost of travel, by enhancing safety and convenience, and through better care coordination and reduced rehospitalizations for those who have chronic diseases (VITA Advisors, date unknown).
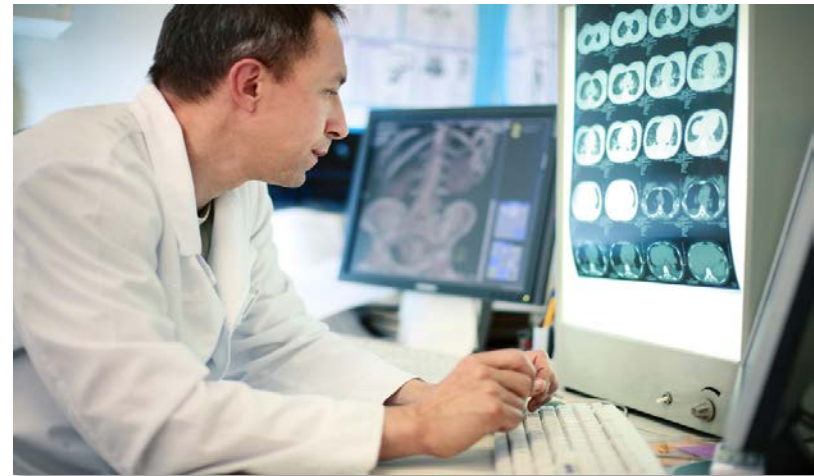
"More effective deployment of telehealth technologies will enhance our ability to better meet the health care needs of those in rural and frontier parts of the country."
– Mary Wakefield, Ph.D., R.N. (IOM, 2012)

TELEHEALTH RESOURCE CENTERS (TRCs)

TRCs serve as focal points for advancing the effective use of telehealth and by supporting access to telehealth services in rural and underserved communities. They are funded by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth, which is part of the Office of Rural Health Policy. Nationally, there are 14 TRCs, including 12 Regional Centers and two National Centers.

- Find the TRC that covers your state at:
  http://www.telehealthresourcecenter.org/

So What?	You may be able to enhance the stability of your MFP clients in remote communities by making access to care more readily available without extensive travel. The TRC serving your state will have information about local access to medical technologies.

MEDICAID REIMBURSEMENT

Medicaid agencies in many states recognize physician consultation when furnished using interactive video conferencing. Payment is typically on a fee-for-service basis consistent with reimbursement for covered services furnished face-to-face. State-specific information is available online:
www.longtermcarelink.net/eldercare/home_telehealth.htm

SUCCESS STORIES

- ### *Reach Montana Telehealth Network*

The Northwest Regional TRC covers Alaska, Washington, Oregon, Idaho, Montana, Utah, and Wyoming, and includes 33 telehealth networks. One is the REACH Montana Telehealth Network, a consortium of healthcare providers linked by live, interactive, video technology. From its hub in Great Falls, Montana, REACH serves its member counties, most of which are frontier with an average regional population density of 2.96 residents per square mile. In addition to other services, REACH connects patients in remote communities with peer support by using video conferencing. More information is available online at: http://www.reach-montana.org/

- ### *Arkansas Money Follows the Person*

The Arkansas MFP Program includes telemedicine as a demonstration service for health care delivery, diagnosis, consultation, and treatment through the use of audio, video, or data communications. Arkansas can monitor MFP participants around the clock right in their homes. A patented technology is used to detect such changes as prolonged inactivity and extreme temperatures, as it captures data in a web-based program monitored at all times by emergency response operators (Arkansas MFP Program, 2013).

INNOVATION: PATHWAYS TO HOUSING VERMONT

Housing First is an evidence-based practice based on the concept that a homeless individual's primary need is stable, permanent housing, and that other issues can be addressed once the person is housed. The practice emerged in New York City, and has been applied with great success in numerous urban centers. Vermont is a predominantly rural state that is working to adapt this best practice to a rural environment. Vermont is instituting this statewide system of Housing First services in partnership with the state departments of Corrections and Mental Health.

Like many rural states, Vermont faces obstacles such as limited public transportation and harsh winters. In response, they have implemented the Housing First strategy practice in extremely rural areas using innovative technology. Their Telehealth Program enables participants to engage in web-based video sessions by providing them with home internet access, a refurbished computer, and basic digital literacy training. This has increased direct contact with clients afflicted with multiple vulnerabilities. For more information, visit:
http://www.pathwaystohousing.org/site/vermont/

SENIOR CENTERS

According to the National Council on Aging (2013), more than a million older adults a day get connected to services and one another through one of the nation's 11,000 senior centers.

