

**OPENING DOORS TO HEALTH:
HEALTH CARE FOR THE HOMELESS**

1996-1997 NATIONAL PROJECT

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Opening Doors to Health: AMSA and Health Care for the Homeless

Dear Chapter President:

Welcome to the project guide for *Opening Doors to Health*, AMSA's 1996-1997 National Project on health care for the homeless. Health Care for the Homeless is a theme that encompasses numerous areas, including community health, political and legislative issues, basic health-care services, and public health concerns.

Founded in 1950, the American Medical Student Association is located in a suburb of Washington, D.C. AMSA is committed to improving health care and healthcare delivery to all people, promoting active improvement in medical education, involving its members in the social, moral and ethical obligations of the professions of medicine, assisting in the understanding and improvements of world health problems, contributing to the welfare of medical students, interns, residents and post M.D./D.O. trainees, and advancing the profession of medicine.

The National Project unifies our local chapters and task forces through community service and activism and raises awareness of the issue on a national level. We believe AMSA is in a unique position to address the health-care needs of homeless people. Through education, definitive action and publicity, we hope to make a real contribution to improving the health of homeless people.

On the national level, we are holding a news event featuring national and local speakers. Each chapter can get involved by volunteering in a homeless shelter, hosting a speaker series, running a homeless clinic or sponsoring a lobby day. Together, we can make a difference! AMSA is *Opening Doors to Health*.

Sincerely,

Glenn Tucker
Sr. Trustee At Large

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Section 1: Introduction

Poverty and inadequate shelter are problems that have afflicted humanity since the dawn of human civilization. Historically, a variety of terms have been used to describe the poor and unhoused, including tramps, hobos, bums, transients and vagabonds. The terminology varies from country to country and often reflects different national attitudes toward the poor. In the United States, the term homeless has gained increasing usage since the 1980s, when Mitch Snyder and other advocates of the poor called attention to a growing social problem. America's homeless include a diverse group of people: teenagers running away from abusive foster parents, the deinstitutionalized mentally ill, people with chronic illnesses such as HIV/AIDS, women and children trying to escape abusive male partners, men with disabling substance addictions, and others. These individuals differ in many respects, but all live in situations of poverty and lack a traditional "home." In fact, home often has a dual meaning when used in this context. It refers to adequate physical shelter--and to the American ideal of a "home," which includes privacy, social support, safety and ownership. Homelessness is a social category, not a defining quality of people. However, without this categorization, it may not have been possible to mobilize resources to address the problems of impoverished and poorly housed individuals.

One example of the mobilization of resources is the concept of Health Care for the Homeless. Between 1985 and 1989, the Robert Wood Johnson and Pew Memorial Trust in association with the National Conference of Mayors funded 19 Health Care for the Homeless demonstration projects in large cities around the country. The project was designed to demonstrate that homeless persons needed and would accept primary health care services if they were delivered in a dignified manner in outreach settings. As these demonstration programs were entering their final years, a new federal Health Care for the Homeless program was established under Title VI-A of the federal Stewart B. McKinney Homeless Assistance Act. Under the federal program, grants were given to local programs that performed the following :

- Provide health services at locations accessible to homeless persons
- Provide round-the-clock access to emergency health services
- Refer homeless persons for necessary hospital services
- Refer homeless persons for needed mental health services unless the services are directly provided
- Provide outreach services to inform homeless individuals of the availability of health services
- Aid homeless individuals in establishing eligibility for assistance and obtaining services under entitlement programs

As of 1994, there were 119 Health Care for the Homeless programs in the United States. In addition to receiving health-care services through these programs, homeless individuals often receive care through other means such as hospital emergency rooms, free clinics, community

health clinics and volunteer-run programs. The Health Care for the Homeless programs are unique in that they define homeless individuals as their target population and work to meet the special needs of this population through aggressive outreach and interdisciplinary, comprehensive health-service projects. The interdisciplinary approach brings together primary health, mental health, substance abuse and social service providers to build a more coordinated network of services.

Why do Health Care for the Homeless programs exist?

Health Care for the Homeless programs in the United States exist for two major reasons. First, homeless individuals typically have no health insurance or receive no Medicare or Medicaid benefits. As a result of their uninsured or underinsured status, homeless individuals do not have adequate access to traditional health-care providers. Second, the current health-care system is often inadequately prepared to address the needs of homeless individuals in a sensitive, comprehensive, and compassionate manner. In Canada, France and other countries with guaranteed health coverage there are no federally sponsored Health Care for the Homeless programs. Homeless individuals are guaranteed access to the health-care system, but these systems are not always prepared to address the multiple needs of homeless individuals. The targeting of homeless individuals for services is a double-edged sword. It helps providers to focus on meeting some of the unique needs of homeless individuals, but it also provides further stigmatization and isolation of a subset of the poor. A system that guaranteed health-care for all and that maintained the capacity to meet the unique needs of homeless individuals without the creation of a separate service system would be ideal.

Health and Homelessness

Certain conditions are more prevalent among homeless individuals than among the general population. Some of these conditions include mental illness, substance addictions, HIV/AIDS, chronic illnesses such as hypertension and diabetes at earlier ages, trauma, thermoregulatory disorders, skin infestations, peripheral vascular disease, bacterial or fungal infections of the skin, diarrheal diseases and food poisoning, acute and chronic respiratory infections, perinatal morbidity and mortality, low immunization levels, environmental hazards for homeless children, and hazards to growth and development of children.

The greater prevalence of poor health conditions among the homeless may reflect three separate phenomena. First, certain health conditions, such as AIDS, mental illness and substance addictions, may increase the likelihood that particular poor individuals become homeless. The greater prevalence may also reflect homeless people's increased risk of getting certain diseases. For example, sleeping in congregate shelters increases the risk of respiratory infection transmission. Life on the streets exposes people to greater risk of violence and environmental threats such as rain and freezing temperatures. Finally, the state of being homeless may exacerbate conditions that are usually minor in the general population. For example, a common cold may lead to pneumonia because of inadequate nutrition, increased stress levels, lack of sleep and poor access to medical care. Promoting the health of homeless individuals can and needs to be approached on a variety of levels. The immediate health-care needs of homeless individuals should be addressed, but emergency services should not supplant long-term efforts to address the root causes of poor health among homeless individuals. This means that health-care providers must

work outside the arena of traditional medical care provision to confront issues of poverty, housing policy, domestic violence, prevention and treatment of addiction, and other factors that contribute to homelessness. This also means that health-care providers must work to return power and voice to a stigmatized and isolated segment of society.

Health Concerns of Homeless Children

Homeless children, although they may be covered by Medicaid, are less likely to be seen regularly by primary care physicians. Some reasons include inconvenient location of the physician's clinic, lack of transportation, inconvenient appointments, and lack of access due to low reimbursement rate to the physician. Fewer well-child care visits mean that chronic conditions such as anemia and poor nutrition are less likely to be detected early. Homeless children are also usually behind on immunizations. These children often suffer the ill effects of substandard housing—for example, exposure to high levels of lead. The long-term effects of these chronic conditions, such as seizure disorders and learning disabilities, can be devastating for children and affect their ability to break the cycle of homelessness.

Barriers to Health Care for the Homeless

There are several reasons why it may be difficult for a homeless individual to access the medical system and receive basic health care. First, most of the homeless population does not have medical coverage, and any costs associated with health care pose a significant barrier. The homeless therefore must receive care through county health facilities, emergency rooms or low-cost or free health clinics. These clinics may be overcrowded with few appointments available and located too far away for those without reliable transportation. Since homeless individuals lack control of their daily circumstances, medical appointments may be difficult to keep.

Control and Voice

One of the often hidden assumptions behind programs for homeless individuals is that people are homeless because they are deficient and incapable of managing their own life. This assumption leads to the creation of patronizing programs that neglect the voices of those they program purport to serve. Finding meaning and control in one's life is central to the development of health. With regard to health care for the homeless programs, meaning and control can be returned to homeless individuals by creating mechanisms that solicit input from and involve homeless people. Examples of this include: 1) The creation of advisory boards that consist of homeless and formerly homeless people; 2) facilitating processes that bring homeless individuals together to identify and tackle mutual problems; 3) focusing and utilizing the strengths and resources of people, and not simply targeting their needs and weaknesses; 4) listening to and addressing the most pressing concerns of homeless people (e.g., if people say that their chief concern is finding housing rather than smoking cessation, help them find housing first and then address their smoking habit when it becomes their priority); 5) acknowledging the contribution of economic, cultural and social factors to an individual's health, well-being and decision-making. The integration of such efforts into programs is one of the most important steps.

What are some characteristics of responsive health programs for the homeless?

In order for a health program to improve the delivery of health care to the homeless, it must address the special needs of this population. The medical care must be accessible, comprehensive and non-judgmental.

Accessible

- Location: mobile clinics on the streets or in shelters are more accessible and will improve the delivery of care.
- Affordability: any out-of-pocket costs are a prohibitive barrier to health care.

Comprehensive

- Providers must have the ability to respond effectively to a wide variety of mental and physical illnesses.
- Treatment responses must be context-appropriate. Providers must take into account the patient's social environment.
- Health promotion/disease prevention activities should be highlighted during their medical treatment.

Non-Judgmental

- Attitude: providers must have a positive attitude and want to work with this difficult population.

What can be done?

AMSA believes strongly in local, grass-roots, community-driven health projects. Such projects are an integral part of efforts at social change and provide a foundation for making public policy recommendations.

- 1) Talk to homeless individuals in your community and find out about their hopes, concerns, needs and strengths, and involve them in projects that address their concerns.
- 2) Get involved with public policy issues that affect homeless individuals or contribute to homelessness:
 - a) Federal reclassification of alcohol and drug addictions as non-disabling conditions. This means that individuals currently receiving SSI benefits for an addiction will no longer receive benefits in the upcoming year. More people may become homeless as a result of this policy change.
 - b) Address federal, state and local funding cuts in mental health care and drug rehabilitation programs.
 - c) Get involved in the welfare reform debate and offer alternatives to the traditional conception of welfare (e.g., microenterprise lending programs).
- 3) If there is a local need, help start a community health project for homeless individuals. Learn from the experience of similar programs around the country by tapping into an evolving network of medical school affiliated clinics for homeless and low-income people. Create projects that return control and voice to homeless individuals.
- 4) Learn about services for homeless individuals in your local area and learn more about the problem through action and reflection.

Section II: Background

I have never been homeless. But I often wondered what it would be like to live, night after night, on the streets or in a public shelter.

Rabbi Charles A. Krolloff

What Is Homelessness?

