

2004 Central Ohio HIV/AIDS Housing Plan

Includes the following counties:

Delaware

Fairfield

Franklin

Licking

Madison

Morrow

Pickaway

Union

November 2004



The research, development, and publication of this plan was funded in part by the Housing Opportunities for Persons with AIDS (HOPWA) National Technical Assistance Program in partnership with the U.S. Department of Housing and Urban Development's Office of HIV/AIDS Housing. The substance and findings of the work are dedicated to the public. The author and publisher are solely responsible for the accuracy of the statements and interpretations contained in this publication. Such interpretations do not necessarily reflect the views of the Government.

Prepared for and funded in part by:

Columbus AIDS Task Force
1751 E. Long Street
Columbus, OH 43203
(614) 299-2437
www.catf.net

Columbus Health Department
240 Parsons Ave.
Columbus, Ohio 43215
(614) 645-6447
www.cmhhealth.org

Prepared by:

AIDS Housing of Washington
2014 East Madison, Suite 200
Seattle, Washington 98122

(206) 322-9444
www.aidshousing.org
info@aidshousing.org

Central Ohio HIV/AIDS Housing Plan Steering Committees Members

Cassandra Ackerman

Community Member

Tom Albanese

Community Shelter Board

Peggy Anderson

Columbus AIDS Task Force

Frankie Arnett

Community Member

Terry Brown

Delaware County AIDS Task Force

Michelle (Rush) Christopher

Columbus AIDS Task Force

Nikki Delgado

Corporation for Supportive Housing

Becky Edwards

Fairfield County Family Adult and Children First Council

Beth Fetzer-Rice

The Salvation Army

Scott Gary

*Ohio Department of Development
Office of Housing and Community Partnership*

Sue Hanson

Helpline of Delaware and Morrow Counties, Inc.

Scott Inskeep

Madison County Health Department

Rob Johnson

The Woodlands, Inc.

John Lemmon

Community Member

Nina Lewis

Columbus Health Department

Kristin McCloud

Licking County Coalition for Housing

Julie Miller

Morrow County Health Department

Kim Oiler-Morely

Union County ADAMH Board

Kevin Sullivan

Ohio AIDS Coalition

Molly Swisher

Fairfield Affordable Housing

Mike Tynan

Community Housing Network

Krista Wasowski

Morrow County Health Department

Phillip Zimmerman

Pater Noster House

AIDS Housing of Washington

Donald Chamberlain

Director of Technical Assistance

Kate Kingery

Housing Planner

Amy Davidson

Planning Consultant

This plan is dedicated to Frankie Arnett and all the other citizen advocates that have cared so much and worked so hard to support affordable housing everywhere, for everyone that needs it.

Key Stakeholders

Amethyst, Inc.

Virginia O'Keefe

**Children's Hospital
Family AIDS Clinic and Education Services**

Linda Crim

Tammy Derden

**City of Columbus, Community Development
Department**

Kim Stands

Columbus AIDS Task Force

Bonnie Baris

Kelley Dorcas

Jim Jarrell

Beverly Moran

Susan Moss

Melissa Sponseller

Tina Taylor

Columbus City Council

Charleta B. Tavares

Columbus Health Care for the Homeless

Karen Fields

Columbus Health Department

Linda Laroche

Teresa C. Long

Columbus Housing Partnerships

Maude Hill

Columbus Metropolitan Housing Authority

Tom Dobies

Community Action Organization

James Cesa

Community Housing Network

Mike Tynan

Community Shelter Board

Tom Albanese

Barbara Poppe

Consolidated Care, Inc.

Ruth Reeve

Corporation for Supportive Housing

Nikki Delgado

Delaware County AIDS Task Force

Terry Brown

Delaware General Health District

Kay Gale

Emmylou Kline

Fairfield Affordable Housing

Molly Swisher

**Fairfield County Family Adult and Children First
Council**

Becky Edwards

Fairfield County Mental Health Consumer Group

Patricia Waits

Fairfield Metropolitan Housing Authority

Mary Bozman

FairHope Hospice and Health Services

Paul Longenecker

**Franklin County Community and Economic
Development Department**

Anthony Forte

Grady Memorial Hospital

Sue Packard

Helpline of Delaware and Morrow Counties, Inc.

Sue Hanson

Licking Alcoholism Prevention Program

Tina Sharkey

Jim Takacs

Licking County Coalition for Housing

Michele (Baker) Arnold

Laura Day

Linda Juarbe

Susan Martin

Kristin McCloud

Kimberly Peck

Deborah Tegtmeyer

Tiffany Unger

Licking County Health Department

Joseph Eble

Licking Metropolitan Housing Authority

Bill Barnetson

Lutheran Social Services (Fairfield County)

Lisa Pickrell

Marion County AIDS Task Force

Cliff Edwards

Moundbuilder's Guidance Center

Jonda Clemings

Netcare Corporation, Netcare Access

Gregg Banks

Newark City Health District

Judith Carr

Ohio AIDS Coalition

Kevin Sullivan

**Ohio Department of Rehabilitation and Correction,
Bureau of Medical Services**

Ramon Perez

Ohio Health Department, Community Linkages

Deanna Howell

Ohio Health Department, Infectious Disease Bureau

Kevin Runyon

Practice of Dr. Andrew Murry

Andrew Murry

Project Open Hand

(will merge with Lifecare Alliance 12/1/2004)

Laurie Weltlin

The Salvation Army

Ronald Demichael

Beth Fetzer-Rice

Southeast, Inc.

Amy Price

Ella Wertz

The Woodlands

Tim Figgins

Rob Johnson

Margaret Senn

Tobias Project

E. William Jones

Union County ADAMH Board

Kim Oiler-Morely

Mike Witzky

Union County AIDS Task Force

Union County Health Department

Julie Armstrong

**Union County Board of Mental Retardation and
Developmental Disabilities**

Kara Brown

United Way of Central Ohio

Joe McKinley

United Way of Union County, Inc.

Shari Marsh

Veterans Service Commission and Office

Gail DeGood-Guy

Wings Enrichment Center (Union County)

Laurel Ladadie

YMCA of Central Ohio

Sunshine Terrace Apartments

Jim Downing

Table of Contents

Executive Summary	i
Planning Process	i
Selected Findings	ii
Critical Issues and Recommendations for Future Action.....	ii
Introduction	1
Background	1
Planning Process	1
HIV/AIDS Housing Plan.....	4
Epidemiology of HIV/AIDS	5
HIV/AIDS in the National Context.....	5
HIV/AIDS in Central Ohio	8
Income, Housing Affordability, and Homelessness	17
Income and Poverty in Central Ohio.....	18
Housing Affordability in the National Context.....	20
Housing Affordability in Central Ohio	21
Homelessness and Related Issues in the National Context.....	30
Homelessness and Related Issues in Central Ohio.....	32
Dedicated Resources	41
Introduction to HIV/AIDS-Dedicated Resources Nationally.....	41
Housing Opportunities for Persons with AIDS (HOPWA)	42
Ryan White CARE Act	44
Findings from Consumer Surveys	49
Overview of the Survey Process and Methodology	49
Presentation of Data	50
Reliability of Data	50
Survey Findings.....	52
Issues Identified in Consumer Focus Groups	57
Overview of Focus Groups	57
Issues Identified by Key Stakeholders	63
Housing	63
HIV/AIDS	65
Homelessness and Related Housing and Social Services	67
Other Services	69
Population Changes.....	70
Suggestions for Change.....	70
Projection of Need	73

Critical Issues	75
Lack of Affordable Housing	75
Inadequate Emergency Options	76
Existing Supportive Housing Options Meet Only Part of the Need	77
Existing Supportive Housing Options are Too Restrictive	78
Current Funding is Inadequate	79
Barriers to Obtaining Housing	79
Perceived Lack of Consumer Empowerment.....	80
Fragmented Network.....	81
Fear of Confidentiality Violations	81
Recommendations	83
Appendix 1: Steering Committee Meeting Notes	A-1
Appendix 2: Focus Group Summaries	A-25
Appendix 3: Central Ohio HIV/AIDS Housing Survey	A-37
Appendix 4: HIV/AIDS Housing Survey Data	A-49
Appendix 5: HIV/AIDS Housing Planning in Central Ohio, 1989 to present	A-73
Appendix 6: Federal Financing Sources for Affordable Housing	A-75
Appendix 7: HIV/AIDS Housing Continuum	A-81
Appendix 8: Glossary of HIV/AIDS- and Housing-Related Terms	A-95

Table of Figures and Tables

<i>Figure 1:</i> People Living with AIDS, New HIV Cases Diagnosed, and HIV/AIDS-Related Deaths in the United States, by Year from 1997–2002	6
<i>Figure 2:</i> Number of People Living with HIV/AIDS in the Eight Counties of Central Ohio, 1999-2003.....	11
<i>Table 1:</i> Total Population (2003 estimate) and Cumulative HIV and AIDS Cases in Central Ohio, as of December 31, 2003	9
<i>Table 2:</i> Cumulative HIV and AIDS Cases in Central Ohio, by Race/Ethnicity, Gender, Age at Diagnosis, and Transmission Category, as of December 31, 2003	10
<i>Table 3:</i> Persons Living with HIV and AIDS in Central Ohio, by County, as of December 31, 2003.....	12
<i>Table 4:</i> Persons Currently Living with HIV and AIDS in Central Ohio, by Race/Ethnicity, Gender, Age at Diagnosis, and Transmission Category, as of December 31, 2003.....	13
<i>Table 5:</i> Percent of General Population (2000) and Percent of Persons Living with HIV/AIDS in Central Ohio (2003), by Race/Ethnicity.....	14
<i>Table 6:</i> Race/Ethnicity and Gender of Persons Living with HIV and AIDS in Central Ohio, as of December 31, 2003	15
<i>Table 7:</i> Median Family Income (2004) and Poverty Rate (2000), by County	19
<i>Table 8:</i> Fair Market Rent (FMR), by County (2004).....	21
<i>Table 9:</i> Monthly Housing Affordability for Individuals with Varying Incomes in Central Ohio, based on 2004 Median Family Income, SSI, and Fair Market Rents.....	22
<i>Table 10:</i> Monthly Housing Affordability for Families with Varying Incomes in Central Ohio, based on 2004 Median Family Income, SSI, and Fair Market Rents.....	23
<i>Table 11:</i> Renters Paying 30 Percent or More Gross Rent, by County and Percent (1999).....	24
<i>Table 12:</i> Selected Housing Market Statistics: Homeownership Rate and Rental Vacancy Rate, by County (2000).....	25
<i>Table 13:</i> Profile of Housing Units (2002), Median Value of Owner-Occupied Units (2000), Housing Units in Multi-Unit Structures (2000), and Households (2000), by County	26
<i>Table 14:</i> Public Housing Authority Units, Total Section 8 Vouchers, and Section 8 Vouchers Targeted to People with Disabilities, by Housing Authority	27
<i>Table 15:</i> Percentage of Occupied Units with Selected Characteristics, by County	28
<i>Table 16:</i> Overview of Single Men, Single Women, and Families Served by the Community Shelter Board in Franklin County (2000).....	33
<i>Table 17:</i> Licking County Continuum of Care, Bed Count by Housing Type	38
<i>Table 18:</i> Columbus EMSA HOPWA Allocations, Percent Change, and New AIDS Cases, Fiscal Years 2001 – 2004	43
<i>Table 19:</i> Ohio Ryan White Title II Program Funding For Ryan White Year 14 (State Fiscal Year 2004/05) and Ryan White Year 13 (State Fiscal Year 2003/04).....	45
<i>Table 20:</i> HIV/AIDS Dedicated Housing Resources in Central Ohio	47
<i>Table 21:</i> People Living with HIV and AIDS as of December 31, 2002 and Survey Respondents in the Columbus EMSA, by Race/Ethnicity, Gender, HIV Status, and County	51

Table 22: Median Monthly Housing Costs and Monthly Housing Costs as a Percentage of Income 53

Table 23: Estimated Need for Housing Assistance for People Living with HIV/AIDS in Central Ohio 74

Executive Summary

This HIV/AIDS Housing Plan, completed in November 2004, covers Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, and Union Counties. This plan addresses the housing needs of the 2,801 people living with HIV/AIDS in the region, including the 2,556 people in Franklin County and the 245 people in the other seven counties combined.

Planning Process

Background

The Columbus Health Department is the grantee and administrator of the Housing Opportunities for Persons with AIDS (HOPWA) program for Central Ohio. HOPWA is a program of the U.S. Department of Housing and Urban Development (HUD) that was established to address the specific housing-related needs of people living with HIV/AIDS and their families. HOPWA funding provides housing assistance and related support services as part of HUD's Consolidated Planning initiative, with a priority on permanent supportive housing. HUD encourages HOPWA grantees to develop community-wide strategies and form partnerships with area nonprofit organizations to ensure the housing stability of people living with HIV/AIDS, a primary goal of the HOPWA program. In 2004, the Columbus Health Department initiated an HIV/AIDS housing needs assessment for the eight Central Ohio counties covered by the local HOPWA allocation.

The Columbus AIDS Task Force (CATF), working in close coordination with the Columbus Health Department, contracted with AIDS Housing of Washington (AHW) to facilitate a community-based needs assessment and planning process and to develop an HIV/AIDS housing plan. Funding from both HUD's National HOPWA Technical Assistance Program and the Columbus Health Department supported the needs assessment and planning process.

The last comprehensive HIV/AIDS housing planning process in Central Ohio was completed in 1993, and culminated in the *Vision 2000: Open Doors* plan. Preparation for the current planning process began in May 2003. A Steering Committee was formed and met between April and October 2004.

Information Gathering

In addition to Steering Committee meetings, the planning process included the following means of gathering information:

- Group and individual interviews with 71 key stakeholders, including case managers, housing and services providers, housing developers, government representatives, clinical social workers, and other concerned community members
- A written survey of 272 people living with HIV/AIDS, including respondents in 7 of the 8 counties in the region

- Consumer focus groups and interviews with 34 people living with HIV/AIDS in 4 of the 8 counties
- Review of related housing and supportive services plans and reports

Selected Findings

From consumer focus groups, the consumer survey, key stakeholder interviews, and other research, selected findings include:

- 2,801 people are now living with HIV/AIDS in the eight-county region, including 2,556 people in Franklin County and 245 people in the 7 surrounding counties combined.
- The total number of people living with HIV/AIDS has increased by 44 percent in the last 5 years, from 1,950 in 1999 to 2,801 in 2003, due to a decrease in death rates combined with continuing new infections.
- 94 percent of survey respondents were unable to afford a one-bedroom apartment renting for the Fair Market Rent.¹
- Nearly half of survey respondents reported having been homeless at some point in the past, while 17 percent had stayed in a shelter and 18 percent had slept outdoors in the three years prior to the survey.
- Consumers living in the suburban and rural areas of the region reported social isolation and fear of other people learning of their HIV status, while key stakeholders working in these areas were more likely to report HIV-related stigma in their community than were people in Franklin County.
- In fiscal year 2003, 703 people living with HIV/AIDS and their households received assistance through the Housing Opportunities for Persons with AIDS (HOPWA) program, including 351 who received housing assistance. The Columbus AIDS Task Force, the Licking County Coalition for Housing, and Pater Noster House provided HOPWA-funded housing and related services.

Critical Issues and Recommendations for Future Action

Critical Issues

Drawing on information gathered in the consumer focus groups, consumer survey, key stakeholder interviews, and Steering Committee discussions, the Steering Committee identified the following critical issues related to HIV/AIDS housing:

- **Lack of affordable housing.** The high cost of housing compared to individual and family incomes throughout the region significantly affects housing needs and the feasibility of addressing these needs.

¹ Based on paying 30 percent of gross income for housing costs, HUD's affordability guideline, and the Fair Market Rent (FMR) for a one-bedroom apartment in Delaware, Fairfield, Franklin, Licking, Madison, and Pickaway Counties in 2004, \$499 per month. Union County had a lower FMR (\$410), as did Morrow (\$353). In other words, 94 percent of respondents had incomes of less than \$1,663 per month.

- **Inadequate emergency options.** Key stakeholders throughout the region indicated a need for more emergency and transitional housing options with related services for people living with HIV/AIDS, either because existing options have no vacancy or because there is no emergency housing at all.
- **Existing supportive housing meets only part of the need.** The region, particularly but not only Franklin County, has many different types of supportive housing serving many people; however most have more demand than they are able to meet.
- **Existing supportive housing options are too restrictive.** The eligibility criteria for supportive housing is largely determined by the restrictions set by funding sources. Of particular concern is that people living with HIV/AIDS may need housing assistance but not meet the definitions of homelessness, diagnosis, or disability required to access assistance.
- **Current funding is inadequate.** Throughout the region, many types of housing and service needs were identified that exceed both the current supply and the capacity of existing funding. Moreover, this issue is not limited to the HIV/AIDS service system; all basic safety net services have more people seeking assistance than their funding permits them to serve.
- **Barriers to obtaining housing.** Even when affordable housing is available, people living with HIV/AIDS may experience barriers to obtaining it, including criminal history, poor credit, poor housing history, behavioral health issues, discrimination based on race/ethnicity or family status, and too great a distance from services, employment, or school without adequate transportation.
- **Perceived lack of consumer empowerment.** Although many efforts are underway to empower people living with HIV/AIDS to be more independent, consumers and providers have suggestions for expanding these efforts.
- **Fragmented network.** Because people living with HIV/AIDS experience a variety of housing and service needs that may be most appropriately dealt with through services offered by a variety of systems and organizations in suburban and rural areas in addition to urban areas, coordination is critical.
- **Fear of confidentiality violations.** Particularly in the suburban and rural areas of the region, consumers are very concerned that confidentiality regarding their HIV-status may be compromised because of the HIV-related stigma that exists; this fear can be a barrier to accessing help.

Recommendations

The Steering Committee identified five key strategies to meeting the housing needs of people living with HIV/AIDS throughout the eight-county region. Within each of these five strategies, the Steering Committee identified a number of specific action steps. For more details about these action steps, please see the Recommendations section of the plan. The five overarching strategies are:

1. Increase housing opportunities for people living with HIV/AIDS, ensuring that a variety of models, including both sober and harm reduction housing, are available throughout the eight-county region by expanding existing partnerships and creating new ones.
2. Strengthen the capacity of suburban and rural communities to address HIV/AIDS housing issues.

3. Local housing and service models that serve people who experience homelessness offer examples of coordination and collaboration, as well as involve the participation of many systems and resources accessed by people living with HIV/AIDS. Continue and increase the connections between the HIV/AIDS service system and homeless systems.
4. Continue efforts to empower people living with HIV/AIDS to increase their independence.
5. Establish an information-sharing and problem-solving network that engages service providers, housing developers, and property managers.

Introduction

The Columbus AIDS Task Force, working in collaboration with the Columbus Health Department, contracted with AIDS Housing of Washington to facilitate this HIV/AIDS housing needs assessment and planning process. The needs assessment began in April 2004 and was completed by October 2004.

The needs assessment process included: interviews with stakeholders, a consumer housing survey, focus groups with people living with HIV/AIDS, and a review of relevant planning and epidemiological data. A Steering Committee was developed to oversee the process, identify critical issues, and develop recommendations.

Background

The Columbus AIDS Task Force, working closely with the Columbus Health Department, hired AIDS Housing of Washington (AHW) to facilitate a community-based needs assessment and planning process and to develop an HIV/AIDS housing plan. Preparations for this planning process began in May 2003. The planning process itself began in April 2004 when the Steering Committee was formed and began to meet. The Steering Committee continued meeting through October 2004.

The Columbus AIDS Task Force (CATF) was founded by volunteers in 1984. Currently, CATF provides case management for more than 700 people in Central Ohio, conducts HIV prevention outreach and education, offers support groups, and operates four housing assistance programs. The Columbus Health Department administers the federal Housing Opportunities for Persons with AIDS (HOPWA) program for the eight counties in Central Ohio: Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, and Union.

AHW, a nonprofit corporation located in Seattle, Washington, has developed more than 140 units of housing for people living with HIV/AIDS since its founding in 1988. AHW also provides information, planning assistance, consultations, and training in communities nationwide, and has worked in more than thirty regions to develop comprehensive HIV/AIDS housing plans. AHW's goal is to help stabilize the lives of individuals and families through improving access to affordable housing and appropriate support services. Housing Opportunities for Persons with AIDS (HOPWA) funds were made available for the needs assessment and plan by the Columbus Health Department and by HUD's National HOPWA Technical Assistance Program.

Planning Process

Interested community members, including people living with HIV/AIDS, representatives of AIDS service and housing organizations, housing developers, members of local government agencies, advocates, and others participated in this planning effort. Relevant planning, housing, homelessness, and epidemiological data were reviewed and incorporated into the *Central Ohio HIV/AIDS Housing Plan*.

Central Ohio's last comprehensive HIV/AIDS planning process took place in 1993, when the *Vision 2000: Open Doors* plan was issued by the HIV/AIDS Advisory Council of Metropolitan Columbus. Since then, a number of updates and smaller-scale plans have been completed. Please see **Appendix 5** for more information about HIV/AIDS housing planning conducted in Central Ohio prior to this plan.

Community Participation

A Steering Committee was formed in April 2004 to oversee and guide the needs assessment and planning process. The committee was comprised of representatives from health, housing, and social service agencies and people living with HIV/AIDS throughout the eight-county area. The Steering Committee identified critical issues and developed recommendations. Minutes from the Steering Committee meetings can be found in **Appendix 1**.

Group and individual key informant interviews were held with 71 people, including case managers, housing and service providers, housing developers, government representatives, clinical social workers, and other concerned community members.¹ These stakeholders were identified by the Steering Committee and other involved stakeholders as most knowledgeable as well as able to provide future leadership on HIV/AIDS services, housing, homelessness, behavioral health, and other related issues.

A housing survey was distributed to people living with HIV/AIDS throughout the region in order to gather more information about individuals' housing histories, needs, and preferences. A total of 272 people living with HIV/AIDS completed surveys. Survey findings are presented in a section of the plan, and complete survey data appears in **Appendix 4**.

Consumers were also included in the needs assessment process through focus groups and individual interviews. Focus groups and interviews allowed for more qualitative and a broader range of information than the survey, and also provided a way to reach people who might be unlikely to complete a survey. Telephone interviews were used as an alternative to groups in more suburban and rural areas where gathering a group was not feasible. A total of 34 people living with HIV/AIDS participated in a focus group or interview. Findings from the consumer focus groups are presented in a section of the plan, and summaries from each group, and groups of individual interviews, appear in **Appendix 2**.

Review of Source Data

Data reviewed in the preparation of this plan include information from the following documents:

- Affordable Housing Task Force of Delaware County, *Affordable Housing Market Study*, 2002.
- City of Lancaster Community Development Department, *Consolidated Housing and Community Development Plan, City of Lancaster, Ohio, FY 2003 – FY 2007*.
- Coalition on Homelessness and Housing in Ohio, *Number of Homeless Ohioans*, 2001.
- Coalition on Homelessness and Housing in Ohio, *Survey of Attitudes and Opinions on Homelessness*, November 1999.

¹ Please see the comprehensive list of key informants and agency affiliations at the front of this plan.

- Columbus Health Department, Housing Opportunities for Persons with AIDS Program, *FY2003 HOPWA Formula Grantee Annual Report*, March 2003.
- Columbus Health Department, Housing Opportunities for Persons with AIDS Program, *Consolidated Annual Performance and Evaluation Report*, 2003.
- Columbus Metropolitan Housing Authority, *PHA Plan: Five-Year Plan for Fiscal Years 2004 – 2008, Annual Plan for Fiscal Year 2004*.
- Community Shelter Board, *Analysis of Characteristics of Rebuilding Lives Supportive Housing Tenants*, March 2003.
- Community Shelter Board, *Columbus and Franklin County 2004 Continuum of Care, Exhibit 1*.
- Fairfield County Housing Coalition, *Homeless Continuum of Care Plan, 2004*.
- Licking County Housing Initiative, *Licking County Continuum of Care, 2004*.
- Ohio Department of Health, Division of Family & Community Health Services, AIDS Client Resources Section, *Ryan White Emergency CARE Act Title II: Ohio's Comprehensive Plan for HIV/AIDS Services*, April 2004.

Other information available on the internet from the following organizations was also reviewed:

- Center on Budget and Policy Priorities
- Centers for Disease Control and Prevention
- Community Shelter Board
- Delaware Cares
- National Alliance to End Homelessness
- U.S. Bureau of Economic Analysis
- U.S. Census Bureau
- U.S. Department of Housing and Urban Development
- U.S. Social Security Administration

Data provided by the Ohio Department of Health form the basis for the epidemiological profile included in this report.

Supplemental Information

Supplemental information for the reader's reference appears in the appendices at the end of this plan for reference. Supporting materials include a summary of federal sources of financing for affordable housing in **Appendix 6**, a description of a continuum of HIV/AIDS housing and services in **Appendix 7**, and a glossary of HIV/AIDS- and housing-related terms in **Appendix 8**.

HIV/AIDS Housing Plan

The *Central Ohio HIV/AIDS Housing Plan* provides a framework for assessing and planning for the housing needs of people living with HIV/AIDS. It was developed through the participation of a broad cross section of concerned citizens to determine the housing needs of people living with HIV/AIDS and their families throughout the eight-county Central Ohio Metropolitan Statistical Area (MSA).

The plan includes an overview of housing and homelessness issues, a demographic profile of individuals who are estimated to be living with HIV and AIDS, an overview of HIV/AIDS housing resources, consumer survey findings, focus group findings, a summary of issues identified by stakeholders, identification of critical issues, and recommendations.

It is anticipated that this plan will provide guidance to the Columbus AIDS Task Force, the City of Columbus, and involved community members in making HIV/AIDS housing-related decisions for the next five years. Given the dynamic nature of the HIV/AIDS disease and other factors that affect HIV/AIDS housing planning, it is essential to regularly reassess the needs of people living with HIV/AIDS and the most appropriate strategies to meet those needs. It is intended that this plan be built upon, revised, and expanded as current objectives are met and new gaps and needs emerge. Five years from now, more comprehensive analysis will again be needed to reassess this plan's assumptions, the current context, and the progress that has been made on the goals established in this plan, as well as to establish a new, complete set of recommendations.

Epidemiology of HIV/AIDS

Key issues about HIV/AIDS in Central Ohio:

- By the end of 2003, there were 2,801 people living with HIV and AIDS in Central Ohio.
- Since Ohio began reporting, nearly 4,300 HIV and AIDS cases have been diagnosed in the eight-county region of Central Ohio.
- 91 percent of all cases in the eight-county region were diagnosed in Franklin County residents. The county with the second-highest number was Licking, followed by Fairfield, Delaware, Pickaway, Madison, Union, and Morrow.
- African Americans/Blacks made up almost one-third of people living with HIV/AIDS, despite being just 13 percent of Central Ohio's total population.

HIV/AIDS in the National Context

More people are now living with HIV and AIDS in the United States than ever before. **The Centers for Disease Control and Prevention (CDC) estimates that between 800,000 and 900,000 individuals are living with HIV, the virus that causes AIDS, and that another 40,000 become infected every year.**² They also estimate that one-fourth of the persons living with HIV in this country are not aware of their infection.³

From 1996 to 1997, the number of new HIV cases significantly declined for the first time by nearly 20,000. This was also the same year new drug therapies were introduced that dramatically slowed the death rates of people living with AIDS. However, this pattern of decline has since leveled off, and medical advances in treatment are not proving to be effective for everyone. By the end of 2002, the CDC estimated that 384,906 individuals in the U.S. were living with AIDS and 16,371 people with AIDS had died that year.⁴

The American public continues to see HIV/AIDS as a serious public health concern (26 percent), second only to cancer (35 percent). Populations that are disproportionately affected by HIV/AIDS—African Americans/Blacks, Hispanics/Latinos, young adults and their parents—consider AIDS a more urgent problem today than five years ago, compared to whites. **Nearly half of the U.S. population (43 percent) says they personally know someone who is living with HIV/AIDS or has died of AIDS.**⁵

² Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *A Glance at the HIV Epidemic*, December 2000. Available online: www.cdc.gov/nchstp/od/news/At-a-Glance.pdf (Accessed: April 2, 2003).

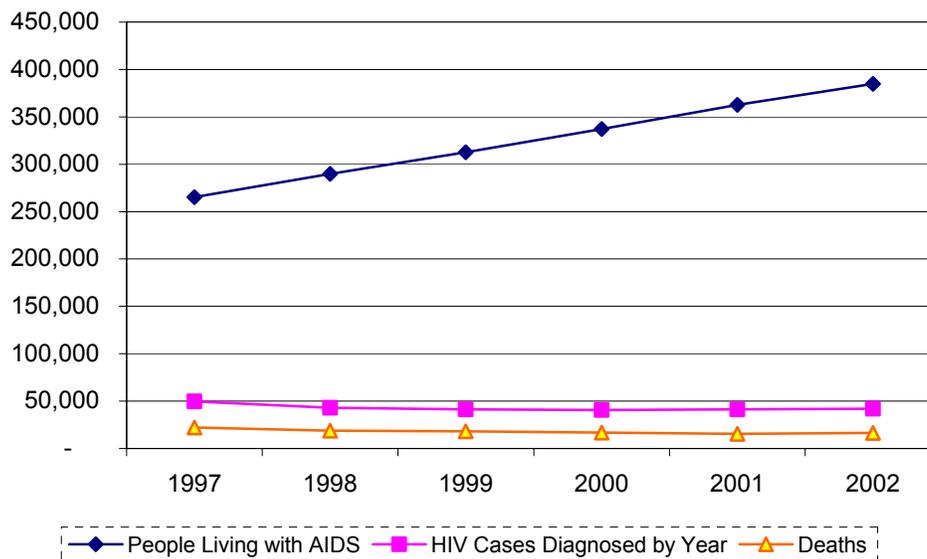
³ Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, "Update: the AIDS Epidemic in the United States, 2001," *Morbidity and Mortality Weekly Report*, 2002, Vol. 51, pp. 592-595. Available online: www.cdc.gov/mmwr/PDF/wk/mm5127.pdf (Accessed: April 2, 2003).

⁴ Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS Surveillance Report, Year End 2002*, pp. 5, 6. Available online: www.cdc.gov/hiv/stats/hasr1402/2002SurveillanceReport.pdf (Accessed: March 23, 2004).

⁵ The Henry J. Kaiser Family Foundation, *The AIDS Epidemic at 20 Years: The View from America*, A National Survey of Americans on HIV/AIDS, 2001, p. 7. Available online: www.kff.org/hivaids/3026-index.cfm (Accessed: April 9, 2003).

Figure 1 shows the number of people living with AIDS, of new HIV cases diagnosed, and the number of deaths from AIDS in the United States over a six-year period. New HIV infections and AIDS death rates have remained steady over recent years. However, the number of people living with AIDS continues to climb as medical advances continue to slow progression of the disease and help individuals live longer.

Figure 1:
**People Living with AIDS, New HIV Cases Diagnosed,
 and HIV/AIDS-Related Deaths in the United States,
 by Year from 1997–2002**



Source: Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS Surveillance Report, Year End 2002*, p. 5, 6. Available online: www.cdc.gov/hiv/stats/hasr1402/2002SurveillanceReport.pdf (Accessed: March 23, 2004).

Demographic Trends

The AIDS epidemic has become more complex over the past twenty years. Originally found in large urban areas of the United States among men who have sex with men and injection drug users, the prevalence of HIV/AIDS among residents of the southeastern United States, African Americans/Blacks, Hispanics/Latinos, women, young adults, persons exposed to HIV through heterosexual contact, and persons exiting the criminal justice system has increased significantly. Limited access to healthcare and preventive services, poverty, social disadvantage, discrimination, and stigma are some of the factors that have contributed to these trends.

Every state in the nation, as well as Puerto Rico, the Virgin Islands, and U.S. territories, reported new AIDS cases diagnosed in 2002.⁶ Approximately 10 percent of the AIDS cases reported were from metropolitan areas with populations less than 500,000 and 6 percent were from rural areas with populations less than 50,000.⁷

Southeastern states make up about one-third of the total U.S. population, but they account for 40 percent of the people estimated to be living with AIDS and 46 percent of the estimated new AIDS cases.⁸ The South also has the largest number and proportion of cases reported from rural areas.⁹

The racial/ethnic, gender, and age profiles of people living with HIV/AIDS have also shifted over the course of the epidemic:

- African Americans/Blacks make up 12 percent of the U.S. population, but accounted for half of new HIV cases reported in 2002. The AIDS rate among African Americans/Blacks was nearly eleven times the rate reported among whites.¹⁰
- AIDS is the leading cause of death among African American/Black women ages 25-34 and African American/Black men ages 35-44.¹¹
- African American/Black women accounted for nearly 64 percent of new HIV cases reported among women in 2001. Hispanic/Latina and White/Caucasian women each accounted for 17 percent of reported HIV cases.¹² Overall, women make up an estimated 30 percent of new infections annually.¹³
- Hispanics/Latinos make up 13 percent of the U.S. population, but accounted for 19 percent of new HIV cases reported in 2000. The AIDS rate among Hispanics/Latinos was three times the rate reported among Whites/Caucasians.¹⁴
- Adolescents and young adults between the ages of 13 and 24 are estimated to make up half of new HIV infections. African American/Black youth represent the majority of these infections. The CDC estimates that 47 percent of new cases among this age group are among females.¹⁵

⁶ Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS Surveillance Report, Year End 2002*, p. 5, 6. Available online: www.cdc.gov/hiv/stats/hasr1402/2002SurveillanceReport.pdf (Accessed: March 23, 2004).

⁷ Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS in Urban and Nonurban Areas*, Fact Sheet, p. 4. Available online: www.cdc.gov/hiv/graphics/images/L206/L206.pdf (Accessed April 2, 2003). Does not include Puerto Rico, U.S. Virgin Islands, and territories. Rural area defined as population less than 50,000.

⁸ The Henry J. Kaiser Family Foundation, *HIV/AIDS and other Sexually Transmitted Diseases (STDs) in the Southern Region of the United States: Epidemiological Overview*, *Southern States Summit on HIV/AIDS and STDs: A Call to Action*, November 13-15, 2002, p. 1. Southern states defined as Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

⁹ Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS in Urban and Nonurban Areas*, Fact Sheet. Available online: www.cdc.gov/hiv/graphics/images/L206/L206.pdf (Accessed April 2, 2003).

¹⁰ Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS Among African Americans*, Fact Sheet, March 2003, p. 1. Available online: www.cdc.gov/hiv/pubs/Facts/afam.pdf (Accessed: March 23, 2004).

¹¹ Ibid.

¹² Ibid, p. 2.

¹³ Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/STD Prevention, *A Glance at the HIV Epidemic*, December 2000. Available online: www.cdc.gov/nchstp/od/news/At-a-Glance.pdf (Accessed: April 2, 2003).

¹⁴ Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS Among Hispanics in the United States*, Fact Sheet. Available online: www.cdc.gov/hiv/pubs/facts/hispanic.htm (Accessed: April 2, 2003).

Medical Advances in Treating People Living with HIV/AIDS

People living with HIV/AIDS who are being successfully treated with Highly Active Anti-Retroviral Therapy (HAART)—often referred to as combination therapies or the ‘cocktail’—are experiencing significant improvements in health. Many people living with HIV/AIDS are considering re-employment and evaluating the impact that returning to work could have on their disability and medical benefits.

However, some individuals with access to these medications are experiencing failure, even though they are being closely monitored and have medications adjusted frequently. In addition, not all people living with HIV/AIDS who might be helped by existing HIV treatments necessarily have access to them. **The medications and monitoring associated with HAART are expensive—at \$10,000 to \$15,000 each year—putting them well out of reach for people who do not have adequate insurance or access to state-run AIDS Drug Assistance Programs.** Studies show persisting disparities in access to these medications, particularly among women, people of color, and injection drug users.¹⁶ Another study published in 2001 estimated that nearly all of the 750,000 people living with HIV (estimated at the time of the study) in the United States would have met the criteria for being offered HAART, but that only about 200,000 were using it.¹⁷

HIV/AIDS in Central Ohio

Nearly 2 million people live in the Central Ohio counties of Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, and Union, which makes up 15 percent of the state’s total population (based on 2002 population estimates).¹⁸ Delaware County, which borders the northern city limits of Columbus, grew by 14 percent between 2000 and 2002, compared to 5 percent or less for the remaining counties. The state population overall grew by only 1 percent during those same two years.¹⁹

More than 13,000 individuals are reported to be living with HIV and AIDS in Ohio. The state ranks 32nd in the nation for the rate of persons per 100,000 diagnosed with AIDS: 6.8 per 100,000. Some of the states in the neighboring vicinity of Ohio had similar rates:

- West Virginia has a case rate of 4.6, the 37th highest case rate in the U.S.²⁰
- Kentucky has a case rate of 7.5, the 30th highest rate
- Michigan has a case rate of 7.9, the 28th highest rate
- Indiana has a case rate of 8.0, the 27th highest rate

¹⁵ Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *Young People at Risk: HIV/AIDS Among America’s Youth*, Fact Sheet. Available online: www.cdc.gov/hiv/pubs/facts/youth.htm (Accessed: April 2, 2003).