Senior centers are one-stop settings where older adults can access community services that can help them stay healthy and independent. They offer a wide variety of programs and services, including congregate meals and nutrition programs such as Meals on Wheels. Though programs vary by site, other common services include: information and assistance; health, fitness and wellness programs; transportation services; public benefits counseling; employment assistance; volunteerism and civic engagement opportunities; and intergenerational programming. The centers are supported with federal, state, and local funding along with a variety of other funds.

Senior centers often serve as the social center in rural and frontier communities, and have become one of the most widely used services among America's seniors. The resources available through local senior centers can be key to helping MFP residents sustain independence in rural communities. The *Eldercare Locator,* a service of the U.S. Administration on Aging can help you find services and contact information by community: www.eldercare.gov/Eldercare.NET.

HPSAS, MUAS, AND MUPS

Many rural and frontier areas are classified as Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs). Telemedicine and telehealth will be key to serving patients in these less populated areas as the Affordable Care Act comes online.

HPSA, MUA, and MUP designations are conferred by the Health Resources and Services Administration (HRSA). In essence, MUAs may have too few primary care providers, high infant mortality or poverty rates, and/or large elderly populations. Populations for MUP designation have economic barriers (low-income or large Medicaid-eligible populations), cultural and/or linguistic access barriers to primary medical care services. HPSAs have shortages of primary medical, dental, or mental health providers and may be geographic (a county or service area), demographic (low-income population), or institutional (e.g., comprehensive health center, federally qualified health center).

So What? Do the rural communities your MFP program works with have HPSA, MUA, and/or MUP designations? If so, it could be a win-win proposition to strike up community partnerships with your local health department to explore the benefits available. Find out if your area has a designated shortage. Go to: http://bhpr.hrsa.gov/shortage/.

BENEFITS OF MUA, MUP OR HPSA DESIGNATION

Benefits to areas with MUA, MUP, and/or HPSA status include enhanced federal grant eligibility, enhanced Medicare payments, Medicare bonus payments for physicians, and the potential to engage with the National Health Services Corps. All can improve your capacity to serve MFP participants. Find local shortage areas at: http://hpsafind.hrsa.gov/.

NATIONAL HEALTH SERVICES CORPS (NHSC)

The NHSC Program offers student loan repayment for licensed primary medical, dental, and behavioral health providers who seek employment at approved sites. There are more than 14,000 primary care clinics and other health care facilities participating in NHSC nationwide. Health professionals who sign up with the NHSC agree to work in areas that have HPSA designations and limited access to care. Even though they are only obligated for a time-limited period of service, Corps members often choose to remain in underserved communities at the end of the service commitment. Sites are approved based on greatest degree of need based on such factors as provider to population ratio, percentage of the population living in poverty, travel time/distance to the nearest source of care, and youth and/or elderly dependency. NHSC-approved sites must provide services on an income-based sliding scale.

- For more information about becoming an NHSC site, go to: http://nhsc.hrsa.gov/currentmembers/membersites/

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APPENDICES

Appendix A: Sample Self-Sufficiency Matrix
Appendix B: Sample Transportation Decision Tree
Appendix C: Transition Considerations
Appendix D: Contributors and Credits

Appendix A: *Sample Self-Sufficiency Matrix*

Directions: This tool can be used to help a client self-assess, and can help MFP staff identify potential resources and issue areas. Looking across domains prior to transition from an institution can be a strong step toward creating reasonable plans for addressing needs in each domain. Once an MFP client has transitioned to the rural or frontier community, this tool can be used to promote housing retention. The lower the scores, the more likely it is that someone will return to an institution. Changes for the better – or the worse – can also help identify the need for additional services or supports or improved self-sufficiency.

1. HOUSING							
Benchmarks	**Thriving (10 -9)**	**Safe (8 – 7)**	**Stable (5 – 6)**	*Prevention Line*	**Vulnerable (3 – 4)**	**In Crisis (1 – 2)**	**Individual**
Criteria for each score	10: Owns a home in a reasonable state of repair that s/he can return to, in a neighborhood of choice.	8: Owns a home that s/he can return to, but choices are limited by moderate income.	6: Has a place to live in affordable housing, at a cost of 30% or less of household income.		4: Living in unaffordable, overcrowded, or transitional housing.	2: Household under eviction or forced displacement.	***Housing Score:***
	9: Has access to a safe rental that s/he can afford in a neighborhood of choice.	7: Has access to a safe rental – but choices are limited by moderate income.	5: Living in rental costing 30 – 50% of income.		3: Living in temporary shelter, unsafe or substandard housing.	1: Couch surfing or doubling up with others.	
Notes on preferences, living arrangements, housing features, support needs, neighborhood, affordability or other resources or potential issues related to housing:							