Among policy makers, social scientist, and homeless advocates, defining homelessness is a controversial point. The literally homeless include those people who live on the streets, in shelters or doubled up with a friend or relative. These are the people that are most easily recognized as homeless. There is also a large group of people known as the precariously housed. These people, while in current shelters, are at high risk for homelessness and many have been homeless in the past. They outnumber the literally homeless, and many advocates would like for them to be included in the definition of homelessness (.5).

Who Is Homeless?

Homelessness is an issue that first garnered mass public attention in the early 1980s, after the 1982-1983 recession that increased unemployment and, correspondingly the numbers of poverty-stricken people in the country. It was thought to be a short term problem that would be remedied by economic growth. However, while the United States experienced the longest period of economic growth in the post-W.W.II period in the late 1980s, homelessness did not disappear or even slow in growth. Instead, there was a rapidly expanding population of people in our communities with no permanent place to live. The American public continued to believe that homelessness was an urban problem that affected only those on the fringes of society: people with mental illness, unmarried women and their children, veterans and minorities. We thought that the homeless were rebels who were able-bodied but chose not to work.

This perception now seems false. Homelessness is not a problem that affects people marginalized and living in the inner city, but an indicator of changes in the fabric of American society. Link and colleagues found that 7.4 percent of all adult Americans (13.5 million) have experienced literal (street and shelter) homelessness in their lives and 3.1 percent of all adult Americans (5.7 million) experienced homelessness between 1985 and 1990. They also found that the incidence of homelessness appears to be no different between men and women, blacks and whites, or urban and rural populations (1). These unprecedented numbers are confirmed by the 1991 General Social Survey, which found that of respondents, 2.6 percent had been homeless in the year before the survey and, by extrapolation, 4.6 percent would have been homeless in the five years prior to the survey (2). This growing population of homeless people appears to be migrating from the urban centers of large cities to less dense metropolitan areas, suburbs and rural areas (2.5). This is probably due to three interrelated issues: community backlash against homeless

people, fears within the homeless population of dangerous living conditions, and problems accessing services and support within urban areas (2.6).

How Many Are Homeless?

Many efforts have been made to specify the number of homeless in the United States. Reports have ranged from hundreds of thousands to several million people. A concrete number is difficult to obtain through scientific survey methods for a variety of reasons. The first and most obvious problem is finding people who are currently homeless. Researchers are unable or unwilling to reach the people living in campgrounds, on rooftops, or in their cars. The second problem is that once homeless people are found, they are unwilling to admit that they are homeless. The third problem is developing an acceptable definition of homelessness and an acceptable methodology for counting homeless people. Each study might define homelessness differently, and therefore certain people might be counted in one study and not counted in another. Another problem is not including the people who have a relatively short time period of literal homelessness. These people are important in differentiating the initial causes of homelessness from reasons for persistent homelessness. The last problem relates to applying data collected in one area to the entire homeless population in the United States. To assume that homelessness is similar in urban, suburban and rural populations is a gross simplification.

The prevalence of homelessness as presented by different studies has varied widely. Hombs and Snyder began the debate in 1982 by putting the number at anywhere between 250,000 to 3,000,000 (3). The 1990 U.S. Census reported that 800,000 adults with children were homeless (4). The study by Link et al. and the General Social Survey, in looking at one-year and five-year prevalence, inflated these numbers dramatically, with 2.6 percent one-year and 3.1 percent five year population prevalence of literal homelessness (5, 6).

*Then he was told: Remember what you have seen, because
everything forgotten returns to the circling winds.*

from a Navajo chant

Why Are They Homeless?

The basic cause of homelessness is poverty. Poverty itself is exacerbated by many factors including lack of affordable housing, inadequate income and health crisis. According to the most recent census data, 14.5 percent of the population, or 38.1 million Americans, are living in poverty (7). The national economy is recovering from the early 1990s recession; however, most of this recovery has benefited households in the upper-income levels. Those people living in poverty, or close to it, must make decisions on how to use their limited resources. They are burdened by an insufficient minimum wage and inadequate government benefits. Housing, which saps a large proportion of any household's income, is the first thing to be left by the wayside.

The problems surrounding housing for poor people are numerous. There is insufficient affordable housing to meet needs. In the last 20 years, 2.2 million low-rent units disappeared from the market while the number of low-income renters increased by 4 million, resulting in a shortage

of 4.7 million affordable housing units (8). Government benefits have been found to be inadequate to meet the housing costs of low-income households. For example Kaufman showed that in 48 states a family of three would have to spend more than their monthly AFDC benefits to pay the fair market rate for a two-bedroom housing unit (9). Additionally, only one fourth of all AFDC recipients receive housing subsidies, meant to bridge the gap left between AFDC benefits and housing costs (10).

Many other factors play a part in forcing people into homelessness. The first is the failure of our health-care system. In 1995, 39 million Americans had no health insurance (11). These people are just one catastrophic illness away from homelessness. The second factor is the prevalence of domestic violence in our society. Many battered women must choose between their abusive relationship and homelessness, often with their children. The third is mental illness. In the past, the increase in homelessness was blamed on the massive release of mentally ill people from institutions in conjunction with the advent of powerful antipsychotic drugs. The reality is that only five to seven percent of homeless mentally ill people need to be in institutions. The majority are unable to access the supportive housing or treatment services that they so desperately need (12). The final factor is chemical dependency. People who are poor and addicted to a drug are put at a higher risk of becoming homeless (13). Once without permanent housing, these people face the double burden of finding shelter and fighting their addiction.

Health is a state of complete mental, physical and social well-being and not merely the absence of disease or infirmity.

World Health Organization (WHO)

Health and Being Homeless

Poor health is closely associated with homelessness. Poor health status both causes homelessness and is caused by being homeless. Thirteen percent of homeless patients surveyed stated that poor physical health was a factor in their becoming homeless. Fifteen percent of these people stated that health was the single most important factor in their becoming homeless (14). Homeless people, both adults and children, suffer from at least one chronic health problem almost twice as often as housed people. Serious health problems can precipitate homelessness and, in cases of diseases that require regular treatment, can be magnified by the instability of the homeless lifestyle. For example, tuberculosis is very difficult to treat or control among people without adequate shelter.

There are four factors that determine health among homeless people. They are genetics, environment, health services and lifestyle. In assessing the situation of a homeless person, it is clear that each factor plays a specific role in the health of a homeless person. A person with a disease such as mental illness or alcoholism in their family tree has a higher risk of these diseases and hence a higher risk of becoming homeless. These chronic condition also give rise to multiple health problems. Living the life of a homeless person is highly stressful. Without a permanent place to live, there is no sense of security, stability or well-being. Neither the lifestyle of being homeless nor the environment in which a homeless person is placed is conducive to a well-balanced, healthy life. Homeless people are exposed to infectious diseases in shelters crowded

with too many people, violence while living on the streets, and the never-ending stress of looking for a place to sleep, a job and enough food on which to survive. The final aspect determining the health of homeless people is the health-care services provided to them and their ability to access those services. It is difficult for providers of homeless health care to develop services that will be most useful to homeless people, and it is even more difficult for homeless people to access these services and use them in a manner that will be the most beneficial. Some of the barriers to health-care access are lack of transportation, mental illness, lack of financial resources, and mainstream values impeding people from seeking care at a homeless clinic.

Health Care for the Homeless

There are three main components of providing health care for the homeless that must be addressed. These are the physical, mental and social aspects of health. Providing solely for physical health without addressing mental health or social issues will not improve the overall health of a homeless person. A holistic approach to health care for the homeless must be taken to address all the problems that are encountered. There are three basic delivery models for primary care for the homeless. These modes of delivery are a community clinic, an outreach clinic, and a triage and screening clinic.

These three models when used together can offer the **seven Cs** of patient care for homeless people:

convenience
confidentiality
compassion
community
centered
coordination
comprehensive

These seven Cs embody the characteristics of a system responsive to homeless health needs. They include location of provision, affordability, and care and attitude of providers, which are all major factors in accessibility. Additionally, they address the ability of a system to respond effectively to wide variety of mental and physical illnesses and provide appropriate treatment responses for the population being served.

Most of the financial aspect of health care for the homeless are covered by the Federal Health Care for the Homeless program, which was established under the Stewart B. McKinney Homeless Assistance Act of 1987, which amended the Public Health Service Act. The Health Care for the Homeless Program seeks to improve access by homeless people to primary health care and substance abuse treatment. Through this program, both private and public organizations are able to receive grants to provide or arrange for the delivery of health services, outreach and case management to homeless individuals. In 1995, 122 community-based organizations received grants, including community and migrant health centers, local health departments and community coalitions.

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Section III: Projects

One of the strongest traditions in AMSA--and one of the best ways to excite and motivate your chapter--is community outreach. Medical students respond to projects that get them out of the classroom and into an environment where they can interact with their community. We strongly encourage you to view this project as a chance to accomplish two major goals: education of your fellows students, and outreach to your community. This section will provide a list of ideas for projects, as well as a short guide which may help you determine the right level of activity for your chapter to take on.

One last note about timing: the National Project on Health Care for the Homeless, like past National Projects, seeks to address curricular needs not met in traditional medical training. Though we at AMSA National are eager for chapters to put on projects at or around the target date, we encourage chapters to design their own programs and implement them throughout the year.

Step 1: Assessing your resources

As with any project, one of the most important steps is the planning of your local effort. When planning, start out with a simple algorithm to determine what resources you have to draw on. This can help you determine what level at which to work:

How large is your chapter?

The size of your chapter determines many of the activities you might want. At a small chapter, it may be more convenient to sponsor more school-based activities: a lecture series by local activists, a panel of public health officials discussing their role in providing care, or even a health insurance information session by Physicians for a National Health Program. Since many of your chapter folks may well be involved, if you have lots to spare, aim for something bigger: a visit to a clinic, information booths at local shopping areas, or even working on an effort to include this information in your school's curriculum.

How many people might be interested in this topic?

For schools in urban areas, where significant amounts of homeless patients are a part of all rotations, this project is a natural. There will also almost naturally be community resources in the form of public health departments, shelters and charitable foundations, religious or otherwise. However, very rural schools may face the obstacles of very little opportunity for interaction with homeless populations, and few experts to tap. The interest level in your chapter is also important,

as more motivation from your members is predictive of the ability to put on a good project. Do you have a large number of students interested in rural health? Or actually very few?

What kind of resources are available?

As mentioned, another important step is to assess what resources are available. Does your school have a free clinic associated with it? Is there a major health department in the vicinity? If not, then this will probably move you to do more school-oriented rather than community-oriented activities.

What are the community resources available for the project?