¹⁶ Usha Sambamoorthi, Ph.D., et al., “Use of Protease Inhibitors and Non-Nucleoside Reverse Transcriptase Inhibitors Among Medicaid Beneficiaries with AIDS,” *American Journal of Public Health*, September 2001, vol. 91, no. 9, pp. 1474-1481. Available online: www.ajph.org/cgi/reprint/91/9/1474.pdf (Accessed January 10, 2002).

¹⁷ James G. Kahn, M.D., M.P.H., Brian Halle, M.P.P., M.A., Jennifer Kates, M.P.A., M.A., and Sophia Chang, M.D., M.P.H., “Health and Federal Budgetary Effects of Increasing Access to Antiretroviral Medications for HIV by Expanding Medicaid,” *American Journal of Public Health*, September 2001, vol. 91, no. 9, pp. 1464-1473. Available online: www.ajph.org/cgi/reprint/91/9/1464.pdf (Accessed: January 10, 2002).

¹⁸ U.S. Census Bureau, *Ohio QuickFacts*. Available online: quickfacts.census.gov/qfd/states/39000.html (Accessed: May 14, 2004).

¹⁹ Ibid.

²⁰ Includes all 50 states plus the District of Columbia.

- Pennsylvania has a case rate of 14.7, the 13th highest rate
- Illinois has a case rate of 16.7, the 10th highest rate²¹

Cumulative HIV/AIDS Cases in Central Ohio

According to the Ohio Health Department, nearly 4,300 individuals have been diagnosed with HIV or AIDS in Central Ohio as of the end of 2003. The State first began reporting AIDS in 1983 and HIV in 1990. Reporting is based on residence at the time of diagnosis.²²

Table 1 presents total number and percent of population by county in Central Ohio and the cumulative HIV and AIDS cases in Central Ohio, as of December 31, 2003. Cumulative case data represents people who are living and people who are deceased. While Franklin County has a disproportionately large share of the cases (91 percent) when compared to the distribution of the population at large (65 percent), the number of HIV/AIDS cases diagnosed in the surrounding 7 counties is also significant, at 399.

Table 1:
**Total Population (2003 estimate) and Cumulative HIV and AIDS
Cases in Central Ohio, as of December 31, 2003**

County	Population	Percent of Central Ohio Population	Cumulative HIV and AIDS Cases	Percent of Central Ohio Cumulative HIV and AIDS Cases
Delaware	132,797	8%	70	2%
Fairfield	132,549	8%	89	2%
Franklin	1,088,944	65%	3,865	91%
Licking	150,634	9%	133	3%
Madison	40,624	2%	29	1%
Morrow	33,568	2%	15	<1%
Pickaway	51,723	3%	39	1%
Union	43,750	3%	24	1%
Central Ohio Total	1,674,589	100%	4,264	100%

Source: U.S. Census Bureau, *Ohio QuickFacts*. Available online: quickfacts.census.gov/qfd/states/39000.html (Accessed: October 12, 2004) and Ohio Department of Health, HIV/AIDS Surveillance, email correspondence with AHW staff, October 7, 2004.

²¹ Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention, *AIDS Cases and Rates (per 100,000 population) by Area of Residence and Age Category, Reported Through December 2002—United States*, Table 14. Available online: www.cdc.gov/hiv/stats/hasr1402/table14.htm (Accessed: May 27, 2004).

²² Ohio Department of Health, HIV/AIDS Surveillance, email correspondence, June 2, 2004.

Table 2 presents cumulative HIV and AIDS data by race/ethnicity, gender, age, and mode of transmission as of December 31, 2003.

Table 2:
**Cumulative HIV and AIDS Cases in Central Ohio,
by Race/Ethnicity, Gender, Age at Diagnosis, and Transmission Category,
as of December 31, 2003**

Demographics	Cumulative HIV Cases (no AIDS diagnosis)		Cumulative AIDS Cases	
	Number	Percent	Number	Percent
<u>Race/Ethnicity</u>				
White/Caucasian	936	56%	1,901	73%
African American/Black	543	33%	645	25%
Hispanic/Latino	42	3%	43	2%
Asian/Pacific Islander	5	<1%	11	<1%
Native American	5	<1%	4	<1%
Unknown	126	8%	3	<1%
Total	1,657	100%	2,607	100%
<u>Gender</u>				
Male	1,342	81%	2,332	89%
Female	314	19%	275	11%
Unknown	1	<1%	0	0%
Total	1,657	100%	2,607	100%
<u>Age at First Diagnosis</u>				
<13	16	1%	14	1%
13-19	54	3%	11	<1%
20-24	191	12%	100	4%
25-29	313	19%	379	15%
30-39	674	41%	1,227	47%
40-49	306	18%	643	25%
50 and older	103	6%	233	9%
Total	1,657	100%	2,607	100%
<u>Mode of Transmission</u>				
Male/Male Sex	485	29%	1,662	64%
Injection Drug Use (IDU)	56	3%	187	7%
Male/Male Sex and IDU	27	2%	89	3%
High Risk Heterosexual Contact	107	6%	183	7%
Blood Products	15	1%	41	2%
Perinatal Transmission	12	1%	13	<1%
No Identified Risk	955	58%	432	17%
Total	1,657	100%	2,607	100%

Source: Ohio Department of Health, HIV/AIDS Surveillance, email correspondence with AHW staff, October 7, 2004.

Note: Percentages may add up to more than 100 due to rounding.

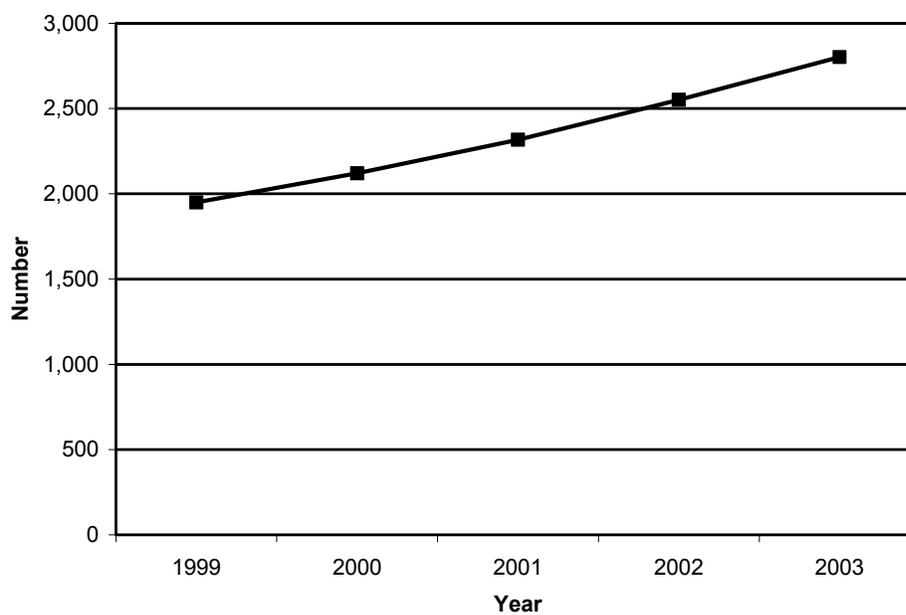
* Values less than four are not presented in order to protect confidentiality; they are included in the total.

** "Unknown" includes individuals who did not indicate mode of transmission or did not know. "Other" includes healthcare worker transmission.

People Living with HIV/AIDS in Central Ohio

In Central Ohio, more than **2,800 individuals** were reported living with HIV and AIDS at the end of 2003. In comparison, approximately 3,600 persons are living with HIV/AIDS in the Cleveland Eligible Metropolitan Statistical Area (EMSA) and approximately 2,000 are living with HIV/AIDS in the Cincinnati EMSA.²³ The number of people living with HIV/AIDS has increased steadily in the recent past, as medical advances lengthen the lives of people living with HIV/AIDS while new infections continue. **Figure 2** shows the number of people living with HIV/AIDS in Central Ohio increasing from 1999 to 2003.

Figure 2:
**Number of People Living with HIV/AIDS in
the Eight Counties of Central Ohio, 1999-2003**



Source: Ohio Department of Health, HIV/AIDS Surveillance, email correspondence with AHW staff, October 7, 2004.

²³ Ohio Department of Health, HIV/AIDS Surveillance, email correspondence, June 2, 2004.

While 91 percent of people living with HIV/AIDS were diagnosed in Franklin County, 9 percent, or 245 people, were living in the 7 surrounding counties. **Table 3** presents the number and percent of people living with HIV (without an AIDS diagnosis) and with AIDS in Central Ohio, by county, as of December 31, 2003.

Table 3:
**Persons Living with HIV and AIDS in Central Ohio, by County,
as of December 31, 2003**

County	People Living with HIV (no AIDS diagnosis)		People Living with AIDS	
	Number	Percent	Number	Percent
Delaware	27	2%	25	2%
Fairfield	33	2%	23	2%
Franklin	1,532	92%	1,024	91%
Licking	48	3%	32	3%
Madison	9	1%	9	1%
Morrow	3	<1%	2	<1%
Pickaway	14	1%	7	1%
Union	5	<1%	8	1%
Central Ohio Total	1,671	100%	1,130	100%

Source: Ohio Department of Health, HIV/AIDS Surveillance, email correspondence with AHW staff, October 7, 2004.

Table 4 on the following page presents the latest data on race/ethnicity, gender, age group, and mode of transmission for people living with HIV (without an AIDS diagnosis) and with AIDS in Central Ohio.

Table 4:
**Persons Currently Living with HIV and AIDS in Central Ohio,
 by Race/Ethnicity, Gender, Age at Diagnosis, and Transmission Category,
 as of December 31, 2003**

Demographics	Persons Living with HIV (no AIDS diagnosis)		Persons Living with AIDS	
	Number	Percent	Number	Percent
<u>Race/Ethnicity</u>				
White/Caucasian	941	56%	747	66%
African American/Black	548	33%	337	30%
Hispanic/Latino	47	3%	33	3%
Asian/Pacific Islander	5	<1%	9	1%
Native American	6	<1%	2	<1%
Unknown	124	7%	2	<1%
Total	1,671	100%	1,130	100%
<u>Gender</u>				
Male	1,353	81%	959	85%
Female	317	19%	171	15%
Unknown	1	<1%	0	0%
Total	1,671	100%	1,130	100%
<u>Age at First Diagnosis</u>				
<13	10	1%	4	<1%
13-19	9	1%	3	<1%
20-24	59	4%	9	1%
25-30	122	7%	35	3%
30-39	604	36%	364	32%
40-49	612	37%	471	42%
50 and older	255	15%	244	22%
Total	1,671	100%	1,130	100%
<u>Mode of Transmission</u>				
Male/Male Sex	494	30%	536	47%
Injection Drug Use (IDU)	57	3%	86	8%
Male/Male Sex and IDU	27	2%	35	3%
High Risk Heterosexual Contact	112	7%	102	9%
Blood Products	15	1%	12	1%
Perinatal Transmission	12	1%	6	1%
No Identified Risk	954	57%	353	31%
Total	1,671	100%	1,130	100%

Source: Ohio Department of Health, HIV/AIDS Surveillance, email correspondence with AHW staff, October 7, 2004.

Note: Percentages may add up to more than 100 due to rounding.

* Values less than four are not presented in order to protect confidentiality; they are included in the total.

** "Unknown" includes individuals who did not indicate mode of transmission or did not know. "Other" includes healthcare worker transmission.

Demographic Trends in Central Ohio

Persons of all ages, races/ethnicities, genders, and sexual orientation are affected by HIV/AIDS. However, as is the case in most parts of the country, HIV/AIDS has disproportionately impacted African Americans/Blacks and Hispanics/Latinos when compared to the general population, in both rural and urban areas of Central Ohio.

Table 5 shows the percent of persons living with HIV/AIDS in Central Ohio by race/ethnicity as compared to the general population.

Table 5:
Percent of General Population (2000) and Percent of Persons Living with HIV/AIDS in Central Ohio (2003), by Race/Ethnicity

Race/Ethnicity	General Population in Central Ohio	Persons Living with HIV/AIDS in Central Ohio
White/Caucasian	82%	60%
African American/Black	13%	32%
Hispanic/Latino	2%	3%
Asian/Pacific Islander	2%	<1%
Native American	<1%	<1%
Unknown/Other	1%	4%
Total	100%	100%

Source: U.S. Census Bureau, DP-1, *Profile of General Demographic Characteristics: 2000*, Data Set: Census 2000 Summary File 1 (SF1). Available online: factfinder.census.gov (Accessed: June 1, 2004) and Ohio Department of Health, HIV/AIDS Surveillance, email correspondence with AHW staff, October 7, 2004.

The Ohio Department of Health (ODH) reported in 2003 that the rate of people living with HIV/AIDS in Franklin County was 182.9 per 100,000 people. For African Americans/Blacks the rate was more than two times higher than for Whites/Caucasians. Among men, the rate was 310.8 per 100,000 persons compared to 62.0 per 100,000 for women.²⁴

For the State's Rural Planning Region, demographic trends were similar to those in Franklin County. The rate of persons living with HIV/AIDS was much lower for rural areas (38.5 per 100,000) than in Franklin County. However, the rate was six times higher for African Americans/Blacks and four times higher for Hispanics/Latinos than for Whites/Caucasians. Among men, the rate was 60.7 per 100,000 persons compared to 16.9 per 100,000 for women.²⁵

²⁴ Ohio Department of Health, HIV/AIDS Surveillance, *HIV/AIDS Epidemiologic Profile – Updated for 2003, HIV/AIDS in Franklin County*, p. 71.

²⁵ Ohio Department of Health, HIV/AIDS Surveillance, *HIV/AIDS Epidemiologic Profile – Updated for 2003, HIV/AIDS in the Rural Planning Region*, pp. 197-198.

Table 6 shows the number and percent of persons living with HIV and AIDS by race/ethnicity and gender for Central Ohio, as of December 31, 2003.

Table 6:
**Race/Ethnicity and Gender of Persons Living with HIV and AIDS
in Central Ohio, as of December 31, 2003**

Race/Ethnicity and Gender	People Living with HIV (no AIDS diagnosis)		People Living with AIDS	
	Number	Percent	Number	Percent
White/Caucasian Male	836	50%	686	61%
White/Caucasian Female	105	6%	61	5%
African American/Black Male	372	22%	240	21%
African American/Black Female	176	11%	97	9%
Hispanic/Latino Male	34	2%	23	2%
Hispanic/Latino Female	13	1%	10	1%
Asian/Pacific Islander Male	4	<1%	8	1%
Asian/Pacific Islander Female	1	<1%	1	<1%
Native American Male	5	<1%	-	0%
Native American Female	1	<1%	2	<1%
Unknown	124	7%	2	<1%
Total	1,671	100%	1,130	100%

Source: Ohio Department of Health, HIV/AIDS Surveillance, email correspondence with AHW staff, October 7, 2004.

Income, Housing Affordability, and Homelessness

Key issues about income, housing affordability, and homelessness in Central Ohio:

- The median family income is \$63,800 for a family of four and \$44,660 for a single individual in seven of the eight counties; Supplemental Security Income (SSI), which many people living with HIV/AIDS receive, is equivalent to just 15 percent of the median for a single person, at \$6,768 annually.
- In no county in the region can a person earning minimum wage or receiving SSI afford to rent a one-bedroom apartment for the HUD-established Fair Market Rent.
- Housing authorities administer the majority of affordable housing resources in the region, including 4,170 public housing units and 13,220 Section 8 vouchers, including 1,306 vouchers set aside for people with disabilities.
- The Community Shelter Board in Franklin County has the largest single role in addressing homelessness in the region, administering \$5.2 million in the current fiscal year and having funded organizations that provided 349,974 shelter nights in the previous year.
- Continuum of Care homelessness planning processes in several counties have identified a variety of housing and service needs for people who are homeless; however, in no county of the region have people living with HIV/AIDS been identified as a large or high priority population among the homeless.

Many individuals and families with low incomes are forced to make critical choices when their finances are not sufficient to meet basic living needs. It may mean fewer meals, no healthcare, loss of utilities, overcrowded housing, or eviction. For people living with HIV/AIDS who have low incomes, these choices can have a serious effect on their health status. Unfortunately, the income gap between the poorest and richest families in the nation has reached an historic peak. In 45 states, the income of the richest 20 percent of households has increased at a faster rate than the 20 percent with the lowest incomes.²⁶

With over 9 million people out of work, the U.S. unemployment rate has reached its highest levels since 1994. In February 2004, the percent of workers on the unemployment roll hovered around 5.6. However, among African Americans/Blacks the rate was nearly double at 9.8 percent.²⁷ **An estimated 12 percent of the population—35 million people—is considered to be living in poverty in this country.**²⁸ In 2003, the poverty threshold for a single person under age 65 was \$9,573 per year, equivalent to \$798 per month. For a family of four, including two related children, the poverty threshold was \$18,660 per year, equivalent to \$1,555 per month.²⁹

²⁶ Center on Budget and Policy Priorities and Economic Policy Institute, *Pulling Apart: A State-by-State Analysis of Income Trends*, p. viii. Available online: www.cbpp.org/4-23-02sfp.pdf (Accessed: May 4, 2004).

²⁷ U.S. Department of Labor, Bureau of Labor Statistics. Available online: www.bls.gov/cps/ (Accessed: March 24, 2004).

²⁸ U.S. Census Bureau, *Poverty in the United States: 2002, Current Population Reports: Consumer Income*, p. 1. Available online: www.census.gov/hhes/www/poverty02.html (Accessed: May 4, 2004).

²⁹ U.S. Census Bureau, *Poverty 2003*. Available online: www.census.gov/hhes/poverty/threshld/thresh03.html (Accessed: March 24, 2004).

The HIV Cost and Services Utilization Study (1996), the most comprehensive study to date, presents a statistical snapshot of the economic well being of people living with HIV/AIDS. At the time of the study, 63 percent were unemployed, 46 percent had a household income of less than \$10,000, 78 percent had no private health insurance, and 20 percent had no health insurance.³⁰

For many low-income and disabled persons in the United States, the cost of healthcare is a significant economic barrier to housing. **Nearly 50 million Americans were uninsured during some period of time in 2002.** The majority, 26 million, had been uninsured for 12 months or more.³¹ People with HIV/AIDS who are able to qualify for Supplemental Security Income (SSI) due to their disability status are usually eligible for health coverage through Medicaid or Medicare, depending on personal income, age, and state regulations. However, the application period can range from a few months to a few years. Under the Medicaid program participants are usually eligible as soon as their disability status is approved, while under Medicare requirements there may be a two-year waiting period.

Income and Poverty in Central Ohio

Every year, the U.S. Department of Housing and Urban Development (HUD) estimates a Median Family Income (MFI) for use with the Section 8 program.³² The national MFI for a family of four is \$57,500 and for an individual \$40,250 per year (calculated at 70 percent of MFI for a family of four).³³ MFI for the state of Ohio is slightly less than the national median at \$56,900; however, in seven out of the eight counties in the Central Ohio region, MFI is significantly higher at \$63,800 for a family of four and \$44,660 for an individual.³⁴ Only Morrow County has a lower MFI at \$52,400 for a family of four and \$36,680 for an individual.³⁵

In comparison with low-wage workers, the annual income for workers earning the federal minimum wage of \$5.15 per hour is \$10,712, which is only 24 percent of the MFI for an individual in the eight-county region (except for Morrow County) and far less than the poverty threshold.³⁶ SSI, which many people living with HIV/AIDS depend on, paid a maximum of \$564 per month to a single person under 65 living alone in 2004.³⁷ This is equivalent to just \$6,768 per year.

³⁰ S.A. Bozzette, S.H. Berry, H.D. Duan, et al., "The Care of HIV-Infected Adults in the United States," *New England Journal of Medicine*, vol. 339, no. 26, December 24, 1998.

³¹ The Henry J. Kaiser Family Foundation, Commission on Medicaid and the Uninsured, *Lack of Coverage: A Long-Term Problem for Most Uninsured*, Fact Sheet, January 2004. Available online: www.kff.org/uninsured/4120-index.cfm (Accessed: May 4, 2004).

³² HUD and the U.S. Census Bureau consider a family to be a household composed of related individuals. For example: a family is a group of two or more people (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered members of one family.

³³ Note: Individual MFI calculated by AHW staff. U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *Transmittal Notice on Estimated Median Family Incomes for FY 2004, State Median Family Incomes*. Available online: www.huduser.org/Datasets/IL/IL04/HUD-Medians.pdf (Accessed: May 14, 2004).

³⁴ Note: Union County MFI is \$63,900. U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *FY 2004 Income Limits*. Available online: www.huduser.org/Datasets/IL/IL04/hud04oh.pdf (Accessed: May 14, 2004); U.S. Census Bureau, *County Estimates for People of All Ages in Poverty for Ohio: 2000*. Available online: www.census.gov/hhes/www/saippe/stcty/a00_39.htm (Accessed: May 14, 2004).

³⁵ Ibid.

³⁶ Note: Ohio minimum wage is lower than the federal wage of \$5.15 per hour. U.S. Department of Labor, Employment Standards Administration Wage and Hour Division, *Minimum Wage Laws in the States*. Available online: www.dol.gov/esa/minwage/america.htm (Accessed: May 26, 2004).

³⁷ Social Security Administration, *Social Security Online*. Available online: www.ssa.gov (Accessed: May 25, 2004).

Table 7 presents the MFI for a family of four and an individual for the state and by county, in comparison to the rate of poverty for 2000, the last year for which county data is available. While income may be similar across counties, the rate of poverty varies greatly. Morrow County has a median income that is nearly 20 percent lower than the rest of the counties of the region, and the poverty rate is among the highest.

Table 7:
Median Family Income (2004) and Poverty Rate (2000), by County

County	MFI for a Family of Four	MFI for an Individual*	Rate of Poverty
Ohio	\$56,900	\$39,830	10%
Delaware	\$63,800	\$44,660	4%
Fairfield	\$63,800	\$44,660	7%
Franklin	\$63,800	\$44,660	10%
Licking	\$63,800	\$44,660	8%
Madison	\$63,800	\$44,660	9%
Morrow	\$52,400	\$36,680	10%
Pickaway	\$63,800	\$44,660	10%
Union	\$63,900	\$44,730	6%

* Calculated by AHW staff.

Sources: U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *Transmittal Notice on Estimated Median Family Incomes for FY 2004, State Median Family Incomes*. Available online: www.huduser.org/Datasets/IL/IL04/HUD-Medians.pdf (Accessed: May 14, 2004); U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *FY 2004 Income Limits*. Available online: www.huduser.org/Datasets/IL/IL04/hud04oh.pdf (Accessed: May 14, 2004); U.S. Census Bureau, *County Estimates for People of All Ages in Poverty for Ohio: 2000*. Available online: www.census.gov/hhes/www/saippe/stcty/a00_39.htm (Accessed: May 14, 2004).

The unemployment rate in the Columbus area has consistently remained lower than the state and national averages. In September 2004, the unemployment rate for the United States was 5.1 percent, while Ohio's was 5.7 percent.³⁸ By comparison, unemployment rates in Central Ohio ranged from a low of 3.5 percent in Delaware County to a high of 6.8 percent in Pickaway County.³⁹

Approximately 12 percent of the state population, more than 1.3 million people, has no health insurance. Another 22 percent rely on Medicaid and/or Medicare to cover health costs. The remainder have insurance either through an employer-provided plan or through an individual plan.⁴⁰

³⁸ Ohio Job and Family Services, Office of Workforce Development, Bureau of Labor Market Information. *Civilian Labor Force Estimates, September 2004*. These estimates are not seasonally adjusted. Available online: lmi.state.oh.us/laus/ColorRateMap.pdf (Accessed: October 22, 2004).

³⁹ Ohio Job and Family Services, Office of Workforce Development, Bureau of Labor Market Information. *Civilian Labor Force Estimates for Cities and Counties with a Population Over 50,000, September 2004*. Complete data as follows: Delaware (3.5%), Fairfield (5.1%), Franklin (4.9%), Licking (5.9%), Madison (4.6%), Morrow (5.0%), Pickaway (6.8%), and Union (4.0%). Available online: lmi.state.oh.us/laus/OhioCivilianLaborForceEstimates.pdf (Accessed: October 22, 2004).

⁴⁰ The Henry J. Kaiser Family Foundation, *State Health Facts Online*. Available online: www.statehealthfacts.kff.org (Accessed: May 26, 2004).

Housing Affordability in the National Context

Unprecedented economic growth in the 1990s did not raise all incomes equally, although it did raise housing costs. **In 2003, there were no states where a full-time, minimum-wage worker could afford to rent a two-bedroom apartment at or above the federally established Fair Market Rent (FMR).**⁴¹

Clearly, people with disabilities who depend on SSI—equivalent to just 17 percent of the national median income for an individual—have even fewer housing choices. For the first time ever, in 2002, the national average rent per year was greater than the annual income provided by the SSI program—105 percent of SSI was needed to rent a modest one-bedroom apartment. From 2000 to 2002, the cost of rental housing rose to twice as high as the cost of living adjustments for SSI.⁴²

People living with HIV/AIDS who have low incomes face the same challenges as other people with low incomes and frequently turn to the same resources to meet their housing and service needs. A small portion of people with low incomes are able to meet their housing needs with assistance, either in the form of subsidized units or through vouchers, such as Section 8, that a tenant can use in available market-rate housing. When it is not possible to obtain affordable housing, residents with low incomes inevitably pay a larger percentage of their income toward housing costs than people earning higher incomes or they combine households to share housing costs. Individuals who pay a high proportion of their income for housing costs and those who are living in overcrowded situations are at increased risk for homelessness.

Housing affordability is determined by the relationship of housing cost to income. **HUD considers housing to be affordable if it costs 30 percent or less of the renter's gross income. An area with very high average incomes can still be unaffordable if rents are typically very high; conversely, very low rents can be unaffordable in areas where incomes are low.** According to the Joint Center for Housing Studies of Harvard University, 14.3 million renters are spending more than 50 percent of their incomes for housing, and 17.3 million are spending 30 percent or more. Of the nation's households with at least one housing problem, an estimated 76 percent have incomes well above the poverty level and 55 percent are homeowners, indicating that housing problems are not limited to very low-income households.⁴³

Both homeownership and rental housing occupy important niches on the housing continuum. However, gains in support for homeownership may have come at the expense of support for rental housing.⁴⁴ Mortgage interest tax deductions represent the largest federal housing subsidy program, valued at \$65 billion in fiscal year 2001, while funding for rental housing continues to diminish.⁴⁵

⁴¹ National Low Income Housing Coalition, *Out of Reach 2003*. Available online: www.nlihc.org/oor_current/table9.htm (Accessed: May 4, 2004).

⁴² Technical Assistance Collaborative, Inc., *Priced Out in 2002*, May 2003, p. 1. Available online: www.tacinc.org/cms/admin/cms/_uploads/docs/PO2002.pdf (Accessed: May 4, 2004).

⁴³ Housing problems include paying more than 30 percent of gross income for housing costs, living in an overcrowded household, or living in a housing unit considered to be physically inadequate. Joint Center for Housing Studies of Harvard University, *The State of the Nation's Housing: 2003*, June 2003, p. 28. Available online: www.jchs.harvard.edu/publications/markets/son2003.pdf (Accessed: May 4, 2004).

⁴⁴ National Low Income Housing Coalition, "Homeownership," *2003 Advocates' Guide To Housing and Community Development Policy*. Available online: www.nlihc.org/advocates/homeownership.htm (Accessed: March 24, 2004).

⁴⁵ Millennial Housing Commission, *Housing Program Tutorial*, June 2002, slide 21. Available online: www.mhc.gov/tutorial_files/frame.htm (Accessed: May 4, 2004).

Housing Affordability in Central Ohio

HUD annually establishes FMR as the rental cost limit for certain rental subsidy programs. FMRs are set for each county at the fortieth percentile of rents paid by people who moved within the past two years, excluding people who moved into newly constructed units. This means that 40 percent of rents were lower than FMR and 60 percent were higher. FMR is not intended to represent the actual cost of available units, but is useful as an estimate of housing costs for an area. **Table 8** shows the FMR for each of the eight counties.

In most of the Central Ohio counties, Fair Market Rent (FMR) on a one-bedroom apartment is \$499 per month, and \$640 per month on a two-bedroom apartment. FMR is slightly lower in Morrow and Union Counties.⁴⁶ Viewed in terms of income:

- A minimum-wage worker would need to work 75 hours per week to afford a one-bedroom apartment at MFI.
- In order for a person to work a 40-hour work week and afford a one-bedroom apartment at FMR, his/her hourly wage would need to exceed \$9.60.⁴⁷
- For an individual living on SSI (\$564 per month, equivalent to a full-time job at \$3.25 per hour), a one-bedroom apartment at the FMR would require 88 percent of the monthly SSI income.⁴⁸

Table 8:
Fair Market Rent (FMR), by County (2004)

County	Efficiency	1-bedroom	2-bedroom	3-bedroom
Delaware	\$422	\$499	\$640	\$813
Fairfield	\$422	\$499	\$640	\$813
Franklin	\$422	\$499	\$640	\$813
Licking	\$422	\$499	\$640	\$813
Madison	\$422	\$499	\$640	\$813
Morrow	\$297	\$353	\$439	\$559
Pickaway	\$422	\$499	\$640	\$813
Union	\$297	\$410	\$542	\$678

Source: U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *2004 Fair Market Rents By State (Final Data)*. Available online: www.huduser.org/datasets/fmr.html (Accessed: May 14, 2004).

⁴⁶ U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *2004 Fair Market Rents by State (Final Data)*. Available online: www.huduser.org/datasets/fmr.html (Accessed: May 14, 2004).

⁴⁷ National Low Income Housing Coalition, *Out of Reach 2003*. Available online: www.nlihc.org/oor2003/data.php?getstate=on&getmsa=on&msa%5B%5D=columbus&state%5B%5D=OH (Accessed: March 5, 2003).

⁴⁸ Calculated by AHW staff.

Housing affordability data is presented for an individual in **Table 9** and for a family of four in **Table 10**. For each of three scenarios, an affordable monthly rent—equal to 30 percent of gross monthly income—is calculated and compared with the FMR. The last two columns show the gap between an affordable rent and an apartment renting for the FMR. Although this cannot represent the difference between what is affordable and what is available, it is a way of estimating and generalizing about housing affordability in the area.

Table 9:
Monthly Housing Affordability for Individuals with Varying Incomes in Central Ohio, based on 2004 Median Family Income, SSI, and Fair Market Rents

	Individual A	Individual B	Individual C
Earns:	SSI	Minimum wage	50% of MFI
Has this much income:	\$564	\$893	\$1,861
Which is equivalent to this percentage of MFI:	15%	24%	50%
Based on income, affordable housing cost is:	\$169	\$268	\$558
*A studio apartment might cost:	\$422	\$422	\$422
Which exceeds the affordable cost by:	\$253	\$154	none
*A one-bedroom apartment might cost:	\$499	\$499	\$499
Which exceeds the affordable cost by:	\$330	\$231	none

Source: U.S. Department of Housing and Urban Development, HUD User, *FY 2004 Income Limits*. Available online: www.huduser.org/datasets/il.html

U.S. Department of Housing and Urban Development, HUD User, *Fair Market Rents 2004*. Available online: www.huduser.org/datasets/fmr.html

* 2004 Fair Market Rent established by HUD.

Notes: SSI is Supplemental Security Income, and the amount given is the maximum for a single person 65 or younger living alone in 2004. MFI is Median Family Income. The MFI established by HUD for a family of one in 2004 is \$44,660, equivalent to \$3,721 per month. Affordable housing cost here is based on HUD's guideline of 30 percent or less of gross monthly income. Minimum wage in 2004 is \$5.15 per hour. Minimum wage example assumes one adult working full time.

Table 10:
**Monthly Housing Affordability for Families with Varying Incomes in Central Ohio,
 based on 2004 Median Family Income, SSI, and Fair Market Rents**

	Family A	Family B	Family C
Earns:	SSI	Minimum wage	50% of MFI
Has this much income:	\$564	\$893	\$2,658
Which is equivalent to this percentage of MFI:	11%	17%	50%
Based on income, affordable housing cost is:	\$169	\$268	\$797
*A two-bedroom apartment might cost:	\$640	\$640	\$640
Which exceeds the affordable cost by:	\$471	\$372	none
*A three-bedroom apartment might cost:	\$813	\$813	\$813
Which exceeds the affordable cost by:	\$644	\$545	\$16

Source: U.S. Department of Housing and Urban Development, HUD User, *FY 2004 Income Limits*. Available online: www.huduser.org/datasets/il.html

U.S. Department of Housing and Urban Development, HUD User, *Fair Market Rents 2004*. Available online: www.huduser.org/datasets/fmr.html

* 2004 Fair Market Rent established by HUD.

Notes: SSI is Supplemental Security Income, and the amount given is the maximum for a single person 65 or younger living alone in 2004. MFI is Median Family Income. The MFI established by HUD for a family of four in 2004 is \$63,800, equivalent to \$5,318 per month. Affordable housing cost here is based on HUD's guideline of 30 percent or less of gross monthly income. Minimum wage in 2004 is \$5.15 per hour. Minimum wage example assumes one adult working full time.

Table 11 shows the percent of renters in each county paying 30 percent or more of their gross monthly income for housing and utilities by county. For all Ohio residents, 34 percent paid 30 percent or more of their income for housing (based on 1999 calculations).⁴⁹

Table 11:
**Renters Paying 30 Percent or More Gross Rent,
by County and Percent (1999)**

County	Percent
Delaware	29%
Fairfield	29%
Franklin	35%
Licking	31%
Madison	26%
Morrow	31%
Pickaway	33%
Union	29%

Source: U.S. Census Bureau, DP-4, *Profile of Selected Housing Characteristics: 2000*, Data Set: Census 2000 Summary File 3 (SF3). Available online: factfinder.census.gov (Accessed: June 1, 2004).

Housing Market in Central Ohio

In all but Franklin County, at least three out of four households owned their homes, which was significantly higher than the state homeowner occupancy rate of 69 percent and the national homeowner occupancy rate of 66 percent, based on 2000 Census data.⁵⁰ Living in areas where the vast majority of residents are homeowners typically means that there are fewer options for renters to choose from. Because many people living with HIV/AIDS are renters, whether through choice or economic necessity, the homeownership rate helps shape HIV/AIDS housing issues.

A vacancy rate of less than 5 percent usually indicates a tight housing market. In the eight-county region, the rental vacancy rate ranges from five to ten percent, similar to Ohio's eight percent rate statewide. Therefore, vacancy rates in Central Ohio are in a range indicating a normal housing market.

⁴⁹ U.S. Census Bureau, DP-4, *Profile of Selected Housing Characteristics: 2000*, Data Set: Census 2000 Summary File 3 (SF3). Available online: factfinder.census.gov (Accessed: June 1, 2004).

⁵⁰ U.S. Census Bureau, DP-1, *Profile of General Demographic Characteristics: 2000*, Data Set: Census 2000 Summary File 1 (SF-1). Available online: factfinder.census.gov (Accessed: March 12, 2003).

Table 12 presents the homeownership rate and the rental vacancy rate for each county in Central Ohio and statewide, from the most recent Census.

Table 12:
**Selected Housing Market Statistics: Homeownership Rate
and Rental Vacancy Rate, by County (2000)**

County	Homeownership Rate*	Rental Vacancy Rate**
Ohio	69%	8%
Delaware	80%	10%
Fairfield	76%	6%
Franklin	57%	8%
Licking	74%	6%
Madison	72%	6%
Morrow	82%	5%
Pickaway	75%	7%
Union	78%	8%

Source: U.S. Census Bureau, DP-1, *Profile of General Demographic Characteristics: 2000*, Data Set: Census 2000 Summary File 1 (SF1). GCT-H5: General Housing Characteristics and GCT-H6: Occupied Housing Characteristics. Available online: factfinder.census.gov (Accessed: June 1, 2004).

* Homeownership rate given is the percentage of owner-occupied housing units out of all occupied housing units.

** Rental vacancy rate is the percentage of rental units vacant out of all rental units.

Table 13 shows a profile of the total number of housing units, median value of owner-occupied units, housing units in multi-unit structures, and total households by county, based on 2002 Census estimates and 2000 Census data. The data offers a comparison across each county.