2. ACCESS TO SERVICES

Benchmarks	Thriving (10 -9)	Safe (8 – 7)	Stable (5 – 6)	Prevention Line	Vulnerable (3 – 4)	In Crisis (1 – 2)	Individual
Criteria for each score	10: Receives a full range of services – all needs are met.	8: Receives needed services, but barriers may limit choice of providers, geography, times of service or other related aspects.	6: Receives most of needed services, but very limited options for providers. Providers are reliable.		4: Receives some needed services, but has barriers to receiving others. Service provided is reliable.	2. Service doesn't exist in where the individual lives, or barriers prevent access (e.g., transportation, disabilities, cost, culture, etc.)..	*Access to Services Score:*
	9(a): Receiving a range of services determined to be needed by Medicaid/insurer (individual would prefer more).	7: Receives most of needed services, but has limitations on providers or types of services available..	5: Receives most of needed services, but very limited options for providers and not a large array of services are available. Services are reliably provided.		3: Living in temporary shelter, unsafe or substandard housing.	1. Is unwilling to receive needed services.	

Notes on moving in to housing, getting settled, assessing service needs and preferences:

3. ACCESS TO FOOD

Benchmarks	Thriving (10 -9)	Safe (8 – 7)	Stable (5 – 6)	Prevention Line	Vulnerable (3 – 4)	In Crisis (1 – 2)	Individual
Criteria for each score	10: Always has resources and knowledge to purchase and prepare nutritious foods of choice.	8: Always has resources and knowledge to purchase and prepare nutritious foods.	6: Has sufficient knowledge and personal/ community resources to purchase and prepare food.		4: Is unable to buy and/or prepare foods on a regular basis. Relies on food banks or commodity foods.	2. Lacks knowledge and/or resources to purchase and/or prepare foods.	**Access to Food Score**
	9: Usually has resources and knowledge to purchase and prepare nutritious foods of choice.	7: Usually has resources and knowledge to purchase and prepare nutritious foods.	5: Generally able to buy and prepare food. Occasionally relies on food banks or commodity foods.		3. Unable to buy and/or prepare food. Inadequate resources to obtain food.	1. Has no food and is not aware of food resources.	

Notes on knowledge and ability to access and prepare food:

4. FUNCTIONAL ABILITY

Benchmarks	Thriving (10 -9)	Safe (8 – 7)	Stable (5 – 6)	Prevention Line	Vulnerable (3 – 4)	In Crisis (1 – 2)	Individual
Criteria for each score	10: Fully able to perform all activities of daily living (ADLs) without assistance or support.	8: Fully able to perform most ADLs without assistance or support.	6: Unable to perform some ADLs, but is in a safe, supportive environment.		4: Requires limited or total assistance, and assistance is available, but inconsistent.	2. Requires extensive or total assistance, but assistance is unavailable or limited.	Functional Ability Score:
	9: Able to perform all ADLs with very limited or occasional assistance or support; assistance or support is available.	7: Fully able to perform most ADLs with limited or occasional additional support, which is available.	5: Requires extensive or total assistance; assistance is available with back-up support.		3. Requires limited or total assistance or supervision, but assistance is not available.	1. Individual cannot function without assistance, which s/he will not accept.	

Notes on ability to perform the activities of daily living, preferences for and access to assistance:

5. INCOME SUFFICIENCY

Benchmarks	Thriving (10 -9)	Safe (8 – 7)	Stable (5 – 6)	Prevention Line	Vulnerable (3 – 4)	In Crisis (1 – 2)	Individual
Criteria for each score	10. Income is sufficient and stable, adequate for monthly bills, allows regular savings for emergencies, and discretionary spending	8. Income is sufficient and stable, adequate for paying monthly bills, but allows little saving for emergencies or discretionary spending	6. Income is adequate for meeting basic needs with budgeting, which the individual does		4. Income is inadequate, but income supports (e.g., "food stamps"/SNAPS, energy assistance, commodity foods) help ensure that basic needs are met; the individual appropriately manages income and supports to cover necessities	2. Income is inadequate for meeting basic needs, even with addition of some income supports	*Income Sufficiency Score*
	9.Income is sufficient and stable, adequate for monthly bills, and usually allows some regular savings for emergencies, and discretionary spending	7. Income is sufficient and stable, usually adequate for paying monthly bills, but rarely allows saving for emergencies or discretionary spending	5. Income is adequate for meeting basic needs with budgeting, but the individual does not always budget appropriately		3. Income is inadequate, and income supports are available, but the person does not manage his/her money to cover necessities.	1. Basic needs cannot be met with current income.	