Again, the level of programming directly determines much of the activity level available to you. Consider the factors mentioned above, and inquire with local primary care centers to find references on speakers, local organizations and other resources.

Don't feel in any way limited by this list. If you have a large chapter that is burned out from other activities, do a modest lecture and panel discussion. Are you at a smaller school, yet want to make a big splash? Try an ambitious clinic visit project. Whatever you do is ultimately dependent on your own time and energy--use them wisely.

Step 2: Picking a Project

Most of the possible projects can be divided into two major categories: in-school, primarily educational ideas; and community-oriented, primarily service ideas. They are certainly not mutually exclusive--indeed, they complement each other. What follows is a small list of possible projects, with a note or two about who and where they best fit.

In-school/educational projects

Easier to arrange, these projects focus on dispensing information and dispelling myths about homelessness and health care. They are perfect for any level of involvement, though they depend somewhat on the availability of lecturers and panelists.

- Invite the head of the city public health department to speak about health-care provision for homeless people in your community
- Convene a panel discussion of nurses, physician assistants, and physicians from a local clinic to talk about the challenges and rewards of their work
- Have a poster session in your school lobby on homeless health issues, and include information for letter-writing to Congress on current legislation
- Meet with your dean to discuss the inclusion in your curriculum of ambulatory rotations in local homeless sites
- Do a public service announcement for local radio, describing the importance of homeless health care in your community
- Mental health and homelessness: convene a panel discussion of local mental health professionals to talk about the impact of state and federal laws on homelessness.
- Do an Internet search on homelessness. There is good information about the homeless issue on the World Wide Web, including general fact sheets on homelessness, personal

testimonies and current legislative updates on issues affecting this population. Contact HCH at: <http://nch.ari.net>

- Join the Health Care for the Homeless (HCH) Clinician's Network as a student member. This is a national association of clinicians dedicated to combating and preventing homelessness and to improving the health and quality of life of homeless people. The student membership is \$15 a year. Call (615) 226-2292, or write P.O. Box 68019, Nashville, TN 37206-8019, for more information.

Community-oriented/service projects

Though these projects may require more legwork and administration, they are often more satisfying due to their "hands-on" approach. They are limited more severely than the educational projects by the needs of your community: If you attend a medical school in a rural area with a very low homeless population, it will make many of these projects difficult. Even so, there are many public health opportunities in any area. Here is a few examples:

- Tuberculosis screenings require some contact with public health officials but they are excellent primary care activities at a number of sites, be they county hospitals, homeless shelters or soup kitchens
- Run a blanket/clothing drive and then deliver personally to a shelter/clinic
- Visit a local shelter, and spend the day or night dispensing food or simply talking with the homeless about their health care and their lives
- Develop a Homeless Health Care night, during which students go into the community and collect food, blankets and other materials, then distribute them on the streets
- Buy a homeless newspaper from a local co-op
- Organize a homeless outreach project that allows students to provide basic health care to homeless populations at a clinic or shelter

However you choose to participate, the National Project is aimed at education, legislative activism, and community outreach. When planning, keep all of these themes in mind, and be aggressive in using the resources in your community. When looking for information, don't hesitate to speak with faculty who are involved in these issues. Call a clinic, ask to speak with its medical director, and ask him/her what you can do to raise awareness and make a difference. If you can do that, you'll find more resources in your community than you could possibly imagine.

Generalist Physicians-In-Training (GPIT) Project-In-A-Box

The Project-In-A-Box on Health Care for the Homeless addresses some of the causes of homelessness, including health and social issues. As medical students, it is our responsibility to understand the pathology of disease as well as the needs of special populations in order to provide effective care. GPIT's Project-In-A-Box provides you with an easy framework to help you coordinate events on the homeless issue.

Enclosed in the Health Care for the Homeless project-in-a-box, you will find:

- A Student Organizer's Guide with tips on planning an activity on providing health care for the homeless.
- Suggestions for what students can do and who they can contact to learn more about health for the homeless.
- A list of written resources on the topic
- Case studies
- An evaluation/feedback form

**For more information on Health Care for the Homeless
Project-In-A-Box,
Go to AMSA's Web site at www.amsa.org**

Section IV: Health Care for the Homeless Legislative Information & How to be an Activist

This information was taken from the National Coalition for the Homeless homepage at <<http://nch.ari.net>>. The NCH regularly updates its web page, so please visit it often for updates on pending legislation regarding the homeless.

How to Think About The Homeless and Politics:

Programs that assist the homeless are largely funded by the federal, state, and local governments. This guide will focus on federal programs. Federal programs are first authorized (a law creates the program) and then appropriated (another law gives funding to the program). The current congressional trend is to decrease federal funds for many programs, even eliminate them. So, keep in mind that there are two steps in maintaining a government-sponsored homeless program: it must first be preserved as an entity, and then it must be funded. Many of the bills discussed below deal with the funding of homeless programs (a.k.a. appropriations) for fiscal year 1997.

Funding for many federal programs was reduced for fiscal year 1996. Therefore, attempts to increase funding for FY1997 may be simply to restore programs to their FY1995 funding levels. Keep in mind that regardless of the course of homeless appropriations in this Congressional session, the same issues and programs will doubtless be debated again in the future. Use the information below to plan your action for the future.

1997 Appropriations for Health and Education Programs

As of September 7, 1996

The 104th Congress (1995-96) is expected to be in session until the last week of September. In these few weeks, its main task will be to send as many appropriations bills to the President as it can, among them a bill funding the Department of Health and Human Services, the Department of Education, and the Department of Labor.

The Senate Appropriations Subcommittee on Labor, Health and Human Services (HHS), and Education is expected to act on its version of the Labor, HHS and Education appropriations bill for FY97 on September 10 and the full Appropriations committee may act on the bill by September 12. It is possible that the Senate will provide substantially less money for programs for homeless people than the House did this year. Programs for homeless Americans contained in this bill include Health Care for the Homeless, Projects for Assistance in Transition from Homelessness (PATH) programs, Education for Homeless Children and Youth and the Substance Abuse Prevention and Treatment Block Grant.

The best chance for increased funding for health and education services for homeless people lies in letting members of the Senate Appropriations Committee know about the need for these services:

Projects for Assistance in Transition from Homelessness (PATH) -- The House agreed to continue targeted funding for PATH in FY97, but voted to fund the program at only \$20 million, 31% below FY95. Increases in the number of homeless people with mental illness and the shredding of the health care safety net make it imperative that we work with the Senate to increase funding for PATH in FY97 to at least \$40 million.

Education for Homeless Children and Youth Program (EHCY) -- The House appropriated \$23 million, the same amount as appropriated in FY96 and a 20% reduction from the FY95 level (see Impact of FY96 Budget Cuts on the Education of Homeless Children). Yet homeless children represent one of the fastest growing segments of the homeless population. Politicians from Bill Clinton to Bob Dole and Newt Gingrich claim that they want to provide a bright future for America's youth, but they have failed so far to provide access to education, health and nutrition for homeless young people. Congress should appropriate \$50 million for FY97 for the EHCY program. The funds represent only .0032% of the federal budget but have a tremendous impact on the growing numbers of children and youth without homes.

Health Care for the Homeless -- Your visits, calls and letters were instrumental in persuading the House to increase funding for the consolidated Health Center Programs (HCH, Community and Migrant Health Centers) to \$802 million for FY97, including \$69 million for HCH. However, years of flat funding, increasing homelessness and a diminishing indigent health care safety net mean that we need to encourage Congress to do more. The Senate should appropriate \$72 million for the HCH program as part of \$832 million overall for consolidated health center programs.

The Substance Abuse Prevention and Treatment Block Grant -- Congress voted in March to end Supplemental Security Insurance and Supplemental Security Disability Insurance (SSI/SSDI) eligibility for persons for whom alcoholism or substance abuse is material to the determination of their disability. This legislation also provided \$50 million for treatment services for people eliminated from the rolls as a result of this change in disability definitions, however, the House failed to add these funds to the block grant for FY97. Waiting lists for treatment services are already long and this new legislation will only make things worse as thousands lose eligibility for SSI/SSDI and, by extension, Medicaid. However, the House has decided to fund the substance abuse block grant at FY96 levels and to provide no additional resources to meet increased needs. In order to address the problem it has created, Congress must appropriate a minimum of \$50 million above current levels, targeted to treatment services for people who would otherwise be qualified for SSI/SSDI.

Recommended Action:

If your Senator is a member of the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, please visit, call, write, and fax to urge him or her to support funding for the McKinney health and education programs at the levels we have suggested.

If your Senator is NOT a member of the Senate Appropriations Subcommittee, please urge him or her to write Senator Arlen Specter (R-PA), the chair of the subcommittee, to support funding for homeless health and education programs at the levels we have suggested. Senator Specter can be reached at 202-224-4254, fax: 202-224-1893. Letters should be addressed to The Honorable Arlen Specter, United States Senate, Washington, DC 20510.

**All Members of Congress can be reached through the
U.S. Capitol Switchboard at 202-224-3121.
Find your Senators' and Representative's email address
at <http://www.senate.gov> or <http://www.house.gov>.**

FY97 Appropriations for Housing and Emergency Assistance Programs

As of September 7, 1996

The Senate passed its version of H.R. 3666, the FY97 appropriations bill for the Veterans Administration (VA), Department of Housing and Urban Development (HUD) and other agencies, on September 5. Action now moves to a House/Senate conference committee, where differences between the two houses will be worked out over the next week. It is therefore still possible to contact members of the House and Senate to urge them to support appropriate funding for programs that serve homeless people. These programs include:

FEMA Emergency Food and Shelter program -- The Senate Committee approved \$100 million for this program, the same level as FY96 and a 23% cut from the FY95 level. Yet the US Conference of Mayors estimate that 19% of all emergency shelter requests went unmet in FY95. To meet this need, we believe that the Senate should appropriate at least \$155 million for FEMA Emergency Food and Shelter in FY97.

HUD Homeless Assistance Programs (Emergency Shelter Grants, Supportive Housing, Shelter Plus Care, Section 8 SRO Moderate Rehabilitation) -- The Committee voted to appropriate only \$823 million, the same as FY96 and a 27% cut from the FY95 level, despite a rapidly growing homeless population in the U.S. We believe that \$2.24 billion is the minimum needed to help provide housing and supportive services to homeless Americans. This is approximately the cost of one B2 Bomber.

Section 8 Incremental Certificates -- No new assistance is provided for the millions of families on waiting lists. In 1994, over 2.5 million people were on waiting lists for public and assisted housing. Therefore, Members of Congress should be urged to provide at least 250,000 new Section 8 certificates in FY97 and every year thereafter until this housing crisis is resolved.