Table 13:
**Profile of Housing Units (2002), Median Value of Owner-Occupied Units (2000),
 Housing Units in Multi-Unit Structures (2000), and Households (2000), by County**

County	Housing Units (2002)	Median Value of Owner- Occupied Units (2000)	Housing Units in Multi-Unit Structures (2000)	Households (2000)
Ohio	4,875,496	\$103,700	24%	4,445,773
Delaware	49,184	\$190,400	16%	39,674
Fairfield	49,817	\$129,500	15%	45,425
Franklin	489,851	\$116,200	38%	438,778
Licking	61,320	\$110,700	17%	55,609
Madison	14,739	\$104,300	15%	13,672
Morrow	12,267	\$97,400	7%	11,499
Pickaway	19,019	\$112,400	13%	17,599
Union	16,240	\$128,800	15%	14,346

Source: U.S. Census Bureau, *Ohio QuickFacts*. Available online: quickfacts.census.gov/qfd/states/39000.html (Accessed: May 14, 2004).

Housing Resources in Central Ohio

Public Housing Authorities (PHA) are the largest providers of low-income and affordable housing in any city, county, or state. Six PHAs provide public housing units, Section 8 vouchers, and other special vouchers to residents in separate jurisdictions in the eight-county Central Ohio region. **Table 14** shows the resources available from each PHA.

Table 14:
**Public Housing Authority Units, Total Section 8 Vouchers, and
Section 8 Vouchers Targeted to People with Disabilities, by Housing Authority**

Housing Authority	Public Housing Units	Total Section 8 Vouchers	Section 8 Vouchers Targeted to People with Disabilities	Targeted Vouchers as a Percentage of Total
Columbus Metropolitan Housing Authority	3,866	10,151	880	9%
Delaware Metropolitan Housing Authority	—	438	95	22%
Fairfield Metropolitan Housing Authority	96	899	20	2%
Licking Metropolitan Housing Authority	100	995	240	24%
Morrow Metropolitan Housing Authority	—	102	30	29%
Pickaway Metropolitan Housing Authority	108	635	41	6%

Note: Licking County Metropolitan Housing Authority also has 45 Shelter Plus Care vouchers.

Source: U.S. Department of Housing and Urban Development, *Housing Authority Profiles List*. Available online: pic.hud.gov/pic/haprofiles/haprofilelist.asp (Accessed: September 13, 2004). Technical Assistance Collaborative, Inc., *Section 8 Made Simple: A Guide To The Housing Choice Voucher Program*, p. 89. Available online: www.tacinc.org/cms/admin/cms/_uploads/docs/AppendixB.pdf (Accessed: September 13, 2004).

Most housing authorities in the region having lengthy waiting lists and therefore may be closed to new applicants. For example, the Licking Metropolitan Housing Authority had a waiting list of approximately 680 households in October 2004 and had been closed.⁵¹ Also in 2004, the Delaware Metropolitan Housing Authority had a waiting list of 800 households, and Fairfield Metropolitan Housing Authority had 1,400 households waiting.

The Columbus Metropolitan Housing Authority (CMHA) estimates a deficit of 22,000 housing units that are affordable for extremely low-income households—those earning less than 30 percent of Median Family Income (MFI). As of June 2003, 75 percent of the CMHA Section 8 waiting list was at or below 30 percent MFI and the public housing waiting list had 91 percent of its applicants in the same income range.⁵² The Section 8 waiting list contained the names of 10,860 families, and the public housing waiting list had 4,635 families.⁵³

⁵¹ Licking County Coalition for Housing, via email to AIDS Housing of Washington, October 20, 2004.

⁵² Columbus Metropolitan Housing Authority, *PHA Plan: Five Year Plan for Fiscal Years 2004 – 2008, Annual Plan for Fiscal Year 2004*, p. 9. Available online: www.cmhanet.com/pdf/PHA5yearPlan04.pdf (Accessed: May 26, 2004).

⁵³ *Ibid.*, pp. 11-12.

Housing Quality in Central Ohio

In addition to affordability, the physical quality of housing is another important characteristic to consider when assessing the housing market. Some aspects of housing quality that are commonly used to classify the quality of housing are the presence of plumbing, reliability of heating equipment, availability and safety of electricity, the safety of public areas (for example, working light fixtures, steps, and railings), and other maintenance problems.⁵⁴

Although living in substandard housing has potential health and safety impacts for anyone, there are particular considerations for a person living with HIV/AIDS. For example, adequate hygiene facilities—hot and cold water, a shower—are particularly important for reducing the likelihood of infections. Because many HIV/AIDS medications must be taken with food, having access to a refrigerator can be a substantial aid to medication compliance.

The 2000 Census included some questions about housing quality, including the presence of complete plumbing facilities, a complete kitchen, and telephone service. *Table 15* presents this information by county.

Table 15:
Percentage of Occupied Units with Selected Characteristics, by County

County	Lacking Complete Plumbing Facilities	Lacking a Complete Kitchen	No Telephone Service
Delaware	<1%	<1%	1%
Fairfield	<1%	<1%	1%
Franklin	<1%	<1%	2%
Licking	<1%	1%	2%
Madison	<1%	<1%	2%
Morrow	1%	1%	4%
Pickaway	<1%	1%	3%
Union	1%	<1%	3%

Source: U.S. Census Bureau, DP-4, *Profile of Selected Housing Characteristics: 2000*, Data Set: Census 2000 Summary File 3 (SF3). Available online: factfinder.census.gov (Accessed: June 1, 2004).

Note: Complete plumbing facilities are defined as hot and cold piped water, a flush toilet, and a bathtub or shower, not necessarily in the same room. Complete kitchen facilities are defined as a sink with piped water, a range or cook top and oven, and a refrigerator, not necessarily in the same room. Telephone service is defined as having a telephone in working order that can make and receive calls. Households where service has been disconnected due to nonpayment or other reason are not counted as having telephone service available.

⁵⁴ These are components of the American Housing Survey definition of physical problems.

Local Affordable Housing Reports

Delaware County

Delaware County has recently completed two initiatives to examine housing needs in the community. First, in April 2002, Delaware County's Affordable Housing Task Force hired the Poggemeyer Design Group to conduct an affordable housing market study, in order to examine the lack of affordable housing in Delaware County and the annual production of housing in the county. The *Affordable Housing Market Study* found that Delaware County's population had grown 64 percent during the 1990's, the number of households increased by 71 percent, and the number of housing units increased by 74 percent. Eighty percent of Delaware County households are homeowners, and the majority of new housing was single-family homes.

The study also reported that there are six Low Income Housing Tax Credit developments in Delaware County, with a total of 516 units. None have been built since 1996. The median gross rent in Delaware County increased by 50 percent during the 1990's, from \$426 to \$639. As of July 2002, the Delaware Metropolitan Housing Authority had a Section 8 waiting list of 464 eligible families, of which three-quarters earned 30 percent or less of median income and about one-third had a member with a disability. The study found a need for more housing affordable at a range of incomes, and made the following recommendations:

- Increase public awareness of the need for affordable housing in Delaware County.
- Increase capacity of local affordable housing delivery system.
- Encourage governmental entities to develop/provide incentives for the development of affordable housing.
- Secure additional funding resources for affordable housing development in Delaware County.
- Develop innovative affordable housing program suitable for Delaware County.⁵⁵

More recently, the United Way of Delaware County sponsored a community needs assessment process called Delaware Cares, which began in mid-2003 and is expected to release a plan in August 2004. In March 2004, affordable housing was identified and prioritized as 11th among 11 issues facing the County. Slightly more than a quarter of residents surveyed described this as a concern, and others raised the issue in interviews and focus groups. Factors in the housing affordability were similar to those described above; the report also mentioned the average home price of \$251,000.⁵⁶

⁵⁵ Affordable Housing Task Force of Delaware County, *Affordable Housing Market Study*.

⁵⁶ Delaware Cares, *Issue Prioritization and Visioning*, March 2004. Available online: www.delawarecares.org/pdf/121.pdf (Accessed: August 18, 2004).

Fairfield County: City of Lancaster

The recently completed *FY 2003 – FY 2007 Consolidated Housing and Community Development Plan* for the City of Lancaster includes information about housing affordability and outstanding needs. The Danter Company completed a real estate market study for the plan. These consultants concluded that there was a need for the development of 975 housing units in Lancaster over the 5 year period, including 380 to 475 rental units, of which 175 to 225 should be made affordable through Low Income Housing Tax Credits and/or other subsidy.⁵⁷ This amount of housing would greatly increase the amount of subsidized housing in Lancaster, which totaled 358 units in March 2003. This study also found that the vacancy rate in subsidized housing was even lower than in market-rate housing, at 1.7% overall and 0.5% or less in studios and one-bedrooms.⁵⁸

The City of Lancaster's Consolidated Plan 2003 – 2007 also cited the growth of Columbus as having had a significant impact on Lancaster over the past decade. It reported that nearly half (46 percent) of the city's residents are employed outside of the city.⁵⁹ Development in Lancaster itself has exploded; from 1995 to 1999, there were an average of 150 housing units started per year, compared to an average of 50 per year from 1990 to 1994.⁶⁰

Homelessness and Related Issues in the National Context

The housing affordability crisis in the United States has been a driving factor for a burgeoning homeless population. It is estimated that on any given night, nearly one million Americans are homeless.⁶¹ **The U.S. homeless population has an estimated median rate of HIV prevalence of at least three times higher—3 percent versus 1 percent—than the general population.**⁶² Among more than 13,000 people living with HIV/AIDS surveyed by AIDS Housing of Washington in twenty-one counties or metropolitan areas and twelve states around the country since 1993, 40 percent indicated they had been homeless at some point in their lives.⁶³

When people are unable to afford housing, they are at risk of becoming homeless. Homeless services are available but meet only part of the outstanding need. People staying in homeless shelters represent a portion of the homeless population. Other marginally housed people may be staying in substandard housing, in cars, or in temporarily doubled-up situations with friends or relatives.

While everyone experiencing homelessness is at risk for related health impacts, there are particular risks for people living with HIV/AIDS. For example, some HIV medications need to be refrigerated; people who are homeless may have no or irregular access to a refrigerator. Many

⁵⁷ City of Lancaster Community Development Department, *Consolidated Housing and Community Development Plan, City of Lancaster, Ohio, FY 2003 – FY 2007, Exhibit: Housing Market Analysis Report*, p. III-2.

⁵⁸ Ibid, p. IV-22.

⁵⁹ Ibid, p 22.

⁶⁰ Ibid.

⁶¹ National Alliance to End Homelessness, Corporation for Supportive Housing, and AIDS Housing of Washington. *Policy Papers: New Partnerships for Ending Homelessness*, July 2003. Available online: www.endhomelessness.org/pol/PolicyPapers03.pdf (Accessed: May 4, 2004).

⁶² Higher rates (8.5 to 62 percent) have been found in selected homeless sub-populations. John Song M.D., M.P.H., M.A.T., *HIV/AIDS & Homelessness: Recommendations for Clinical Practice and Public Policy*, November 1999, National Health Care for the Homeless Council, Health Care for the Homeless Clinician's Network, p. 1. Available online: www.nhchc.org/Publications/HIV.pdf (Accessed: January 10, 2002).

⁶³ AIDS Housing of Washington, *Fact Sheet: AIDS Housing Survey*, 2003. Available online: www.aidshousing.org/usr_doc/Survey_Factsheet_2003.pdf (Accessed: March 24, 2004).

medications must be taken either with a meal or between meals on a regular schedule, but people who are homeless often have little control over their eating schedule. Being outside, whether just during the day or all the time, can expose people to extremes of weather and increase fatigue. Although being in a shelter offers protection, studies have found tuberculosis and other communicable diseases to be common in larger, dormitory style shelters. People living with HIV/AIDS are at particular risk of contracting infectious diseases in congregate living facilities.⁶⁴

Increasingly, people living with HIV/AIDS also have substance use or mental health issues that may or may not be combined with homelessness. People with both substance use issues and mental illness are at a greater risk for HIV/AIDS, are over-represented in the homeless population, and experience more barriers to housing and healthcare. In a study published in 2001, 40 percent of people receiving HIV care reported using an illegal drug other than marijuana in the past twelve months, and 12 percent were found to be “drug dependent.”⁶⁵ Thirty-one percent of people living with HIV/AIDS surveyed by AIDS Housing of Washington reported a disability related to substance use issues, and 30 percent reported being disabled by mental illness.⁶⁶ Studies of various segments of the population with mental illness have found HIV prevalence rates ranging from 4 percent to 18 percent, compared to an estimated prevalence of 1 percent in the general population.⁶⁷

Substance use and homelessness are also closely associated with incarceration and involvement with the criminal justice system. Particularly as people living with HIV/AIDS live longer lives, incarceration is a growing concern. **The prevalence of AIDS among inmates is five times higher than that in the general population.**⁶⁸ The Department of Justice found that female prisoners have a higher infection rate than male prisoners—3 percent versus 2 percent.⁶⁹ Having a criminal history can make a person ineligible for many types of housing and services, as well as limit employment opportunities.

Appropriate services and housing for people with histories of homelessness, mental illness, substance use, and/or incarceration can make a critical difference in improving health and quality of life. For example, housing stability is often necessary for a person living with HIV/AIDS to gain access to healthcare and adhere to treatment regimens. Individuals who have had histories of substance use, mental illness, and homelessness often need ongoing support services in order to maintain stable housing. People affected by these issues may need job skills training and ongoing support in order to obtain and maintain employment.

⁶⁴ Health Care for the Homeless Clinician’s Network, *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with HIV/AIDS*, 2003, p. 1. Available online: www.nhchc.org/Publications/HIVguide52703.pdf (Accessed: November 9, 2004).

⁶⁵ Eric G. Bing, M.D., Ph.D., M.P.H., et al., “Psychiatric Disorders and Drug Use Among Human Immunodeficiency Virus-Infected Adults in the United States,” *Archives of General Psychiatry*, vol. 58, August 2001, p. 721.

⁶⁶ AIDS Housing of Washington, *Fact Sheet: AIDS Housing Survey*, 2003. Available online: www.aidshousing.org/usr_doc/Survey_Factsheet_2003.pdf (Accessed: May 4, 2004).

⁶⁷ American Psychiatric Association, Office on HIV Psychiatry, *HIV and People with Severe Mental Illness*, Slide 9, July 2002. Available online: www.psych.org/aids/modules/illness/sld009.htm (Accessed: May 4, 2004).

⁶⁸ National Commission on Correctional Health Care, *The Health Status of Soon-to-be-Released Inmates: A Report to Congress*, p. 17. Available online: www.ncchc.org/stbr/Volume1/Chapter3.pdf (Accessed: March 20, 2003).

⁶⁹ Laura M. Maruschak, *HIV in Prisons, 2001*, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, January 2004, NCJ196023. Available online: www.ojp.usdoj.gov/bjs/pub/pdf/hivp01.pdf (Accessed March 24, 2004).

Homelessness and Related Issues in Central Ohio

Recognizing the difficulty in quantifying the number of individuals and families that are homeless in any part of the country, the Coalition on Homelessness and Housing in Ohio (COHHIO) estimates that approximately 180,000 Ohioans experience homelessness in a year and nearly 30,000 individuals are homeless on any given night.⁷⁰ With the exception of Franklin County, little to no data exists on the number of individuals and families who are without housing in each of the eight counties in Central Ohio.

One of the many challenges in counting the number of individuals who are homeless starts with the fundamental definition of homelessness. For example, the McKinney-Vento Homeless Assistance Act, administered by HUD, defines homelessness as:

an individual who lacks a fixed, regular, and adequate nighttime residence; and an individual who has a primary nighttime residence that is a (A) supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.⁷¹

Programs that receive federal funding under McKinney-Vento are limited to this definition, which is often interpreted with slight variations at the federal, state, and local levels. Individuals and families that are living in overcrowded housing, staying with family or friends, or are struggling to keep their current housing are not considered homeless under the federal standards. In many cases, individuals and families in rural areas who rely on informal networks or substandard shelter do not meet the federal criteria for homelessness, and therefore are not eligible for assistance.

In 1999, COHHIO sponsored a study of the attitudes and opinions on homelessness in Franklin County. Five hundred households were reached with a telephone survey. Among respondents, homelessness ranked second only to drugs and crime as a community concern, and as many respondents were concerned about homelessness and public schools (86 percent). More than half of respondents (55 percent) said they would support a proposal to build supportive housing for the homeless somewhere in their neighborhoods. More than three-fourths of respondents (82 percent) strongly agreed that more supportive housing with services was needed to help people who are homeless get off the streets.⁷²

Community Shelter Board, Franklin County

Columbus and Franklin County has taken a unique and nationally recognized approach to addressing homelessness, by combining planning, coordination, and funding roles in the Community Shelter Board (CSB) starting in 1986. In 2004, CSB administers multiple sources of funds from the City of Columbus, Franklin County, the U.S. Department of Housing and Urban

⁷⁰ Coalition on Homelessness and Housing in Ohio, *Number of Homeless Ohioans*. Available online: www.cohhio.org/resources/howmanyhomeless.html (Accessed: May 26, 2004).

⁷¹ U.S. Department of Housing and Urban Development, Community Planning and Development, McKinney-Vento Homeless Assistance Act, Title I – General Provisions, Section 103. Available online: www.hud.gov/offices/cpd/homeless/rulesandregs/laws/title1/sec11302.cfm (Accessed: May 28, 2004).

⁷² Coalition on Homelessness and Housing in Ohio, *Survey of Attitudes and Opinions on Homelessness*. Available online: www.cohhio.org/resources/homelessnesssurvey.html (Accessed: May 26, 2004).

Development, the United Way, and private fundraising. For fiscal year 2004-2005, CSB has contracts with 13 organizations totaling \$5.2 million. These organizations are Catholic Social Services, Inc., Community Housing Network, Friends of the Homeless, Gladden Community House, Homeless Families Foundation, Lutheran Social Services/Faith Mission, Maryhaven, National Church Residences, The Salvation Army, Southeast, Inc., Volunteers of America, YMCA of Columbus, and YWCA of Columbus.⁷³

Table 16 presents an overview of individuals and families served by CSB programs in 2000, the most recent year for which detailed data is available.

Table 16:
**Overview of Single Men, Single Women, and Families Served by the
Community Shelter Board in Franklin County (2000)**

	Single Men	Single Women	Families
Number served	3,869	931	740
Adults in families	NA	NA	989
Children in families	NA	NA	1,724
Average income	\$307	\$294	\$630
Percent working	27%	15%	33%
Average length of stay	43	42	71
Average served per night	456	107	144

Source: Community Shelter Board, *Community Shelter Board Statistics 1995-2000*.

In the fiscal year 2003-2004, CSB partner organizations sheltered a total of 6,910 people, including:

- 2,291 family members
- 3,516 single men
- 1,103 single women

The total number of shelter nights (meaning a person for a night) was 349,974. The Community Shelter Board reports that since 2000, the overall number of people sheltered has declined, but that there has been an 18 percent increase in single, unaccompanied women.

Rebuilding Lives

Franklin County's approach to addressing homelessness has been shaped substantially by the plan completed in October 1998 called *Rebuilding Lives: A New Strategy to House Homeless Men*. The report was the result of work by the Scioto Peninsula Relocation Task Force, a group of community leaders convened by the Community Shelter Board at the community's request to deal with the current issues at that time: downtown area development plans, men's shelter plans, and Franklinton neighborhood concerns.

⁷³ Community Shelter Board, Programs Funding Chart. Available online: www.csb.org/Programs/programs.htm (Accessed: September 24, 2004).

The plan found that the majority of men in the shelter system (85 percent) were there for only a short time, usually following a catastrophic event, while a minority (15 percent) had long-term needs and typically moved between shelters, drug or alcohol detoxification, hospitals, and the streets. The majority used 44 percent of shelter system services, while the minority with long-term needs used more than half. The plan called for a shift to permanent supportive housing as a means for linking housing and services, ending homelessness, and addressing needs in a more cost-effective way. Specifically, the plan recommended the development of a “housing stabilization system,” including the development of 800 additional units of supportive housing in Franklin County over a five-year period, a crisis stabilization service program, and continued basic emergency shelter, which would eventually be reduced to 300 total beds (from 450 in 1997) as housing became available. Other recommended components were affordable housing, street outreach, employment and training services, shelter diversion, provider support systems, and a centralized meal service.

One component of the Rebuilding Lives initiative is the Rebuilding Lives Funder Collaborative, which includes representatives of CSB, the Columbus Health Department, the City of Columbus, Franklin County, Columbus Foundation, United Way, CMHA, the ADAMH Board of Franklin County, Columbus Medical Association Foundation, Veterans Services Commission, Ohio Capital Corporation for Housing, and the Corporation for Supportive Housing. The Rebuilding Lives Funder Collaborative oversees and makes recommendations on funding actions and policy issues related to Rebuilding Lives.⁷⁴ In addition, several groups of homeless service providers meet on a regular basis to address program issues, seasonal facility demand, and to coordinate resources, outreach, referral and program linkages.

An innovative new component of Rebuilding Lives is the Rebuilding Lives PACT Team Initiative (RLPTI), which received funding from the Interagency Council on Homelessness (ICH) in FY 2003-2004. It is a new inter-agency collaborative between the Veterans Administration, Franklin County Department of Job and Family Services, Community Shelter Board, Columbus Metropolitan Housing Authority, non-profit housing and mental health providers, and the Franklin County Alcohol, Drug and Mental Health Board.⁷⁵

RLPTI focuses on chronically homeless single adult men and women with severe and persistent mental illness, who may also have co-occurring issues with substance use or a disability. The federal funding requirements restrict access to single, unaccompanied adults (i.e., without children). The program plans to serve 156 individuals, including 47 veterans, over the three-year period and develop 108 new supportive housing units (part of the 800 called for in the *Rebuilding Lives Plan*).

Partners in the initiative include: Community Housing Network; Columbus Neighborhood Health Centers, Inc.; Community Research Partners; Community Shelter Board (CSB); Franklin County Department of Job and Family Services; Southeast, Inc.; and Chalmers P. Wylie VA Outpatient Clinic. CSB sponsors are: The City of Columbus, Franklin County, and United Way of Central Ohio. The Rebuilding Lives Funder Collaborative is responsible for raising funds needed to implement the *Rebuilding Lives Plan*.⁷⁶

⁷⁴ Community Shelter Board, *Columbus and Franklin County 2004 Continuum of Care, Exhibit 1*, pp. 3-4.

⁷⁵ Ibid, p. 2.

⁷⁶ Community Shelter Board, *Rebuilding Lives PACT Team Initiative (RLPTI)*, May 2004.

Continuum of Care

In order to encourage the integration and coordination of community homeless assistance, HUD combined three major homeless assistance programs—Supportive Housing Program, Shelter Plus Care, and Section 8 Moderate Rehabilitation Program Single Room Occupancy Program (SRO)—under the Continuum of Care planning and allocation process.

The Continuum of Care system includes four components: outreach to and needs assessment of individuals or families who are homeless, emergency shelters with supportive services, transitional housing with support services, and permanent independent or supportive housing to meet long-term needs. The establishment of a Continuum of Care system involves a community-wide or region-wide process involving nonprofit organizations (including those representing persons with AIDS and other disabilities), government agencies, other homeless providers, housing developers and service providers, private foundations, neighborhood groups, and homeless or formerly homeless individuals.

Columbus and Franklin County

For Columbus and Franklin County, the Community Shelter Board is the lead agency. CSB is responsible for coordinating and submitting the community's annual application to HUD for federal homeless assistance funds. Additionally, CSB participates in and facilitates research, planning, discussion, and policy development among community leaders, government representatives, service providers, homeless consumers, and others concerned with community-wide solutions to homelessness.

Franklin County's Continuum of Care, meaning its array of housing and services for people experiencing homelessness, includes the following housing resources:

- 980 emergency shelter beds, including 440 for people in families with children and 540 for individual adults
- 645 transitional housing beds, including 343 for people in families with children and 302 for individual adults
- 1,393 beds in permanent supportive housing, including up to 460 beds in 133 units for families with children and 933 units for individual adults
- 125 units of permanent supportive housing in development, including 60 through the PACT team (described above), 25 in Community Housing Network's Briggsdale development, and 40 in Maryhaven/National Church Residence's Chantry Place.

Franklin County's 2004 *Continuum of Care Exhibit 1* reported on the following achievements for the previous year:

- 450 single adults obtained permanent supportive housing through a Rebuilding Lives program.
- National Church Residents opened the Commons at Grant in July 2003, a 100-unit supportive and affordable housing building including fifty apartments for the Rebuilding Lives eligible chronically homeless men and women.
- Community Housing Network opened East Fifth Avenue Apartments in February 2004, a 32-unit supportive housing project for Rebuilding Lives eligible chronically homeless women with mental health and/or substance abuse issues.

- Columbus and Franklin County’s Rebuilding Lives PACT Team Initiative (RLPTI) was one of 11 projects nationwide to receive funding from the Interagency Council on Homelessness’ Collaborative Initiative to End Homelessness (described above).
- The length of time for appropriate individuals to receive Social Security benefits was decreased from 6 months to 3 weeks through a collaborative effort.
- Amethyst, Inc. added 4 units of transitional supportive housing for chronically homeless families with alcohol or other drug problems.
- A new statewide initiative that helps released prisoners avoid homelessness assisted in the development of 9 new units of independent housing in Franklin County called “Build the Bridge” for discharged offenders.
- Through the Franklin County Special Docket Advisory Committee, new mental health and drug courts have been established to provide alternatives to persons with mental illness and/or substance abuse problems who are being adjudicated, including housing related assistance, as part of their alternative sentencing.

The *2004 Continuum of Care Exhibit 1* also identified the following remaining obstacles to ending chronic homelessness in Franklin County:

- Lack of affordable housing. A 1997 analysis of the Central Ohio rental housing market found a deficit of 21,892 rental units affordable to households at or below 30% of the area median income, or one affordable housing unit for every two households (Replacement Housing Collaborative, *Providing Affordable Rental Housing in Central Ohio*, 1997).
- Shortage of jobs that pay a living wage. The 2003 National Low Income Housing Coalition *Out of Reach* report indicated that a household would need an annual income of \$25,600, or 239% of the federal minimum wage to afford a two-bedroom apartment at Fair Market Rent in Franklin County.
- Difficulty accessing mainstream benefits and resources. According to a March 2003 analysis of tenants in Rebuilding Lives permanent supportive housing, at admission to housing only 15 percent of tenants were receiving SSI/SSDI and just 2 percent of tenants were receiving VA benefits.⁷⁷
- Need for improved systems integration between major mainstream and homeless housing and service providers. Local research indicates that access to mainstream programs and resources by chronically homeless persons is limited. Previous community studies, including one conducted by the Scioto Peninsula Relocation Task Force, indicate that a majority of chronically homeless persons who needed mental health and/or substance abuse treatment did not receive such services.
- Insufficient supply of permanent supportive housing. The Rebuilding Lives plan documents the need for 800 units of supportive housing; currently 450 exist.
- Challenges related to locating housing throughout the county, such as “not in my backyard” (NIMBY) attitudes and local resistance.
- Limited connections between affordable rental housing, public transportation, and major employment locations. Much of the regional job growth is occurring where there are deficits of affordable housing.

⁷⁷ Community Shelter Board, *Analysis of Characteristics of Rebuilding Lives Supportive Housing Tenants*, March 2003.

Particularly relevant to people living with HIV/AIDS is the Continuum of Care goal for this year to improve access to and coordination with health care programs and reduce referrals and discharge to shelters from hospital facilities. There are also goals related to improving coordination with substance use treatment and corrections discharge, both systems likely to involve some people living with HIV/AIDS. There are other goals related to preventing homelessness and providing permanent housing for people with disabilities.

Fairfield County

The Fairfield County Housing Coalition was recently reinvigorated with leadership from the Fairfield Metropolitan Housing Authority in order to improve the coordination of housing and services in Fairfield County. Fairfield County has housing and service providers working in outreach, emergency shelter, transitional shelter, supportive services, permanent housing, and homelessness prevention. However, gaps identified include affordable permanent housing, all types of housing for special needs populations and the hard to serve, and lack of transitional housing and services for domestic violence survivors, the elderly, and single parent families.⁷⁸

The City of Lancaster's 2004 *Continuum of Care* Gaps Analysis estimated the population of homeless individuals with HIV/AIDS at 3 and the number of people in families with children at 2. Because the inventory of resources for this population was 0, the total gap was 5 units, assigned a "low" relative priority.⁷⁹ In addition, a "high" level need was identified for mental health services, to serve 35 people.⁸⁰

Licking County

Licking County's Continuum of Care, meaning those housing resources for people experiencing homelessness, includes emergency, transitional, and permanent supportive housing. **Table 17**, on the following page, presents the programs, units, and beds by type of housing.

⁷⁸ Fairfield County Housing Coalition, *Homeless Continuum of Care Plan, 2004*, p. 11.

⁷⁹ City of Lancaster Community Development Department, *FY 2003 – FY 2007 Consolidated Housing and Community Development Plan: City of Lancaster, Ohio*, pp. 50-52.

⁸⁰ *Ibid*, p. 54.

Table 17:
Licking County Continuum of Care, Bed Count by Housing Type

Provider	Family Beds	Individual Beds	Total Beds	Overflow/ Voucher
Emergency Shelter	22	22	44	103
The Salvation Army, emergency shelter	6	12	18	3
The Woodlands, New Beginnings	16	10	26	—
Local churches, vouchers	—	—	—	100
Transitional Housing	85	27	112	—
Licking County Coalition for Housing	85	20	105	—
Moundbuilders	—	7	7	—
Permanent Supportive Housing	9	4	52	—
Licking Metropolitan Housing Authority, scattered-site Shelter Plus Care	9	41	50	—
Main Place	—	2	2	—

Source: Licking County Housing Initiative, Continuum of Care 2004, Exhibit 1.

In the *2004 Continuum of Care Exhibit 1*, Licking County reported that a new collaborative called Licking County Housing Initiative (LCHI) had been formed to take the lead on Continuum of Care activities. LCHI reported on the follow achievements of the preceding year:

1. Conducted several meetings (including Discharge Planning Policy reviews) to identify “sources” for chronically homeless populations. Several agencies (Licking County Coalition for Housing, Moundbuilder’s Guidance Center, The Main Place, and St. Vincent de Paul Center) ran preliminary analyses of their respective client bases to identify past and current chronically homeless.
2. Increased community awareness of the issue.
3. HOPWA funds for long-term rental assistance helped 2 chronically homeless adults.
4. Moundbuilders Guidance Center and LMHA leased up all Shelter Plus Care vouchers for 45 seriously mentally ill and SMI/SA clients.
5. Conducted first-ever street count of unsheltered homeless on June 21, 2004, identifying chronically homeless in the process.
6. Licking County Coalition for Housing undertaking pilot program for Ohio Balance of State Homeless Management Information Strategies (HMIS) – beginning steps towards establishing an infrastructure identifying and characterizing chronically homeless.
7. While local agencies worked to secure new funding for homelessness prevention services through a special Homelessness Request for Proposals (RFP) issued by the Ohio Department of Development, both agencies (Licking County Coalition for Housing and The Salvation Army) were unsuccessful in their efforts, though The Salvation Army did receive some funding to increase security in its emergency shelter. Licking County Coalition for Housing was successful in securing a small grant from the Licking County United Way to provide budget counseling to single adults receiving emergency rent or mortgage funds, in an effort to prevent homelessness in the future.

The *Licking County 2004 Continuum of Care Exhibit 1* also reported the following remaining obstacles to ending chronic homelessness:

1. Still need as close to an accurate picture of the number of chronically homeless (per HUD definition), their special characteristics (male, female, veterans, serious mental illness, substance use issues, etc.) and their specific needs in order to plan for and fund housing and services necessary to end homelessness.
2. Few housing and/or employment options are available locally for those chronically homeless repeatedly moving through the criminal justice system, particularly those with violent or sexual offender histories.
3. Few options for permanent housing are currently available for chronically homeless individuals, and supportive services funding is currently stretched.

On June 21, 2004, Licking County conducted a point-in-time count of homeless men, women, and children, and found a total of 97 people. This included 11 people living outdoors and 86 in shelters.

Dedicated Resources

Key findings related to dedicated HIV/AIDS housing and services resources in Central Ohio:

- In FY 2004, the eight-county Columbus metropolitan statistical area (MSA) received an allocation of \$584,000 in Housing Opportunities for Persons with AIDS (HOPWA) funds, a 3.4 percent increase from FY 2003.
- In FY 2004, the Ryan White Title II Columbus Consortia, which includes 7 of the 8 counties in the HOPWA region, received \$421,961. However, the Consortia recently eliminated housing as a funding category.
- In FY 2003, HOPWA funds assisted 703 people living with HIV/AIDS and their families, including 351 people who received direct housing assistance.
- HIV/AIDS-dedicated housing opportunities include transitional housing at Pater Noster House, 15 sponsor-based Shelter Plus Care vouchers, 71 tenant-based Shelter Plus Care vouchers, 19 Section 8 vouchers, long-term rental assistance for approximately 24 households, and short-term rental assistance.

Introduction to HIV/AIDS-Dedicated Resources Nationally

No specific funding dedicated to AIDS housing existed prior to 1990. Local corporations, foundations, churches and faith-based communities, generous individuals, local governments, and significant volunteer labor drove the creation of early housing projects. Much of the development and provision of AIDS housing has since shifted to mainstream affordable and supportive housing providers, as well as public housing authorities and local governments.

The federal government has established two programs that now provide funding dedicated to serving people living with HIV/AIDS—the Housing Opportunities for Persons with AIDS (HOPWA) program administered by the U.S. Department of Housing and Urban Development (HUD) and the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act program administered by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). Both can be used to fund housing and related support services, although the eligible activities differ between programs. Other federal programs also provide funding for housing low-income people, regardless of HIV status, and are described in *Appendix 6*.

Since 1992, the federal government has allocated more than \$1.7 billion for the HOPWA program to support community efforts to create and operate HIV/AIDS housing and provide related services.⁸¹ In the first year of the program, 27 Eligible Metropolitan Statistical Areas (EMSAs) and 11 eligible states received formula allocations of \$42.9 million. By FY 2004, \$292

⁸¹ U.S. Department of Housing and Urban Development, Housing Opportunities for Persons with AIDS (HOPWA) web site: www.hud.gov/offices/cpd/aidshousing/programs/index.cfm (Accessed: June 7, 2004).

million in HOPWA funds was available for formula allocations and competitive awards. A total of 117 jurisdictions—79 metropolitan areas and 39 states—received formula allocations in 2004.⁸²

The Ryan White CARE Act was first authorized in 1990 to address the full range of unmet health needs of people living with HIV/AIDS by funding primary healthcare and related support services, and increasing access to care for underserved populations. In fiscal year 2004, Congress appropriated \$2 billion for use under the CARE Act, which serves more than 500,000 individuals each year.⁸³

Many AIDS housing and service providers rely on funding from HOPWA and the Ryan White CARE Act to support their programs. The first phase of a Vanderbilt University AIDS housing cost study determined that 66 percent of the nation's AIDS housing providers received HOPWA funding in 1999 for AIDS housing and services, while 55 percent received CARE Act funds.⁸⁴ These two funding sources are extremely important to agencies providing AIDS housing and are often used in tandem—44 percent of AIDS housing providers indicated that they receive funding from both HOPWA and the Ryan White CARE Act.⁸⁵

Housing Opportunities for Persons with AIDS (HOPWA)

Housing Opportunities for Persons with AIDS (HOPWA), a program of HUD, provides funding for housing and housing-related services for people living with HIV/AIDS and their families. EMSAs and states receive direct allocations of HOPWA funding when 1,500 cumulative cases of AIDS are diagnosed in a HUD-determined geographic region.

HOPWA funds are awarded to state and local governments to design long-term, comprehensive strategies for meeting the housing needs of people living with HIV/AIDS and their families. Participating jurisdictions have the flexibility to provide a range of housing assistance, including:

- Short-term rent, mortgage, and utility payments to prevent homelessness
- Project- or tenant-based rental assistance
- Housing operations
- Housing development
- Housing information services

Ninety percent of HOPWA funds are awarded through formula grants, and the remaining 10 percent are awarded through a competitive grant program. HUD awards 75 percent of HOPWA formula grant funds to eligible states and qualifying cities. The remaining 25 percent of funds are allocated

⁸² U.S. Department of Housing and Urban Development, Office of HIV/AIDS Housing, *Housing Opportunities for Persons with AIDS (HOPWA) Fact Sheet*. Available online: www.hud.gov/offices/cpd/aidshousing/programs/factsheet.pdf (Accessed: March 31, 2004).