Notes on income sufficiency and ability to manage household:

6. FAMILY AND OTHER RELATIIONSHIPS						
Benchmarks	Thriving (10 -9)	Safe (8 – 7)	Stable (5 – 6)	Vulnerable (3 – 4)	In Crisis (1 – 2)	Individual
Criteria for each score	10. Has plenty of supportive relationships, and strong, local family connections. Can give and receive help.	8. Has supportive relationships or strong, local family connections.	6. Has a healthy support system that is available in times of crisis.	4. Has a support system that is usually available in times of crisis, but is occasionally unreliable.	2. Has very limited support within the community.	**Family and Other Relationships Score**
	9. Has plenty of supportive relationships and strong, local family connections.	7. Has a healthy support system that is available most of the time.	5. Has a healthy support system that is usually available in times of crisis.	3. Has a support system that is usually available in times of crisis, but is frequently unreliable.	1. Has no relationships in the community, and no support system.	

(Prevention Line marked between "Stable" and "Vulnerable" columns)

Notes on family and other relationships:

7. PHYSICAL HEALTH

Benchmarks	Thriving (10 -9)	Safe (8 – 7)	Stable (5 – 6)		Vulnerable (3 – 4)	In Crisis (1 – 2)	Individual
Criteria for each score	10. Good general health; chronic condition or disability is well-managed; has medical home or established primary care physician.	8. Health is generally good; chronic condition or disability is well-controlled, and help is available when needed.	6. Health is fair; chronic condition or disability is usually well-controlled, with occasional flare-ups that require additional assistance, but assistance is usually available.	**Prevention Line**	4. Health is usually fair; chronic condition or disability is not well-controlled. There are frequent flare-ups that require assistance, which is usually available, but can be unreliable.	2. Health is poor. Chronic condition or disability is not well-controlled. There are frequent flare-ups and help is sporadic.	*Physical Health Score*
	9. Good general health; chronic condition or disability is well-managed; has local access to local medical care.	7. Health is generally good; chronic condition or disability is usually well-controlled, and help is available when needed.	5. Health is fair; chronic condition or disability is usually well-controlled, with frequent flare-ups that require assistance. Assistance is usually available.		3. Health is usually fair; chronic condition or disability is not well-controlled. There are frequent flare-ups that require assistance, which is frequently unavailable or unreliable.	4. Health is usually fair; chronic condition or disability is not well-controlled. Assistance is not available as needed.	

Notes on physical health and health needs:

	8. BEHAVIORAL HEALTH AND WELLBEING						
Benchmarks	**Thriving (10 -9)**	**Safe (8 – 7)**	**Stable (5 – 6)**		**Vulnerable (3 – 4)**	**In Crisis (1 – 2)**	**Individual**
Criteria for each score	10. No behavioral health issues now or in the past. If there is alcohol or prescription drug use, it is appropriate.	8. No current behavioral health issues. Engaged in maintenance activities to manage any substance abuse and/or mental health issues.	6. Behavioral health issues are usually well-controlled, with occasional flare-ups that require additional assistance. Assistance is usually available.	**Prevention Line**	4. Behavioral health is not well-controlled. Frequent flare-ups require assistance, which is usually available, but can be unreliable.	2. Behavioral health is poor. Condition impacts ability to sustain housing and relationships. There are frequent flare-ups, but help is sporadic.	*Behavioral Health Score:*
	9. No current behavioral health issues. If there is alcohol or prescription drug use, it is appropriate.	7. Behavioral health issues are generally well controlled. Engaged in maintenance activities to manage any substance abuse and/or mental health issues.	5. Behavioral health issues are usually well-controlled, with frequent flare-ups that require additional assistance. Assistance is usually available.		3. Behavioral health is not well-controlled. Frequent flare-ups require assistance, but help is often unreliable or unavailable.	1. Behavioral health is poor. Condition impacts ability to sustain housing and relationships. Help is not available.	
Notes on behavioral health and health needs:							