Maternity Stay and Mental Health Parity -- Senator Bill Bradley succeeded in amending the VA/HUD legislation to require insurers to pay for a 48 hour hospital stay following a vaginal birth and a 96 hour stay after a C section. This amendment will allow mothers and their medical practitioners, rather than HMO accountants, to make decisions about maternal and infant health after birth. Senators Pete Domenici and Paul Wellstone also succeeded in getting the Senate to add a provision assuring some level of parity between mental and physical health benefits. This amendment is similar to one they had proposed earlier this year on the Kassebaum/Kennedy health care bill. While both of these amendments enjoy wide support in Congress, the Health Insurance industry is already gearing up to have them eliminated in conference. We believe that both constitute important steps in making health care more available and effective and urge you to ask members of Congress to support them.

Recommended Action:

It is important that you contact your Senators and Representatives now and urge them to support appropriate funding levels for programs that meet the needs of homeless Americans.

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Find your Senators' and Representative's email address at
<http://www.senate.gov> or <http://www.house.gov>.**

Public Housing Reform

As of September 7, 1996

Although the opportunity to affect this legislation may have passed, this is a good example of possible upcoming legislation in the 105th Congress beginning in January 1997.

Senate Republicans have indicated a renewed interest in completing work on S. 1260, the United States Housing Act of 1996, in the next week or so. Conference committee staff have been meeting since June to try and resolve differences between House and Senate versions of the bill. Your advocacy has been important in slowing down this legislation and continued effort may yet succeed in stopping it before the end of the 104th Congress. **This legislation is a potential disaster for low income families because it:**

- Allows public housing authorities to raise rents for households with incomes above 30% of Area Median Income (AMI), with the exception of elderly persons, disabled persons, and veterans. This provision will ultimately lead to increased rent burden and possible eviction for hundreds of thousands of low-income families.
- Loosens income targeting, so that scarce housing resources will not reach those in need, and does nothing to address the diminishing supply of affordable housing for the poorest households.
- Establishes minimum rents of \$25, with Public Housing Authority discretion to go as high as \$50, thus raising rents of the poorest households.
- Requires tenants to sign "self-sufficiency contracts," which establish a time frame for "graduating" out of assisted housing. The bill does not, however, provide any resources (education, job training, etc.) to help tenants achieve this goal.

Permanently repeals federal preferences for public and Section 8 housing; these preferences often enable homeless individuals and families to move up to the top of the waiting list for assistance. Permanently repealing federal preferences would prolong the length of time people who are homeless or precariously housed must wait for housing assistance.

- Modifies HUD's definition of "person with disabilities" to conform with the Social Security Act. According to the Bazelon Center for Mental Health Law, this change will eliminate access to public housing, project based assistance and Section 8 vouchers and certificates for many people who work, for those who have severe mental illnesses and for people with substance abuse disorders. If enacted, these provisions may contribute substantially to an increase in homelessness in the next few years.

Recommended Action:

S. 1260, contains provisions destined to increase homelessness and prolong the length of time people who are without homes remain homeless. **Thus, S. 1260 should be opposed.**

Urge President Clinton to veto S. 1260. The Administration has signaled its support for the bill despite the increases in poverty and homelessness it would cause if enacted. The President can be reached at 202-456-1111.

Urge your Representatives and Senators to vote no on S. 1260 when it comes to them for a vote.

**All Members of Congress may be reached through the
U.S. Capitol Switchboard at 202-224-3121.
Find your Senators' and Representative's email address at
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Changes in SSI/SSDI Disability Definitions

SSI is Supplemental Security Income, and SSDI is Supplemental Security Disability Income. On March 29, 1996, President Clinton signed into law legislation (P.L. 104-121) that would deny SSI and SSDI disability benefits and, by extension, access to Medicaid, to people whose addictions are considered to be a "contributing factor material to" the determination of their disability status. More than 200,000 people who are currently on SSI or SSDI receive their benefits due to a disability determination linked to drug addiction or alcoholism (DAA). All of these people are liable to have their benefits terminated on January 1, 1997. Furthermore, as of March 29, no new beneficiaries for whom addictions are material to their disability will be added to the rolls.

While many current beneficiaries can be reclassified as disabled through conditions not related to addictions, the Social Security Administration believes that at least 40,000 people are likely to be eliminated from the rolls due to these changes. Starting in 1997, the Congressional Budget Office estimates that as many as 50,000 people per year will be prevented from receiving these benefits due to classification as DAA.

SSI and SSDI benefits are often the only resources available for individuals to access housing and treatment, both of which are fundamental to recovering from drug addiction and alcoholism. Furthermore, they provide needed access to health care through Medicaid. Changes in the disability definitions are likely to result in 40,000 more Americans becoming homeless beginning in 1997, and in many thousands more becoming homeless over the next few years as people are found to be ineligible for SSI and SSDI. Without housing and treatment, these individuals will be highly vulnerable to renewed substance abuse and personal suffering. This will also lead to increased pressure on homeless service providers and greater costs to the indigent medical care system.

Recommended Action:

Help Prevent Homeless From Losing Eligibility. Persons (and their Representative Payees) currently receiving benefits due to DAA must be notified by SSA no later than June 28, 1996 that their benefits will end on January 1, 1997. If they reapply by July 28, 1996, SSA must make a new medical determination no later than January 1, 1997. If the homeless "client" is found to have a non-DAA condition, benefits will continue. Homeless "clients" should be receiving notice of these changes in the mail. Placing notices with dates, contacts and addresses in shelters, soup kitchens and clinics will help reach people who may not regularly receive or read their mail.

Contact your local Social Security Office and state Disability Determination Service to determine what steps you can take to facilitate the reapplication process. The National Coalition for the Homeless will serve as a clearing house for information related to discussions with local SSA and DDS offices. Please contact David Beriss at (202) 775-1322 with your experiences or if you would like to hear about other approaches.

Prepare other local service providers to help prevent people from losing their benefits. Anyone whose clients may receive benefits due to addictions, as well as medical practitioners who may perform disability evaluations, should be provided with training concerning these changes. The Coalition on Homelessness in San Francisco has begun training providers and can provide ideas and materials if you are interested in organizing such training. Contact Jennifer Freidenbach at (415) 346-9693.

Congress' action in this situation was based neither on solid data nor on a well thought out approach to helping vulnerable Americans address their addictions or overcome their disabilities. \$50 million was added to the Substance Abuse Block Grant in this legislation, but this is hardly enough to significantly impact the problem. In fact, these additional funds are not even targeted to current or former SSI or SSDI recipients, housed or homeless. Currently, there are no federal funds targeted to services for homeless persons with substance abuse disorders. However, there are steps you can take to change this situation.

Let members of Congress and the Administration know that this change will result in a significant increase in homelessness. Health problems will also worsen and health costs for the medically indigent - borne by states and local governments - can be expected to rise, with increased use of emergency rooms and detoxification facilities. Furthermore, an additional \$50 million does not begin to address the need for treatment resources, especially since there are an estimated 1 million Americans currently on waiting lists for treatment. If Congress and the Administration are serious about addressing substance abuse, they should substantially increase resources available for treatment, targeting a significant portion to people excluded from SSI and SSDI. Members of Congress can be reached at (202) 224-3121. Carol Rasco, head of the President's Domestic Policy Council, can be reached at (202) 456-1414.

The Substance Abuse Prevention and Treatment Block Grant is the main source of federal substance abuse treatment funds. There are currently no set-asides within this grant for outreach to or treatment services for homeless people. However, you may be able to work within your

state to target some of these funds to the needs of homeless people. Contact your state Alcohol and Drug Abuse Director and Governor and alert them to the impact these changes in SSI and SSDI will have on homelessness. Remind them that housing and treatment play essential roles in helping people control their addictions. If you do not know who your state alcohol and drug abuse director is, please contact David Beriss at the National Coalition for the Homeless, at (202) 775-1322 or email at nch@ari.net.

The increase in homelessness, in substance abuse on the streets and begging will come at a high political cost for local elected officials. Your governor, mayor, city council members, police chief and public health officials may be enlisted as allies in working to make sure more resources are made available to prevent homelessness among people with substance abuse disorders. We will need to build strong local coalitions if we are to motivate Congress to devote resources to addressing the problem it has created. Help educate people: Treatment works and housing is the first form of treatment.

**For further information, please contact David Beriss at the
National Coalition for the Homeless at
(202) 775-1322, email: nch@ari.net.**

Welfare Reform

as of September 7, 1996

Introduction and Overview

On August 1, Congress passed the most sweeping welfare legislation since the 1960s and on August 22, President Clinton signed it into law. This legislation will destroy the federal safety net and dramatically contribute to homelessness in the U.S. It effectively ends Federal efforts to combat poverty. Congressional leaders claim that the "Personal Responsibility and Work Opportunity Reconciliation Act of 1996" will "end welfare as we know it," move poor Americans out of dependence and into jobs. They believe that this legislation will provide an effective way to strengthen families and discourage single parenthood, which they view as the fundamental problems facing America. However, without increased resources for jobs that pay livable wages, affordable housing, health care, education and child care this reform will prove to be most effective at moving people from welfare into deeper poverty and homelessness. Congress has missed an important opportunity to provide new programs that would truly enable people to rise out of poverty and has instead opted for a politically easy attempt to punish people for being poor.

This legislation makes changes to many programs; however, there are three areas where its impact on homelessness will be especially significant. First, in order to maintain the Federal contribution to the new welfare block grants, states will be encouraged to move people off the welfare rolls. While the ostensible goal is to encourage people to work, the likely result will simply be rules that eliminate people from the welfare rolls faster, denying them needed resources and pushing them into homelessness. Second, changes in the Food Stamp program will reduce eligibility and benefit levels for thousands of people. In many cases, families will have to choose between housing and food. Finally, the law makes changes in SSI eligibility for disabled children and legal immigrants, cutting off needed resources for individuals and families who may be unable to work.

Ending Welfare As We Know It

Perhaps the most significant change in current law is the end of the entitlement to cash assistance for low income families, some disabled children and all legal immigrants. While the entitlement to assistance ends on October 1, 1996, access to assistance will only change with the approval and implementation of state plans in subsequent months. The Aid to Families with Dependent Children Program (AFDC), Job Opportunities and Basic Skills (JOBS) and Emergency Assistance (EA) programs are eliminated under this legislation, to be replaced, no later than July 1, 1997, by state programs funded under a new Temporary Assistance for Needy Families (TANF) block grant.