⁸³ U.S. Department of Health and Human Services, Health Resources and Services Administration, *HRSA FY 2004 Budget*. Available online: newsroom.hrsa.gov/NewsBriefs/2004/FY04-HRSA-Budget.htm (Accessed: March 31, 2004).

⁸⁴ Debra Rog and Sidra Goldwater, *Preliminary Results on the Landscape of AIDS Housing: A Report from the National AIDS Housing Cost Study*, Vanderbilt University, Washington, DC, 1999, p. 9.

⁸⁵ *Ibid.*

among metropolitan areas that have had a higher than average per capita incidence of AIDS. HOPWA grantees may carry out eligible programs themselves, deliver them through any of their administrative entities, select or competitively solicit project sponsors, and/or contract with service providers.

HOPWA Funding in Central Ohio

The Columbus Health Department (CHD) is the HOPWA grantee for an EMSA covering eight counties: Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, and Union. Morrow County was added to the EMSA in 2003. The Columbus EMSA HOPWA Program has funded two project sponsors to serve people living with HIV/AIDS in Central Ohio: Columbus AIDS Task Force (CATF) and the Licking County Coalition for Housing (LCCH). The Program also provides support for the housing operations of Pater Noster House via the agency's formal affiliation with CATF.

Table 18 shows the HOPWA allocations, percent change, and new AIDS cases for the eight counties included in the Columbus EMSA for fiscal years 2001 through 2004.

Table 18:
**Columbus EMSA HOPWA Allocations, Percent Change,
and New AIDS Cases, Fiscal Years 2001 – 2004**

	FY2001	FY2002	FY2003	FY2004
HOPWA Allocation	\$508,000	\$543,000	\$565,000	\$584,000
Percent Change	NA	6.9%	4.1%	3.4%
New AIDS Cases	102	102	126	133

Source: U.S. Department of Housing and Urban Development, Office of HIV/AIDS Housing.

In fiscal year 2003, HOPWA funds were used for long-term rental assistance, short-term rental assistance, rent/mortgage/utility assistance, housing operations, housing information services, supportive housing services, housing resource identification, and administration for project sponsors and grantees. Last year 703 individuals received some form of assistance from HOPWA funds, including housing information. Among that group, 214 individuals resided in unduplicated housing units that were supported by the HOPWA Program. Direct housing assistance represented 57 percent of the funds expended by the project sponsors. The average unit cost was \$1,030 per year.⁸⁶

Overall, 351 persons received some form of direct housing assistance in fiscal year 2003. Of those, 245 had incomes less than 30 percent of the Median Family Income (MFI) for the region (\$63,800 for a family of four and \$44,660 for an individual), 25 percent were between 31 and 50 percent of MFI, and 19 percent were between 51 and 80 percent of MFI. Twenty-seven percent were female-headed households. Fifty-three percent were White/Caucasian, 44 percent were African American/Black, and 3 percent were Hispanic/Latino.⁸⁷

⁸⁶ Columbus Health Department, Housing Opportunities for Persons with AIDS Program, *FY2003 HOPWA Formula Grantee Annual Report*, March 2003.

⁸⁷ Columbus Health Department, Housing Opportunities for Persons with AIDS Program, *Consolidated Annual Performance and Evaluation Report*, 2003.

Ryan White CARE Act

The Ryan White CARE Act represents the largest dollar investment made by the federal government specifically for the provision of services for people living with HIV/AIDS. As part of that goal, the CARE Act allows housing-related assistance as eligible expenditures under Titles I, II, and IV. Two types of eligible housing-related expenditures are typically covered:

- Housing referral services, such as assessment, search, placement, and advocacy services
- Short-term emergency housing, such as short-term rental assistance, emergency shelter stays, short-term residential treatment, short-term assisted living, and temporary/transitional housing programs

Ryan White CARE Act Funding in Central Ohio

Ryan White CARE Act Title I funds are awarded to metropolitan areas of over 500,000 people with at least 2,000 AIDS cases in the preceding five years. Columbus is not eligible for Title I funding. The only city in Ohio receiving Title I funds is Cleveland, which became eligible in 1996.⁸⁸

Ryan White CARE Act Title II program funds are awarded to all states based on a formula. Title II funds are for services for people living with HIV/AIDS and for state AIDS Drug Assistance Programs (ADAP). Ohio's first year of Ryan White Title II funding was 1991, when a total of \$1,117,823 was received. The Title II award has increased every year since then, to a total of \$16,762,266 in fiscal year 2004.⁸⁹

In Ohio, Ryan White Title II has decided not to fund short-term residential treatment or short-term assisted living, although these are permissible under the federal guidelines. In addition, the Columbus Consortia recently eliminated housing as an allowable category, in an effort to better coordinate with HOPWA.

Table 19 on the following page presents the amount of Title II funding and associated state funding for the entire state in the fiscal years 2003 and 2004.

⁸⁸ Community Planning Forum for Ryan White Title II Funding for Ryan White Year 14 (4-1-04 to 3-31-05), presented by: Richard Aleshire, Ryan White Title II Program Administrator, Ohio Department of Health, AIDS Client Resources Section II, Powerpoint presentation.

⁸⁹ Ibid.

Table 19:
Ohio Ryan White Title II Program Funding For Ryan White Year 14 (State Fiscal Year 2004/05) and Ryan White Year 13 (State Fiscal Year 2003/04)

	FY04/05			FY03/04		
	Total Funds	Federal Ryan White	State of Ohio	Total Funds	Federal Ryan White	State of Ohio
Consortia						
Emergency Financial Assistance	2,023,500	185,625	1,837,875	1,036,553	1,036,553	***
Consortia P & E	298,725	298,725	—	284,500	284,500	—
Statewide Needs Assessment Activity	63,000	63,000	—	75,000	75,000	—
Case Management	2,665,434	2,665,434	—	2,659,184	2,659,184	—
Home Health	58,575	58,575	—	58,575	58,575	—
HIV/HIPP						
Insurance Continuation Program	1,421,625	1,395,000	26,625	1,224,750	1,065,000	159,750
Medicaid Spend-Down	3,727,500	—	3,727,500	2,509,673	—	2,509,673
HIV Drug Program*	**8,993,048	8,985,048	8,000	11,283,166	8,117,886	3,165,280
Other Programming						
Emerging Communities	250,000	250,000	—	125,155	125,155	—
Minority AIDS Initiative	75,000	75,000	—	72,298	72,298	—
Ohio AIDS Coalition	156,000	156,000	—	97,500	97,500	—
Program Operations						
Meetings	34,000	34,000	—	34,000	34,000	—
Brochures, supplies	15,218	15,218	—	15,218	15,218	—
AIDS Awareness Week	24,000	24,000	—	24,000	24,000	—
Total Award	22,400,000	16,800,000	5,600,000	21,566,873	15,732,171	5,834,702

* HIV Drug Program total includes specific funds only for OHDAP.

** The total is short \$1,000,000 for dispensing of drugs and \$2,538,452 for purchasing of drugs.

*** There is a shortfall of \$986,947 between the total cost and the federal funds available.

Source: Community Planning Forum for Ryan White Title II Funding for Ryan White Year 14 (4-1-04 to 3-31-05), presented by: Richard Aleshire, Ryan White Title II Program Administrator, Ohio Department of Health, AIDS Client Resources Section II, Powerpoint presentation.

The Title II program has established local consortia across the state that administer the funds locally. In fiscal year 2004, a total of \$1,900,000 was divided between the local AIDS consortia across the state. The Columbus Consortium, which includes 7 of the 8 counties in HOPWA's Columbus MSA,⁹⁰ received 22 percent of the funds, or \$421,961, proportional with the 21 percent of statewide cases diagnosed in Columbus.⁹¹ The top service category priorities identified by the Columbus Consortium for fiscal year 2004 were food, housing, and transportation.⁹²

Dedicated HIV/AIDS Housing in Central Ohio

The Columbus AIDS Task Force (CATF) operates four different housing assistance programs: Shelter Plus Care, project based Section 8, HOPWA short-term rental assistance, and HOPWA long-term rental assistance:

- The Shelter Plus Care program is the largest, serving people who qualify under the federal Shelter Plus Care regulations, including meeting HUD's definition of homeless. There are 15 sponsor-based Shelter Plus Care units and 71 tenant-based rental assistance Shelter Plus Care vouchers. The Columbus Metropolitan Housing Authority administers the Shelter Plus Care.
- There are 19 project-based Section 8 one-bedroom apartments on West Broad Street. Once tenants fulfill a one-year lease, they become eligible for a portable Section 8 voucher that allows them to move to an apartment of their choosing. The Columbus Metropolitan Housing Authority administers the Section 8 vouchers.
- CATF administers short-term rental assistance funded by HOPWA. The total number of consumers served is not limited. This assistance is only used to house consumers who are expected to have permanent subsidy within 6 months.
- CATF's HOPWA-funded long-term rental assistance program has 24 households at a time in the past, and this number is expanding as the budget allows. Participants in this program must have some form of disability income.

The Pater Noster House is the oldest HIV/AIDS housing program in the Columbus metropolitan area. Since 1985, it has operated as a congregate living facility for 5 people living with HIV/AIDS, relying on a mixture of paid staff and volunteers. Recently, Pater Noster House has rehabilitated the house, and shifted its services focus to a more transitional, short-term stabilization approach.

The Licking County Coalition for Housing (LCCH) has operated a HOPWA program in Licking County since 2000. Currently, LCCH can provide long-term rental assistance for 10 households at a time and short-term rental assistance or rent and utilities payments for 24 households. Participants are required to apply for Section 8, to participate in budgeting training, and to comply with a drug and alcohol treatment plan, as appropriate.

⁹⁰ Ryan White Title II's Columbus Consortium includes all of the counties in the HOPWA MSA with the exception of Morrow County.

⁹¹ Ohio Department of Health, Division of Family & Community Health Services, AIDS Client Resources Section. *Ryan White Emergency CARE Act Title II: Ohio's Comprehensive Plan for HIV/AIDS Services*, April 2004, p. 20.

⁹² *Ibid*, p. 13.

Table 20 presents information about existing HIV/AIDS-dedicated housing resources in Central Ohio. Short-term resources are presented in terms of the number of households who can be served annually, while long-term resources are given in terms of units or vouchers. Currently, Central Ohio's HIV/AIDS housing system can provide short-term assistance for approximately 209 people annually and long-term assistance for 139 households. The number of households receiving short-term assistance may fluctuate based on the amount of funding available annually, and the amount of and length of time assistance is need.

Table 20:
**HIV/AIDS Dedicated Housing Resources
in Central Ohio**

Type of Housing Assistance	Short-Term: Households Assisted Annually	Long-Term: Vouchers or Units
Permanent Housing: Shelter Plus Care (sponsor-based or tenant-based)	—	86
Permanent Housing: Project-based Section 8	—	19
Short-term rental assistance (CATF and LCCH) ⁹³	195	—
Long-term rental assistance (CATF) ⁹⁴	—	24
Long-term rental assistance (LCCH) ⁹⁵	—	10
Transitional housing: Pater Noster House ⁹⁶	14	—
Total	209	139

⁹³ Determined by funding available. Includes the unduplicated number served during FY2003, according to the HOPWA APR.

⁹⁴ Determined by funding available.

⁹⁵ Determined by funding available.

⁹⁶ Pater Noster House can serve five people at a time in its current configuration. The number above is an unduplicated count of the people who were served between February 2004, when the management and programming changed, to October 2004. Personal communication with AIDS Housing of Washington, October 19, 2004. This number is likely to be larger for the full year, and will vary in the future depending on the length of stay of each participant. On October 19, 2004, there were 21 people on the waiting list.

Findings from Consumer Surveys

A total of 272 people living with HIV/AIDS in Central Ohio were surveyed about housing and services experiences, needs, and preferences.

- The majority (two-thirds) lived in an apartment or house they rented, and nearly half lived alone.
- 63 percent had incomes at or below the poverty level.
- One-third paid more than half of their income towards housing costs, meeting HUD's definition of a "severe housing cost burden."
- Almost half had been homeless at some point, including 17 percent who had spent at least one night in a shelter in the previous 3 years.

Overview of the Survey Process and Methodology

Consumer input is a vital component of the HIV/AIDS housing needs assessment process. Information and feedback from people living with HIV/AIDS in the eight-county Columbus EMSA was gathered through focus group meetings and a consumer housing survey. The survey was available in English and Spanish. Respondents received a \$10 grocery voucher for completing the survey. The Columbus AIDS Task Force coordinated the survey process, and the following organizations worked to distribute the survey:

- Columbus AIDS Task Force
- Columbus Health Department
- Licking County AIDS Task Force, a program of the Woodlands, Inc.
- Licking County Coalition on Housing
- Marion County AIDS Task Force
- Southeast, Inc.

The primary purpose of the survey was to gather quantitative data on housing situations, needs, and preferences of people living with HIV/AIDS in the Columbus EMSA. The organizations above surveyed people living with HIV/AIDS who were connected to services, using a method called a convenience sample. The results are just one of several sources of information gathered in order to describe the housing and service gaps and opportunities in the EMSA. They are offered as one point of reference in the overall planning process. Individuals were asked questions pertaining to personal demographics; current housing situation, income, and benefits; housing history and preferences; and unmet support service needs. Survey results were compiled and analyzed by AIDS Housing of Washington staff, and a summary of the findings is presented below. A complete copy of the survey tool is in *Appendix 3* and all response data can be found in *Appendix 4*.

Presentation of Data

The majority of information is characterized by frequency or the number of times that respondents gave a response. In presenting subsections of information, the percentage of the actual number of responses to the question was used. Some of the results have been cross-tabulated to determine possible differences between respondent cohorts, such as between men and women.

A total of 272 completed surveys were analyzed. Of the 272 respondents, some individuals did not respond to one or more question(s). Because the number of non-responses varies by question, unless otherwise noted, all percentages listed through this document represent the entire survey sample. This presentation of the analysis is a more stable basis for comparison of responses to survey questions.

Reliability of Data

The survey pool represents approximately 11 percent of the 2,512 individuals known to be living with HIV and AIDS in the counties of Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, and Union.⁹⁷

The survey instrument included both “African American” and “Black, not African American” as options on a list of racial and ethnic categories. This option was designed for people of African descent who did not identify as African American, such as African and Caribbean immigrants. Respondents chose a category based on their self-identification. For this reason, survey data is not exactly comparable to other sources of data that use only one demographic category for African American/Black.

Compared to the demographic profile of those known to be living with HIV and AIDS in the eight-county EMSA, the survey sample proportionately included:

- Slightly more African Americans and Blacks and fewer Whites/Caucasians
- Slightly more females and fewer males
- More people living with HIV and fewer living with AIDS

These demographic differences are not the result of targeted outreach; the differences merely reflect the demographics of those who returned completed surveys. In general, however, the demographics of the survey respondents are very close to the known characteristics of people living with HIV/AIDS in the area.

Table 21 on the following page compares selected demographic characteristics of people living with HIV/AIDS in the Columbus EMSA to those of the survey respondents.

⁹⁷ Four respondents reported a county of residence outside of the Columbus EMSA: one each in Hancock, Highland, Knox, and Warren. These respondents were included because they must be accessing some type of HIV/AIDS services within the Columbus EMSA to have completed the survey.

Table 21:
**People Living with HIV and AIDS as of December 31, 2002 and Survey Respondents
 in the Columbus EMSA, by Race/Ethnicity, Gender, HIV Status, and County**

Demographics	People Living with HIV and AIDS as of December 31, 2002		Survey Respondents	
	Number	Percent	Number	Percent
<u>Race/Ethnicity</u>				
White/Caucasian	1,537	61%	137	50%
African American	785	31%	81	30%
Black, not African American	not reported	not reported	25	9%
Hispanic/Latino	66	3%	11	4%
Asian/Pacific Islander	13	1%	2	1%
American Indian/Alaska Native	8	<1%	3	1%
Other	not reported	not reported	13	5%
Unknown	103	4%	—	—
Total	2,512	100%	272	100%
<u>Gender</u>				
Male	1,988	79%	208	77%
Female	421	17%	59	22%
Transgender	not reported	not reported	5	2%
Unknown	103	4%	—	—
Total	2,512	100%	272	100%
<u>HIV Status</u>				
Living with HIV	1,550	62%	184	68%
Living with AIDS	962	38%	69	25%
Unknown	—	—	19	7%
Total	2,512	100%	272	100%
<u>County of Residence</u>				
Delaware	44	2%	5	2%
Fairfield	51	2%	6	2%
Franklin	2290	91%	236	87%
Licking	71	3%	12	4%
Madison	18	1%	3	1%
Morrow	4	<1%	2	1%
Pickaway	19	1%	4	2%
Union	15	1%	—	—
Total	2,512	100%	*272	100%

Source: Ohio Department of Health, HIV/AIDS Surveillance, email correspondence with AHW staff, June 2, 2004.

Note: Percentages may add up to more than 100 due to rounding.

* Four respondents reported a county of residence outside of the Columbus EMSA: one each in Hancock, Highland, Knox, and Warren. These respondents were included because they must be accessing some type of HIV/AIDS services within the Columbus EMSA in order to have completed the survey.

Survey Findings

The majority of respondents lived alone or with a partner in an apartment they rented.

Nearly half of respondents were living alone, and 20 percent were living with their partner. The next most frequently reported household composition was living with friends or roommates (13 percent). A total of 12 percent reported having children in their household, including more than a third of women. Men lived alone twice as often as women.

A two-thirds majority live in an apartment they rent. The second most common type of housing was a home the respondent owned (11 percent), and the third was a time-limited stay with friends or family (6 percent).

About two-thirds indicated that they do not intend to move within the next 12 months, and slightly more than half report their satisfaction with their current situation as either a 4 or a 5 on a scale of 1 to 5, with 5 meaning “very satisfied.”

The majority of respondents reported at least one source of income and a median income of \$580 per month. One-quarter supported someone else with their income.

The most commonly reported source of income was Social Security Disability Income (SSDI), with 28 percent of respondents. Income from work followed closely, with 27 percent of total respondents. Nineteen percent reported receiving Supplement Security Income (SSI). One-third of respondents reported receiving Food Stamps. Fifteen percent reported having no income or benefits.

The median monthly income reported was \$580, meaning that half of respondents had more than \$580 per month in income, and half had less. Viewed another way, just 6 percent of respondents could afford a one-bedroom apartment renting for the HUD-established Fair Market Rent in 2004. This is based on HUD’s definition of affordability as paying 30 percent of gross income for rent, and an apartment costing \$499 per month.⁹⁸ Even if respondents were to pay half of their gross income toward housing costs, just 21 percent could pay the Fair Market Rent.

While the majority support only themselves with their income, 10 percent support their partner and 10 percent support a minor child or children.

Most respondents were paying more for housing than is considered “affordable.” One-third had a “severe housing cost burden,” and many were behind on utility and rent or mortgage payments at the time of the survey.

The U.S. Department of Housing and Urban Development considers someone to have a “housing cost burden” if they pay more than 30% of their income toward housing costs, including rent or mortgage and utilities. More than half of survey respondents were paying more than 30 percent of their monthly income toward housing costs. Almost one-third were paying more than half of their

⁹⁸ \$499 is the HUD-established 2004 Fair Market Rent for Delaware, Fairfield, Franklin, Licking, Madison, and Pickaway Counties. The Fair Market Rent for a one-bedroom apartment in Union County is \$410 and in Morrow it is \$353.

income for housing costs, which is considered to be a “severe housing cost burden.” The median housing cost reported was \$350 per month. **Table 22** presents the median monthly housing cost and median percentage of income toward housing costs.

Table 22:
**Median Monthly Housing Costs and Monthly Housing Costs
as a Percentage of Income**

Selected Characteristics of Respondents	Median Monthly Housing Costs	Monthly Housing Costs as a Percentage of Income
Women	\$300	52%
Men	\$373	47%
African Americans	\$558	43%
Black, not African American	\$193	32%
White/Caucasian	\$455	50%
Franklin County	\$330	46%
All other counties	\$507	54%
All Respondents	\$350	47%

More than one-third (38 percent) reported being behind on their utility payments, and 18 percent were behind on their rent or mortgage payment.

Respondents were asked about the potential impact of a \$50 increase in monthly rent or utilities. Only one quarter would be able to pay the increase, responding either that they would pay (15 percent) or that it would not impact them (12 percent). The most common responses included apply for assistance (29 percent), move (23 percent), or borrow money (20 percent).

When asked whether they had experienced financial barriers to accessing housing, more than one in five reported difficulty due to their bad credit. The other commonly reported factors were not having enough money (18 percent) and not being able to find housing they could afford (18 percent).

Many received ongoing or short-term housing assistance. However, many also identified a need for housing assistance. Housing quality problems were fairly common.

One-third received ongoing housing assistance, and one-third had received short-term assistance within the past 12 months. The most common type of ongoing housing assistance received was Section 8 vouchers, reported by 15 percent of respondents, followed by Shelter Plus Care (10 percent). Of the one-third who had received short-term assistance within the prior year, most (27 percent) had gotten assistance from an HIV/AIDS service organization.

About one-third of Franklin County residents reported receiving housing assistance, compared to 19 percent of residents of other counties. Women were slightly more likely to report receiving ongoing housing assistance, at 41 percent versus 31 percent for men. Women were somewhat more likely to

have Shelter Plus Care or be in public housing, while men were more likely to receive HOPWA. Finally, African American respondents reported receiving housing assistance at twice the rate of Black, not African American respondents and White/Caucasian respondents.

When asked to respond to a list of housing services, the most frequently selected type was financial assistance with housing, with 38 percent of respondents.⁹⁹ An equal number selected “a person to help you with your housing if your situation changes.”

Many respondents experience housing quality problems and neighborhood safety issues. More than one-third (37 percent) reported one or more selected physical quality problems,¹⁰⁰ including water leaks (15 percent), cracks or holes in the walls (12 percent), and mold (11 percent). Forty-two percent of respondents reported one of selected neighborhood quality or safety issues, including noise (29 percent), illegal drug activity (25 percent), and street harassment or many people hanging out on the street (19 percent).

Nearly half of all respondents had been homeless at some point.

Almost half of all respondents reported having been homeless at some point in the past. Homelessness in the survey was defined as “without a regular place to stay for the night.” A greater proportion of women (58 percent) than men (44 percent) reported prior homelessness. More African American (59 percent) and Black, not African American (48 percent) reported prior homelessness than white respondents (40 percent).

In the past three years, 17 percent of respondents had spent at least one night in a shelter, 18 percent had slept outdoors, and one-third had spent at least one night with family or friends because they did not have a place of their own. Common reasons leading up to homelessness were not having any income (17 percent) and being evicted (16 percent).

Three percent of respondents (7) appear to meet HUD’s definition for chronic homelessness. HUD defines the chronically homeless as a single unaccompanied adult, with a disabling condition, who has been homeless at least a year, or homeless 4 or more times in the past 3 years.¹⁰¹

Many respondents experienced behavioral health issues in addition to their HIV/AIDS.

When asked whether they had any challenges that made their day-to-day lives difficult, 15 percent reported a mental illness, 6 percent reported difficulty with drugs, and 4 percent reported difficulty with alcohol. Two percent reported co-occurring mental illness and substance use issues.

⁹⁹ Survey respondents were asked whether they needed the following housing services: lists of apartments or houses that they might be able to afford, a staff member to take them around to look at apartments, help filling out applications and other forms, assistance with first and last month’s rent or deposits, housing that will accept pets, or a person to help with housing if their situation changes. Respondents could also write in another service.

¹⁰⁰ Survey respondents were asked to respond to a list of selected housing problems: water leaks or broken pipes, open cracks or holes in walls, electric outlets that don’t work or exposed wiring, roof damage or leaks, insect infestation or rats, mold, no window screens, windows that are painted or nailed shut, broken plaster or peeling paint, lack of a complete kitchen (sink, refrigerator, oven, and stove), not enough or too much heat, and lead paint.

¹⁰¹ These 7 respondents reported either living in a shelter or outdoors or in a car at the time of the survey, and reported being homeless for more than a year within the prior 3 years, or reported 4 or more episodes of homelessness within the prior 3 years. In addition to HIV/AIDS, 3 reported mental illness, 2 a physical disability, and 2 substance use as making their day-to-day life difficult.

Nearly half had participated in some type of mental health services within the past six months, including 30 percent who had met with a mental health counselor and 22 percent had seen a psychiatrist for medications for a mental illness. Just 16 percent had participated in a substance use treatment program, including 12 percent who had participated in a 12-step program.

The 8 percent of respondents (22 total) who reported having day-to-day difficulties with drugs or alcohol were much more likely to report prior homelessness (68 percent) and having spent time in a homeless shelter in the previous three years (27 percent).

More than a quarter of respondents had been in jail or prison within the last ten years, and some had related challenges with housing.

While 28 percent had been in jail or prison within the last ten years, 10 percent were released within the year prior to the survey. Felony convictions are more often used as screening criteria for housing, services, and employment than other types of convictions. About half of those who had been in jail or prison had a felony conviction, including the six percent of all respondents who had a felony conviction within the past five years. Six percent reported having become homeless after release from jail or prison, and five reported they had difficulty obtaining housing because of their history of incarceration. Respondents who had been incarcerated within the past ten years were almost twice as likely to report prior homelessness (73 percent compared to 37 percent).

Respondents indicated a preference for living independently and being integrated into the community.

Respondents were asked about the hypothetical situation in which they had to move next month; 58 percent indicated they would plan to have a place of their own, even if it cost more, compared to 31 percent who would plan to share with other people. Similarly, 58 percent would plan to move in with family or friends, versus 27 percent who would prefer shared HIV/AIDS housing. Respondents preferred living in an apartment building with a mixed population instead of HIV/AIDS-only, 80 percent to 10 percent.

Still, respondents recognized the benefit in having services available near their home. Respondents were fairly evenly split regarding having services on site, with 46 percent desiring on-site services and 44 percent not. In the event they were no longer able to care for themselves, respondents preferred living in a place with services to moving in with friends and family, 49 percent to 41 percent.

Issues Identified in Consumer Focus Groups

Key issues identified in consumer focus groups:

- Many participants reported having Section 8 housing assistance, and commented favorably on the program.
- Most groups identified affordability and prior incarceration as barriers to housing.
- Consumers identified more education, training, and support groups as needs.
- Consumers outside of Columbus were more likely to report social isolation and depression, and a need for privacy and confidentiality.

Overview of Focus Groups

Conducting focus groups of people living with HIV/AIDS was a method used to obtain information from consumers that, compared with the survey, was similar but more qualitative. The structure of focus groups also allowed consumers to identify issues of importance to them that may not have been included in the survey, or approached from the same angle.

Three groups were held at the Columbus AIDS Task Force (CATF): one with ten people from Franklin County, one with thirteen women from Franklin County, and one with four people from Columbus with a recent history of homelessness. In order to increase rural participation, seven consumers from Delaware, Fairfield, and Licking Counties were interviewed individually or in pairs via telephone between May and August 2004. A total of thirty-four people participated in focus group discussions or interviews. The Columbus AIDS Task Force recruited participants, who received \$10 in cash for their participation, as well as refreshments.

Summaries of each group appear in *Appendix 2*. To ensure confidentiality, individual interviews were summarized as though they had been conducted as a group.

Housing Assistance and Priorities

More than half of the consumer focus group participants (18 of 34) were receiving housing assistance, such as Shelter Plus Care, Section 8, or HOPWA. By comparison, the women's group had the smallest proportion of people receiving housing assistance; the other groups included primarily male participants. It is reasonable to assume that people with housing assistance are more likely to participate in focus groups than people without stable housing, because they presumably have less chaotic lives.

A number of consumers commented favorably on the **Section 8 program**. They liked the fact that it allows for housing choice and that it allows a person to move to another jurisdiction. One participant had heard about proposed changes in the Section 8 program nationally, and had attended the focus group in order to help national policy makers know how valuable and needed the program was. Participants reported that more Section 8 vouchers are needed.

Three participants in the homelessness group reported that housing assistance was available fairly quickly once they applied. Others reported being on **waiting lists** for Section 8.

Consumers were asked about their **preferences and priorities** for housing. They highlighted:

- **Affordability.** Above all, a home needs to be affordable.
- **Safe neighborhood.** In particular, women with children raised this issue.
- **Good physical quality.** Several people stressed the need for a safe building, with functioning systems.
- **Choice.** Consumers appreciate being able to choose a place to live.
- **Location.** Different consumers define this in different ways. It could mean a familiar area, or good access to transit.

Several participants mentioned concerns related to how their **household composition affects eligibility** for housing assistance. For example, one person indicated that both he/she and his/her partner were eligible for housing assistance individually. However, due to income restrictions, if they were to choose to live together, they would no longer be eligible, even though they would be only marginally better able to afford housing. Others mentioned that in order to maintain their housing, they must maintain their relationship with their partner. For them, ending a personal relationship would mean losing access to housing assistance.

Participants had the following **suggestions** related to housing:

- Increase Section 8.
- Convert all the Shelter Plus Care into Section 8 because Section 8 has more flexibility.
- Provide lists of affordable, safe, good quality rentals.
- Offer assistance for people with mortgages.
- Create homeownership programs.
- Provide more assistance setting up a household.
- Keep hospice available to those who need it.

Barriers to Housing

Affordability was a concern for many focus group participants. Each of the eighteen participants who were receiving housing assistance had clearly experienced housing affordability problems at some point.

In three of the focus groups, participants reported that their **history of incarceration** had been a barrier to obtaining housing. None reported receiving assistance finding housing when they were released from jail or prison.

Participants indicated **other barriers** to accessing and maintaining housing, including:

- Poor credit history
- Poor rental history, including eviction
- Racism and discrimination

Homelessness and Emergency Housing

In addition to the four consumers who were recruited to come to a group because of their experience with homelessness, another six participants reported receiving Shelter Plus Care (for which prior homelessness is an eligibility criteria) and two others reported a history of homelessness. Based on this information, a third of participants had a history of homelessness.

Participants in the homeless group were asked about their recent experiences in homeless **shelters**, and whether they thought it was different for people living with HIV/AIDS to be homeless than it was for other people. All reported a dislike of the shelters, primarily because of the lack of privacy. In addition, all were very concerned about hygiene and sanitation. Participants felt that being around so many other people and their germs was a threat to their health, and they were very concerned about the lack of cleanliness. One reported that he would “rather sleep in my car and use a fast food bathroom” than stay in a shelter, and had done so in the past. Another participant reported being somewhat afraid in the shelter, both because the people there were “rough and tough” and because of a lack of confidence in the confidentiality from the staff related to HIV/AIDS.

A participant in the women’s focus group reported that she and her children had stayed in a church-sponsored shelter that changed locations every night. While it was helpful to have a place to stay, she found it difficult to change locations every night with children.

Despite these concerns about homeless shelters, participants acknowledged the need for emergency housing and assistance.

Education, Training, and Peer Support

In most of the groups, consumers identified a need for more access to information about resources, more training for self-advocacy, and more opportunities for peer support.

In particular, a need for more **information about available housing options** was identified in the women’s group. Although participants in the homeless group reported that information was available for those prepared to put in some effort, one participant reported frustration at not learning about housing assistance until he/she had been in case management for 3 years, despite having been homeless and doubled-up during that time. He/She acknowledged that becoming sober a year and a half before had led to an offer of housing assistance from his/her case manager, but thought the assistance would have been helpful earlier. A few participants expressed an interest in **education and job training**. Another suggested that a business run by people living with HIV/AIDS could be linked to a housing program.

In the women’s group, a participant commented that because many of the women living with HIV/AIDS are relatively young, more guidance and direction for **mothers** would be helpful. Another participant commented that some people living with HIV/AIDS have difficulty managing their situation because of poor **social skills** and that more assistance and support is needed. Several participants thought that more **peer support groups** and self-advocacy trainings were needed. For example, one participant in the homeless group reported that he was aware of just one peer support group, and that it conflicted with his work schedule.

A few participants thought that the information and services available were too focused on some groups without **including others**. For example, a participant in Columbus thought the information was too targeted at people with substance use issues, and a participant from a rural area thought that most information was targeted at women and gay men. Identifying with other groups, these consumers felt excluded by the existing information.

Finally, a few participants said they would like to have more information about the **funding sources** for HIV/AIDS housing and services, what the priorities are, and how decisions are made. In the case of CATF, a consumer acknowledged that cuts in the agency's budget had led to reductions in the amount and types of assistance available, and reported that some consumers felt frustrated with CATF because they have come to expect this assistance, even though it is no longer feasible. He recommended having community forums or in-service trainings about this, because consumers can relate to budgeting with limited resources.

Consumers in focus groups also had some comments about **HIV/AIDS case management**. Generally, some consumers thought that there was considerable variation in the quality of case management between case managers, and that more training might help make staff more consistent. In particular, participants noted that interns were not as aware of personal boundaries as other staff. In addition, an older consumer reported not feeling understood by the younger agency staff. At both CATF and agencies serving people living with HIV/AIDS in the surrounding counties, there was concern that there is too much turnover in case management staff. Participants indicated that it becomes difficult to tell a personal story over and over again to different staff and to get to know a new person. Finally, a few commented about wanting their case manager to be more accessible; one mentioned responsiveness to phone calls, and another reported that their case manager would not come to their apartment because it was in a "bad" neighborhood.

Rural Issues

Because just seven interviews were completed outside of Franklin County, it is difficult to generalize widely about consumers in more suburban and rural locations. However, these consumers identified some concerns that are consistent with AIDS Housing of Washington's research in other rural communities and also with the key informant interviews in these areas:

- Rural consumers are more likely to report feeling **social isolation** and related **depression**. This may be related to not knowing other people living with HIV/AIDS in the area or more stigma around HIV/AIDS.
- Rural consumers report a need for more **public education**, support, and advocacy around HIV/AIDS, to reduce misconceptions and stigma about HIV/AIDS.
- Rural consumers report a need for more **privacy and confidentiality**. For example, one reported a preference for going to an HIV/AIDS-dedicated service provider rather than a non-HIV/AIDS-dedicated provider, in order to have more privacy. Another recommended an increased commitment to consumer confidentiality among providers.

Other Issues

Several participants stated that relying on **public transportation** outside of Columbus' urban core was difficult. A woman with children reported that getting her children to school and herself to work with public transportation was very time consuming. Participants in the homeless group said they appreciated assistance from CATF for bus passes and gas money. Rural consumers reported that more assistance with gas vouchers and transportation was needed.

Participants also reported receiving assistance from CATF with food, furnishings, and utilities, which were all helpful. Rural consumers reported that HOPWA assistance for utilities and clothing from the Coalition for Housing was also helpful.

CATF consumers reported that they preferred the **food vouchers** that CATF previously had available because this allowed for much greater choice than the food pantry, but understood that for funding reasons, the vouchers are no longer available. Meanwhile, rural consumers reported a need for more food assistance generally.

Issues Identified by Key Stakeholders

Main issues identified in key informant interviews:

- Columbus's dramatic growth during the past decade has had a significant impact on housing costs in the surrounding areas.
- Outside of Columbus, housing authorities are the primary affordable housing resource.
- Columbus is nationally recognized for its work in addressing the needs of the chronically homeless. However, until now there has been little information about the correlation between HIV/AIDS and homelessness in Central Ohio.
- In communities outside of Columbus and Franklin County, HIV/AIDS is a low-profile issue, and HIV/AIDS-related stigma is a concern.
- Key informants made many suggestions for future activities.

The following issues were identified and described by housing and service providers, state and local agencies, and funders who were interviewed during the key stakeholder interview process. Steering Committee members contributed the original list of potential key stakeholders, and stakeholders identified additional contacts during interviews. The majority of interviews occurred in person, either individually or in small groups. A complete list of people interviewed for the needs assessment appears at the front of this plan.

A total of seventy-one people participated in key stakeholder interviews for this planning process. Members of the AHW team interviewed contacts between May and September of 2004, asking key stakeholders about resources already in place to assist low-income people in general, and people living with HIV/AIDS in particular, as well as their perceptions of related unmet needs.

Housing

Columbus's dramatic **growth in the past decade** has affected housing costs throughout the region. Within Columbus itself and Franklin County, housing costs have increased greatly. The spillover has impacted the surrounding counties. Areas that have historically been agriculturally based are turning into bedroom communities, and housing costs are being driven up by the increased demand. Delaware County is now the fastest growing county in Ohio, according to key stakeholders, and is becoming one of the most expensive. There, costs are reaching a point where lower-income residents are leaving to find housing elsewhere.