9. LIFE SKILLS

Benchmarks	Thriving (10 -9)	Safe (8 – 7)	Stable (5 – 6)	Prevention Line	Vulnerable (3 – 4)	In Crisis (1 – 2)	Individual
Criteria for each score	10. Has skills and ability to manage household independently. Can understand and manage personal financial matters.	8. Can manage most aspects of running a household and personal finances. Has assistance as needed.	6. Can manage some aspects of running a household and basic personal financial matters, but needs regular assistance (which is available).		4. Doesn't have basic knowledge or skills. Help is needed, but is not always available.	2. Has very limited household skills, and has not learned how to manage basic household finances. Help is rarely available.	Life Skills Score
	9. Has skills and ability to manage household independently, and can understand and manage personal financial matters with occasional assistance, which is available.	7. Can manage many aspects of running a household and personal finances with limited assistance. Assistance is available.	5. Can manage some aspects of running a household and basic personal financial matters, but needs assistance, which is generally available.		3. Doesn't have basic knowledge or skills Help is needed, but often unreliable or unavailable.	1. Has very limited household skills, and has not learned how to manage basic household finances. Help is unavailable.	

Notes on life skills and abilities:

	10. TRANSPORTATION						
Benchmarks	**Thriving (10 -9)**	**Safe (8 – 7)**	**Stable (5 – 6)**		**Vulnerable (3 – 4)**	**In Crisis (1 – 2)**	**Individual**
Criteria for each score	10. Owns a dependable vehicle and can drive, and/or has access to a regular ride or public transportation. Can afford costs associated with transportation.	8. Owns a vehicle that is usually dependable. Generally has someone willing to drive, and/or generally has access to a regular ride or public transportation. Can usually afford costs associated with transportation.	6. Usually has access to a ride and/or public transportation, but it is often difficult to afford the cost of transportation.	Prevention Line	4. Sometimes has access to a ride, but the driver can sometimes be undependable. Public transportation is limited. It is usually difficult to afford the cost of transportation.	2. Rarely has access to a ride. No public transportation options available. Cannot afford the cost of transportation.	*Transporta-tion Score*
	9. Owns a dependable vehicle and has someone willing and able to drive, and/or has access to a regular ride or public transportation. Can usually afford the costs associated with transportation.	7. Owns a vehicle that is usually dependable. Generally has someone willing to drive, and/or has access to a regular ride or public transportation. Sometimes difficult to afford the costs associated with transportation.	5. Usually has access to a ride, but the driver can sometimes be undependable. Public transportation is limited. It can be difficult to afford the cost of transportation.		3. Rarely has access to a ride. Few transportation options beyond volunteer and agency services. Cannot afford the cost of transportation.	1. No access to rides. No public transportation.	

This self-sufficiency matrix is partially based on *Self-Sufficiency Matrix: an Assessment and Measurement Tool Created through a Collaborative Partnership of the Human Services Community in Snohomish County* (2004) by the Snohomish County Self-Sufficiency Taskforce. Accessed online 12.4.2012 at: http://www.performwell.org/index.php/find-surveyassessments

Client Name **Transition Date** **Community**

SELF-SUFFICIENCY SCORES BY DOMAIN

Scale: 9-10 (Thriving); 7-8 (Safe); 5-6 (Stable); 3-4 (Vulnerable); 1-2 (In Crisis)

Domain	Housing	Access to Services	Access to Food	Functional Ability	Income Sufficiency	Family and Other Relationships	Physical Health	Behavioral Health and Wellbeing	Life Skills	Transportation
Score										
Date					Signed by					
Score										
Date					Signed by					
Score										
Date					Signed by					
Score										
Date					Signed by					
Score										
Date					Signed by					
Score										
Date					Signed by					

The self-sufficiency matrix looks at domains on a scale that ranges from "thriving" to "in crisis" on the other. When the transition is a success, client status should be stable or improving across the various dimensions. Additional domains can be added as needed.

Notes: Particular areas of concern or progress, with dates.