The eliminated programs are entitlements under which states receive funds from the Federal government in amounts that correspond to the size of the population that qualifies for the program. The size of the new TANF block grant will be a combination of the amounts each state received in previous years for AFDC, JOBS and EA. States that reduce illegitimacy rates and meet other performance criteria may be eligible for increased grants in some years. Matching

requirements are also eliminated; however, states will be required to provide 75% of the funds they spent in fiscal year 1994 on the terminated programs as a "maintenance of effort" contribution. According to the Congressional Research Service, total Federal funding for this grant will not exceed \$16.4 billion nationally in each of the fiscal years 1996 through 2002.[1]

The new legislation places few limits on the ability of states to design programs and set eligibility requirements:

- States will not be able to use block grant funds to provide assistance to adults for more than five years, although 20% of each state's caseload can be exempted.
- Adults will cease to receive benefits if they do not begin to work within two years of joining the welfare rolls.
- Adults who do not cooperate with child support enforcement agencies seeking to establish paternity will have their family benefit reduced by at least 25%, although states may choose to eliminate the benefit completely.
- Individuals convicted of a drug-related felony will be denied welfare benefits and food stamps. States may choose to opt out of this provision, however, it is hard to imagine how legislation designed to provide benefits for "convicted drug pushers and addicts" would survive most state legislatures.
- States may deny additional assistance to children born to mothers already receiving welfare.
- States may require that minor, unmarried parents live with an adult and attend school in order to receive benefits.
- People who move to a new state may be provided benefits at the level of the state in which they previously resided, rather than at the level of their new state of residence.

Block Grants and Work Requirements

Moving welfare recipients into work has long been the cornerstone of welfare reform proposals. It is also one of the key features of this legislation. However, H.R. 3734 is designed to encourage states to reduce their welfare rolls without necessarily investing in a serious or effective jobs program. Incentives to move people into work and reduce welfare rolls include the following:

In order to continue to receive their full TANF grant, states will be required to have 25% of their caseload engaged in work at least 20 hours/week by 1997 and 50% by 2002 working at least 30 hours/week. All families receiving assistance are counted in these percentages, although states may exclude those with children under 1 year of age. States that fail to meet the work targets will have their block grants reduced by 5% initially and 2% each subsequent year, for a total of 21% by 2002.

The relationship between TANF block grants and work requirements will provide states with a strong incentive to reduce caseloads by redefining eligibility, closing the rolls or other means, instead of creating and paying for work programs. As Mark Greenberg, of the Center for Law and Social Policy, has noted, the principal barrier to greater participation of welfare recipients in work programs has long resided in a lack of resources for administration of a jobs program and child care, not in bureaucratic barriers to work.[2] According to the Congressional Budget Office, if states maintain their 1994 level of spending on job programs, they will, in 6 years, be \$12 billion short of the funds required to meet the work requirements contained in H.R. 3734.[3] The new law provides a "caseload reduction credit" that lowers the work requirements for a state's caseload, provided HHS cannot prove that eligibility requirements were defined specifically to reduce caseloads. The lack of sufficient work program investments and child care funding combined with this credit are likely to encourage states to remove people from the rolls without jobs, a move that will lead to increased homelessness.

Child Care

As noted, the new welfare bill does not provide enough resources for child care to enable poor parents to work. As with cash benefits, its goal is to eliminate entitlements and restructure federal funding, not to reduce poverty or enable people to rise above poverty. H.R. 3734 eliminates the entitlement to child care assistance for families on welfare who are working or in school. H.R. 3734 also eliminates the guarantee of one year of Transitional Child Care Assistance for families who leave welfare.

The child care entitlement programs are replaced with a modified Child Care and Development Block Grant (CCDBG) which will be funded through a combination of a capped block grant to the states of close to \$14 billion over 7 years and an annual appropriation that may vary from year to year (initially authorized at \$1 billion per year).

If the full amount is appropriated each year, this would amount to nearly \$6 billion more between 1996 and 2002 for child care than states spent in 1995. However, the bill also cuts 15% from Title XX of the Social Services Block Grant, which is used by many states for child care costs. Unless states redirect child care funding for working families into child care for families moving off welfare, the Office of Management and Budget estimates that state coffers will fall significantly short of the funds needed to provide child care for those families moving into work.[4]

Education and Training

H.R. 3734 substantially reduces the ability of states to allow welfare recipients to participate in education and training programs while receiving TANF funds, thus limiting the type of employment that will be available to these individuals in the long term. States cannot count, for purposes of meeting work requirements, individuals in education for more than 12 months as working (with exceptions for some teens). In addition, education must be specifically oriented toward employment. This will have the effect of locking welfare recipients in low wage, low skill

jobs with few benefits and little job security, leaving them at high risk for returning to welfare and, eventually, losing eligibility for benefits.

Food and Nutrition

While H.R. 3734 makes significant changes to welfare, it achieves most of its savings through the Food Stamp program. Over the next 6 years, the bill cuts \$27.7 billion from the program, including \$3.8 billion cut from benefits for immigrants.[5] While food stamps will remain an entitlement (except for immigrants), individual allotments will be reduced.

The shelter deduction cap will increase from \$247 in 1997 to \$300 in 2000 and remain frozen at that level thereafter. Under current law, families that pay more than 50% of their income for housing have their excess shelter costs taken into account when determining the value of their food stamp benefit. The cap limits the amount of the excess costs that can be taken into account - freezing the cap will gradually erode the value of the deduction. Thus, low-income families with "worst-case housing needs" (those that pay more than 50% of their income for housing, which HUD estimates included 5.3 million households in 1993[6]) will be more likely to be required to choose between food and housing.

Welfare recipients will face additional work requirements in order to continue to receive food stamps. Able-bodied adults between the ages of 18 and 50 will be required to work at least 20 hours/week or they will be limited to 3 months of food stamps in any 36 month period. CBO estimates that one million unemployed individuals who would work, if work slots were available, will be denied food stamps in an average month under this provision.[7]

According to the Food Research and Action Center, on average, benefits will be reduced by 18% by the year 2002, while elderly recipients will face a 25% loss in benefits and working poor families will lose about 20% of their benefits.[8] The Center on Budget and Policy Priorities estimates that over half the food stamp cuts will be absorbed by families whose incomes are below 50% of the poverty line and that 2/3 of the cuts will fall on families with children.[9]

The bill also makes a wide variety of administrative changes to the Food Stamp program and makes cuts in many child nutrition programs. The requirement for special application procedures for "special populations," including homeless people, is eliminated, along with the eligibility for homeless households to have expedited access to Food Stamps (under current law, homeless persons can receive food stamps within 5 days of application). Cuts to reimbursement rates for meals at day care homes and to the Summer Food Program will greatly reduce meals available for poor and homeless children.

These changes will have a direct impact on the ability of homeless individuals and families to eat. Food stamps are the benefit homeless people are most likely to receive. In 1995, 17.5% of the clients seen in Health Care for the Homeless programs received food stamps, while only 11.6% were eligible for AFDC benefits.[10] However, new work requirements are likely to result in many homeless people losing eligibility for food stamps, since holding down a regular job can be difficult without a stable place to live (hours of work, for instance, often conflict with times when

homeless people need to be seeking shelter space or lining up for food). Furthermore, these changes are occurring at a time when alternative resources for food are insufficient. In 1995, according to the U.S. Conference of Mayors, 72% of the cities they surveyed reported an increase in requests for emergency food assistance. 18% of those requests went unmet while available resources increased by only 1.5%. Furthermore, in most of the cities, sources for emergency food served families and individuals in both emergencies and as a steady source of food.[11] There is little doubt that the changes in food stamp eligibility and other nutrition programs enacted in H.R. 3734 will substantially increase hunger in America.

Disabled Children

Congress has also achieved significant savings by reducing SSI benefits for disabled children and by eliminating eligibility for most programs for legal immigrants. Families with disabled children will be at greater risk of homelessness as they struggle to pay for care, along with housing. Elderly and disabled immigrants will be cut off from their only sources of income and, lacking any other safety net, will find themselves on the street.

The children's SSI program will be cut by \$8.2 billion over the next six years and, according to the Bazelon Center for Mental Health Law, 315,000 low-income children with disabilities will lose or be denied access to benefits. In addition, CBO calculates that 15% of those who no longer benefit from SSI will also lose eligibility for Medicaid.[12] These savings will be achieved through a substantially narrower definition of disability, eliminating, for instance, many children who are disabled by tuberculosis, arthritis, mental retardation, schizophrenia and mood disorders. The \$470 currently provided by this program allows families to meet many medical expenses and often allows at least one parent to cut back on work in order to care for a disabled child. These new restrictions will severely limit the ability of many parents to care for their children and many will fall deeper into poverty or homelessness. Furthermore, families that are no longer able to rely on Medicaid for their children will be forced to seek medical care in emergency rooms, the most expensive point of entry into the medical system.

Legal Immigrants

Under this new legislation, legal immigrants are ineligible for most welfare, food stamp and SSI benefits unless they become citizens. The bill will cut benefits available for legal immigrants by more than \$22 billion. This will result in savings for the Federal government, but it will also result in substantial difficulties for poor, elderly and disabled immigrants and their families. CBO estimates that nearly 500,000 elderly and disabled legal immigrants will find their SSI benefits terminated under this change. Furthermore, 260,000 elderly immigrants, 65,000 disabled people, 175,000 other adults and 140,000 children will lose Medicaid coverage as a result of this bill.[13] While we are already apparently used to the highest rates of child poverty among industrialized nations, the provisions pertaining to immigrants will allow the U.S. to join European countries in the rush to scapegoat and stigmatize "foreigners."

The Consequences of Welfare Repeal

The precise effects of this new block grant are impossible to predict at this time. However, the Urban Institute estimates that the combined effect of these changes may throw 2.6 million more people below the poverty line, including 1.1 million children. In addition, they argue that over 1/5 of all families with children will see their incomes fall by about \$1,300 per year. Finally, they note that almost half of the families adversely affected already work and 4 out of 5 of the affected families have incomes below 150% of poverty.[14] Clearly, despite work and assistance, the primary victims of this new legislation will be families teetering on the edge of homelessness, as well as those who are already homeless. Work requirements will be especially difficult for this population, whose access to jobs and training is often hampered by the lack of a fixed address. Similarly, food stamps are often one of the last resources homeless individuals can count on, but new work requirements will eliminate eligibility for many. Finally, changes to SSI disability for children and eligibility for most programs for poor and disabled immigrants will eliminate scarce resources that often stand between families and homelessness. Successful welfare reform would address the links between housing, work, health care and food in the lives of real people. Because this legislation does not, it will only contribute to further growth in poverty and homelessness in America.