A major affordable housing resource for people living with HIV/AIDS in Columbus is the Columbus Metropolitan Housing Authority's **Section 8 program**. CMHA has 10,000 Section 8 vouchers and 525 Shelter Plus Care vouchers, and works with about 2,300 landlords. Ten percent of the Section 8 vouchers are linked to supportive housing providers. CMHA is one of many housing authorities that were severely impacted by the revisions that HUD made to the Section 8 program this spring. However, due to the efforts of the state's Congressional delegation, most of the funding has been restored, except about \$300,000. However, in response to HUD's changes, CMHA will

now provide housing for households with higher incomes than previously accepted, for up to 25 percent of the total households assisted. CMHA is also seeking to save money by targeting smaller units, which may provide an opportunity to house more people with disabilities who need a one-bedroom apartment and have disability income.

CMHA reports they will also be increasingly restrictive toward zero-income tenants. CMHA will waive the minimum payment requirement for one year, but if a tenant has not found income by then, they will be cut from the program. Legal Aid has approved this policy, as long as the tenants are afforded due process.

Key stakeholders reported that resistance to affordable housing, characterized as a “**Not In My Backyard (NIMBY)**” attitude, is a major challenge facing affordable housing developers in Central Ohio. One characterized this as being based in a lack of understanding about the people who live in affordable housing and what it looks like. Educating the community about the need for affordable housing, showing people other successful examples of affordable housing in the community, and executing Good Neighbor agreements to provide more accountability over operations are all strategies being used to overcome NIMBY.

Several key stakeholders in Columbus commented that the **housing needs of people living with HIV/AIDS are not perceived as being different** than the housing needs of HIV-negative people in similar situations. Many do not see HIV/AIDS housing as a distinct need or issue. Presumably, plans and programs that address the housing needs of low-income and homeless people will also assist people living with HIV/AIDS.

A service provider in Columbus reported that few affordable housing providers there allow **pets**. For people with histories of mental illness, substance abuse, and/or homelessness, who are more likely to have severed relationships with family and former friends, pets can be a significant source of support and can benefit mental health.

In Suburban and Rural Areas

Outside of Franklin County, **housing authorities** are the primary providers of affordable housing. However, these housing authorities have more people seeking housing than resources available. For example, the Delaware Metropolitan Housing Authority, which also serves Union County, reportedly has 800 people on the waiting list and the Fairfield waiting list holds 1,400 names, in each case exceeding the total number of vouchers available by 150 percent. To manage their waiting lists, housing authorities often close them, as is currently the case in Licking County, with 680 households on its waiting list.¹⁰²

Some housing authorities have programs that can offer **special assistance** for people living with HIV/AIDS. For example, the Fairfield Metropolitan Housing Authority has a preference for people with a terminal illness, people with disabilities, and homeless people. Documentation requires a doctor’s certification, but not identification of a specific illness or disability. However, consumers report that the Housing Authority presses for identification of the nature of the disability or illness, which makes people living with HIV/AIDS reluctant to participate.

¹⁰² Kristin McCloud, Licking County Coalition for Housing, email communication with AIDS Housing of Washington, October 20, 2004.

Other than the housing authorities, the counties surrounding Franklin have little to no capacity or leadership around **affordable housing development**. There are some exceptions: in Union County, Alcohol, Drug, and Mental Health Board (ADAMH) has been a leader on housing issues and has some development experience. Generally, though, the local governments in suburban and rural areas primarily focus their housing efforts on single-family home development.

In addition to housing costs, key stakeholders in Fairfield and Licking Counties reported that **housing quality** is a significant concern. In Licking County, for example, key stakeholders mentioned that people now live in the summer homes around Buckeye Lake year-round, even though these were not meant for year-round habitation. Housing quality issues can make utilization of the Section 8 program difficult. A key stakeholder in Licking County reported that many affordable apartments there do not meet HUD's Housing Quality Standards (HQS).

HIV/AIDS

Case managers at the Columbus AIDS Task Force (CATF) commented on the climate they are working in. First, they reported that changes in the epidemic have changed **public perceptions about HIV/AIDS**, and that this impacts their work. Now that people are seen to be living with HIV, not dying, public perception of a crisis is decreasing, and with it, support and funding. Every part of the service system has needed to make changes in response. For some consumers who have been in the system for a longer time, their expectations concerning level of assistance no longer match the present reality.

Second, CATF case managers reported some frustration that when it comes to support services, **"HIV trumps everything."** Regardless of number, type, or acuity of issues, once service providers in other systems learn an individual is HIV-positive, they consider CATF to be the organization that should work on all of that individual's issues. In some cases, particularly with behavioral health care, another organization might be better suited to assist. Consumers themselves may not see HIV/AIDS as the primary issue in their lives. To some providers, it seems as though HIV/AIDS services have become a place to "dump" consumers whom other systems cannot or will not assist.

Finally, CATF case managers report that **substance use and abuse** are prevalent among many of the consumers they serve. This complicates the situation for many consumers.

A number of key stakeholders commented on the **high turnover of HIV/AIDS case managers** at AIDS task forces throughout the state. This turnover is difficult for both consumers and other housing and service providers who are trying to establish connections and relationships.

Key stakeholders working in **corrections health care** reported that twelve percent of Ohio's new HIV diagnoses are made in Ohio prisons, because all prisoners are tested at entry.¹⁰³ This indicates that a substantial number of people living with HIV/AIDS have some involvement with the criminal justice system. Other key stakeholders expressed concern that prisoners are not also tested when they are discharged, given that prisoners are at risk due to largely undocumented, prohibited contacts while incarcerated. Many believe that testing at discharge would identify even more new infections.

The Ohio Health Department's Community Linkages program contacts inmates living with HIV/AIDS before they are released to develop a discharge plan, connecting the person with HIV/AIDS services in the community and trying to maintain access to HIV/AIDS medications. This program has assisted 150 people in its first year of operation, and is funded by Ryan White. Many of the people being discharged need assistance with housing, but the majority was not eligible for most housing programs, due to their history of incarceration.

Key stakeholders working in corrections health care commented that a program like Community Linkages in the **city and county jails** would be very helpful. The Ohio Health Department has an infectious disease consultant who could be involved in exploring a program like this with HIV/AIDS service organizations.

In Suburban and Rural Areas

Like many other rural areas in the United States, key stakeholders in the counties outside of Franklin identified **confidentiality and stigma** related to HIV/AIDS and sexual orientation as serious concerns for people living with HIV/AIDS and the organizations that serve them. One service provider described a consumer who felt uncomfortable going back to the doctor, because the consumer depended on a volunteer driver who, at the last appointment, asked why the consumer was going to the doctor and wouldn't take him/her without finding out. A key stakeholder in Lancaster summarized the issue as: when it comes to gaps for people living with HIV/AIDS, housing is not the most critical issue. Awareness, understanding, political will, and leadership are more pressing concerns. The environment is very conservative and HIV remains hidden.

Accessing **HIV/AIDS-related housing assistance** creates concerns for consumers about confidentiality. Although measures are in place to protect confidentiality, when landlords get a check from a third party, they know that something is out of the ordinary. This may trigger some type of prejudice or bias, whether related to poverty or something else.

In most areas outside of Franklin County, HIV/AIDS is a very low profile issue, because there is little to **no leadership or advocacy** for people living with HIV/AIDS. The general public and even opinion leaders do not understand the scope of the issue. Some of the lack of awareness is likely due to the relatively low prevalence of the disease. For example, the Delaware County Health Department reports having had no positive HIV tests in 12 months. Of course, people may leave their communities to be tested in larger metropolitan areas.

¹⁰³ The Ohio Department of Health confirmed that over the past five years, from 1998 to 2003, the percentage of the state's total cases diagnosed in a correctional facility averaged twelve percent. Email communication with AIDS Housing of Washington, October 13, 2004

Another factor is likely the **limited capacity** of the local AIDS task forces. Mostly volunteer run, these smaller task forces are not very active and typically play a limited role in providing funds for emergency services. Key stakeholders also report frequent turnover and administrative changes in the smaller AIDS task forces, which makes collaboration more difficult.

Without an advocate to speak up, people living with HIV/AIDS are **not seen as a population of particular concern**. Key stakeholders in Licking and Union Counties reported that HIV/AIDS does not appear to be an important issue when other issues, such as homelessness and mental illness, are more prevalent and funding is not available.

As a result of stigma, many people living with HIV/AIDS **go to Columbus** for housing and services. On the other hand, Ohio State University's specialized medical care and clinical trials are a draw for consumers.

Homelessness and Related Housing and Social Services

Key stakeholders working in homelessness reported that Columbus has been quite effective in working to provide **permanent supportive housing options**, particularly for the disabled, single-adult population that is defined by HUD as "chronically homeless." Permanent supportive housing is housing with no limit to the length of stay, with which supportive services are provided in order to assist residents in remaining stably housed. Key stakeholders particularly highlighted Community Housing Network's (CHN) buildings as successes. CHN's Safe Haven and Parsons Avenue programs were seen as great assets for people with behavioral health care issues, and there is general agreement regarding the need for more similar programs.

Columbus has been recognized nationally as a leader in redesigning its homeless system to focus principally on getting the chronically homeless off the streets and into permanent supportive housing quickly and effectively. Prior to this needs assessment, however, there had been little local documentation on the **correlation of HIV/AIDS and homelessness**—that is, the extent of homelessness among people who are living with HIV/AIDS, or the extent of HIV/AIDS among people who are homeless. A key stakeholder reported that there is limited communication and referrals between the homeless and HIV/AIDS service system; this makes it difficult for medical providers to follow up with people who are HIV-positive and homeless.

A major strategy of Columbus' Rebuilding Lives Initiative is to reduce reliance on existing emergency shelter and transitional housing resources and focus on permanent housing options as a means of turning the system away from managing homelessness and towards ending it. At the same time, however, case managers at CATF reported that the greatest housing need they are seeing for people living with HIV/AIDS is more **emergency housing options and very short, structured transitional housing** programs, which would allow people the opportunity to stabilize and move on. Although Pater Noster House provides a structured transitional living opportunity for people living with HIV/AIDS, it can serve only a few people at a time. As these interviews were conducted in July 2004, soon after the Open Shelter's closure, this issue was at the forefront of many people's minds.

When discussing specific housing and service components, key stakeholders advocated that although housing that allows for active substance use in a harm reduction model was needed for some, sober housing, such as the programs operated by Amethyst, Inc., still has its place, particularly for families. Key stakeholders also expressed concern about the lack of emergency shelter options for single women. Both housing and service providers also expressed concerns that child welfare, HIV/AIDS, and employment programs are not well integrated into homeless initiatives.

While **Section 8** is a critical housing resource for very low-income people throughout the eight-county region, the program can be difficult for consumers, particularly those with multiple disabilities, to manage without assistance. One HIV/AIDS case manager working with suburban and rural consumers related an experience with a mentally ill client who finally received a Section 8 voucher after a long period on the waiting list. This client was unable to obtain an apartment, probably not understanding the way the program worked, and by the time this case manager became involved, the time limit for using the voucher had expired.

In Suburban and Rural Areas

In the counties outside of Franklin, coalitions are coming together to **raise awareness** and collect data on homelessness. Generally, homelessness in suburban and rural communities is invisible because people who are homeless or at risk of becoming homeless there tend to double-up, live in cars, camp at campgrounds during the summer, and bounce around between temporary situations. There are few, if any, emergency, transitional, and permanent (independent and supportive) housing resources. Perhaps as a result, the issue of homelessness in suburban and rural communities receives less attention than in areas where it is more visible. To the extent that Continuum of Care planning processes exist in the suburban and rural areas of the eight-county region, there is generally little or no participation from local AIDS task forces and people living with HIV/AIDS are not usually identified as a priority population.

Following are selected issues identified by key stakeholders regarding homelessness in Delaware, Fairfield, Licking, and Union Counties:

- **Delaware County** is beginning a Continuum of Care process for first time. Currently, no emergency, transitional, or permanent supportive housing exists in Delaware County. People who are homeless are referred to a shelter in Marion County, which is outside of the Columbus EMA. The Salvation Army offers a homeless family program. The EMA's HOPWA coordinator has been invited to and participated in the Continuum of Care process.
- **Fairfield County** has a Continuum of Care process, coordinated by the Housing Authority. The Housing Authority has a priority for people with a terminal illness and people who are homeless, but the waiting list has nearly 1,500 households. Currently, a range of shelter, transitional housing, permanent housing, and supportive services are available in Fairfield County. Key stakeholders identified a need for transitional housing, particularly for families, shelter options for the seriously mentally ill, and permanent supportive housing for people with disabilities.

- **Licking County** has a Continuum of Care process and just conducted its first homeless count, identifying 97 people homeless at the time of the survey.¹⁰⁴ Key stakeholders report that the Salvation Army's shelter program and related services are a major resource in Licking County. The Moundbuilder's Guidance Center offers some structured supportive housing programs for adults with mental illness. The Licking County Coalition for Housing works with people who are homeless, as well as providing assistance to prevent homelessness. Key stakeholders report seeing increasing rates of substance use, tuberculosis, and hepatitis. All key stakeholders cited the high cost of housing compared to incomes as a primary barrier.
- **Union County** has a Continuum of Care process that is coordinated by the Alcohol, Drug, and Mental Health Board of Union County. Currently, Union County does not have an emergency shelter but is able to refer people to a shelter in Marion County. The Continuum of Care process has identified a need for more transitional and permanent supportive housing. Union County does not have its own housing authority. Key stakeholders in Union County emphasized that many available apartments rent for more than the Fair Market Rent limit, making it difficult to use Section 8 vouchers. The EMA's HOPWA coordinator has been invited to and participated in the county's Continuum of Care.

Other Services

One provider in Columbus expressed concerns about the **separation of mental health and substance abuse services** there. People with co-occurring disorders have a difficult time succeeding in either system. Similarly, it is challenging to find appropriate housing for this population.

Enrollment for entitlements usually works best for people who are able to keep follow-up appointments. For people with more chaotic lives, enrollment can be very difficult to complete. A one-stop shop would be simpler. Additionally, there is a need for assistance getting identification materials for people who are homeless. Most services, including food pantries, require identification, but identification costs money that people, particularly those who are homeless, may not have.

Another service provider commented that outside of Franklin County, **mental health services** are typically not available until a person's issues reach a crisis level. This is because counties' budgets are stretched and they are overwhelmed by more people than they have the capacity to serve. Providers in Union and Fairfield Counties acknowledged that there are not enough services available in any system to meet needs. The lack of resources makes it difficult to do more than "band-aid fixes," and makes thinking about large-scale changes challenging.

A number of key stakeholders commented on the lack of **employment training and opportunities** in the area, particularly for people who are homeless. One commented that Columbus has many major employers who are potential assets in addressing the issue.

For most rural communities, **transportation** is a significant concern for very low-income people. Public transportation does not serve many areas, nor is a more extensive public transportation likely to be feasible because of the low population density. Generally, people need to rely on their own car

¹⁰⁴ More information about the Continuum of Care process and the homeless count appear in the Income, Housing Affordability, and Homelessness chapter.

or the car of their friends or family to get around. As a result, there are ongoing needs for gas vouchers and auto maintenance and repair costs. Other possibilities exist, such as the nonprofit mini-bus system called DATA in Delaware. A case manager serving rural consumers said that Title XX funds from the Ohio Department of Jobs and Family Services are a great source of assistance for people with Medicaid to access transportation to medical appointments, which can make more flexible funds available for other types of assistance.

Population Changes

In Columbus, many key stakeholders reported on the increase in **African immigrants** living in the area. A recent United Way report identified 17,231 Sub-Saharan Africans as the sixth largest ancestry group by population in Franklin County according to the 2000 Census. The 2000 Census found 3,074 people of Somali descent, while the United Way report estimated the Somali population in Franklin County at 15,000 to 30,000.¹⁰⁵ Although social service providers had provided services to limited numbers of African immigrants to date, several anticipated that social services agencies would need to develop the capacity to provide culturally competent services in the future.

Key stakeholders in Union County report seeing an increase in the **Latino population** and people without documentation in the behavioral health care system. Providers there are challenged by differences in language and culture, and eligibility problems related to immigration status.

Suggestions for Change

In interviews, key stakeholders made many suggestions for possible changes and improvements to the status quo. Some of these may be appropriate for this planning process, and others may best be taken up by others. Suggestions received appear below.

Medical Care

- Medical care at OSU is excellent and the clinic and hospital are in a strong position to provide care to people who are homeless. More transportation assistance for people living with HIV/AIDS who are homeless, and a social worker at that clinic would make this valuable care more accessible.

Partnerships

- Create incentives for organizations to collaborate on the provision of housing and services.
- Continue and expand relationships with landlords, so that vacancies in existing housing can be used to house people living with HIV/AIDS.
- CHN could be an excellent partner for CATF to combine resources for supportive housing. The Columbus Housing Partnership also has extensive experience developing housing and working

¹⁰⁵ United Way of Central Ohio, 2003 Racial Disparities Report, a project of ACCORD (A Collaborative Committee on Race and Diversity), September 2003, pp. 2-13. Available online: www.communityresearchpartners.org/htm/news.cfm?viewNews=1&NewsID=42 (Accessed: September 29, 2004).

with service providers. Other potential partners identified include the YMCA, YWCA, Southeast, Amethyst, and National Church Residences.

- Columbus has African American community development corporations that could be potential new partners.
- The Salvation Army is a potential partner for more housing in Delaware and Union Counties.

Increasing Housing Opportunities

- Several people emphasized integrating people living with HIV/AIDS into existing housing and services systems, rather than creating separate systems.
- Develop more HIV/AIDS housing in Central Columbus. It tends to be in the peripheral areas.
- There is interest from several organizations regarding developing reentry housing for the previously incarcerated.
- Create more emergency housing and highly structured transitional housing options for people living with HIV/AIDS, especially those with behavioral health issues.
- Duplicate Safe Haven and the Parsons Avenue programs, which use a harm reduction approach, in order to increase housing for people with co-occurring disorders and active substance use, including people living with HIV/AIDS.
- Work with affordable housing providers so they will distinguish between different types of felonies, in order to help address the lack of housing options for the formerly incarcerated.
- Increase homeownership opportunities for people below median income, including getting banks to participate more actively in this market.
- CATF could identify existing direct access to housing programs that are appropriate for people living with HIV/AIDS for duplication.
- Increase partnerships with housing authorities throughout the region to improve access by people living with HIV/AIDS to existing and new housing resources.
- Utilize HUD's 811 program to develop new housing for people living with HIV/AIDS

Enhancing HIV/AIDS Services

- Help people living with HIV/AIDS understand the larger picture of HIV/AIDS services – i.e. less community support, less funding, and more people with more challenges living with HIV/AIDS – and help them adjust their expectations accordingly.
- Open a dialog between consumers and providers about HOPWA and its priorities and uses.
- Explore e-mail or telephone support groups for rural consumers. This could be more confidential than meeting face-to-face; it could also reduce social isolation and allow consumers to assist each other by exchanging information, where limited case management services are available.
- Create a program modeled on the Community Linkages program for people living with HIV/AIDS leaving city and county jails.
- Increase life skills and housing readiness training for people living with HIV/AIDS.
- Increase emergency opportunities for very sick people (medical respite).

- Increase coordination between HIV/AIDS case managers and infectious disease doctors, especially in more rural areas. Use releases to make a two-way exchange of information possible for the consumer's benefit.

Education and Outreach

- Get this plan out to a wide audience.
- Share the findings of this plan and its recommendations with state legislators and county commissioners.
- Educate the general public about HIV/AIDS and people living with HIV/AIDS in Central Ohio.
- Increase awareness of homelessness in rural communities. Because people tend to stay in cars, under bridges, and camp out, homelessness is not a visible problem and people think it does not exist.
- Increase information sharing among social service and housing providers, particularly outside of Columbus.

Additional Resources

- Explore federal resources that are available for refugee resettlement. Currently, new immigrants, including African immigrant families, are coming into the shelters because they have no other place to go. If other resources were available to help this population, it would reduce the strain on shelters.

Other Services

- Expand job training and placement options, especially for people who are homeless. The job placements that are available often do not pay a wage that makes housing affordable. The Bidwell Center in Pittsburgh could be a good model; it has corporate support and emphasizes higher paying jobs that can lead to self-sufficiency.
- Find a way to streamline the bureaucracy associated with all types of services. It is time-consuming for case managers, and when case managers are not available, it can be intimidating and overwhelming for consumers. This applies to entitlements, medical care, and other social service supports.
- Increase assistance with transportation, particularly for appointments other than medical care.
- Increase assistance with utilities payments.

Projection of Need

During the planning process, the unmet need for housing assistance in the eight-county region was estimated at 500 people living with HIV/AIDS and their family members. Unmet need for housing and housing assistance has approximately the same geographic distribution as reported HIV/AIDS cases: 90 percent, or 450 people, living in Franklin County, and 10 percent, or 50 people, living in Delaware, Fairfield, Licking, Madison, Morrow, Pickaway, and Union Counties. It is anticipated that half of this need could be filled access to existing resources, and half by new housing resources.

In order to develop an estimate of the number of people living with HIV/AIDS who need housing assistance for themselves and their families, AIDS Housing of Washington and the Steering Committee considered a number of measures of housing need. The survey conducted for this needs assessment was used, as well as current local service participation data and national studies. Measures considered include the ability to afford a one-bedroom apartment at Fair Market Rent, late rent or mortgage payments, current housing cost burden, poverty level, and an estimate of HIV/AIDS in the homeless population, based on national studies.

Using these various measures, the smallest estimate of people in need of housing assistance was 163 people, an estimate of the number of people living with HIV/AIDS who are already in the homeless system in Franklin County alone. The largest estimate was 1,765, the estimated number of people living with HIV/AIDS in Central Ohio who are below the poverty level. **Table 23** on the next page presents each estimate. Several measures produced an estimate near 500, and for that reason, this plan estimates that there are 500 people living with HIV/AIDS in Central Ohio in need of housing assistance.

Many of these people live with other family members, and so it may be more accurate to say that there are 500 households in need of assistance, although a household may have just one person living with HIV/AIDS. It is anticipated that half of this need could be met by access to existing housing resources, both HIV/AIDS dedicated and non-HIV/AIDS-dedicated, and half will need to be met by new housing resources, including short-term assistance, long-term assistance, and permanent dedicated housing units.

Table 23:
**Estimated Need for Housing Assistance for People
 Living with HIV/AIDS in Central Ohio**

	Available Data	Calculated Estimate
Total number of people living with HIV/AIDS in Central Ohio as of December 31, 2003	2,801	
Percentage of survey respondents unable to afford area Fair Market Rent (FMR) for a one-bedroom apartment	94%	
Estimated number of people living with HIV/AIDS unable to afford FMR ¹⁰⁶		2,633
Assuming 20 percent of people living with HIV/AIDS who are unable to afford the FMR need housing assistance		527
Percentage of survey respondents behind on rent or mortgage at time of survey	18%	
Estimated number of people living with HIV/AIDS who are behind on their rent/mortgage payments, and in need of assistance ¹⁰⁷		504
Percentage of survey respondents paying more than 50 percent of their income for rent at time of survey	32%	
Estimated number of people living with HIV/AIDS paying more than 50 percent of their income for rent, and in need of assistance		896
Survey respondents with incomes below poverty rate for a single individual at time of survey ¹⁰⁸	63%	
Estimated number of people living with HIV/AIDS who have an income below the poverty rate, and in need of assistance		1,765
Total number of people living with HIV/AIDS served by the Columbus AIDS Task Force (CATF) annually	1,032	
Number of people living with HIV/AIDS served by the Columbus AIDS Task Force with incomes less than \$10,000 per year ¹⁰⁹	580	
Adult homeless population in Franklin County homeless system ¹¹⁰	5,444	
Estimating that 3 percent of the adult homeless population in Franklin County is living with HIV/AIDS ¹¹¹		163

¹⁰⁶ Estimate calculated by applying the 94 percent statistic from the survey data to the entire population of people living with HIV/AIDS (2,801).

¹⁰⁷ Estimate calculated by applying the 18 percent statistic from the survey data to the entire population of people living with HIV/AIDS (2,801).

¹⁰⁸ Poverty level for a single individual in 2004 was equivalent to \$776 per month, or \$9,312 annually.

¹⁰⁹ Provided by Columbus AIDS Task Force via e-mail dated November 8, 2004. \$10,000 is slightly above the poverty rate for a single adult in 2004.

¹¹⁰ In fiscal year 2003-2004, Community Shelter Board partner organizations sheltered 1,103 single women, 3,516 single men, and 2,291 people in families. This estimate assumes 36 percent of people in families, or 825 people, were adults.

¹¹¹ 3 percent of the adult homeless population nationally is thought to be living with HIV/AIDS, per AHW personal communication with Dennis Culhane.

Critical Issues

The Steering Committee identified the following major issues in September 2004, drawing on the background data, the consumer survey results, the consumer focus group findings, the issues identified in key stakeholder interviews, and the experience of the Steering Committee members. These issues served as a starting point for developing recommendations for future action. The group began its discussion of future actions by identifying the strengths the region already had, which will form the basis for follow up. The identified strengths follow the discussion of each issue.

The Steering Committee identified a number of critical issues. The scope of the issues and existing regional strengths are discussed below. Issues include:

- Lack of affordable housing
- Inadequate emergency options
- Existing supportive housing options meet only part of the need
- Existing supportive housing options are too restrictive
- Current funding is inadequate
- Barriers to obtaining housing
- Perceived lack of consumer empowerment
- Fragmented network
- Fear of confidentiality violations

Lack of Affordable Housing

A lack of affordable housing opportunities was identified as an issue in every phase of the needs assessment process. While permanent independent and permanent supportive housing exist throughout the eight-county metropolitan area, in no county is there enough affordable housing for all the households in need.

In the survey of 272 people living with HIV/AIDS in Central Ohio, just 6 percent of respondents could afford to pay \$499 per month, the 2004 Fair Market Rent for a one-bedroom apartment in 6 of the 8 counties.¹¹² This is based on the U.S. Department of Housing and Urban Development's (HUD's) housing affordability criteria of paying no more than 30 percent of gross income for housing, which in this case would require \$1,663 per month in gross income. Even assuming the ability to pay half of gross income toward housing costs, just 21 percent of respondents had enough income (more than \$998 per month) to afford a one-bedroom apartment renting at the Fair Market Rent.

¹¹² \$499 is the HUD-established 2004 Fair Market Rent for Delaware, Fairfield, Franklin, Licking, Madison, and Pickaway Counties. The Fair Market Rent for a one-bedroom apartment in Union County is \$410 and in Morrow it is \$353.

Throughout the region, key stakeholders reported that **housing authorities** are a major source of affordable housing, through both the Section 8 voucher program and public housing. However, in all areas, the number of people seeking assistance from the housing authorities greatly exceeds the amount of assistance available. For example, key stakeholders reported that the Delaware Metropolitan Housing Authority has a waiting list of more than 800 households, even though it administers only 438 Section 8 vouchers. Similarly, key stakeholders report that the Licking Metropolitan Housing Authority has a waiting list of more than 1,400 households, although it has 100 units of public housing and 996 Section 8 vouchers.

Strengths Related to Affordable Housing

Despite these challenges, the eight-county region has many strengths upon which to build. The HIV/AIDS system is already actively engaged in housing. Assets include a central coordinating role and advocate in the position of the HOPWA administrator, currently staffed by Nina Lewis, and participation in the National AIDS Housing Coalition by community member Cassandra Ackerman and the Columbus AIDS Task Force's Aaron Riley. In addition, the HIV/AIDS case management system has recently improved its ability to collect data, including richer housing data.

Outside the HIV/AIDS system, Central Ohio has many strengths related to affordable housing generally, including:

- housing development capacity, particularly in Franklin County
- existing housing stock throughout the eight-county area
- available land, particularly in the suburban and rural areas of the region
- successful models that can be duplicated or expanded upon
- more plentiful housing subsidies from a greater diversity of sources than in other parts of Ohio.

Inadequate Emergency Options

Key stakeholders throughout the eight-county region identified a need for more emergency and transitional housing options. For example, the Continuum of Care processes in Delaware, Fairfield, Licking, and Union Counties identified a need for more **emergency and transitional housing**. In Franklin County, HIV/AIDS case managers identified the need for more structured transitional housing with intensive services as the primary need for the people they serve, including people with behavioral health care needs related to mental health and substance use.

Nearly half of the 272 people living with HIV/AIDS who completed surveys in this planning process reported that they had been **homeless**, defined as “without a regular place to stay for the night,” at some point in the past. Specifically, a total of 17 percent reported they had slept in a shelter in the past three years, while 18 percent had slept outside for lack of another place to go. In the past three years, 21 percent (58) had been homeless for more than a month, and 6 percent (17) had been homeless three or more times.

Strengths Related to Emergency Options

While there are unmet shelter needs in the metropolitan area, there is a good deal of capacity to build on. Within the HIV/AIDS service system, HOPWA funds are an excellent resource, particularly because of their flexibility. The Pater Noster House, due to recent improvements in its facility and programming, serves and houses people in need, and is an example to build on. Throughout the region, there are strong shelter programs that are connected in varying degrees to the HIV/AIDS service system. These include Friends of the Homeless and other emergency shelters in Columbus, churches that provide shelter in Madison County, and the shelter system in Fairfield County. In Franklin County, there is more capacity and better coordination than in most metropolitan areas and the Shelter Plus Care program provides an example of success.

Existing Supportive Housing Options Meet Only Part of the Need

While there are many models of supportive housing currently operating in Central Ohio, in most cases the need exceeds the supply. The result is that an individual may not be able to access the type of supportive housing for which they would otherwise be eligible.

The term “supportive housing” refers to affordable housing that is accompanied by support services that are designed to help residents maintain their housing and stabilize their lives. Support services may relate to homelessness, mental health and substance use issues, HIV/AIDS and other medical conditions, physical disabilities, and the skills of daily living, depending on the target population served. Supportive housing units may be located together in one facility or scattered among different sites. Supportive housing has evolved over the past decade as the most appropriate and cost-effective means of solving chronic homelessness, and one that is a key strategy in Franklin County’s Continuum of Care. While communities outside of Franklin County have identified the need for more supportive housing, the capacity and political will to meet that need do not yet exist.

In some cases, there may not be awareness of programs that are already effectively bridging gaps. For example, CATF offers mental health counseling through two programs, but these programs are not widely known to other service providers in Central Ohio.

Strengths Related to the Quantity of Supportive Housing

Franklin County already has 933 units of permanent supportive housing for individuals, and 133 units for families (serving 450 people in families with children). Columbus and Franklin County have received national recognition for their success in creating supportive housing options through the Rebuilding Lives initiative, described in detail elsewhere in this plan. The Community Housing Network, Amethyst, Inc., and Southeast, Inc. are all examples of organizations providing innovative and collaborative programs. Developers, service providers, and funders are continuing to create more supportive housing options in Columbus and Franklin County.

Existing Supportive Housing Options are Too Restrictive

In interviews with key stakeholders, some mentioned the need for supportive housing assistance that could help people living with HIV/AIDS who are experiencing their first episode of homelessness, and those homeless for a longer period of time or repeatedly, as well as approaches that would help prevent homelessness for people experiencing housing instability. Nearly one in five persons living with HIV/AIDS who responded to the survey on housing needs had moved three or more times in the past three years, suggesting housing instability.

Assuring that all people with HIV/AIDS have stable housing and do not fall into homelessness is a critical component of helping them maintain their health and well-being. Since the resources for housing and supportive services for people living with HIV/AIDS are extremely limited relative to the need, it is essential that consumers have access to housing and support service resources across the broad spectrum of their needs, including mental health and substance use treatment, domestic violence and homeless assistance, vocational and job training, benefits counseling, housing subsidies, and educational advancement. However, people living with HIV/AIDS who may have significant needs in one or more of these areas may not be eligible under current program guidelines.

Eligibility restrictions are usually determined by funding sources, many of which originate at the state or federal level. State and federal sources often have additional local priorities layered on them, which further restrict the population that can be served. Restrictions on funding sources have been established to ensure that people in need are served, but this targeting results in the exclusion of others who need services but do not neatly fit into the defined categories. Key stakeholders stressed the importance of tying multiple services together for a holistic approach and also acknowledged the challenge due to the different eligibility and targeting criteria, which can be mutually exclusive. Tying together existing resources is very important in more suburban and rural areas where the resources do not exist to create new stand-alone models.

Related to people living with HIV/AIDS, restrictive eligibility criteria are primarily a concern related to the homeless system. Because many people living with HIV/AIDS may cope with their housing needs by living in an overcrowded situation or rotating between temporary arrangements with friends, family, and acquaintances, rather than going to a shelter, they may not meet HUD's definition of "homeless." In addition, people living with HIV/AIDS who are homeless for the first time will not meet eligibility guidelines for assistance in the services and housing in the Rebuilding Lives initiative, which constitutes about half of Franklin County's supportive housing units and emphasizes serving people who have been homeless for a long period of time or multiple times. So far, transitional housing programs in Franklin County that serve people who are homeless for the first time are not strongly connected with permanent supportive housing programs.

Additionally, key stakeholders remarked on the continuing need for both abstinence-based and harm reduction housing models, as well as both intensive transitional and permanent housing options. Franklin County now has programs operating on all of these models. A number of stakeholders thought that people living with HIV/AIDS would benefit from more transitional housing programs. However, many stakeholders believe that it would be difficult to garner support for a transitional living program for people living with HIV/AIDS, due to the Franklin County Continuum of Care's emphasis on permanent supportive housing. At this point, no new transitional housing programs for people living with HIV/AIDS have been proposed.

Strengths of Supportive Housing Models

The HOPWA program creates opportunities because creativity within its regulations is encouraged, from the federal level to the local level. In addition, both HUD's Supportive Housing Program (SHP) and Shelter Plus Care funds may be used to serve people who are homeless for the first time. The local Corporation for Supportive Housing office is another asset in the region; CSH has national expertise and is actively engaged in the more suburban and rural areas of Central Ohio. Finally, public policy advocates in housing and services are already active in the region.

Current Funding is Inadequate

Throughout the eight-county region, key stakeholders identified housing and service needs that exceed the current supply as well as the capabilities of current funding. The understanding that current funding is inadequate is not limited to the HIV/AIDS system, but also affects systems serving people with physical disabilities, HIV/AIDS, first-time homebuyers, mentally disabled, working poor, and chronically homeless people.

The HIV/AIDS system is particularly affected by changes in the epidemic. As medical advances help people live longer and healthier lives, but new infections continue, more people are now living with HIV than ever before. This means that HIV/AIDS-dedicated funds must serve that ever-expanding number of people. Many key stakeholders suggested that new partnerships are a strategy for making each system's limited funding go further. At the same time, key stakeholders were concerned that current resources and the programs they support not be eliminated in the effort to make new ones available.

Strengths Related to the Quantity of Current Funding

Central Ohio has advocates who work at the local, state, and national levels to make sure that these needs are being addressed. In addition, Central Ohio has attracted positive national attention for its innovative and effective approaches to addressing housing and homelessness, and has experienced housing and service providers who can create effective programs and leverage resources well. HOPWA is a valuable asset because it can be used flexibly to help make the most of other funding sources.

Barriers to Obtaining Housing

For many people living with HIV/AIDS, affordability is not the only barrier to obtaining housing. Other barriers include:

- a **criminal history**
- **poor credit**
- a **poor housing history** including eviction or homelessness

More than one quarter (28 percent or 77 people) of the 272 people living with HIV/AIDS surveyed in this planning process had been in jail or prison within the past 10 years, including 10 percent who had been released within the prior year. Because a history of incarceration is commonly used as a

screening criteria for housing, this means that many people living with HIV/AIDS may experience related housing problems.

Behavioral health issues can be a barrier for others. Sixteen percent of those surveyed said they had challenges in their day-to-day life due to mental illness, 6 percent due to drug use, and 4 percent due to alcohol use.

At the time of the survey, 38 percent of respondents were behind on their utility bills and nearly one in five was behind on their rent or mortgage. In addition, 21 percent reported they had difficulty obtaining housing in Ohio because of their negative credit history. Fourteen percent indicated that their last move was because they were evicted or asked to move.

Key stakeholders throughout the eight-county region identified the location of affordable housing and **transportation** as significant barriers. In particular, the key stakeholders in more suburban and rural areas, including Delaware, Licking, and Union counties, highlighted transportation as a key issue. People living with HIV/AIDS in these areas need to cover long distances to access services locally, in addition to commuting to another county to receive specialty medical care. Nearly half of respondents reported using their own car for transportation—essential to getting around but nearly impossible to maintain with an extremely low income.

Finally, while illegal, housing discrimination based on race and ethnicity, family status, and disability does occur. It is likely that some people living with HIV/AIDS are affected by this type of discrimination.