_____

_____

_____

_____

Appendix B: *Sample Transportation Decision Tree*

I.	**Does the individual own a car?** *(Check yes or no)*						**Yes**		**No***	
If YES	Is the car reliable?				**Yes**		**No**			
	a. Is the car insured (if insurance is required by the state)?		N/A		**Yes**		**No**			
	b. If required, has the car been inspected?		N/A		**Yes**		**No**		**If NO*, move to Section II**	
	c. Does the car have a current license?		N/A		**Yes**		**No**			
	d. Are all other state requirements met?		N/A		**Yes**		**No**			
	e. Does the individual have a valid driver's license?				**Yes**		**No**			
	f. If no, can the individual get a valid driver's license?				**Yes**		**No**			
	g. Can/should the person be driving?				**Yes**		**No**			
	h. If no, is there someone who could drive the car for the individual?				**Yes**		**No**			
	If someone could drive for the individual, who?	Name: Relationship: Contact Information:								
II.	**Is public transportation available?** *(Check yes or no)*						**Yes**		**No***	
If YES	a. Is the public transportation on a route?				**Yes**		**No**			
	b. Are the routes run every day?				**Yes**		**No**			
	c. Are the routes run week-days only?				**Yes**		**No**			
	d. Do system rules interfere with the individual's ability to use it?				**Yes**		**No**		**If NO*, move to Section III**	
	e. Is there a limitation on frequency of use?				**Yes**		**No**			
	f. Are the vehicles used accessible for the individual?				**Yes**		**No**			
	g. Are there regular routes?				**Yes**		**No**			
	h. If there are routes, are they close enough for use?				**Yes**		**No**			
	Program specifics	Name of Service: Cost per Ride: Types of transportation: Website: Contact number:								

II.a.	Can individual public transportation be arranged ahead of time?		Yes		No	
If YES	*If individual public transportation can be arranged ahead of time…*	How far in advance? Cost? Contact number: Types of transportation:				

III.	Are there others in the community who can help provide transportation? *(Check yes or no)*			Yes		No*	
If YES	a. Are there family members who can help?		Yes		No		
	b. Are there friends or others who can help?		Yes		No		
	c. Are there any volunteer programs that can help?		Yes		No		
	d. Are the transportation providers reliable?		Yes		No		**If NO*, move to Section IV**
	e. Are the providers' vehicles reliable?		Yes		No		
	f. Will the vehicle(s) accommodate the individual's needs?		Yes		No		
	g. Can the providers afford to assist without compensation?		Yes		No		
	h. Will rising gas costs impact the ability to provide rides?		Yes		No		
	If family members can help…	Relationship: Name: Contact number:					
	If others can help…	Relationship: Name: Contact number:					
	If there are volunteer programs that can help…	Agency Name: Program Name: Contact Name: Cost: Requirements: Contact number:					

IV.	Are there forms of emergency/urgent need transportation available? *(Check yes or no)*		Yes		No*		
If YES	a. Is an ambulance service available?	Yes		No			
	b. Are there urgent transportation services available?	Yes		No			
	c. Are there transportation services for chronic condition care? (e.g., dialysis, oncology visits, blood sugar checks)	Yes		No			
	d. Are there transportation services for preventive/routine care? (e.g., physicians, clinics, dentists)	Yes		No		**If NO*, move to Section V**	
	e. Are there transportation or delivery services for goods? e.g., groceries, pharmacy, laundry)	Yes		No			
	f. Are there transportation services for quality of life? (e.g., worship services, entertainment, volunteering)	Yes		No			
	If there are alternative transportation services, please describe…	Personal Relationship: Name: Contact number:					
		Volunteer Service: Agency: Contact Name: Contact number: Cost:					
		Fee for Service: Agency: Contact Name: Contact number: Cost:					
V.	**Please describe how the individual will meet his/her transportation needs in the absence of a personal vehicle, assistance from family/friends, or public transportation?**						

Appendix C: *Transition Considerations*

Some issues and risks may be enhanced in rural areas. These bullet points can be useful for starting conversations with clients who wish to transition to rural communities, with family members and/or other stakeholders in the transition.

- Is it likely that weather (such as excessive snow) or other situation would interfere with the individual's access to transportation?

- Could there by a delayed response to emergencies due to distance, use of volunteer providers, weather, other?

- Is the individual willing to assume the increased risk?

- Will location impact the availability of providers? Will their reliability be impacted due to such factors as distance, weather, volunteer status?

- Is there sufficient access to health services?

  - Small/rural hospitals often don't have the same level of expertise as larger/teaching/specialty facilities and transportation to facilities with more expertise. Is this an issue?

  - Is there is lack of medical specialists needed for ongoing care in the area?

  - Is care for chronic conditions, such as dialysis or chemotherapy, accessible?

  - Is there a shortage of family practice physicians?

  - Do family practice physicians in the area accept Medicaid?

- Is telemedicine available?

Appendix D: *Contributors and Credits*

Thank you to the many MFP leaders, staff, and contractors who took time from their work to provide insight, tips, and expertise for the Rural Housing Tool Kit. We have tried to ensure that everyone who contributed has been listed, but apologize in advance for any inadvertent lapses.

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