The failure of legislators to take into account the real needs of poor and homeless people in designing this reform suggests that it will lead to significantly more poverty and homelessness in the next few years. Instead of giving states incentives to provide livable benefits and access to real job training, this legislation will provide incentives to lower benefits and remove poor people from the rolls. It is also important to note that this is a population with particular needs. Single parent households make up over 40% of families living below poverty and single mothers with children represent a substantial proportion of homeless families. Clearly, without child care, it is difficult to imagine how many welfare recipients will make ends meet in the low-wage, low-skill jobs they are likely to find. As people eventually come up against the time limits created in H.R. 3734, homelessness seems increasingly likely. For people who are already homeless, job requirements will inevitably run up against the need to seek food and shelter. This new law will make welfare even less likely than it already is to provide people with a hand up from homelessness and poverty.

Welfare Repeal or Serious Reform?

According to recent census data, 14.5% of the population, or about 38.1 million people, live below the poverty line at this time. 40% of all poor people in the United States are children.[15] It is extremely difficult for poor people to make ends meet, even with jobs and government assistance. A head of household (one worker and two children) earning the minimum wage (\$4.25/hour, although it will rise to \$4.75 on October 1, 1996) and benefiting from the Earned Income Tax Credit, would still earn \$1,080 less than the poverty line in 1996.[16] Furthermore, a minimum wage job does not cover the cost of a one-bedroom apartment at Fair Market Rent in any state.[17] According to the U.S. Conference of Mayors, one in five homeless persons is in fact employed in full or part-time work.[18] Government benefits do not help people rise above poverty either. Currently, the combined value of AFDC and Food Stamp benefits is below the poverty line in every state of the union and in 39 states it is below 75% of poverty.[19] The

National Low Income Housing Coalition has found that AFDC benefits are inadequate in all but two states to pay the FMR for a two-bedroom housing unit.[20]

It is difficult for people to find the resources, whether through work or government assistance, to meet their basic needs. But even with benefits and work, it is difficult to rise above poverty. Close to 40 million Americans are without health insurance, leaving them at risk of devastating poverty should they or a member of their family suffer from a serious illness or accident. Affordable housing is also in short supply in the United States. By some estimates, there is a shortage of 4.7 million affordable housing units, leaving millions homeless or living in insufficient housing.[21] As noted above, hunger is also an increasing problem in many American cities for which resources are increasingly inadequate.

In other words, poor and homeless people face a complex set of problems. Effective approaches to dealing with poverty would help people get jobs that pay livable wages. In order to work, families with children need access to child care that they can afford. But jobs and child care are not enough. Without affordable, decent housing, people cannot keep their jobs and they cannot remain healthy. Serious welfare reform would link cash benefits and job assistance to affordable housing. Preventing poverty and homelessness also requires access to affordable health care, so that illness and accidents no longer threaten to throw individuals and families into the streets. The current programs - AFDC, Food Stamps, EA and others in a wide range of Federal and state administrations - do not, for the most part, effectively link all of these elements. There is no doubt about the fact that the current American welfare system is an ineffective way to fight poverty. But the new legislation makes this bad situation significantly worse.

H.R. 3734 does not begin to provide a comprehensive approach to poverty in America. In fact, this legislation is likely to result in a great deal more homelessness and hunger. Despite the bill's express intent to support families, many families will be driven apart as parents find themselves unable to feed, house and educate their children. Moving people off of government assistance may be a laudable goal, provided people can be helped to find dignified jobs, housing and health care. But in such a scenario, people are responsible for themselves without necessarily being self-sufficient. Personal responsibility is not, of course, the same thing as self-sufficiency. Few Americans, rich or poor, are truly self-sufficient. Even as responsible, hard working breadwinners, they rely on family, community and even government to help them with those things, such as roads and public schools, they could not create only through their own work. In fact, being a responsible citizen goes well beyond taking care of one's own family. Personal responsibility includes a willingness to contribute to the well-being of our neighbors. With H.R. 3734, we have instead chosen to turn our backs on them.

Next Steps: Areas for Advocacy

While this legislation does represent the biggest shift in Federal welfare policy in at least 30 years, its impact may be mitigated by action at the local, state, and national level. Advocates can work to

roll back some of the changes by pressuring Congress and the Clinton administration. More importantly, 46 states currently have waivers in place that exempt them from parts of this new law. These waivers, combined with the law's focus on state programs, gives states a great deal of latitude to define eligibility requirements and benefits as they please. It is essential that advocates for homeless people have a place at the table over the next few months as states formulate their own welfare programs.

- Organize homeless people and advocates to participate in state plan design. Make sure state welfare officials understand the importance of linking work, housing, child care, health care and education. In New York City, the Mayor has been trying to impose work requirements on homeless people even before finding them a place in the shelter system. This is unacceptable. No work should be required without access to stable housing.
- Insist that states take advantage of the various food stamp waivers available in H.R. 3734. For instance, states can request waivers from work requirements for areas that have unemployment rates over 10% or for areas where insufficient jobs exist for people required to work. H.R. 3734 allows states to create a "simplified food stamp program" that would make income calculations conform with the state's new TANF program and also allows states to apply for a wide range of waivers for local program changes. Advocates need to learn the applicability of these waivers to their local circumstances.
- Demand earnings disregards in the calculation of state welfare benefits that take into account income qualifications applied by local housing authorities. Housing authority leaders should be willing allies in this effort since a reduction in the benefit levels available to tenants will translate into a reduction in rents.
- Make sure families continue to apply for Medicaid. Under current law, eligibility for AFDC automatically qualifies parents and children for Medicaid. Families that qualify for TANF programs will not necessarily qualify for Medicaid. However, anyone who would have met the state's AFDC requirements on July 16, 1996 will continue to qualify for Medicaid. Advocates need to make sure people know they can still apply for and receive Medicaid coverage.

As under current law, families that move into work and off of welfare will lose eligibility for Medicaid after 1 year. However, states can enact less restrictive income and resource qualifications for access to Medicaid. If private hospitals bill states for treating the medically indigent, people leaving Medicaid could begin to cost the states a great deal more. Advocates should insist that people be kept on Medicaid until they can obtain private health insurance.

- Insist that states implement domestic violence waivers. H.R. 3734 allows states to waive time limits, child support cooperation requirements, family cap provisions and other requirements of the TANF grants in cases where compliance would make it more difficult for individuals to escape domestic violence or penalize people at risk for domestic violence. Advocates should insist that states implement these waivers.

- Demand that cash benefits not be reduced to pay for child care. States can use up to a third of their TANF grant to pay for child care. This may result in reduced cash assistance levels, since child care often costs more than direct cash assistance per child. Advocates should be prepared with data to indicate the costs of child care to the states and the impact of reduced benefit levels on families. There should not be a trade-off between benefit levels to families and child care.
- Encourage states to create public jobs programs in housing development and construction. Housing is the major critical need not addressed by welfare reform. Without sufficient affordable housing, welfare reform will not succeed. States should be encouraged to create their own jobs program that will both create livable income jobs for TANF participants and, at the same time, produce much needed affordable housing.

By participating in the development of state plans, advocates can make sure that new programs take into account the real life situations faced by homeless people. They can also work to prevent program developments that are likely to create more homelessness. Above all, they can bring the voice of homeless people into the discussion.

The National Coalition for the Homeless will continue to examine this new legislation as states begin to develop their plans. We would appreciate hearing from state coalitions, homeless people and service providers regarding their participation in and experience with state welfare plans.

**For future analyses, questions or further information,
please contact David Beriss at the National Coalition for the
Homeless at (202) 775-1322 or by email at nch@ari.net.**

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National Coalition for the Homeless Advocacy Tips:

Communicating with Congress

Being an effective advocate on legislative issues means knowing where and when to exert your influence. This guide provides pointers on how you can influence your elected officials through phone calls, letters and meetings.

The Telephone Call

A phone call is a good way to let your legislator know how you feel about a particular issue. Congressional offices pay close attention to these calls as a measure of voters' sentiment. An outpouring of calls can sometimes change the vote of a legislator, but even a small number of calls can make a difference.

When you call, ask if your Senator or Representative will send you a written response. This will ensure that your call is counted. Ask if the office has received other calls from constituents on the same issue and, if so, what position most of the callers took on the issue.

Most Senators and Representatives maintain one or more offices in the state or congressional district they represent. You can find the phone number in the U.S. government section of your telephone directory or by calling information.

If you wish to call the Washington, D.C. office, you can reach your Senator or Representative through the Capitol switchboard. Simply dial (202) 224-3121, and ask for your Representative's or Senator's office.

The Letter

Your letters to Washington can make a difference. Legislators rely on letters to find out what the people back home are thinking. And, for you, letter-writing can be the first step in building an ongoing relationship with your legislators. Here are some guidelines to follow when writing:

- Spell your legislator's name correctly. If you know your legislator at all, use his or her first name; your letter will receive more attention.
- Write legibly or type your letters.
- Use your own words and your own experiences. Personal letters and real stories are more effective than preprinted postcards or petitions.
- Make the topic you are writing about, and your position on it, clear in the opening sentences. For example: "I'm writing to oppose H.R. 4, the Personal Responsibility Act."
- Refer to bills by name or number if you can.

- Address your legislator properly:

For Senators:

The Honorable Firstname Lastname
U.S. Senate
Washington, DC 20510

For Representatives:

The Honorable Firstname Lastname
U.S. House of Representatives
Washington, DC 20515

- For a salutation, use "Dear Representative Lastname" or "Dear Senator Lastname."
- Stay on one topic. If you want to write about other issues, send another letter later on.
- Give reasons for your position. As appropriate, use personal experience or a concrete example to make your case.
- Raise questions. A question can get a personal response.
- Keep it short. One page is best. Use two pages only if necessary for clarity and completeness.
- Be polite, positive, and constructive. Don't plead, and never threaten.
- Be timely. Write before decisions are made and action is taken. But don't write too long before- a letter six months before a vote will probably be forgotten.
- Use your name and address on both the envelope and the letter. This helps staff in replying and identifies you as a constituent.
- Thank your legislators when they take an action you agree with. It's surprising how few letters of thanks are received on Capitol Hill. If a staff member is particularly helpful, thank him or her, too- or mention your gratitude in your letter to your legislator.
- Keep writing!

Meeting with Elected Officials

Most legislators travel to their home districts as often as they can-- on weekends, if possible, and whenever Congress is not in session. They go home, in part, to meet with their constituents.

You can set up a meeting with your Representative or Senator during one of these visits. If possible, arrange for a small group of people who share your concerns to participate in the meeting. Decide ahead of time what the group will say and who will cover each issue. Limit your visit to one, or at most two, topics.

If you want press coverage of your meeting, make arrangements beforehand. If you need help, contact the National Coalition for the Homeless and ask for a "Media Tips" guide to working with the press.