Strengths in Overcoming Housing Barriers

Seasoned case managers who are able to work with consumers to overcome housing barriers are an important asset. In addition, Central Ohio has housing programs with a Housing First approach and/or a harm reduction model; both of these strategies are designed to address the barriers identified. Finally, providers in many communities have good relationships with landlords and experience in working with them to overcome consumers' potential barriers. For example, Fairfield County uses a bimonthly landlord appreciation dinner and meeting to strengthen relationships and preempt problems.

Perceived Lack of Consumer Empowerment

HIV/AIDS service providers have worked for years to provide opportunities to increase consumer empowerment. Efforts include the Ohio AIDS Coalition leadership conference, consumer participation in the Ryan White CARE Consortium, and various housing-related workshops. These approaches are valued by consumers and providers alike. However, some are unaware of these opportunities, while many have ideas for expanding efforts at consumer empowerment.

In consumer focus groups, many consumers expressed a desire for **training and education** that would help make them more independent. Specifically, consumers expressed an interest in a support group for **young mothers, peer support groups, and self-advocacy** trainings. Consumers also expressed an interest in participating in setting priorities and making decisions about **HIV/AIDS funding**, including funding for housing. Both consumers and key stakeholders expressed an interest

in additional **job training and education**, including a consumer suggestion to combine housing with a job program.

Strengths in Empowering Consumers

The active interest expressed by consumers in focus groups, the consumer survey, and participation in the existing system is an essential building block for increasing consumer empowerment. Already, the HIV/AIDS system has numerous strategies in place to help increase consumer empowerment. For example, the Central Ohio HIV/AIDS Consortium includes 25 percent consumer members. Service providers across the state provide various forms of training and education with this goal in mind.

Fragmented Network

Although a variety of housing and services are available throughout the eight-county region, and in some areas service and housing providers are extremely well connected, there are other parts of the region where the network of housing and services are more fragmented. One concern is the amount of time needed for consumers to **enroll in benefits**, such as Supplemental Security Income (SSI). The Rebuilding Lives PACT Team Initiative, which recently began in Franklin County, is piloting an approach to expedite access to benefits for the chronically homeless.

Within the HIV/AIDS service system, key stakeholders identified some inconsistencies in the **case management** system. In more rural areas, local AIDS task forces rely mainly on volunteers and have inconsistent capacity, which makes it more difficult to provide services. In other cases, turnover among staff and variations in training and experience mean that consumers receive different levels of services. Finally, particularly in the more rural communities, service providers are not well connected and may not have **complete information** about the housing and services available in their area.

Strengths of the HIV/AIDS Services Network

The existing network of HIV/AIDS-related housing and services is a manageable size; while Central Ohio has many programs, it is not so extensive as to be unwieldy. Moreover, many connections already exist. Many members of this plan's Steering Committee hold seats on relevant coordinating groups, such as the Family Councils, and members are already active in local government planning and coordination groups and meetings.

Fear of Confidentiality Violations

Consumers' concern that their HIV-status will not be kept confidential can be a barrier to accessing services and housing assistance, and is an added **source of stress** for those who do access services and housing. For example, a consumer in a focus group of formerly homeless people reported feeling anxious in an emergency shelter after revealing his HIV status to the staff there, because he was not confident that the information would remain confidential and was concerned about what could happen if others found out. In this situation, the information was kept confidential, but the fear itself was an issue.

Fear of confidentiality violations is particularly high in the more suburban and rural parts of the region, where key stakeholders reported **HIV/AIDS-related stigma** more often than those in Columbus and Franklin County. Most rural consumers who were interviewed talked about feeling social isolation, because they were not connected with other people living with HIV/AIDS, yet felt fear about identifying publicly as HIV-positive. In some cases, **confidentiality standards** may be lacking. One case manager mentioned a volunteer driver who demanded that a consumer reveal why s/he was going to the doctor before driving there; the consumer was forced to choose between maintaining confidentiality and accessing medical care.

A new discussion area related to confidentiality is the Homeless Management Information Systems (HMIS) required by the U.S. Department of Housing and Urban Development. While the Community Shelter Board has had HMIS for fifteen years, it is anticipated that the Shelter Plus Care units administered by the Columbus AIDS Task Force will be added to the system in the near future. The Ohio Department of Development's system is being expanded at this time as well. Exactly what information will be included for people living with HIV/AIDS and how it will be reported still needs to be worked out in a way that both complies with HUD's requirements and addresses community concerns.

Strengths in Confidentiality Protections

Laws already support protection of consumer confidentiality, and community members have extensive experience advocating for, understanding, and communicating confidentiality laws. The Health Insurance Portability and Accountability Act (HIPAA) provides privacy protections. Legal aid organizations in the eight-county region are an additional resource in this area. Finally, licensed social workers all have training and education on the issues, and are in a good position to educate both providers and consumers about confidentiality laws and protocols.

Recommendations

The Steering Committee and AIDS Housing of Washington developed these recommendations in September and October 2004. Recommendations are grouped into five themes. Implementation of these recommendations will require the input and participation of many groups and individuals throughout the region. Recommendations should be revisited regularly to gauge progress, assess strategies, and prioritize next steps.

1. Increase housing opportunities for people living with HIV/AIDS, ensuring that a variety of models including both sober and harm reduction housing are available throughout the eight-county region by expanding existing partnerships and creating new ones.
 - Explore opportunities to use HOPWA funding to secure units set-aside for people living with HIV/AIDS in new affordable housing developments, such as those being developed by the Community Housing Network and the Columbus Housing Partnership.
 - Issue a Request for Proposals to provide HOPWA funds for costs in new affordable housing developments outside of Franklin County, with a preliminary goal of two new set-aside units each in two counties, drawing on the expertise of the local Corporation for Supportive Housing office.
 - Seek new funding sources for a flexible rent and mortgage assistance program, potentially allowing for shallow rent subsidies, that serves multiple counties of the region.
 - Explore setting aside a portion of HOPWA funds to combine with Community Shelter Board funds for programs serving people with multiple disabilities.
 - Analyze the potential for expanding Pater Noster House at its existing site, possibly using HUD's Section 811 program.
 - Explore opportunities for additional housing authority partnerships throughout the region.
 - Participate in efforts to increase resources for affordable housing development at the local, state, and national levels.

2. Strengthen the capacity of suburban and rural communities to address HIV/AIDS housing issues.
 - Develop consistent messages about HIV/AIDS and HIV/AIDS housing to communicate to policy makers and the general public, in order to increase the awareness, understanding, and political will to address HIV/AIDS housing needs locally.
 - Recruit existing community leaders in housing and services and interested consumers to act as spokespersons for HIV/AIDS housing issues in relevant forums, including Consolidated Plan processes, the Delaware County Affordable Housing Task Force, the Union County Housing Coalition, the Licking County Housing Initiative, and others.

- Partner with the Coalition on Homelessness and Housing in Ohio (COHHIO) and the Ohio Department of Development to support increasing the capacity of Continuum of Care systems, particularly in Fairfield and Union Counties, to better address the housing needs of all people experiencing homelessness, including those living with HIV/AIDS.
 - Encourage the participation of the HIV/AIDS services system in the Ohio Department of Development Continuum of Care review committee.
3. Local housing and service models that serve people who experience homelessness offer examples of coordination and collaboration, as well as involve the participation of many systems and resources accessed by people living with HIV/AIDS. Continue and increase the connections between the HIV/AIDS service system and homeless systems.
- Provide information and training as needed to emergency, transitional, and permanent supportive housing programs to increase their capacity to reach out to and serve people living with HIV/AIDS.
 - Explore opportunities for homeless outreach teams to offer rapid HIV testing throughout the metropolitan area.
 - Collaborate with the Community Shelter Board and the Ohio Department of Development to ensure that HIV/AIDS housing programs serving people who are homeless participate in the homeless information management systems (HMIS) in a way that handles confidential information so as to address both HUD's standards and community concerns.
 - Support and strengthen the Columbus Health Department's current participation in the Community Shelter Board's Rebuilding Lives Funder Collaborative and Continuum of Care Steering Committee.
 - Explore the feasibility of replicating direct access to housing models that are appropriate for people living with HIV/AIDS.
4. Continue efforts to empower people living with HIV/AIDS to increase their independence.
- Seek opportunities to connect with education, entrepreneurship, job training, and employment programs, including housing organizations that employ residents and the Center for Vocational Alternatives.
 - Educate and support consumers to advocate for themselves wherever they seek assistance.
 - Explore the creation of a peer-mentoring program, in which consumers with successful housing experiences are employed to assist others in their search for housing, providing support for consumers while freeing case manager time to address other issues.
 - Train organizations in ways they can enhance consumer participation.
 - Develop volunteers to participate in HIV/AIDS and non-HIV/AIDS-related groups and councils; provide support to volunteers on an ongoing basis to ensure success.

5. Establish an information-sharing and problem-solving network that engages service providers, housing developers, and property managers.
 - Create a landlord speaker and outreach bureau, building on existing relationships with landlords to create more housing opportunities. This may help consumers who would otherwise be screened out due to personal circumstances including poor rental or credit histories and histories of incarceration.
 - Institute a regular regional meeting to discuss systems issues to overcome disconnections between housing and service providers.
 - Institute a regular regional meeting to discuss and coordinate clinical staffing.
 - Identify the population living with HIV/AIDS that is appropriate for supportive housing but not served by existing models by engaging case managers and housing providers.
 - Participate in and/or develop local initiatives to address housing issues for formerly incarcerated people.
 - Offer ongoing training on confidentiality protocols for front-line staff.
 - Educate consumers to understand laws regarding confidentiality and how they can advocate for themselves if needed.

Central Ohio HIV/AIDS Housing Plan

Appendices

November 2004



The research, development, and publication of this plan was funded in part by the Housing Opportunities for Persons with AIDS (HOPWA) National Technical Assistance Program in partnership with the U.S. Department of Housing and Urban Development's Office of HIV/AIDS Housing. The substance and findings of the work are dedicated to the public. The author and publisher are solely responsible for the accuracy of the statements and interpretations contained in this publication. Such interpretations do not necessarily reflect the views of the Government.

Table of Contents: Appendices

Appendix 1: Steering Committee Meeting Notes	A-1
April 6, 2004	A-1
May 4, 2004	A-4
June 22, 2004	A-6
July 27, 2004.....	A-9
September 20, 2004.....	A-12
September 21, 2004.....	A-16
October 19, 2004.....	A-20
Appendix 2: Focus Group Summaries	A-25
Franklin County Consumers	A-25
Franklin County Consumers: Homelessness Focus	A-28
Women: Franklin County.....	A-31
Rural Consumers: Delaware, Fairfield, and Licking Counties	A-33
Appendix 3: Central Ohio HIV/AIDS Housing Survey	A-37
Appendix 4: HIV/AIDS Housing Survey Data	A-49
Appendix 5: HIV/AIDS Housing Planning in Central Ohio, 1989 to present	A-73
HIV/AIDS Housing Planning in Central Ohio.....	A-73
Update of the Vision 2000 HIV/AIDS Housing Plan	A-74
Appendix 6: Federal Financing Sources for Affordable Housing	A-75
U.S. Department of Housing and Urban Development (HUD) Consolidated Plan Programs	A-75
Homeless Assistance Continuum of Care	A-77
Other HUD Programs.....	A-78
Low Income Housing Tax Credits	A-79
Appendix 7: HIV/AIDS Housing Continuum.....	A-81
Emergency Housing Assistance	A-81
Transitional Housing Assistance.....	A-84
Permanent Housing Assistance	A-86
Specialized Care Facilities	A-94
Appendix 8: Glossary of HIV/AIDS- and Housing-Related Terms.....	A-95

Appendix 1: Steering Committee Meeting Notes

A list of attendees and meeting notes are included in the appendix for each of the Steering Committee meetings that occurred during the needs assessment process.

April 6, 2004

Attendees

Cassandra Ackerman	<i>Community Advocate</i>
Tom Albanese	<i>Community Shelter Board</i>
Peggy Anderson	<i>Columbus AIDS Task Force</i>
Terry Brown	<i>Delaware County AIDS Task Force</i>
Nikki Delgado	<i>Corporation for Supportive Housing</i>
Becky Edwards	<i>Fairfield County Families and Children First Council</i>
Beth Fetzer-Rice	<i>The Salvation Army</i>
Scott Gary	<i>Ohio Department of Development</i>
Nina Lewis	<i>Columbus Health Department</i>
Kristin McCloud	<i>Licking County Coalition for the Homeless</i>
Tom McNamara	<i>Pater Noster House</i>
Julie Miller	<i>Morrow County Health Department</i>
Kim Oiler-Morely	<i>Mental Health & Recovery Board</i>
Michelle Rush	<i>Columbus AIDS Task Force</i>
Kevin Sullivan	<i>Ohio AIDS Coalition</i>
Phillip Zimmerman	<i>Pater Noster House</i>

AIDS Housing of Washington: Donald Chamberlain and Kate Kingery

Welcome and Introductions

Nina Lewis welcomed everyone to the first Steering Committee meeting of the Central Ohio HIV/AIDS Housing Needs Assessment and Planning Process. She asked everyone to share their name, agency affiliation, and expertise or interest in housing.

Context of AIDS Housing Nationally and Locally

Donald Chamberlain presented information on HIV/AIDS nationally, regionally, and locally about HIV/AIDS, housing affordability, AIDS housing resources, consumer survey findings, and related planning issues. An estimated 800,000 to 900,000 individuals are living with HIV in the United States. In the Central Ohio Eligible Metropolitan Statistical Area (EMSA), the Ohio Department of Health reported 1,970 individuals living with HIV/AIDS as of December 31, 2002. The eight counties in the EMSA covered in the planning process include: Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, and Union Counties.

History and Context of Planning in Central Ohio

Nina Lewis shared some of the history of planning in the Central Ohio area. The last HIV/AIDS housing plan was completed in 1993. It covered only Columbus, and it envisioned activities until 2000. Other planning efforts that related to this work include the Continuum of Care planning process for people who are homeless and Consolidated Plan process for use of U.S. Department of Housing and Urban Development funds.

Steering Committee members suggested changing the name of the planning process from “Columbus EMSA” to “Central Ohio” HIV/AIDS Housing Needs Assessment and Planning Process.

Overview of the Needs Assessment and Planning Process

Kate Kingery walked Steering Committee members through the steps of the needs assessment process and expectations for participants. She explained that AIDS Housing of Washington would facilitate the process and gather data, which will be presented to the Steering Committee. At the end of the data gathering process, the Steering Committee will identify critical issues and recommendations for addressing those issues. AIDS Housing of Washington will then write the plan, which is expected to be issued by the end of November.

Kate described the data steps including consumer focus groups, a consumer housing survey, key stakeholder interviews, and review of background data on housing, homelessness, epidemiology of HIV/AIDS, and dedicated resources for people living with HIV/AIDS.

Anticipated Outcomes of the Needs Assessment and Planning Process

Donald Chamberlain asked participants to identify their desired or anticipated outcomes from the planning process, which included:

- Long-term rental assistance in Fairfield County
- Services available in Fairfield County so people can stay home
- Identification of local needs and opportunities to meet them
- Putting dollars where the needs are
- Learn more about resources
- Show linkage between housing and treatment
- Find out why more people are diagnosed
- Strengthen Central Ohio Ryan White Consortium, especially in the rural counties
- Better coordination with other planning processes
- Raise awareness and understanding of people living with HIV/AIDS and their housing situations
- Increase housing units dedicated to people living with HIV/AIDS

- Nurture relationships in Madison and Pickaway Counties
- Address staff turnover in rural areas
- Correctional and institutional discharge and in-reach
- Coordinate programs and resources
- Examples of re-entry housing for ex-offenders
- Identify individuals and families who self-identify as homeless, including both those in shelters and those not using shelters

Next Steps

Kate Kingery explained that one consumer focus group was held the previous evening in Columbus and asked participants for recommendations on additional groups to hold during the process. Priority members identified included: rural consumers, southern counties, northern counties, Licking County, Fairfield County, families with children, Hispanics/Latino, Somalis, and homeless men and women. Kate said she would develop a proposal to present at the next Steering Committee meeting.

Kate also asked for volunteers to participate on the survey development workgroup. Volunteers included: Cassandra Ackerman, Becky Edwards, Kim Oiler-Morley, Nina Lewis, Tom McNamara, Julie Miller, and Michelle Rush. The group planned to meet by conference call and develop a draft survey tool to present to the Steering Committee at the next meeting.

Participants were asked to identify key stakeholders for AIDS Housing of Washington staff to interview in each of the counties. Forms were distributed and participants were invited to fax or email additional names to Kate.

Next Meeting

The next meeting was scheduled for Tuesday, May 4 from 2:00 to 4:00 pm at the Columbus Health Department. AIDS Housing of Washington offered to show a video on rural AIDS housing in Alabama prior to the Steering Committee meeting from 1:00 to 2:00 pm.

May 4, 2004**Attendees**

Cassandra Ackerman	<i>Community Advocate</i>
Peggy Anderson	<i>Columbus AIDS Task Force</i>
Terry Brown	<i>Delaware County AIDS Task Force</i>
Becky Edwards	<i>Fairfield County Families and Children First Council</i>
Beth Fetzer-Rice	<i>The Salvation Army</i>
Sue Hanson	<i>HelpLine of Delaware and Morrow Counties</i>
Scott Inskeep	<i>Madison County Health Department</i>
Nina Lewis	<i>Columbus Health Department</i>
Kristin McCloud	<i>Licking County Coalition for the Homeless</i>
Julie Miller	<i>Morrow County Health Department</i>
Kim Oiler-Morely	<i>Mental Health & Recovery Board</i>
Michelle Rush	<i>Columbus AIDS Task Force</i>
Phillip Zimmerman	<i>Pater Noster House</i>

AIDS Housing of Washington: Kate Kingery

Alabama Rural AIDS Project

Kate Kingery presented a video on the Alabama Rural AIDS Project (ARAP) prior to the meeting for Steering Committee members interested in rural housing. More information about rural housing or ARAP is available from AIDS Housing of Washington (AHW).

Welcome and Introductions

Nina Lewis welcomed everyone to the second Steering Committee meeting of the Central Ohio HIV/AIDS Housing Needs Assessment and Planning Process. She announced that the first week in May was HIV/AIDS awareness week and shared information about some of the events being held in Columbus.

Phillip Zimmerman shared photographs from Pater Noster House showing the condition of the house prior to board members taking over operations. Kate Kingery said that she had visited Pater Noster House earlier in the day and commented on the dramatic changes in the physical structure and positive comments from residents.

Vision for the HIV/AIDS Housing Planning Process

At the last meeting, Donald Chamberlain from AHW proposed developing a vision statement for the needs assessment and planning process to help frame the work and guide the process. In response, Julie Miller prepared a draft statement, which served as the basis for recommendations and revisions from Steering Committee members. The statement proposed by the Steering Committee was:

The vision of the Central Ohio HIV/AIDS Housing Needs Assessment and Planning Process Steering Committee is to establish a regional baseline of and advocate for quality housing resources for persons living with HIV/AIDS and their families. In pursuit of this vision, the commitment of Steering Committee members is to increase knowledge and understanding of the housing and service needs of people living with HIV/AIDS in Central Ohio and to identify opportunities to address those needs.

The draft statement will be presented at the next Steering Committee meeting for final comment and approval.

Consumer Housing Survey

Prior to the meeting, Steering Committee members received a copy of a draft consumer housing survey that was prepared by the survey workgroup participants who volunteered at the last meeting. Kate Kingery walked everyone through the questions and asked for proposed revisions to the draft tool. After incorporating the Steering Committee members' comments into the revised survey, Kate said she would coordinate the Spanish translation with other AHW staff then work with the Columbus AIDS Task Force (CATF) staff to distribute copies across the eight counties. The goal is to get 200 completed surveys returned by August 6. CATF will coordinate the survey process and participants will be offered a \$10 gift card for completing the survey. AHW plans to present mid-point survey results to the Steering Committee at the July meeting. Final results will be presented in September.

Update on Needs Assessment Activities

Kate Kingery provided an update on activities scheduled during her stay in Ohio. She planned to meet with key stakeholders in Licking County and conduct one consumer focus group by phone and another in person. Both groups were arranged by Kristin McCloud and the Licking County Coalition for Housing. Kate said she expects to focus on Fairfield County during her next trip to Ohio. Nina Lewis encouraged all Steering Committee members to continue to submit names and contact information of key stakeholders for Kate to talk to in person or by phone.

Next Meeting

The next meeting was scheduled for Tuesday, June 22 from 2:00 to 4:00 pm at the Columbus Health Department.

June 22, 2004

Attendees

Cassandra Ackerman	<i>Community Advocate</i>
Tom Albanese	<i>Community Shelter Board</i>
Peggy Anderson	<i>Columbus AIDS Task Force</i>
Becky Edwards	<i>Fairfield County Families and Children First Council</i>
Sue Hanson	<i>HelpLine of Delaware and Morrow Counties</i>
Scott Inskeep	<i>Madison County Health Department</i>
Nina Lewis	<i>Columbus Health Department</i>
Michelle Rush	<i>Columbus AIDS Task Force</i>
Kevin Sullivan	<i>Ohio AIDS Coalition</i>
Molly Swisher	<i>Fairfield Affordable Housing, Inc.</i>
Mike Tynan	<i>Community Housing Network</i>

AIDS Housing of Washington: Kate Kingery

Welcome and Introductions

Nina Lewis welcomed everyone to the third Steering Committee meeting of the Central Ohio HIV/AIDS Housing Needs Assessment and Planning Process. She announced a few changes in the membership of the Steering Committee. Both Julie Miller and Tom McNamara have left the Steering Committee after leaving their respective positions, and Molly Swisher from Fairfield Affordable Housing, Inc. joined the Steering Committee.

Kate Kingery also announced that she planned to leave AIDS Housing of Washington (AHW) on July 8. She will be replaced by Amy Davidson who formerly worked with AHW and was raised in the Columbus area. Amy and Donald Chamberlain will be facilitating the July Steering Committee meeting.

Panel Discussion with HIV/AIDS Case Managers

Nina Lewis invited three panelists to share their perspectives and experiences working as case managers for people living with HIV/AIDS: Linda Laroche from the Columbus Health Department (CHD), Bev Moran from Columbus AIDS Task Force (CATF), and Susan Moss from CATF.

The three case managers focused on people newly diagnosed with HIV/AIDS, people who are homeless, and residents of rural areas. Some of the issues raised by the panelists and Steering Committee members included:

- Seeing more co-occurrences between tuberculosis and HIV, especially among African nationals
- More non-English speakers testing positive, increasing issues of documentation of legal status, confidentiality, homelessness, and transgender clients
- HIV another issue for people with already complex lives
- Seeing more young men, particularly minors who are not living independently
- Overcrowded housing an issue, especially among immigrant populations

- Many immigrants and refugees rely on familiar and ethnic community networks, not mainstream social service organizations
- Seeing issues that are reflective of poverty
- Stigma attached to homelessness
- Family ties often broken due to addiction, mental illness, and other family relationship issues
- People who are homeless more likely to come into care only when faced with a crisis
- Not a lot of information about HIV and resources available among homeless community
- Difficult to take medications when homeless
- At shelters, medications need to be locked up and not always accessible
- Difficult to take medications with food when homeless
- Poor credit, history of evictions, and struggles with addiction are barriers to housing
- Harder to get housing after being without housing
- Importance of peer network and social support
- Cannot find subsidized housing for sex offenders and seeing more offenders in need of help
- Estimated 50 percent of rural clients without stable housing
- Rural issues include: isolation, no transportation, no peer support, discrimination/stigma related to HIV, sexual orientation, homelessness, few services available, no shelters available
- Importance of providing training for staff at agencies in rural areas

Review of Background Chapters

Kate asked participants for their comments on the background chapters to be included in the final plan. The chapters are intended to present a context for epidemiology of HIV/AIDS, population, income, housing, homelessness, and resources dedicated for people with HIV/AIDS.

Steering Committee members requested more information about comparative state rankings for AIDS case rates, references to multiple diagnoses and data specific to Central Ohio, and information about emerging populations such as immigrants and refugees. Steering Committee members involved with the consumer housing survey asked for a note to be included in the survey results write-up reflecting their concern that consumers may not have accurately identified their housing challenges or had different expectations of acceptable housing environments compared to providers.

Steering Committee members also identified additional data sources to reference in the background sections:

- Franklin County Rebuilding Lives Plan (Tom Albanese will send)
- Fairfield County Consolidated Plan, Community Housing Plan, and Continuum of Care (Becky Edwards will send)
- Franklin County Continuum of Care (available from Nina Lewis in August)
- Delaware County Continuum of Care and Delaware County Housing Affordability Study (Sue Hanson will send)
- Delaware County United Way needs assessment (www.delawarecares.org)
- Licking County Homeless Coalition (ask Kristin McCloud)

- State Consolidated Plan (ask Scott Gary)
- Ryan White funding information (Peggy Anderson will send)
- Review Community Research Partners data (web site)

Update on Needs Assessment Activities

Kate Kingery provided an update on the needs assessment activities. She scheduled group meetings in Delaware, Fairfield, and Union Counties during the week. She focused on Licking County during her previous trip. Contacts in Madison, Morrow, and Pickaway Counties will be covered by phone. Columbus contacts will be covered in July by Donald Chamberlain and Amy Davidson.

Three focus groups have been completed: one for Franklin County residents, one for Licking County residents, and one for women (held in Columbus). Kate said she hopes to be able to talk to additional consumers in counties outside of Franklin by phone. A final group may be held in July for residents in Franklin County with an emphasis on individuals who are currently homeless.

Michelle Rush announced that approximately 110 completed consumer housing surveys have been returned. The target goal to complete by August 6 is 200. She printed an additional 100 copies of the survey and hopes to surpass the 200 goal. Midpoint survey data will be presented to the Steering Committee at the July meeting.

Approval of Steering Committee Vision

Steering Committee members approved the vision statement draft that was revised during the May Steering Committee meeting.

Schedule of Meeting Dates

The next Steering Committee meeting will be held on Tuesday, July 27 from 2:00 to 4:00 p.m. at the Columbus Health Department.

Members were asked to hold the following dates and times for the remaining meetings:

- Monday, September 20 from 2:00 to 4:00 pm (presentation of findings from data collection)
- Tuesday, September 21 from 8:00 – 12:00 pm (identification of critical issues)
- Wednesday, October 20 from 8:00 – 12:00 pm (identification of recommendations)

July 27, 2004

Attendees

Cassandra Ackerman	<i>Community Advocate</i>
Tom Albanese	<i>Community Shelter Board</i>
Peggy Anderson	<i>Columbus AIDS Task Force</i>
Scott Inskip	<i>Madison County – Lincoln City Health Department</i>
Nina Lewis	<i>Columbus Health Department</i>
Michelle Rush	<i>Columbus AIDS Task Force</i>
Kevin Sullivan	<i>Ohio AIDS Coalition</i>
Deb Tegtmeyer	<i>Licking County Coalition for Housing</i>
Mike Tynan	<i>Community Housing Network</i>

AIDS Housing of Washington: Donald Chamberlain and Amy Davidson

Welcome and Introductions

Donald Chamberlain asked participants to go around the room and share something about themselves as an ice-breaker. Amy Davidson welcomed participants and asked Nina Lewis to say a few words. Nina thanked participants for coming and announced a new support group for HIV+ women on healthy relationships at Tobias, and she passed out flyers. Nina also announced a meeting on July 28, sponsored by the Sierra Club and the Columbus Coalition for the Homeless to discuss affordable housing and smart growth in Columbus. Mike Tynan reported that he had made outreach phone calls, and was really encouraged by the high level of interest in this issue.

Nina made a brief report on the status of HOPWA funding, having recently reported to the HUD regional office. Columbus has received \$14 million in HOPWA funds on behalf of the metropolitan area in total, and currently has approximately \$700,000 that is not obligated. Nina reported that this has been a strategic decision so that funds are available once the plan is complete, for an RFP later this year. Cassandra Ackerman and Kevin Sullivan had questions about requirements for administering HOPWA. Because a jurisdiction has up to 3 years to allocate the HOPWA funds, there is flexibility about how they can be used. Donald reported that some jurisdictions set aside a portion for capital development every year, and wait until a sufficient amount is available to invest it. Cassandra commented that the population outside of Columbus and Franklin County is growing dramatically, and it would be helpful to look at this growth in the plan to help guide future action.

Nina announced that Cassandra will be joining the National AIDS Housing Coalition as the Midwestern consumer representative. NAHC is a prominent and active group. Cassandra's new national role is an affirmation of her advocacy locally. Congratulations, Cassandra!

Donald reported that HUD is revising the CAPER and that HOPWA programs should expect new data reporting requirements soon.

Survey Data

Amy Davidson took a few minutes to introduce herself before reviewing the midpoint survey data. She is taking over Kate Kingery's role. Amy worked for AIDS Housing of Washington for several years in Seattle before moving to San Francisco last year. She grew up in the Columbus area and still has family here. Her other background includes working for a nonprofit housing developer, in city government, and in a homeless shelter. She has a master's degree in public policy.

Amy walked participants through a handout of mid-point survey data which had been distributed before the meeting. As of early July, 97 surveys had been completed. The original goal was 200 surveys, which has been increased to 300 since the response has been so strong. So far, survey respondents appear to be similar to the population known to be living with HIV/AIDS, which means survey outreach is going as it should be. AHW will present all the final survey data in the plan, and summarize findings.

Michelle Rush reported that survey distribution is continuing to go well, and that a total of 196 surveys have been completed to date.

Presentation by Nikki Delgado from the Corporation for Supportive Housing

Nikki Delgado gave the group a presentation about the Corporation for Supportive Housing. Slides from her presentation are attached.

A summary of participants' questions and comments follow, with responses:

- *HUD's focus with the chronically homeless now is on single adults. Does CSH have the same focus, or does it work with families? Does CSH ever get involved with transitional housing?* CSH works with more than single adults, acknowledging the needs of others, including families and foster youth. CSH has actually funded transitional housing for certain populations, but that is not the focus.
- *Who is the target audience for the various trainings CSH provides?* CSH trains service providers, housing developers, property managers, government, and others.
- *Can you tell us more about what is happening with Housing First?* Housing First is a program just being implemented in Cleveland. There, the 2 primary sponsors were the Enterprise Foundation and the Sisters of Charity, and involved 23 other organizations, including AIDS service organizations, in the planning. Two projects just received Low Income Housing Tax Credit allocations.
- *Does CSH usually fund buildings that have one specific population, or does it mix together different populations, for example, people with different disabilities?* It really depends on the project sponsor and the way they have designed the program. CSH has funded both.
- *Everybody's talking about mixed-income projects. Has CSH funded mixed-functioning projects? In other words, have you mixed people who need intensive services with people who need little or none?* Mixing income can sometimes have the effect of mixing functioning, to some extent. CSH has funded mixed-income projects, but not any that include market rate. Developers are often concerned about marketing market-rate units in a building that has supportive units. Donald commented that AHW often uses set-asides in mixed income, not entirely supportive housing projects, buying down the affordability level with Section 8 or HOPWA. AHW finds that having less than 10 percent, and no more than 20 percent of units in a project set-aside for supportive housing is ideal, because at that concentration, other residents don't really notice. With mixed income, location is often a critical factor; affordable housing is often in more affordable neighborhoods that may be less attractive to market-rate renters.

- *There doesn't seem to be a lot going on in Central Ohio related to employment in the supportive housing world. Is that true and why?* No, there aren't many employment activities. Community Housing Network (CHN) has a staff person for employment, but most providers aren't working on and don't necessarily understand the whole employment arena—the resources, organizations, the system. This is an opportunity for the future. CSH has a lot of expertise nationally on the topic. Mike reported that it is difficult to fund a staff position at a high enough level to make a strong impact. Donald commented that the United Way and the business community here are potential partners. Cassandra commented that employment is becoming more important as more people living with HIV/AIDS are living longer. Deb asked whether it is really necessary to have a separate HIV/AIDS jobs program. What would help is a homeless jobs program. Nikki encouraged participants to follow up with her if they needed more information or assistance. She can be reached at 614.228.6263, ext. 223 or nikki.delgado@csh.org.

Discussion of Counties outside of Franklin

Nina had invited Deb Tegtmeier to discuss her experience with the Licking County Continuum of Care and the recent one-night count. The meeting was starting to run late, and the group had a general discussion of housing outside of Franklin County.

Donald reported that Coalition on Homelessness and Housing in Ohio (COHHIO) has submitted an application for 700 Shelter Plus Care vouchers for the balance of state. Participants were not sure which counties would be able to participate in the program, but this is a potential resource.

Deb commented that the biggest hurdle is not necessarily capital or housing resources, but that services are very difficult to provide. The county is really stretched, and possibly facing a decrease in state funding due to the tight budgets all around. Donald commented that if the only barrier to more housing units is services funding, then a good investment of Ryan White Title II funds may be in related services funding. Donald said that the context for this plan is that the reality includes no new resources. More than ever, it is critical to think about strategic spending to maximize leverage.

What are the practical models and what can be replicated? What are the existing resources and strengths to build on? CSH and CHN are both strong local assets.

Deb related her concerns about the Section 8 program and national policy changes. This is one of the most important resources. Fortunately, Ohio's national delegation has been able to help the state retain Section 8 resources in the short term. From Donald's perspective, the long-term outlook for Section 8 is good because so many people see the value in it.

Kevin commented that the capacity of AIDS task forces was an important factor in thinking about growth outside of Franklin County, and that just adding another staff person might do more harm than good to these small organizations. Donald responded that there may be other potential partners that already have the capacity to add additional services.

Schedule of Meeting Dates

Previously reserved meeting dates were revised to account for newly-identified conflicts. The group settled on the following times for the final 3 meetings:

- Monday, September 20, 12:30 to 4:00 pm
- Tuesday, September 21, 8:30 to 11:00 am
- Tuesday, October 19, 9:00 am to 1:00 pm (will include lunch)

All Steering Committee members participation is crucial at these final 2 meetings. AHW will report on its findings, then members will determine the critical issues, and devise strategies for future action.

September 20, 2004

Attendees:

Cassandra Ackerman	<i>Community Advocate</i>
Peggy Anderson	<i>Columbus AIDS Task Force</i>
Terry Brown	<i>Delaware County AIDS Task Force</i>
Becky Edwards	<i>Family and Children First Council of Fairfield County</i>
Beth Fetzer-Rice	<i>The Salvation Army</i>
Scott Inskeep	<i>Madison County – Lincoln City Health Department</i>
Nina Lewis	<i>Columbus Health Department</i>
Kristin McCloud	<i>Licking County Coalition for Housing</i>
Kim Morley	<i>Mental Health Recovery Board, Union County</i>
Michelle Rush	<i>Columbus AIDS Task Force</i>
Kim Stands	<i>City of Columbus Department of Development</i>
Kevin Sullivan	<i>Ohio AIDS Coalition</i>
Molly Swisher	<i>Fairfield Affordable Housing, Inc.</i>
Mike Tynan	<i>Community Housing Network</i>
Phillip Zimmerman	<i>Pater Noster House</i>

AIDS Housing of Washington: Amy Davidson

Welcome and Introductions

Amy Davidson welcomed participants to the first day of two days of meetings. Donald Chamberlain with AIDS Housing of Washington had been scheduled to attend these meetings but was unable to due to recent illness and work commitments. Donald will attend the final meeting in October.

Participants introduced themselves and made announcements. Phillip Zimmerman announced that Pater Noster House will be having an open house on Saturday, September 27 at 7 pm. The event will feature a concert. In addition to showing the community the recent improvements to Pater Noster House, the open house will also be a fundraiser. Pater Noster House was also recently featured in *Columbus Monthly*.

Kevin Sullivan announced that in 2005, the annual Ohio HIV/AIDS conference will feature a housing track of sessions to attend, in recognition of the increasing importance of the issue. The conference will take place on April 25-26, 2005.

Nina Lewis announced the upcoming 4th Annual Public Forum on Homelessness, sponsored by the Columbus Coalition for the Homeless, which will take place in Columbus on Wednesday, October 13 from 8:30 am to 5 pm. The Coalition has information on their website at www.columbushomeless.org.

Presentation of Findings

Amy walked the group through the six sections that were distributed prior to this meeting: the list of key stakeholders, the issues identified by key stakeholders, the survey data, the survey findings, the consumer focus group summaries, and the consumer focus group findings.

Participants had the following comments on the Issues Identified by Key Stakeholders:

- The sections that describe “rural issues” really include more “suburban issues.” Many areas that were rural until recently are more bedroom communities of the Columbus metro area at this point.
- Participants asked that the statistic cited by key stakeholders working for the Department of Corrections, that 12 percent of new HIV/AIDS cases in Ohio are diagnosed in the prisons, be double-checked. This is different from what some have heard.
- Add a definition of supportive housing to the section discussing it, so the section will be clear to readers.
- Cite Pater Noster House as an example of a successful existing structured transitional living program for people living with HIV/AIDS.
- Homelessness itself is invisible, but it is not an invisible issue.
- Some of the information in the sections on homelessness in Delaware, Fairfield, Licking, and Union Counties that was reported by key stakeholders is not correct.

Participants had the following comments on the Findings from Consumer Surveys:

- It would be helpful to include more of the information about housing stability (for example, the number of moves respondents have made recently) in the Findings section.
- The survey has enough information to identify people who are chronically homeless, and this would be good to include. It will be slightly different than HUD’s definition, but that can be clarified in the text.
- Income should be compared to the Fair Market Rents rather than poverty level. FMR is more relevant for housing purposes.
- It would be helpful to reference the sample size, especially in relationship to Franklin Counties versus counties outside of Franklin.
- Add data for people receiving SSI as their source of income.
- Clarify the last sentence.

Development of Critical Issues

The second half of the meeting was spent trying to answer the question “What are the most important issues the plan needs to address or acknowledge?” Participants were asked to draw on the consumer survey data, the consumer focus groups findings, the key stakeholder interviews, and their own experience. Participants started working alone then in small groups to identify issues. The entire group then worked to form these issues into themes. Themes identified follow below:

Lack of Affordable Housing

- Lack of affordable housing
- Housing affordability
- To better identify the availability of affordable housing all over the metropolitan area
- Rural area: lack of affordable housing
- Rural housing availability (resources)
- To emphasize the essential need for a “continuum” of affordable housing options for low-income persons infected with HIV

Inadequate Emergency Options

- Lack of shelter/emergency beds
- Transitional and shelter options

Existing Supportive Housing Options are Too Restrictive

- Substance abuse
- Housing instability
- Serious consideration of mental health issues
- Homelessness: episodic versus chronic
- Create a sharper emphasis on findings related to recent and past homelessness of low-income people infected with HIV
- Need for supportive housing

Existing Funding Sources are Too Restrictive

- Resistance to housing options (sober or harm reduction)
- Resistance to transitional housing by funders and developers
- Create a broad-based system of housing services coordination in rural/suburban areas, partnerships with “special needs” providers (Mental health, alcohol and other drugs, HIV)

Current Funding is Inadequate in Both the Amount and the Allowable Uses

- Need a bigger piece of the pie. Physical disability, HIV/AIDS, first time homebuyer, mentally disabled, home owners, working poor, and chronic homeless are all pieces.
- Maintain current resources
- People are living with HIV/AIDS longer than ever, which means there are more people to serve.
- Development of new partnerships between AIDS service organizations and housing developers, especially in Fairfield, Licking, and Delaware Counties.

Barriers to Obtaining Housing

- Relationship between housing and transportation
- Housing/services for persons leaving prison
- Criminal history
- Life after corrections
- Credit/eviction history
- To more strategically address/reduce affordable housing barriers such as negative credit, housing history, and legal history

Lack of Consumer Empowerment

- Peer support systems
- Education and empowerment of consumers
- Move clients towards more independence
- Vocational rehab options

Fragmented Network

- Reducing time for benefit enrollment
- Consistent case management system
- Resource provider education (provider communication about what resources exist, between organizations)

Fear of Confidentiality Violations

- Confidentiality concerns
- Lack of confidentiality (rural)

The plan document will include a section that identifies these issues, citing related data from the various types of research completed.

Preparation for Tuesday

Amy asked the group to start thinking ahead to the recommendations as they drove home. What can or should be done to address the issues identified? On Tuesday, the group will develop draft recommendations, but will not finalize these until October.

September 21, 2004

Attendees:

Cassandra Ackerman	<i>Community Advocate</i>
Tom Albanese	<i>Community Shelter Board</i>
Peggy Anderson	<i>Columbus AIDS Task Force</i>
Nikki Delgado	<i>Corporation for Supportive Housing</i>
Becky Edwards	<i>Family and Children First Council of Fairfield County</i>
Beth Fetzer-Rice	<i>The Salvation Army</i>
Scott Inskeep	<i>Madison County – Lincoln City Health Department</i>
Rob Johnson	<i>The Woodlands</i>
Nina Lewis	<i>Columbus Health Department</i>
Michelle Rush	<i>Columbus AIDS Task Force</i>
Kevin Sullivan	<i>Ohio AIDS Coalition</i>
Molly Swisher	<i>Fairfield Affordable Housing, Inc.</i>
Mike Tynan	<i>Community Housing Network</i>
Phillip Zimmerman	<i>Pater Noster House</i>

AIDS Housing of Washington: Amy Davidson

Welcome and Introductions

Amy welcomed participants back for the second day.

Discussion of System Strengths and Possible Recommendations

The issues identified on the first day of the meeting were used as a starting point for the second day. Specifically, participants were asked to think about what strengths the existing system has in these issue areas. Despite the needs that exist, and the possibilities for improvement, there are many things working well in the existing system. Participants worked in small groups to identify existing strengths and think about what recommendations for change could or should be made. Participants then shared the strengths and recommendations identified and shared them with the larger group. Notes from this discussion follow.

Critical Issue Identified	Existing Strengths	Recommendations
<p>Lack of Affordable Housing</p>	<p>Leadership has expertise</p> <p>2 members of this group (Aaron Riley at CATF and Cassandra Ackerman) are on the National AIDS Housing Coalition</p> <p>Case management system able to collect data better</p> <p>Land available in rural counties</p> <p>Central voice(s): Nina Lewis with HOPWA; in Fairfield County UW Director is a former director of LSS</p> <p>Available housing stock</p> <p>Housing development capacity</p> <p>Models exist</p> <p>Subsidy slots are more plentiful than in other parts of Ohio</p>	<p>New affordable housing developments in the metropolitan statistical area (MSA)</p> <p>New community-based organizations and housing development partnerships</p> <p>Additional housing development capacity</p> <p>Current analysis of gaps/needs</p> <p>Incorporate HIV/AIDS needs assessments and plans into the mainstream planning efforts; for example, the Consolidated Plan</p> <p>Additional affordable housing development resources: a local, state, and federal issue</p>
<p>Inadequate Emergency Options</p>	<p>Pater Noster House: recent improvements to facility and program</p> <p>Flexibility of HOPWA</p> <p>Friends of the Homeless is a helpful organization in Columbus</p> <p>Sheltering in Fairfield County</p> <p>Churches in Madison County</p> <p>Community Shelter Board Shelter Plus Care</p> <p>Good coordination and better capacity than most metropolitan areas in Franklin County</p>	<p>Empower the Coalition and Maryhaven to have outreach teams do instant HIV testing</p> <p>Establish or enhance rural homeless outreach teams to do instant HIV testing</p> <p>Improve access to shelter options in rural counties</p> <p>Licking County Housing Initiative to address capacity, policies, and procedures with the Salvation Army Shelter in Newark, to increase the ability to serve people living with HIV/AIDS</p>

<p>Existing Supportive Housing Options are Too Restrictive</p>	<p>Organizational capacity Supportive services network Relationships with Community Housing Network Amethyst, Inc. (provider in Columbus) Southeast, Inc. (provider in Columbus) Columbus AIDS Task Force (CATF) programs, Central and Reachout, make mental health counseling available but are not well known</p>	<p>Additional supportive housing that can also accommodate people with HIV/AIDS who are not chronically homeless, including mixed population supportive housing such as the examples of the Commons at Grant and Sunshine Terrace in Franklin County Advocates, service providers, and planners knowledgeable about HIV/AIDS needs to participate in local planning efforts, to include the Delaware County Affordable Housing Task Force, the Union County Housing Coalition, the Licking County Housing Initiative, and others</p>
<p>Existing Funding Sources are Too Restrictive</p>	<p>Creativity is endorsed and embraced, particularly with regard to the HOPWA program CSH is interested and involved, including active engagement with rural communities Strong public policy advocates are already involved</p>	<p>More service providers to get involved with public policy making</p>
<p>Current Funding is Inadequate in Both the Amount and the Allowable Uses</p>	<p>HOPWA funds are flexible Partnership network is strong</p>	<p>Lobbying and advocacy</p>
<p>Barriers to Obtaining Housing</p>	<p>Seasoned case managers Housing First approaches Harm reduction Ability to communicate and work with local landlords Bi-monthly landlord appreciation dinner and meeting to strengthen relationships</p>	<p>Use of or creation of more Shelter Plus Care vouchers Use of pre-existing landlords to educate other communities or new landlords on program experiences Use of supportive and status guidelines with landlords and clients</p>

<p>Lack of Consumer Empowerment</p>	<p>Opportunities for involvement exist Consumers are interested Consumers are active of the Central Ohio HIV/AIDS Consortium (25% of total members) Multiple efforts currently on educating consumers in HIV/AIDS community statewide Active consumer participant in this planning process</p>	<p>Consumer education: break up experiences so that clients experience small victories and stay motivated. Link motivated/empowered clients to follow up in appropriate arenas Expand model outside the HIV/AIDS community so that other community planning bodies include consumer participation Leadership training for consumers Training for agencies on how to include consumers Develop a cadre of volunteers (consumer and non-consumer) to sit at various commissions and boards; continue active mentoring and support for these volunteers Entrepreneurship training for consumers</p>
<p>Fragmented Network</p>	<p>The existing network is a smaller, manageable size with known players Members of the Steering Committee already hold seats in relevant coordinating groups, such as the Family Councils Members of the Steering Committee already participate in local government meetings</p>	<p>Regional meeting(s) to discuss and educate each other on systems needs/issues Regional meeting(s) to discuss and coordinate clinical staffing Potential name change for Licking County AIDS Task Force (program) to reflect all the counties served (more inclusive name) Directory of service providers needed to open communication</p>
<p>Fear of Confidentiality Violations</p>	<p>Laws Strong advocates in the community Legal Aid system Licensed social workers have strong knowledge of the issues and can educate both providers and consumers</p>	<p>Consistent staff trainings at community agencies, particularly front line worker Client trainings</p>

These draft recommendations will be a starting point for the next and final meeting of the planning process.

Next Steps

All Steering Committee members will receive a draft of the entire plan, including all of the background chapters distributed in June and those discussed on Monday, along with a section on the critical issues identified Monday. All members will have the opportunity to comment on the draft plan. Amy invited members to participate in a workgroup that will review and discuss the draft in more detail. Mike Tynan, Cassandra Ackerman, and Becky Edwards volunteered to participate. The draft will be mailed out on October 5, two weeks prior to the next meeting.

The next meeting will take place on Tuesday, October 19, from 9:00 am to 1:00 pm at the Columbus Health Department.

At the October meeting, the primary activity will be finalizing recommendations for inclusion in the plan. Participants also commented that it would be helpful to devote some time to planning for the roll-out of the plan.

October 19, 2004

Attendees:

Cassandra Ackerman	<i>Community Advocate</i>
Tom Albanese	<i>Community Shelter Board</i>
Peggy Anderson	<i>Columbus AIDS Task Force</i>
Michelle (Rush) Christopher	<i>Columbus AIDS Task Force</i>
Becky Edwards	<i>Family and Children First Council of Fairfield County</i>
Beth Fetzer-Rice	<i>The Salvation Army</i>
Nina Lewis	<i>Columbus Health Department</i>
Kristin McCloud	<i>Licking County Coalition for Housing</i>
Kim Oiler-Morley	<i>Mental Health Recovery Board, Union County</i>
Molly Swisher	<i>Fairfield Affordable Housing, Inc.</i>
Mike Tynan	<i>Community Housing Network</i>
Steven Wilson	<i>Pater Noster House</i>
Jennifer Zimmerman	<i>The Ohio State University College of Social Work</i>

AIDS Housing of Washington: Donald Chamberlain and Amy Davidson

Welcome and Introductions

Nina Lewis and Amy Davidson welcomed participated and reviewed the agenda. Participants introduced themselves. Michelle Rush had gotten married since the September meeting, and she is now Michelle Christopher. Congratulations, Michelle!

Discussion of Critical Issues Draft

The group started by discussing the draft of critical issues that had been distributed prior to the meeting. This 5-page document was developed based on the group's discussion at the September meeting, drawing together the findings from the consumer focus groups, key informant interviews, consumer survey, and Steering Committee meetings. The heading for each issue was developed by the group in the prior meeting.

Much of the discussion focused on the section entitled "Existing Supportive Housing Options are Too Restrictive." Many participants agreed that much of the section described the existing system, and was not clear enough on what is too restrictive, and that more discussion on the restrictions was needed. The group agreed to split the section into two parts, the first focusing on the need for additional supportive housing. While the existing system does include many models, there is not enough supportive housing to accommodate everyone.

The second part would focus on how funding sources and local priorities restrict eligibility. For example, while the mental health system has a well-developed range of housing options, it is geared toward people with certain diagnoses and others are ineligible. Primarily, though, participants were concerned about meeting HUD's definition of homeless, finding this to exclude many who had housing needs. For example, people who are doubled-up or "couch surfing," rather than on the street or in a shelter, are ineligible for many types of housing assistance. This section will be revised to clarify the issue.

There was a suggestion to make the specific barriers to obtaining housing into a bulleted list, in order to make that section easier to read. In addition, there was a suggestion to add discrimination based on race, family size or status, and HIV/AIDS to this section.

The group agreed to rename an issue "*perceived* lack of consumer empowerment". There are many efforts at consumer empowerment already going on, and although they need to be expanded, the initial name made it sound like there was nothing happening, which is not the case.

Finally, the group discussed adding some mention to the "fear of confidentiality violations" section about homeless management information systems (HMIS). All programs with McKinney funding are now required to participate. HOPWA programs are able to report aggregate data. Still, there is increasing momentum to report information including name and social security number, and this may increase fears.

Development of Recommendations

Donald led the group in developing recommendations to guide future action, starting with a draft list of recommendations developed by AIDS Housing of Washington, attached. Participants had the following additions (summarized here but will be incorporated fully into the recommendations that appear in the plan):

- Broaden HOPWA funding for housing to include operating and services funding, not just capital funds; developers may be able to piece together capital funds but have more difficulty with other types of funding. In some cases, a memorandum of agreement along with a commitment about existing services may be enough to secure dedicated units.
- Add a reference to working with the Corporation for Supportive Housing (CSH) related to the units outside of Franklin County.
- Clarify that the new source of rent and mortgage assistance would preferably serve any or all of the 8 counties, not just Franklin. Details of the administration would need to be worked out.
- Add a bullet point specifying that housing types should include both sober and harm reduction housing.

- Add a recommendation regarding expanding Pater Noster House. HUD's 811 program might be a good candidate for funding; it can fund up to 22 units for people with disabilities. A consultant can determine whether this might be feasible fairly quickly.
- Add a recommendation about working with housing authorities. The CATF Shelter Plus Care and Section 8 programs with CMHA are important resources and might be expanded and/or duplicated.
- Add a recommendation about working with COHHIO and ODD to develop Continuum of Care systems, especially in Fairfield and Union Counties. This will be an important step in increasing the capacity of those counties to address housing needs.
- Add a recommendation about HIV/AIDS participation in the Continuum of Care review for the state. Right now the only special needs system that appears to participate is the mental health system.
- Modify the recommendation about HMIS participation so that it includes all the counties, not just Franklin.
- Include a recommendation about replicating direct access to housing programs that are suitable for this population.
- Make the recommendation about vocational programs more specific.
- Modify the recommendation about participating in local initiatives to address housing for people who have a history of incarceration to include developing these initiatives as well. COHHIO has recently obtained a grant to deal with this issue.

Projection of Need

The group spent some time discussing data provided by AIDS Housing of Washington (attached) to develop a projection of the number of people living with HIV/AIDS who need housing assistance in the region. The survey found that 94 percent of respondents were unable to afford a one-bedroom at the Fair Market Rent in 2004, and that many of these have additional complicating factors, including history of homelessness, history of incarceration, substance use, mental illness, and other disabilities. While there are many ways of looking at the data, ultimately the group agreed that an estimate around 500 seems accurate. Approximately half of this need might be met by access to existing housing resources, while the other half might be met by increasing the housing resources dedicated to housing people living with HIV/AIDS. AHW will refine the information that was distributed prior to the meeting for inclusion in the plan, and will distribute it to Steering Committee members for final review.

Comments on Plan Draft

Amy thanked Mike Tynan and Cassandra Ackerman for volunteering to review the draft in detail, and having a conference call on Monday to give their detailed input. Amy reported that the epidemiology data appearing in the plan will be updated to the end of December 2003. Previously the most recently available data went through 2002. Amy also apologized for some computer errors in the glossary which rendered that section difficult to read; it will be corrected in the final draft.

Nina proposed making a dedication to Frankie Arnett, who agreed to serve on the Committee, but was unable to due to declining health and recently passed away. Other Steering Committee members thought this was appropriate. AHW agreed to add a dedication to Frankie and others who did not survive to see this plan.

The group made comments regarding the entire plan. Comments ranged from corrections to names, to typos, clarifications, and additional information that is required. The plan will be revised to reflect these changes.

Planning for Roll-Out of Central Ohio HIV/AIDS Housing Plan Draft

In the time remaining, the group discussed briefly the introduction of the plan. Nina mentioned that every Continuum of Care, the Ryan White CARE consortium, the CSB Funder Collaborative, the Columbus City Council's Health, Housing, and Human Services Committee were among the likely places that the plan should be presented. All agreed that just mailing out copies would not be sufficient, and individual and group meetings would be important to spreading the word.

The group also discussed the need for on-going meetings of a group similar to this one, which could bring together people working on HIV/AIDS housing throughout the region. Nina agreed to convene the group. Initially, quarterly meetings, potentially combined with another meeting, seem to be appropriate.

Peggy reported that CATF is planning a special event for World AIDS Day, December 1. The event will be at the Palm House at Franklin Park Conservatory, and will include an arts show and candlelight vigil. Donald suggested that this event might be a good time to launch the plan, with a housing theme and related speakers at the event.

Wrap-Up

Donald asked the group to share something that they appreciated about or learned during the planning process. Many expressed appreciation for working in a regional group, and developing a better understanding for how their local issues related to those in other areas.

Donald and Amy thanked the group for the opportunity to work in Central Ohio. Donald reported that another technical assistance organization has now contracted with HUD to serve the Midwest, so this will be AHW's last time working with this group.

Amy reported that Steering Committee members will be asked to review the Critical Issues, Recommendations, Executive Summary, and Projection of Need again. Those who are interested in seeing the entire revised draft prior to finalization should contact Amy.

Appendix 2: Focus Group Summaries

A total of 34 people living with HIV/AIDS in Delaware, Fairfield, Franklin, and Licking Counties participated in focus groups or individual interviews to discuss housing and services issues. Following is a summary from each group. Notes from meetings with consumers outside of Franklin County were written as though they had participated in one group in order to protect confidentiality. Potentially identifying details have been omitted to protect confidentiality. A summary of findings from these groups appears in the section of the plan called *Findings from Consumer Focus Groups*.

Franklin County Consumers

Location: Columbus AIDS Task Force (CATF)

Date: April 4, 2004

Interviewer: Kate Kingery, AIDS Housing of Washington

Notetaker: Donald Chamberlain, AIDS Housing of Washington

Participants: Ten participants

Participant Demographics and Background

Gender Identification: Nine men, one woman

Racial Identification: Six African American/Black, four White/Caucasian

County of Residence: Franklin County

Current Housing Situation

Participants were asked to describe their current housing situation. The following circumstances were described:

- Had lived with partner for sixteen years. Moved to Columbus a few years ago from another state. Partner ended relationship when tested positive for HIV. Was left with nothing and ended up moving recently into a one-bedroom apartment. Has been relying on Housing Opportunities for Persons with AIDS (HOPWA) subsidy.
- Diagnosed with HIV in 1990. Was incarcerated for about a decade and released within past few years without any transitional help. Got connected with support at the Columbus Health Department. Relied on that support to help get connected to medical care, housing, and employment. Concerned about previous partners. Has not shared information about HIV infection with family members. Beginning to make connections with neighbors and other peers. Currently renting an apartment with a Section 8 subsidy from the Metropolitan Housing Authority and CATF.

- Diagnosed with HIV last year. Met with case manager at Columbus Health Department. Yet did not ask for housing assistance due to lack of employment at that time. Currently living alone in a one-bedroom apartment in building with project-based Section 8 assistance and needs to stay for a minimum of one year. Moved in within the past year. Prior to that was living month-to-month in a market-rate efficiency.
- Currently lives in a one-bedroom with assistance from Shelter Plus Care and has been there for a few years. Was very ill and diagnosed with AIDS. Lived in a group home and expected to die there. Liquidated property before health improved.
- Currently renting own apartment and cares for other family member for nearly a year. Formerly lived in a clean and sober group home. Has never received Section 8 and believes that better services would have been available if had not been supporting another family member.
- Currently living with partner in an apartment with assistance from Shelter Plus Care. Both partners originally had Shelter Plus Care voucher but one had to give up the voucher when they married. Concerned about loss of housing resource if they decided to split up or divorce. Would have to start the housing assistance process over again. Has received help from CATF.
- Lives in a two-bedroom apartment with a caregiver. Receives assistance from CATF. Prior to that lived in a group home. HIV-positive for nearly ten years.
- Relocated to Columbus from another state about a year ago to be closer to family. Currently lives alone in an apartment with assistance from Shelter Plus Care. Also receives help from CATF.
- Currently lives in an efficiency apartment with assistance from Shelter Plus Care. Diagnosed with HIV more than twenty years ago and has received Shelter Plus Care voucher for almost a decade. Was a homeowner but lost house in foreclosure. Does not receive HOPWA assistance. Would like more information on different programs, where housing dollars come from, and how funding decisions are made.
- Was kicked out of housing upon HIV diagnosis. Currently lives in a quiet neighborhood in a private market apartment and pays 30 percent of income for rent. Has received some help from CATF. Has another disability.

Housing Preferences and Challenges

Participants were asked to indicate what they liked best about their housing situation and what they liked least. The following characteristics of their housing situations were cited:

- Feels some resentment about other residents of HIV/AIDS-dedicated housing who have no income and are not required to work. Dissatisfied with the drug and alcohol use in the building. Has strong self-advocacy skills and thinks that has helped him navigate the system. Is trying to share more knowledge with peers.
- Also expressed resentment about working and taking care of own bills but those who don't work get assistance for housing. Would like to see more assistance for those who are working but need a little more help.
- Worked for many years with HIV and does not understand why others cannot. Depression is certainly an issue for those diagnosed with HIV/AIDS. Medications can also cause health restrictions.
- Would like to have own house but does not have access to any resources. Would be very interested in getting connected with homeownership program.
- Partners must combine income if they live together, which makes them ineligible for assistance. However, living alone, both are faced with high rent burdens. Does not think the economics are very good. The option is to leave current housing program to live in a private market apartment with partner. Feels too vulnerable about the future to give up housing assistance.

- Housing inspection by Columbus Metropolitan Housing Authority seemed very brief and not comprehensive. Inspector arrived late and did not check smoke detector, appliances, or plumbing. Not certain now what to do about housing quality concerns that landlord won't fix.
- Very concerned about activity in AIDS-dedicated housing. Police are often called and there is a lot of onsite drug activity. No resident manager onsite and tenants must monitor each other and themselves.
- Grew up in Section 8 supported housing with family. Able to use parent's voucher.

Experiences Identifying, Securing, and Maintaining Housing

Participants were asked to relate their experiences searching for and maintaining a place to live. The following experiences were cited:

- Found housing on own and did not rely on CATF list. Enjoys private lifestyle out in more rural part of the county.
- Many housing subsidy certificates are being wasted on sub-standard housing in central, urban areas. Not many people are willing to move further out into suburban and rural areas. There should be a model of what standard housing looks like.
- Transportation a barrier to housing outside of the urban core of Columbus. If someone has to rely on the city bus, then housing options are limited.
- When looking for housing, need to have voucher in hand. The Columbus Metropolitan Housing Authority asks people to find a place first, then get the voucher. It's hard to give a 30-day notice on existing housing, then try to get approval for another apartment from the Housing Authority.
- Waited six months for housing assistance. Looked at three apartments from a list before giving up search. Ended up moving in with relatives at that time.
- A few years ago lived in AIDS-dedicated housing but had to go to a nursing home due to decline in health. Later moved in with family member. Could have gone to a shelter but was trying to stay clean and sober. Did not get much help from case managers and did not feel that different systems were talking to each other. Questioned the knowledge and education of case managers.
- Has not had problems finding a place to live with Shelter Plus Care voucher. Would like to move somewhere else (near the beach) but cannot move with voucher.
- Was living in a market-rate efficiency but could not continue to afford rent. Waited six months for assistance from CATF and was limited to where there was public transportation. Lives in AIDS-dedicated housing and is trying to stay one year to get a portable Section 8 voucher. Transportation still remains a problem and will impact next move.
- Poor credit or history of incarceration are barriers to finding a place to live. Was told that criminal history would keep individual out of housing. If convicted of a felony while in AIDS-dedicated housing, then voucher will not be renewed.

Recommendations for Improvement

Participants were asked what recommendations they would make for improvements in the housing continuum. The following suggestions were made:

- Case management staff varies. Need more consistency and training.
- Would like more connections to veteran's benefits and help from case manager.
- Turnover in case managers a problem. Have had several case managers over the past few years. It gets difficult telling personal story over and over again to different staff and having to get to know a new person. For some it is just a nine to five position, but others care a lot.
- Would like case manager to respond to phone calls.

- Need more self-advocacy and information. Individuals need to be more active in getting what they need and need more information. Would like more workshops.
- People with HIV/AIDS need to be involved in making decisions about HOPWA.
- Would like to start a business that is run by people living with HIV/AIDS that can provide incomes and help support housing programs.
- Interns can be too nosy about personal business and not respect boundaries. It is helpful for them to learn about the people they're dealing with.
- Had to meet case manager at agency because case manager would not come to client's apartment in a bad neighborhood.
- Don't feel understood as an older adult by some of the younger agency staff.
- Discontinue Shelter Plus Care program and put everything into Section 8 with a priority for people living with HIV/AIDS. Vouchers need to be more flexible.
- Some clients cannot fend for themselves, cannot work with other people, do not have social skills, so more help and support is needed.
- Would like more programs for people with HIV/AIDS who are not drug or alcohol users.

Franklin County Consumers: Homelessness Focus

Location: Columbus AIDS Task Force (CATF)

Date: July 26, 2004

Interviewer: Kate Kingery, AIDS Housing of Washington

Participants: Four participants

Participant Demographics and Background

Gender Identification: Three men, one woman

Racial Identification: Two African American/Black, two White/Caucasian

County of Residence: Franklin County

Current Housing Situation

Participants were asked to describe their current housing situation and whether they are seeking a different situation at this time. Responses were as follows:

- Currently staying with a friend. Has been staying with various friends since returning to Columbus after Job Corps in November 2003. This friend says she will allow participant to stay as long as needed, but it is difficult because she has children and it is kind of chaotic. Completed housing application with CATF case manager, and also is keeping an eye out for other options. Would prefer to live alone in a studio or one-bedroom.

- Staying with a friend at this point and paying to do so. Was living with his/her adult child and the child's partner before, but that did not work out very well. Has been approved for Section 8, after a May 2004 application. Pleased that it went so quickly. At this point, needs to provide a few other personal documents to complete the process. A little worried about it because does not know where the Section 8 can be used. Would prefer to select an apartment and hoping that it won't require living in an undesirable place.
- Just got Section 8 and has been living in the apartment for one month. Really likes the apartment because it is spacious and has an alarm system. Was very happy to get a list from the property manager, through CATF, of possible apartments to choose from and got to view several before selecting this one. Normally the rent would be \$410 per month but pays just \$56. Has been positive for five years, and has lived in other metropolitan areas. Came to Columbus because s/he thought there would be housing assistance. Was homeless for the first month here, but was able to find CATF pretty quickly. CATF case manager accompanied him/her to the Columbus Metropolitan Housing Authority and s/he was approved right away for Section 8. Thought this process worked very well, but very concerned that others won't have the same opportunity in the future. Knows that more people need help than there are resources available. Wants HUD to know that there is a real need for Section 8.
- Living in a nonprofit housing development and has been there about a month and a half. Before that, was staying with a relative but that was awkward because of her discomfort with HIV. Is glad to have this apartment, but it is not ideal—would have preferred another location further north. Now in the first pay period of a new part-time job.

Housing Preferences

Participants were asked about the most important considerations for housing:

- Affordability is the biggest criteria.
- Familiar location. Like being in places where lived previously.
- Safety of the apartment: safe wiring, sound ceiling, etc.
- Access to a bus line.
- Safety of the location. It is not desirable to have a lot of drug and illegal activity going on nearby. However, two participants commented that they were accustomed to living in "bad" neighborhoods so it didn't really matter; safety of the unit itself was more important.
- Enough space.
- Choice of apartments. "If this is my once-in-a-lifetime shot at an apartment, I want it to be a place I am comfortable."

Experiences Identifying, Securing, and Maintaining Housing and Assistance

All participants were working with CATF on housing or had already gotten housing assistance from CATF. Other helpful things were transportation assistance, such as gas money and bus passes, and food assistance, vouchers and pantry. Participants who had recently moved reported getting help with furnishings and also utility deposits. One participant reported that his/her adult child, who is not HIV-positive, gets counseling at CATF and that is a great resource.

Participants were asked about the type of transportation they used most. One had a car, and another a bike. One relied mostly on the bus, and the other used a combination of rides from mother or friends and bus if necessary. Most agreed that CATF's location is much more convenient than its old location, because the bus runs much more often.

One participant received medical services in the FACES program and the others go to the OSU hospital. None reported problems accessing medical care or medications.

One participant commented that it would be nice to have more support groups at CATF. S/he is aware of only one, and it conflicts with his/her work schedule.

Experiences with Homeless Shelters

One reported staying in a homeless shelter for a month after first arriving in Columbus. This shelter has a resource center, where s/he found information about and made connections to a doctor and CATF within a month. Based on this experience, s/he thinks that if people are ready and willing to work on it, there are opportunities for them to move on.

Another reported staying in a shelter a few years ago. At that time, s/he was using substances, which contributed to his/her homelessness. S/he felt a bit frustrated that s/he had been involved with case management at CATF for three years, including time spent in a shelter, before finding out that housing assistance was available. S/he surmised that the delay was related to his/her substance use; once s/he had been sober for a year and a half and was about to become homeless again, the CATF case manager offered housing assistance.

One reported being in a shelter for a month and a half before joining Job Corps. S/he found out about Job Corps independently. It was appealing because in addition to meals and a place to stay, Job Corps (unlike a homeless shelter) also offered job training. It was at Job Corps that s/he first tested positive for HIV. Before the shelter stay immediately before Job Corps, s/he was in a different a shelter. Of the two, s/he vastly preferred the shelter which had shared apartment-style rooms for a few people over the one that housed everyone together. Because of the lack of privacy, homelessness seemed preferable to that shelter.

Another reported having lived for about a year in a car in Cleveland. This was preferable to going into a shelter at that time. Also, was using substances then which made living in the car more appealing.

Participants were asked whether they thought being homeless was different for people who are HIV-positive versus people who are not. All agreed that it was different. The main difference participants saw was related to the immune system and physical health. Because there are so many people in shelters, there are many more possibilities for infection. It can be difficult to find a clean place to wash yourself. One participant reported that s/he would “rather sleep in my car and use a fast food bathroom” than stay in a shelter. Participants thought that many people who stay in shelters don’t have many domestic/living skills and tend to make the place messy and dirty as a result.

Participants also reported feeling vulnerable in a homeless shelter, because of personal safety and because of the lack of confidentiality. One described the people in the shelter as “rough and tough,” and felt out of place and somewhat scared. Also, a shelter staff person who knew a participant’s HIV status once yelled something over the counter that the participant thought was potentially too revealing. This made him/her nervous that other people would find out about his/her HIV status. One participant reported being open with shelter staff about HIV, saying that s/he was comfortable about his/her status, and felt that people could either accept it or not. Still, most agreed that disclosing HIV status only to people that seemed trustworthy was a good course of action, especially in shelters.

When asked about anything they had wanted or sought help with and not found, participants reported that housing was the only challenge. Other types of assistance and services were readily available when sought.

Recommendations for Improvement

Participants were asked about their ideas for improvements and priorities. Their responses were:

- Am new to all of this so really don't know. Mother works in the medical field and helps with most things, such as conducting internet research.
- More money is needed for housing. The programs now, especially Section 8, are good but need to be available for more people. Would like HUD and people in Washington DC to know that.
- Maybe more private fundraising from individuals would be helpful for CATF, and allow them to assist more people. Some AIDS organizations have art auctions or other special events.
- Community forums or in-service trainings about CATF's funding and budget for consumers would be helpful. Many consumers who have been in the system for a long time feel negative about CATF because they see assistance from CATF as an entitlement. People expect a level of assistance which is no longer available now that there is less money available and more people who need assistance. Consumers understand budgeting, though. If CATF offered a forum to let people know about their budget, consumers would be more understanding and also less frustrated with the help they are getting.

Women: Franklin County

Location: Columbus AIDS Task Force

Date: June 21, 2004

Interviewer: Kate Kingery, AIDS Housing of Washington

Participants: Thirteen participants

Participant Demographics and Background

Gender Identification: Thirteen women

Racial Identification: Eleven African American/Black, two White/Caucasian

County of Residence: Franklin County

Current Housing Situation

Participants were asked to describe their current housing situation. The following circumstances were described:

- Moved to Columbus within the past year from another state to live with extended family. Currently waiting for Medicaid, food stamps, and other assistance. Hard to get help. Would like to live independently. Has a history of substance use.
- Lives with child in apartment with assistance from Section 8 or possibly Shelter Plus Care (not certain). Been there less than a year and concerned about safety. Can't find a place that is safe and meets housing quality standards for only \$550 per month. Has to pay for storage and laundry machine in current apartment and is filling the gap between what Section 8 cap will cover and what's available in the housing market.
- Both partners have Shelter Plus Care voucher. Like being able to find own housing but would like more choices.

- Lives with child and grandchild. Very concerned about housing quality issues. Been in current place for many years.
- Lost job last year and had to move. Used relationship as a way to get into stable housing but ended up leaving relationship after some difficulty. Left state to stay with extended family but eventually returned to stay with immediate family. Got on waiting list through CATF for housing. Currently living alone in market-rate apartment and getting some help from family.
- Lives in apartment with children. Moved from another state to find a better community for family. Spent time in a shelter with children to get away from a bad living situation. Stayed at a different church each night. Through a transitional program, ended up living with children in a studio apartment. Grateful to have a place. Got a job and became eligible for a Section 8 voucher. Now living in a two-bedroom apartment and paying additional rent to live in a safer neighborhood. Been there for a few years. Able to get a car.
- Currently living alone in own place and working. Formerly homeless. Raised three children and now has grandchildren.
- Lives with child in apartment with assistance from Shelter Plus Care. Would like a portable voucher to be able to move to another community.
- Lives in condo after transitioning out of AIDS-dedicated housing. Formerly lived in transitional housing. Has raised more than ten children. Has developed self-advocacy skills and children are not supportive. Has good peer support and network of peers.
- Formerly homeless and now in an apartment with help from family. Waiting for assistance but has been difficult with an eviction on rental history. Currently relying on Supplemental Security Income (SSI) and does not have much money for housing.
- In current place for about a year. Not getting any help. Was on Section 8 waiting list through CATF.
- Renting an apartment and living with three children. Working full-time and has a flexible landlord. Been on Section 8 waiting list a while.
- Lost home and now renting. No assistance available to help with mortgage.

Housing Preferences and Challenges

Participants were asked to indicate what they liked best about their housing situation and what they liked least. The following characteristics of their housing situations were cited:

- Concern about neighborhood and building safety, especially for children.
- Would like to go to school but does not know how to make that happen.
- Very concerned about quality of current housing and working with housing authority and landlord on improvements.
- Concerned about racism and discrimination from current landlord.
- Would like portability with housing voucher. Shelter Plus Care does not allow residents to take the voucher to a new jurisdiction.

Experiences Identifying, Securing, and Maintaining Housing

Participants were asked to relate their experiences searching for and maintaining a place to live. The following experiences were cited:

- Did not want original case manager to know that much personal information.
- Challenge staying in emergency housing with children that changed every night.
- Difficulty with transportation trying to get children to school then going to work. Many bus routes are very time consuming.
- History of incarceration and eviction as barriers to housing.
- Difficult to get housing when not currently in housing.
- Hard to get things to start up a new household.

Recommendations for Improvement

Participants were asked what recommendations they had to improve the housing continuum. The following suggestions were made:

- Majority of women under age 35 with children need more guidance and direction.
- Want to know that hospice care will be available.
- Need more emergency housing and care.
- Need more peer support and self-advocacy training.
- Need more housing options and more information.
- Want places that are safe for children.
- Need a list of affordable, safe, quality rental properties.
- Need assistance for people with mortgages.