You can call your legislator's local office or the office in Washington, D.C. to make the appointment. Let the staff know who will attend the meeting and what you will discuss. Your legislator can then prepare for the meeting, which will make it more productive.

Here are some tips for making sure it is effective:

- Present your case. Explain what you want your legislator to do and why.
- Give examples of the impact the proposal will have on poor and homeless people.
- If you don't know the answer to a question, don't make it up. Offer to find out and send information back to the office later.
- Don't expect members of Congress to be specialists; their schedule and work load make them generalists- open, we hope, to listening.
- Keep control of the visit. Don't be put off by smokescreens or long-winded answers. Ask for specific answers if you don't feel you are getting them.
- Don't make promises you can't deliver.
- Try to find out if your legislator has heard opposing views. If so, ask what the arguments were and what groups were involved.
- Spend time with your legislator even if his or her position is different than yours. Sometimes you can lessen the intensity of the opposition.
- Don't confront, threaten, pressure, or beg.
- Follow up your visit with a thank you note.

You can also invite your elected officials to participate in your organization's activities. You might ask them to address your group or present them with an award. These events leave a lasting positive impression about the organization and build a relationship with the legislator that can be useful.

Expanding Your Influence

Your influence can be multiplied by getting other people to join in contacting your Representative and Senators. Talk to coworkers, friends, and neighbors- at club meetings, senior centers, churches or temples, union halls, and other places where concerned people get together. Letters to the Editor of your daily newspaper are another effective way to "spread the word." You can probably think of others: be creative!

Explain the issues and how people in your community will be affected. Let people know what they can do. Give clear instructions, following the pointers in the section above about letter writing and making phone calls.

The Role of Congressional Staff

Each Member of Congress has a professional staff. Some are assigned to the legislator's personal staff; others, to a committee or subcommittee. Staff members recommendations concerning

legislative issues. Because of the busy schedules legislators keep, it is important to develop and maintain a good working relationship with staff members responsible for health or related issues. When you call the Washington office, make sure that you speak with the staff person responsible for the legislation you are calling about.

Communicating with the White House

Sometimes you may want to call or write the White House to register your opinions. The Clinton Administration uses calls and letters to the White House as a gauge of public opinion. It is especially important to contact the White House in the current political environment, when Congress is preparing to pass bills (welfare reform, the budget, etc.) that will hurt poor and homeless people. President Clinton should be urged to veto any such bills.

To write the White House, start your letter with "Dear Mr. President" and address it as follows:

The President
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

The President's email address is: president@whitehouse.gov.

If you would like to call the White House in response to a particular issue, you can call the White House comment line at 202-456-1111 to register your opinions on selected issues, using your touch-tone phone. You may also choose to leave your message with an operator if you wish.

Section V: Local Homeless Organizations

Use these contacts to help you plan activities in your area.

Alaska Local Homeless Organizations

Crossover House Homeless Project-Crossover House provides outreach, showers, laundry facilities, storage, a mailing address, private bathrooms, referrals for substance abuse treatment, and access to psychiatric treatment for seriously mentally ill homeless people in Anchorage, Alaska.

1000 4th Avenue, Anchorage, Alaska 99501
Phone: 907-258-4512, Fax: 907-276-1399
Contact: Dan Murphy RN
Email: murph@servcom.com

Arizona Local Homeless Organizations

Casa de los Ninos-The mission of the Casa de los Ninos is the prevention, intervention and treatment of child abuse and neglect by providing residential shelter care for children who are abused, neglected or homeless.

101 N 4th Ave., Tucson, AZ 85705
Phone: 520-624-5600, Email: casa@azstartnet.com

Central Arizona Shelter Services, Inc.

Central Arizona Shelter Services (CASS) operates two shelters: a downtown shelter houses 400 single adults, and a shelter in northern Phoenix houses 30 families. Their home page provides a description of both facilities, information on how to volunteer, and writing samples from residents.

1209 West Madison St., Phoenix, AZ 85007
Phone: 602-258-5951, Fax: 602-256-6401
Email: helpnet@amug.org

California Local Homeless Organizations

Bay Area Homelessness Project-The Bay Area Homelessness Project is consortium of 15 Bay Area universities and colleges that teach courses on homelessness, or have student advocacy groups around the issue, or offer programs to help homeless student's transition to school. Their home page provides information on their activities including, a course description, class activities and other information related to homelessness.

Email: stewartd@ece.ucdavis.edu

Family Emergency Shelter Coalition (FESCO)-the Family Shelter- is a nonprofit organization which provides food, shelter, clothing, counseling and access to community resources in the Hayward, Castro Valley, and San Leandro areas. The 24-bed shelter is open all-day and houses approximately 100 families with children each year. Their home page provides information on FESCO, nutrition and health programs, and links to other shelter programs and resources related to homelessness.

22671 Third Street, Hayward, CA 94541
510-581-3223, Office Phone: 510-886-5473
Office Fax: 510-886-5814, Email: FESCO@coordinet.com

Kicked Up-Kicked Up is a documentary that focuses on the images, lives and stories of youth who are homeless or at-risk of becoming homeless. Their home page contains the youth's stories, descriptions of the program's accomplishments and information on how to contribute.

P.O. Box 1206, Novato, CA 94948
Phone: 415-206-9953, Email: Jcoving44@aol.com

House of Hope-House of Hope, operated by the Orange County Rescue Mission, provides shelter and food for homeless women and children. Their home page provides general information on homelessness, opportunities to email the guests, the story of one single mother's homelessness and information on how to assist the organization.

P.O. Box 4007, Santa Ana, CA 92702
Phone: 714-541-4100, Email: jim_palmer@ocmission.com

InnVision-InnVision provides a continuum of services, including emergency shelter, meals, clothing, job development, vocational skills training, case management, and transitional housing.

44 South Fifth St., San Jose, CA 95112
Phone: 408-292-4286, Fax: 408-292-0307
Email: jan@innvision.sj.ca.us

Shelter Assistance Association-provides a directory of California organizations that offer support or recovery services for homeless people.

Email:johnd@sonic.net

Colorado Local Homeless Organizations

Samaritan House-Samaritan House is a shelter for homeless men, women and children located in Denver, Colorado. Samaritan House assists with resources such as case management, employment counseling and resources, job training, and family and children services. Samaritan House provides services to over 300 people every day, most of whom can stay for a period of 30-

90 days. Samaritan House was built specifically as a shelter in 1986 and is a service of Catholic Charities.

2301 Lawrence St., Denver, CO 80205
Phone: 303-294-0241, Fax: 303-294-9523
E-mail: ejudy@csn.net or samhouse@usa.net

Connecticut Local Homeless Organizations

Interfaith Housing Association-The Interfaith Housing Association provides shelter for homeless people in Westport, Connecticut. It operates the Gillespie Center shelter for homeless men (203-226-1191), the Hoskins' Place shelter for homeless women (203-226-1191), the Bacharach Community emergency shelter for homeless families headed by women (203-222-9260), and the Linxweiler House for men in recovery (203-226-1661).

45 Jesup Road, Westport, CT 06880
Phone: 203-226-3426
Contact: Rev. Peter R. Powell
Email: 105147.2172@compuserve.com

District of Columbia Local Homeless Organizations

Her House-Her House is a coalition of organizations and concerned individuals and corporations, working to help women gain the safety and economic freedom of home ownership. Her House is a project of DC Habitat for Humanity. Their home page provides a description of the program, information on how you can help and links to other related sites on the Internet.

P.O.Box 30884, Washington, DC 20030
Phone: 202-628-9171
Email: miriam_neugeboren@habitat.org

Georgia Local Homeless Organizations

Atlanta Task Force for the Homeless-The Atlanta Task Force for the Homeless is a 24-hour emergency placement facility for homeless persons in the metro Atlanta area, assisting more than 1,500-3,000 homeless people every month to find new housing options. It serves as the central clearinghouse for services for homeless people and is the organizer of a local coalition of social service providers, advocates and representatives of the public and private sectors. The Task Force home page provides detailed information on homelessness in Atlanta, a guide to developing and implementing a shelter program, and the Georgia Resource Directory, a database of information from agencies that provide food, clothing, rental assistance, emergency shelter, permanent housing, etc. in the state of Georgia.

363 Georgia Avenue, SE, Atlanta GA 30312
Phone: 404-230-5000, Fax: 404-589-8251

Emergency Shelter Hotline: 1-800-448-0636
Email: postmaster@leveller.org

Northeast Georgia Homeless Coalition-The Coalition is a coordinating agency for the homeless service providers in a ten county area of Northeast Georgia. The Coalition also operates a 24 hour homeless assistance hotline. The Coalition is currently implementing a grant from the State Housing Trust Fund for the Homeless Commission. This grant is designed to identify non-profits in rural Northeast Georgia with the ability to develop low-income affordable housing in their communities.

P.O. Box 80582, Athens, GA 30608
Phone: 706-546-8293, Fax: 706-546-9331
Email: lbarrett@athens.net

Illinois Local Homeless Organizations

Community Emergency Shelter Organization-The Community Emergency Shelter Organization (CESO) was organized in 1982 to facilitate the transition of homeless people from homelessness to independence. CESO works to find creative, effective solutions to homelessness and enhance the system of services for homeless people in metropolitan Chicago. CESO currently operates three program divisions: Partnership to End Homelessness, Management Support Services, and Homeless Helpline.

1313 S. Wabash, Chicago, IL 60605
Phone: 312-913-2030, Fax: 312-913-2053
Email: ceso@ais.net

Indiana Local Homeless Organizations

Center for the Homeless-The Center for the Homeless is a non-profit corporation that houses over 140 guests each night. It provides 80 beds for single men, 25 beds for single women, and 15 apartments for families. The Center also offers comprehensive services, including classes on personal development and work placement.

813 S. Michigan, South Bend, IN 46601
Phone: 219-282-8700, Fax: 219-287-5023
Email: quintonsmith@hotmail.com

Maine Local Homeless Organizations

Hope Haven Gospel Mission-Hope Haven Gospel Mission is a nonprofit organization serving poor and homeless persons in Lewiston/Auburn and surrounding areas of Maine. The organization operates a shelter and a soup kitchen, which serves meals twice a day. Counseling and a Christian environment are provided to those who wish to join their rehabilitation program.

209 Lincoln St., Lewiston, Maine 04240-9954
Phone: 207-783-6086, Fax: 207-783-3904
Email: Jericho@megalink.net

Mid-Maine Homeless Shelter-The Mid-Maine Homeless Shelter provides shelter and meals to up to 10 individuals each night. Their home page contains a description of their services, a brief history of homelessness, and information about contributing and volunteering.

28 Ticonic Street, P.O. Box 2612, Waterville, ME 04903
Phone: 207-872-6550, Email: judid@mint.net

Maryland Local Homeless Organizations

Health Care for the Homeless, Inc.-Health Care for the Homeless, Inc. provides comprehensive health care services for homeless people in the Baltimore, Maryland area. The organization also promotes public education on the relationship between health and homelessness and the importance of developing policy which meets the health care needs of homeless people. Their homepage includes information on the history of Health Care for the Homeless, the effects of homelessness on health and provides suggestions on how individuals can take action.

111 Park Avenue, Baltimore, MD 21201
Phone: (410) 837-5533 ext. 332, Email: hch@gate.dev.jhu.edu

Homeless Resource Manual-The Homeless Resource Manual was prepared by Action for the Homeless in Baltimore. It provides general information on how to find shelter and obtain public benefits. Also, the Manual lists the services provided for homeless individuals in each Maryland county.

Massachusetts Local Homeless Organizations

Springfield Action Commission, Inc.-The Primary goal of the Coalition is to promote the improvement of community life for the economically disadvantaged in Springfield through a program which attacks the causes of poverty. Their home page describes the services they offer.

718 State St., Springfield, MA 01109
Phone: 413-263-6500, Fax: 413-263-6511
Email: srmsac@earthlink.net

St. Francis House-St. Francis House is a comprehensive day center providing food and a range of emergency and rehabilitative services. Their home page provides a description of their services and information on how to contribute.

P.O. Box 120499, Essex Station, Boston, MA 02112
Phone: 617-542-4211

Minnesota Local Homeless Organizations

Partners for Affordable Housing-In addition to advocacy work, they operate an emergency shelter, transitional housing and three SRO apartment buildings. They serve a 12 county area in south central Minnesota.

101 East Hickory St., #408, Mankato, MN 56001
Phone: 507-387-2115, Email: wlaw19@skypoint.com

Missouri Local Homeless Organizations

Care of Poor People, Inc.-Care of Poor People is a referral agency linking homeless persons with work and housing.

105 North Topping, Kansas City, MO 64123
Phone: 816-483-4081, Email: coppinc@sound.net

Sheffield Place-Sheffield Place is a transitional living program for homeless mothers and their children. Families can stay at Sheffield Place up to 24 months. The mission is to empower families to break out of the cycle of homelessness and poverty and become self-sufficient. Sheffield Place opened in 1991 and have assisted over 85 families since then.

6604 E. 12th Street, Kansas City, MO 64126
Contact: Karen Streeter, Executive Director
Email: shfplace@coop.crn.org

St. Louis ACCESS-St. Louis ACCESS works to coordinate and provide services for homeless individuals and families affected by mental illness.

1430 Olive, Suite 500, St. Louis, MO 63103
Phone: 314-877-1723, Fax: 314-877-1709
Email: vickifw@ix.ntcom.com

New Jersey Local Homeless Organizations

Helping Hands Mission, Inc.-Helping Hands Mission, Inc. is a charitable organization set up for the sole purpose to purchase, collect and distribute supplies such as food, clothes, furniture, etc. for children whose parents are homeless or at risk of becoming homeless. Their page contains information on how to contribute to the organization.

P.O. Box 504, Barnegat, NJ 08005
Phone: 609-978-0311, Email: gthorne@eden.rutgers.edu

Housing and Economic Opportunities, Inc.-The organization provides pre-purchase counseling, LIFE Program (Low Income Family Empowerment), housing rehabilitation, rental

housing for seniors, and environmental services benefiting affordable housing and community development projects.

600 Cuthbert Blvd., 2nd Floor, Westmont, NJ 08108
Phone: 888-NJ-HOUSING, Email: 71042.2253@compuserve.com

New Mexico Local Homeless Organizations

Albuquerque Rescue Mission-The Albuquerque Rescue Mission is a Christian ministry founded in 1954 to help the homeless men, women, and children of Albuquerque. The Rescue Mission provides van service, shelter, meals, food boxes, clothing, medical care, chapel services, and a recovery program.

509 2nd Avenue, SW, Albuquerque, NM 87102
Phone: 505-889-6359, Fax: 505-889-6361
Email: a_r_m@ix.netcom.com

North Carolina Local Homeless Organizations

Homeless Coalition Day Center-The Homeless Coalition Day Center coordinates and provides services for homeless people in Fayetteville. Their home page describes the services the Center provides.

P.O. Box 36296, Fayetteville, NC 28303
Phone: 910-323-4673, Fax: 910-323-4673
Email: cosgriff@sequent.uncfsu.edu

Ohio Local Homeless Organizations

Greater Cincinnati Coalition for the Homeless-Since 1984, the Greater Cincinnati Coalition for the Homeless has been working to end homelessness in the Cincinnati area through coordination of services, public education and grassroots organizing. Their home page provides a listing of member agencies, the latest study on homelessness in Cincinnati, and the latest issue of The Homeless Grapevine, Cincinnati's street newspaper.

1506 Elm Street, Cincinnati, OH 45210
Phone: 513-421-7803, Email: homecoal@primax.net

Help Hotline Crisis Center, Inc.-Help Hotline is the information and referral, crisis intervention, victims assistance, senior information, and suicide prevention hotline for Mahoning and Columbiana Counties in the state of Ohio. The Hotline is available 24 hours a day, 7 days a week, 365 days a year. The Help Hotline also operates a Winter Emergency Shelter Program from December 1 through March 31; the program assists homeless persons in finding shelter, providing

transportation when necessary. Throughout the year, the hotline refers homeless persons to appropriate services.

Help Hotline Crisis Center, Inc.
P.O. Box 46, Youngstown, OH 44501-0046
Contact: Bob Altman
Email: aa339@yfn.ysu.edu

Section VI: Health Care for the Homeless Calendar of Events

Use this calendar of events to help you plan homeless initiatives in your area.

October

September 29 - October 5

Local Candidate Forums on Homelessness/ Housing/Poverty/Hunger Issues -

Part of the "You Don't Need a Home to Vote" Campaign, local candidate forums provide an opportunity to question candidates on their views on poverty and homelessness.

For more information, please contact:

Michael Stoops

National Coalition for the Homeless

1612 K Street, NW #1004

Washington, DC 20006

Phone: 202-775-1322

Fax: 202-775-1316

HN0055@handsnet.org

October 10-12

Building and Working Together for School Success: Addressing the Needs of Homeless Children -

Sponsored by the National Association of State Coordinators for the Education of Homeless Children and Youth (NASCHHCY), this 8th Annual Conference includes participation by state coordinators, homeless coalition members, state officials and administrators, program managers, teachers, psychologists, and social workers who aim to improve services to homeless children. Workshops, panel discussions, and presentations will examine the full range of social, developmental, and educational needs of homeless children and youth.

Topics include consolidated and state plans, counts and needs of homeless children and youth, evaluating state program outcomes, monitoring local programs, homeless coalition and advocacy work, social-developmental needs of homeless children and youth, model programs for educating homeless children and youth, private-public partnerships in homeless education, and set-aside Title I funds

The conference will be held at the Doubletree Hotel in Nashville, Tennessee on October 10-12. Conference registration and materials: \$200

For more information, please contact:
Doug Vickers Conference Chairman
Tennessee Department of Education
5th Floor, Gateway Plaza
710 James Robertson Parkway
Nashville, TN 37243
Phone: 615-532-6186
Fax: 615-532-7860
dvickers@mail.state.tn.us

November

Election Day - *November 5* - Drive Homeless People to the Polls

Part of the "You Don't Need a Home to Vote" Campaign, driving homeless persons to the polls on election day is a critical component of get-out-the-vote activities.

For more information, please contact:
Michael Stoops
National Coalition for the Homeless
1612 K Street, NW #1004
Washington, DC 20006
Phone: 202-775-1322
Fax: 202-775-1316
HN0055@handsnet.org

November 17-23

National Hunger and Homelessness Awareness Week:

Every year during the first full week before Thanksgiving, the National Student Campaign Against Hunger and Homelessness and the National Coalition for the Homeless co-sponsor National Hunger and Homelessness Awareness Week. This week is designated as a time for local communities across the country to engage in awareness-raising events

For more information, please contact:
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National Coalition for the Homeless
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Washington, DC 20006
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Fax: 202-775-1316
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December

December 12-14

National Rural Housing Conference -

Organized by the Housing Assistance Council, this annual conference, to be held in Washington, D.C., will give people and organizations concerned with rural housing an opportunity to meet with each other and discover new ideas.

For more information, please contact:

Housing Assistance Council
1025 Vermont Ave., NW
Washington, DC 20005
Phone: 202-842-8600
Phone: 202-347-3441--fax
HN0143@handsnet.org

December 21, 1996

National Homeless Persons' Memorial Day -

This will be the 7th Annual National Homeless Persons' Memorial Day on which local groups hold memorial services for homeless people who have died. Last year, over 60 cities across the country participated. Because National Homeless Persons' Memorial Day falls on a Saturday this year, some groups will hold their event on Thursday, December 19 or Friday, December 20.

For more information, please contact:

Michael Stoops
National Coalition for the Homeless
1612 K Street, NW #1004
Washington, DC 20006
Phone: 202-775-1322
Fax: 202-775-1316
HN0055@handsnet.org

This information was taken from the National Coalition for the Homeless (NCH) homepage at <http://nch.ari.net>. The NCH regularly updates its web page, so please visit it often for updates on events regarding the homeless.

Section VII: Additional Resources

Health Care for the Homeless Information Resource Center, John Snow Inc., (617) 482-9485, has annotated bibliographies and other information on many aspects of health care and how it affects homeless people.

National Health Care for the Homeless Council (NHCHC), (615) 226-2292, is an association of 25 Health Care for the Homeless projects in 23 cities. NHCHC advocates for federal policy with regard to issues of health care for homeless people, coordinates the staffing of an HCH clinicians network and provides support to local projects.

National Resource Center on Homelessness and Mental Illness, (800) 444-7415, has annotated bibliographies and other information on mental health and homelessness.

Health Care for the Homeless 1994 Directory, 1994. Available for \$7.50 from Health Care for the Homeless Information Resource Center, (617) 482-9485.

Kozol, Johnathon, *Rachel and Her Children: Homeless Families in America*, 1988. Available for \$8.95 from Random House, Inc., 400 Hahn Road, Westminister, MD 21157-3000, (800) 733-3000.

Legislative Affairs Director, AMSA, 1902 Association Drive, Reston, VA 20191, (703) 620-6600, ext. 207, e-mail: LAD@www.amsa.org.