Rural Consumers: Delaware, Fairfield, and Licking Counties

Locations: Lancaster, Newark, and by phone

Date: May 4, May 5, June 24, and August 23, 2004

Interviewers: Kate Kingery and Amy Davidson, AIDS Housing of Washington

Participants: Seven participants

Participant Demographics and Background

Gender Identification: Five men, two women

Racial Identification: Five White/Caucasian, one African American/Black, one Native American

County of Residence: Delaware, Fairfield, and Licking Counties

Current Housing Situation

Participants were asked to describe their current housing situation. The following circumstances were described:

- Lives alone in a market-rate apartment. Receives rental assistance from HOPWA and can continue through 2005. Formerly lived with partner in own home and had to move after the relationship ended. Would like to live in Columbus where there are more resources but does not have transportation.
- Lives alone in a market-rate apartment since last summer and does not receive any housing assistance. Working full-time in occupation with physical demands.
- Lives with partner and other family member in apartment. Does receive some help from HOPWA for rental and utility assistance.
- Lives in house with child. Receives support from Section 8 through the local housing authority. Has concerns about housing quality.
- Living in house with partner. Concerned about what might happen if relationship ends.
- Is HIV-negative but lives with spouse who tested positive for HIV very recently and their two minor children. Have paid for apartment themselves but spouse recently had to stop working, at least temporarily and maybe indefinitely.
- Getting assistance from Section 8.

Housing Preferences and Challenges

Participants were asked to indicate what they liked best about their housing situation and what they liked least. The following characteristics of their housing situations were cited:

- Does not like current neighborhood. Has had property stolen. Formerly lived with a family member who was dealing drugs before moving into own apartment.
- Two-bedroom apartment is too small for family of four, and the landlord refuses to fix anything. Thinking about moving to a larger apartment but concerned about \$100 increase in price.
- Appreciates HOPWA assistance from the Coalition for Housing, especially utility assistance and help with clothing.
- Likes being able to have pets.
- Has a good landlord.
- Current landlord ok.
- Not getting any help from Licking County AIDS Task Force. No one available for assistance and staff turnover has been a problem.
- Evicted from previous housing and has a felony background. Fought discrimination case and won but could not renew housing assistance.
- Has family ties in the community.
- Out of jail for almost five years. Made choice to stay in longer because of no place to go. No help with transition from jail.
- Not pleased with quality of current housing but moved in for low rent.
- No family support and feel isolated in the community.
- Feel social isolation and depression.
- “Scared to death” anyone will find out about HIV/AIDS status; concerned about rumors in community. At the same time, feeling overwhelmed by issues to deal with, and wish for contact with others who have gone through the same.

- Has another disability.
- Concerned about losing job after sharing status with employer.
- Currently apartment building has issues with drug use.
- Difficult paying bills after having two incomes in household and now has only one.
- Biggest concern so far has been getting more information about HIV/AIDS. Infectious disease doctor made a referral to case management and was able to get “more information than I could have hoped for” right away.
- Other major concern was paying for medications. Has private insurance but could not afford co-payments for HIV medications. Was able to get assistance with this.
- Concerned about maintaining car. Medical appointments with infectious disease doctor are a 30 - 40 minute drive away, and car has some problems. Looking at getting some financial assistance with utilities so can divert other money to car repair.

Experiences Identifying, Securing, and Maintaining Housing

Participants were asked to relate their experiences searching for and maintaining a place to live. The following experiences were cited:

- Help has been offered for moving to Franklin County.
- History of incarceration a barrier to getting housing. Was able to get housing in partner’s name.
- Difficult to find employment. Has to lie about background.
- Was not able to get help for deposit or first month’s rent from housing authority.
- Had to get a doctor’s signature of illness to help get housing deposit back.
- Housing authority has asked about nature of disability.
- Cost of food an issue, especially when supporting other household members.
- Have been denied for Social Security Disability Income (SSDI) multiple times.

Recommendations for Improvement

Participants were asked what recommendations they would make for improvements in the housing continuum. The following suggestions were made:

- Need more housing for people with AIDS.
- Would like to live in a better neighborhood.
- Trying to do the best we can. People do not want to help. They are often afraid to help.
- Need more information and knowledge about available resources.
- “Would love to see Delaware County have a support group for HIV-positive people, their spouses, and families.”
- Need more peer support.
- Need a separate Task Force in Fairfield County. Need a place that is consistent, private, and dedicated to people living with HIV/AIDS to meet and get information.
- Providers need to do a better job protecting confidentiality and making a commitment to serving people living with HIV/AIDS.
- Need more public education about HIV/AIDS.
- Need more respite care and emergency shelter for medical needs.

- HIV/AIDS classes and training often targeted to women and gay men. Need to broaden focus to include other groups who are affected by the disease.
- Need more support and advocacy in community for people living with HIV/AIDS.
- Need help with transportation, gas vouchers, and food.

Appendix 3: Central Ohio HIV/AIDS Housing Survey Tool

Central Ohio HIV/AIDS HOUSING SURVEY

We need your help. This is the first time people living with HIV/AIDS in Central Ohio have been asked about their housing situations in a survey. Your participation is very important, and we would like to have your input. The information gathered in this survey will be used to tell AIDS service providers and funders if people living with HIV/AIDS in Central Ohio are getting the housing help they need and want.

Your answers are completely confidential and will not affect your housing assistance. Do not write your name on this survey. If you need assistance to complete this survey, please talk with the person who gave it to you. Thank you for your participation.

Si prefiere contestar estas preguntas en español, favor de hablar con la persona que le dio la encuesta.

1. Do you have HIV or AIDS?

- Yes** → *Please check only one answer.*
- I am HIV-positive with symptoms.
 - I am HIV-positive with no symptoms.
 - I have been diagnosed with AIDS by my doctor.
- No**, I do not have HIV or AIDS. I am HIV-negative. → **Please stop here!**

Section 1: Tell Us About Yourself

2. What is your sex or gender?

- I am female.
- I am male.
- I am transgender (Male to Female).
- I am transgender (Female to Male).

3. How old are you?

4. Which best describes you? Please check all the answers that apply.

- African American
- Black, not African American
- American Indian/Alaskan Native
- Asian/Pacific Islander
- Hispanic, Latino, or Latina
- White/Caucasian
- Other: *(please describe)* _____

5. Which sexual orientation best describes you?

- I am gay or lesbian.
- I am bisexual.
- I am straight.
- Other: *(please describe)* _____

6. Do you have any challenges that make your day-to-day life difficult?

- Yes** → *Please check all the answers that are true about you.*
 - I have difficulty day-to-day with my HIV/AIDS.
 - I am physically disabled.
 - I am developmentally disabled.
 - I am blind.
 - I am deaf.
 - I have a mental illness.
 - I have difficulty day-to-day with my alcohol use.
 - I have difficulty day-to-day with my drug use.
 - I am disabled by something else: *(please describe)* _____
- No**

10. Who lives with you now? Please check all the answers that apply.

- No one, I live alone.
- My husband, wife, or partner lives with me.
- My child or children live with me.
- My mother, father, grandparent, cousin, or other family members live with me.
- One or more friends or other adults live with me.
- I live in a group home or care facility with other people.
- I live in a shelter with other people.
- I live with other people: *(please describe)* _____

11. Are you currently behind on any housing or utility bill payments?*Please check Yes or No for each.***Yes****No**

- I am currently behind on paying a utility bill.
- I am currently behind on paying my rent or mortgage.
- I am currently not responsible for paying any housing or utility bills.

12. Does the place where you currently live have any of the following problems?*Please check all the answers that apply.*

- | | |
|---|---|
| <input type="checkbox"/> Water leaks or broken pipes | <input type="checkbox"/> Windows that are painted or nailed shut |
| <input type="checkbox"/> Open cracks or holes in walls | <input type="checkbox"/> Broken plaster or peeling paint |
| <input type="checkbox"/> Electric outlets that don't work or exposed wiring | <input type="checkbox"/> Lack of a complete kitchen (sink, refrigerator, oven, and stove) |
| <input type="checkbox"/> Roof damage or leaks | <input type="checkbox"/> Not enough or too much heat |
| <input type="checkbox"/> Insect infestation or rats | <input type="checkbox"/> Lead paint |
| <input type="checkbox"/> Mold | <input type="checkbox"/> I do not have any of these problems. |
| <input type="checkbox"/> No window screens | |

13. Do you have problems with any of the following activities in your current building or neighborhood? Please check all the answers that apply.

- | | |
|--|---|
| <input type="checkbox"/> Illegal drug activity | <input type="checkbox"/> Noise |
| <input type="checkbox"/> Other criminal activity | <input type="checkbox"/> Street harassment or many people hanging out |
| <input type="checkbox"/> Violence | <input type="checkbox"/> I do not have any of these problems. |
| <input type="checkbox"/> Prostitution | |

Section 3: Housing Assistance**14. Does the government or any other organization currently help pay for your housing each month?**

- Yes** → *Please check all of the answers that are true about you.*
- I have a Section 8 certificate or voucher (that stays with me when I move).
 - I live in a project-based Section 8 program (that stays with the apartment when I move).
 - I have a Shelter Plus Care voucher.
 - I get help to pay my rent from HOPWA (Housing Opportunities for Persons with AIDS).
 - I live in subsidized or public housing.
 - I live in a transitional housing program.
 - I live in a home for people living with HIV infection or AIDS.
 - I am getting help paying for my housing, but I don't know what it is called.
 - I am getting another kind of help paying for my housing.
- No**, I don't get any help with my housing.
- I am not sure** if I am getting help paying for my housing.

15. Over the past 12 months, has the government or any other organization helped you with a short-term or one-time payment for your housing or related expenses at any time?

- Yes** → *If so, please check all the places you got assistance from.*
- HIV/AIDS service organization
 - Other community organization
 - Other: *(please explain)* _____
- No**, I did not get any short-term help with my housing during the past 12 months.
- I am not sure** if I got any short-term help paying for my housing during the past 12 months.

16. What would the impact be on your life if your monthly housing costs (rent or mortgage and utilities) went up by about \$50? Please check all the answers that apply.

- I would pay the increase without making other changes.
- I would borrow money from friends or family.
- I would look for more employment.
- I would look for another person to share my housing.
- I would apply for more benefits or emergency assistance.
- I would move.
- I would stop buying and taking medications.
- I might need to resort to illegal activities.
- I would do something else. *(please describe)* _____
- It would not affect me.

Section 4: Income, Benefits, and Expenses

17. What kind of income and benefits do you currently receive? Please check all the answers that apply.

- I get paid by check or cash for work I do.
- I get Supplemental Security Income (SSI).
- I get Social Security Disability Insurance (SSDI).
- I get welfare assistance (TANF, cash assistance, Medicaid, general assistance).
- I get alimony or child support.
- I get Food Stamps.
- I get Veteran's benefits.
- I get an unemployment check.
- I get a retirement check.
- I get a different kind of benefit. *(please describe)* _____
- I don't have any income or benefits.

18. Please answer the following questions to help us understand your financial situation. Give us your best estimate of only the bills you pay yourself.

What is your monthly income?	\$
How much do you pay in rent/mortgage every month?	\$
How much do you pay for utilities (for example, gas, electric, water, and phone) in an average month?	\$

19. Do your income and benefits support anyone other than yourself?

- Yes**
- No** → *Skip to # 20.*

19a. If yes, who do you support? Please check all the answers that apply.

- My husband, wife, or partner
- My minor children
- My adult children
- My grandchildren
- My parents, other family members, or other household members
- My pets
- Other: *(please describe)* _____

20. Have you received any assistance in paying your medical bills in the past 12 months?

- Yes** → *If so, please check all that apply.*
- Family or friends
 - Private health insurance or private disability insurance
 - Medicaid, Medicare, or Veteran's Administration (VA) benefits
 - Ryan White Program (PC 3) or Ohio AIDS Drug Assistance Program (OHDAP, ADAP, HIPP, Medicaid spend-down)
 - Other: *(please describe)* _____
- No**

Section 5: Housing History**21. Have you moved in the last three years?**

- Yes** → If so, how many times?
- No** → *Skip to # 22.*

21a. Please check all of the answers that are true about the last time you moved.

- I moved because I was evicted or asked to move.
- I moved because I didn't have enough money for rent.
- I moved to live with or near my partner, family, or friends.
- I moved to live in a safer neighborhood.
- I moved to live in a bigger or better apartment.
- I moved because I wanted to live in a smaller community.
- I moved because I wanted to live in a larger community.
- I moved so that I could stay clean and sober.
- I moved to get better services or medical care for my HIV or AIDS.
- I moved because of domestic violence.
- I moved because of my drug or alcohol use.
- I moved for another reason. *(please describe)* _____

22. Have you ever been homeless (without a regular place to stay for the night)?

- Yes**
- No** → *Skip to # 23.*

22a. In the past three years, did you ever spend a night in a shelter?

- Yes
 No

22b. In the past three years, did you ever spend a night with family or friends because you did not have a place of your own?

- Yes
 No

22c. In the past three years, did you ever have to sleep outside because you did not have anywhere else to sleep?

- Yes
 No

22d. In the past three years, what is the longest amount of time you were homeless?

- Less than one week
 One week to one month
 More than a month to one year
 More than a year
 I have not been homeless in the past three years.

22e. In the past three years, how many different times have you been homeless?

22f. Please check all of the answers that are true about the last time you were homeless.

- I became homeless because I was evicted or asked to move from my home.
 I became homeless because I had no income from a job or from benefit checks.
 I became homeless because my family or partner or roommate made me move.
 I became homeless because I moved to a new area and had no money, friends, or family.
 I became homeless because of domestic violence.
 I became homeless after I was released from jail or prison.
 I became homeless after I was released from another institution (such as a hospital, mental health facility, or drug or alcohol treatment program).
 I became homeless because of my mental illness.
 I became homeless because of my drug or alcohol use.
 I became homeless for another reason. (*please describe*)
-

23. Have you been in jail or prison within the past 10 years?

- Yes** → *If you have been in jail or prison, when was the last time you were released?*
- I was released within the last 12 months.
 - I was released more than a year ago.
- No** → *Skip to # 24.*

23a. Please check the answer that is true about you.

- I was convicted of a felony within the past 5 years.
- I was convicted of a felony more than 5 years ago.
- I have never been convicted of a felony.

24. Have you been unable to get housing in Ohio because of any financial reasons?

- Yes** → *Please check all of the reasons you had trouble getting housing.*
- The landlord was unwilling to accept my payment source (such as Section 8 voucher)
 - Where my income comes from
 - My negative credit history
 - I didn't have enough money for security deposit, and first and last months' rent.
 - I could not find housing I could afford.
 - I had no access to transportation to search for housing.
 - I had trouble getting housing for a different reason.
(please describe) _____
- No**, I have not had trouble getting housing because of financial reasons.

25. Have you had other problems when trying to get housing in Ohio?

- Yes** → *Please check all of the reasons you had trouble getting housing.*
- My race or ethnic background
 - My sexuality: gay, lesbian, bisexual, or transgender
 - The number of children or people in my family
 - My HIV or AIDS status
 - My disability or handicap
 - My history of incarceration
 - My alcohol or drug use
 - My mental illness
 - My appearance
 - My immigration status
 - I do not speak English well.
 - I cannot read or understand the forms.
 - I have had problems getting housing for a different reason: (please describe)

- No**, I have not had any problems when trying to get housing.

Section 6: Housing Support Gaps

26. Do you need these housing services? Please check Yes or No for each.

Yes No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Lists of apartments or houses that you might be able to afford |
| <input type="checkbox"/> | <input type="checkbox"/> | A staff member to take you around to look at apartments |
| <input type="checkbox"/> | <input type="checkbox"/> | Help filling out housing applications and other forms |
| <input type="checkbox"/> | <input type="checkbox"/> | Assistance with first or last month's rent or deposits |
| <input type="checkbox"/> | <input type="checkbox"/> | Housing that will accept pets |
| <input type="checkbox"/> | <input type="checkbox"/> | A person to help you with your housing if your situation changes |
| <input type="checkbox"/> | <input type="checkbox"/> | Other kind of housing service: <i>(please describe)</i> _____ |

27. Have you used or needed any mental health services or programs in the past six months? Please check Yes, No, or Need for each service.

Yes No Need

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS support group |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Another kind of support group |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mental health counselor or therapist |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatrist for medication to help with a mental illness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Group home or apartment for people with mental illness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric hospital |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other program |

28. Have you used or needed any of these kinds of alcohol or drug programs in the past six months? Please check Yes, No, or Need for each.

Yes No Need

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12-step program (AA, NA, CA) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drug and alcohol counseling program (no methadone) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Methadone maintenance program |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Residential treatment or recovery program |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other program |

29. Do you have to leave your county of residence to get medical or other services?

- Yes** → *If so, what county do you go to for medical care or services?* _____
- No**, I do not have to leave my county of residence to get medical or other services.

30. What are the most common types of transportation you use to get to appointments or to look for housing? Please check Yes or No for each.

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | My car |
| <input type="checkbox"/> | <input type="checkbox"/> | The car of a friend or family member |
| <input type="checkbox"/> | <input type="checkbox"/> | Bicycle |
| <input type="checkbox"/> | <input type="checkbox"/> | Walking |
| <input type="checkbox"/> | <input type="checkbox"/> | Public bus |
| <input type="checkbox"/> | <input type="checkbox"/> | Taxi |
| <input type="checkbox"/> | <input type="checkbox"/> | Special transportation for people with disabilities |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS agency |
| <input type="checkbox"/> | <input type="checkbox"/> | Other social service agency van |
| <input type="checkbox"/> | <input type="checkbox"/> | Volunteers or friends |
| <input type="checkbox"/> | <input type="checkbox"/> | Other types of transportation |

Section 7: Housing Preferences

31. For the next 12 months, do you plan to:

- Stay where you are,
OR
 Move to another place?

32. If you had to move next month, would you plan to:

- Have a place of your own even if it means paying more rent,
OR
 Share a place with other people.

33. If you had to move next month, would you plan to:

- Move in with family or friends,
OR
 Move into shared housing with other people who are living with HIV/AIDS in a building that was developed for people living with HIV/AIDS?

34. If you had to move next month, would you plan to:

- Live in an apartment building where *only* people with HIV or AIDS live,
OR
 Live in an apartment building where different kinds of people live together, whether they have HIV or not?

35. If you had to move next month, would you plan to:

- Live in a place where there are services available on-site throughout the day,

OR

- Live in a place with no services on-site?

36. If suddenly you could no longer care for yourself, would you plan to:

- Move in with family or friends,

OR

- Move into a place or program with other people where your needs can be met?

Section 8: Other Comments

Are there any other comments that you would like to share with us?

Thank You!

Please return the completed survey to the persons who gave it to you or mail it to:

Central Ohio HIV/AIDS Survey
c/o Columbus AIDS Task Force
1751 E. Long Street
Columbus, Ohio 43203

Appendix 4: Central Ohio HIV/AIDS Housing Survey Data

The following pages present data from every question in the survey in the form in which the question was asked. Cross-tabulated data (combining responses to two or more questions) and written-in responses are interspersed with the survey questions. Additional comments made by respondents appear at the end. A total of 272 surveys were completed between June and August 2004.

1. Do you have HIV or AIDS?

253	93%	Yes → <i>Please check only one answer</i>
98	39%	I am HIV-positive with symptoms.
86	34%	I am HIV-positive with no symptoms.
69	27%	I have been diagnosed with AIDS by my doctor.
—	0%	No , I do not have HIV or AIDS. I am HIV-negative. → Please stop here!
19	7%	No response

Section 1: Tell Us About Yourself

2. What is your sex or gender?

59	22%	I am female.
208	77%	I am male.
4	2%	I am transgender (Male to Female).
1	<1%	I am transgender (Female to Male).

3. How old are you?

—	0%	Under 20
24	9%	20-29
91	34%	30-39
112	41%	40-49
40	15%	50 and older

4. Which best describes you? Please check all the answers that apply.

81	30%	African American		
25	9%	Black, not African American		
3	1%	American Indian/Alaskan Native		
2	1%	Asian/Pacific Islander		
11	4%	Hispanic, Latino, or Latina		
137	50%	White/Caucasian		
13	5%	Other: <i>(please describe)</i>		
		Biracial	1	<1%
		Mixed Black and White	1	<1%
		Black/Hispanic/White	1	<1%
		Black/White/Indian	1	<1%
		Indian and Black	3	1%
		Indian and White	2	1%
		Mix	2	1%
		White/African American/Indian	1	<1%

5. Which sexual orientation best describes you?

129	47%	I am gay or lesbian.		
37	14%	I am bisexual.		
95	35%	I am straight.		
6	2%	Other: <i>(please describe)</i>		
		I love people (denial)	1	<1%
		Sexless	1	<1%
		Transsexual	1	<1%
		Transgender	2	1%

6. Do you have any challenges that make your day-to-day life difficult?

199	73%	Yes → <i>Please check all the answers that are true about you.</i>
133	49%	I have difficulty day-to-day with my HIV/AIDS.
58	21%	I am physically disabled.
9	3%	I am developmentally disabled.
3	1%	I am blind.
5	2%	I am deaf.
43	16%	I have a mental illness.
10	4%	I have difficulty day-to-day with my alcohol use.
16	6%	I have difficulty day-to-day with my drug use.
36	13%	I am disabled by something else:

Respondents described a number of difficulties. Generally, they fell under the following categories:

Physical health issues	23	9%
Mental health issues	2	1%
Fatigue	3	1%
Other	2	1%

71 | **26%** | **No**

Number of disabilities checked by each respondent:

73	27%	Zero
120	44%	One
50	18%	Two
24	9%	Three
4	2%	Four
1	<1%	Five

Section 2: Housing Situation

7. What county do you currently live in?

5	2%	Delaware County
6	2%	Fairfield County
236	87%	Franklin County
12	4%	Licking County
3	1%	Madison County
2	1%	Morrow County
4	2%	Pickaway County
—	0%	Union County
4	2%	Other County: <i>(please name)</i>

One respondent each named Hancock, Highland, Knox, and Warren Counties.

8. On a scale from 1 to 5, how satisfied are you with your current housing situation? *Please circle one.*

51	19%	1 (Not very satisfied)
22	8%	2
54	20%	3
58	21%	4
85	31%	5 (Very satisfied)

9. Please pick the one kind of place that best describes where you are living today.

181	67%	An apartment, house, condo, or mobile home that I rent
4	2%	A group home or care facility for people with HIV or AIDS
12	4%	A room that I rent
1	<1%	A hotel/motel that is paid for by the week or month
29	11%	A house, condo, or mobile home that I own
3	1%	A transitional place or program where I can stay for up to two years
2	1%	A place or program where I get help for alcohol or drug problems
17	6%	With friends or relatives, but I can stay only for a short while
11	4%	With friends or relatives, and I can stay as long as I need to
3	1%	A shelter
6	2%	The streets, in parks, or in a car
—	—	In jail or prison
3	1%	Other kind of place: <i>(please describe)</i> Nursing home (2)

10. Who lives with you now? Please check all the answers that apply.

129	47%	No one, I live alone.
54	20%	My husband, wife, or partner lives with me.
32	12%	My child or children live with me.
26	10%	My mother, father, grandparent, cousin, or other family members live with me.
36	13%	One or more friends or other adults live with me.
7	3%	I live in a group home or care facility with other people.
3	1%	I live in a shelter with other people.
4	2%	I live with other people: <i>(please describe)</i>
		Caregiver 2 1%
		Nursing home 1 <1%

11. Are you currently behind on any housing or utility bill payments? Please check Yes or No for each.

102	38%	I am currently behind on paying a utility bill.
48	18%	I am currently behind on paying my rent or mortgage.
36	13%	I am currently not responsible for paying any housing or utility bills.

12. Does the place where you currently live have any of the following problems? Please check all the answers that apply.

42	15%	Water leaks or broken pipes
33	12%	Open cracks or holes in walls
27	10%	Electric outlets that don't work or exposed wiring
20	7%	Roof damage or leaks
28	10%	Insect infestation or rats
30	11%	Mold
36	13%	No window screens
19	7%	Windows that are painted or nailed shut
25	9%	Broken plaster or peeling paint
12	4%	Lack of a complete kitchen (sink, refrigerator, oven, and stove)
18	7%	Not enough or too much heat
6	2%	Lead paint
167	61%	I do not have any of these problems.

Number of housing quality problems checked by each respondent:

170	63%	Zero
34	13%	One
19	7%	Two
17	6%	Three
14	5%	Four
5	2%	Five
5	2%	Six
5	2%	Seven
3	1%	Eight or more

13. Do you have problems with any of the following activities in your current building or neighborhood? Please check all the answers that apply.

69	25%	Illegal drug activity
44	16%	Other criminal activity
29	11%	Violence
25	9%	Prostitution
78	29%	Noise
47	17%	Street harassment or many people hanging out
155	57%	I do not have any of these problems.

Number of problem activities checked by each respondent:

158	58%	Zero
42	15%	One
20	7%	Two
24	9%	Three
9	3%	Four
12	4%	Five
7	3%	Six

Section 3: Housing Assistance

14. Does the government or any other organization currently help pay for your housing each month?

90	33%	Yes → <i>Please check all the answers that are true about you.</i>
40	15%	I have a Section 8 certificate or voucher (that stays with me when I move).
6	2%	I live in a project-based Section 8 program (that stays with the apartment when I move).
26	10%	I have a Shelter Plus Care voucher.
12	4%	I get help to pay my rent from HOPWA (Housing Opportunities for Persons with AIDS).
6	2%	I live in subsidized or public housing.
91	34%	I live in a transitional housing program.
4	2%	I live in a home for people living with HIV infection or AIDS.
4	2%	I am getting help paying for my housing, but I don't know what it is called.
4	2%	I am getting another kind of help paying for my housing.
179	66%	No , I don't get any help with my housing.
3	1%	I am not sure if I am getting help paying for my housing.

Demographic breakdown of rental assistance:

Demographic category	Receives rental assistance
Women	41%
Men	31%
African American	54%
Black	24%
White	24%
Franklin County	35%
Not Franklin County	19%

15. Over the past 12 months, has the government or any other organization helped you with a short-term or one-time payment for your housing or related expenses at any time?

89	33%	Yes → <i>If so, please check all the places you got assistance from.</i>
73	27%	HIV/AIDS service organization
18	7%	Other community organization
9	3%	Other: (please describe) Respondents named several other sources of assistance: Church, CMA CAO (heat), CMHA, Coalition for Housing, HEAP, LCCH, and PIP
180	66%	No , I did not get any short-term help with my housing during the past 12 months.
—	—	I am not sure if I got any short-term help paying for my housing during the past 12 months.

16. What would the impact be on your life if your monthly housing costs (rent or mortgage and utilities) went up by about \$50? Please check all the answers that apply.

40	15%	I would pay the increase without making other changes.
53	20%	I would borrow money from friends or family.
50	18%	I would look for more employment.
25	9%	I would look for another person to share my housing.
80	29%	I would apply for more benefits or emergency assistance.
63	23%	I would move.
27	10%	I would stop buying and taking medications.
15	6%	I might need to resort to illegal activities.
16	6%	I would do something else. <i>(please describe)</i>
		Reduce expenses
		5 2%
		Increase income
		2 1%
		Pray
		1 1%
		Live on the streets
		1 1%
		Don't know
		1 1%
		Other response
		2 1%
33	12%	It would not affect me.

Section 4: Income, Benefits, and Expenses

17. What kind of income and benefits do you currently receive? Please check all the answers that apply.

72	27%	I get paid by check or cash for work I do.
52	19%	I get Supplemental Security Income (SSI).
76	28%	I get Social Security Disability Insurance (SSDI).
32	12%	I get welfare assistance (TANF, cash assistance, Medicaid, general assistance).
3	1%	I get alimony or child support.
88	32%	I get Food Stamps.
8	3%	I get Veteran’s benefits.
3	1%	I get an unemployment check.
3	1%	I get a retirement check.
11	4%	I get a different kind of benefit: <i>(please describe)</i> . Respondents wrote in responses including CATF, various sources of disability income, family support, and pension.
40	15%	I don’t have any income or benefits.

Median monthly income by source of income:

Source of income	Median monthly income
Works for pay	\$1000
SSI	\$564
SSDI	\$700
TANF	\$465

18. Please answer the following questions to help us understand your financial situation. Give us your best estimate of only the bills you pay yourself.

	Median
What is your monthly income?	\$580
How much do you pay in rent/mortgage every month?	\$250
How much do you pay for utilities (for example, gas, electric, water, and phone) in an average month?	\$100

Reported income by range

Income by range	Number of respondents	Percentage of respondents
\$0	61	22%
\$1 to \$250	20	7%
\$251 to \$500	19	7%
\$501 to \$750	70	26%
\$751 to \$1,000	39	14%
\$1,001 to \$1,250	19	7%
\$1,251 to \$1,500	12	4%
\$1,501 or more	19	7%
Not reported	13	5%

Percentage of income paid to housing costs, by range, calculated by AIDS Housing of Washington using reported income and housing costs

Percentage, by range	Number of respondents	Percentage of respondents
30% of income or less	35	13%
31% to 50%	56	21%
More than 50%	86	32%
Not enough information to calculate	95	35%

Other measures of income and affordability

Measures	Number of respondents	Percentage of respondents
30% of gross income is equal to or exceeds Fair Market Rent for a one-bedroom apartment (\$499) ¹ , meaning income exceeds \$1,663 per month	15	6%
50% of gross income is equal to or exceeds Fair Market Rent for a one-bedroom apartment (\$499), meaning monthly income exceeds \$998	56	21%
Income is less than 2004 poverty level for a single person (\$776 per month)	171	63%

¹ \$499 is the HUD-established 2004 Fair Market Rent for a one-bedroom in Delaware, Fairfield, Franklin, Licking, Madison, and Pickaway Counties. The Fair Market Rent for a one-bedroom apartment in Union County is \$410 and in Morrow it is \$353.

Median monthly income, housing costs, and percentage of income paid to housing, by selected demographic categories

Demographic category	Median monthly income	Median rent and utilities	Median percentage of income paid to housing
Women	\$554	\$300	52%
Men	\$600	\$373	47%
African American	\$558	\$247	43%
Black	\$507	\$193	32%
White	\$666	\$455	50%
Franklin County	\$565	\$330	46%
Not Franklin County	\$739	\$507	54%

19. Do your income and benefits support anyone other than yourself?

59	22%	Yes
212	78%	No → <i>Skip to # 20.</i>

19a. If yes, who do you support? Please check all the answers that apply.

26	10%	My husband, wife, or partner
27	10%	My minor children
2	1%	My adult children
4	2%	My grandchildren
6	2%	My parents, other family members, or other household members
10	4%	My pets
3	1%	Other: <i>(please describe)</i> All 3 respondents wrote in “friend.”

20. Have you received any assistance in paying your medical bills in the past 12 months?

204	75%	Yes → <i>If so, please check all the places you got assistance from.</i>
14	5%	Family or friends
16	6%	Private health insurance or private disability insurance
105	39%	Medicaid, Medicare, or Veteran’s Administration (VA) benefits
104	38%	Ryan White Program (PC 3) or Ohio AIDS Drug Assistance Program (OHDAP, ADAP, HIPP, Medicaid spend-down)
14	5%	Other: <i>(please describe)</i> Other reported sources were ADAP, CATE/OSU, church, Department of Rehabilitation and Corrections, FTA, Grant Hospital, hospital program, and the Veterans Administration.
60	22%	No

21. Have you moved in the last three years?

169	62%	Yes → <i>If so, how many times?</i>
65	24%	Once
38	14%	Twice
23	9%	Three times
16	6%	Four times
7	3%	Five times
2	1%	Six times
1	<1%	Seven times
3	1%	Ten times
1	<1%	Twenty times
99	36%	No → <i>Skip to # 22.</i>

21a. Please check all of the answers that are true about the last time you moved.

38	14%	I moved because I was evicted or asked to move.
49	18%	I moved because I didn't have enough money for rent.
30	11%	I moved to live with or near my partner, family, or friends.
32	12%	I moved to live in a safer neighborhood.
27	10%	I moved to live in a bigger or better apartment.
4	2%	I moved because I wanted to live in a smaller community.
6	2%	I moved because I wanted to live in a larger community.
18	7%	I moved so that I could stay clean and sober.
21	8%	I moved to get better services or medical care for my HIV or AIDS.
8	3%	I moved because of domestic violence.
16	6%	I moved because of my drug or alcohol use.
53	20%	I moved for another reason: <i>(please describe)</i> Respondents wrote in the following reasons: <ul style="list-style-type: none"> • Aunt was dealing drugs where I was living • Thought I was selling drugs • Drugs took over me • Rehab • Helping mother move • To look for mother • Parent divorced, can't live with either • To take temporary custody of nieces and nephews • Closer to husband's family • Closer to work • Homeless • Was homeless, then got housing • Bought a house • To a house

- Invested inherited money in real estate
- Incarceration
- Illness
- Cancer treatment
- Roommate moved
- Change in relationship status
- Thrown out of Section 8 due to loss of partner from AIDS
- Cheaper rent
- Needed independent housing
- To get my own place
- Too many people living in one apartment
- Too small
- Wanted a smaller apartment
- Confidentiality
- People were harassing me at my old place
- Refugee from (African country)
- City shut it down
- Foreclosure
- House was sold
- Court ordered
- Landlords
- Mobility issues: no steps
- Relocated to Ohio
- Start over
- Fire

22. Have you ever been homeless (without a regular place to stay for the night)?

128	47%	Yes
143	53%	No → <i>Skip to # 23.</i>

22a. In the past three years, did you ever spend a night in a shelter?

47	17%	Yes
79	29%	No

22b. In the past three years, did you ever spend a night with family or friends because you did not have a place of your own?

95	35%	Yes
32	12%	No

22c. In the past three years, did you ever have to sleep outside because you did not have anywhere else to sleep?

49	18%	Yes
77	28%	No

22d. In the past three years, what is the longest amount of time you were homeless?

12	4%	Less than one week
27	10%	One week to one month
42	15%	More than a month to one year
16	6%	More than a year
28	10%	I have not been homeless in the past three years.

22e. In the past three years, how many different times have you been homeless?

34	13%	Zero times
40	15%	Once
16	6%	Twice
6	2%	Three times
4	2%	Four times
2	1%	Five times
1	<1%	Seven times
3	1%	Ten times
1	<1%	Fifteen times

22f. Please check all of the answers that are true about the last time you were homeless.

43	16%	I became homeless because I was evicted or asked to move from my home.
46	17%	I became homeless because I had no income from a job or from benefit checks.
21	8%	I became homeless because my family or partner or roommate made me move.
16	6%	I became homeless because I moved to a new area and had no money, friends, or family.
9	3%	I became homeless because of domestic violence.
16	6%	I became homeless after I was released from jail or prison.
4	2%	I became homeless after I was released from another institution (such as a hospital, mental health facility, or drug or alcohol treatment program).
5	2%	I became homeless because of my mental illness.
22	8%	I became homeless because of my drug or alcohol use.
21	8%	I became homeless for another reason: (<i>please describe</i>) Respondents wrote in the following reasons: <ul style="list-style-type: none"> • Couldn't afford high rent • No money • No money and a lot of places don't accept pets • Violence in home country • Dangerous environment • Illegal activity in home • Illness • Medical reasons • Surgery on eye • HIV-positive • Section 8 evicted me because my partner passed away from AIDS • Mom was on her sick bed and I had to leave college to help out • Moved from California • Just left my home • Landlord • Move to a bigger place

Chronic Homelessness

AHW tabulated responses to approximate the number of respondents meeting HUD's definition of chronic homelessness. HUD defines the chronically homeless as a single unaccompanied adult, with a disabling condition, who has been homeless at least a year, or homeless 4 or more times in the past 3 years. Of survey respondents, 7 either:

- Reported living in a shelter or in the street or outside at the time of the survey, and reported being homeless one year or more within the past three years, OR
- Reported being homeless 4 or more times in the past three years.

In addition to HIV/AIDS, 3 reported mental illness, 2 drug or alcohol use, and 2 physical disabilities as impacting their day-to-day life. Based on the information available, these 7 respondents (3%) appear to meet HUD's chronically homeless definition.

23. Have you been in jail or prison within the past 10 years?

77	28%	Yes → <i>If you have been in jail or prison, when was the <u>last time</u> you were released?</i>
26	10%	I was released within the last 12 months.
39	14%	I was released more than a year ago.
190	70%	No → <i>Skip to # 24.</i>

23a. Please check the answer that is true about you.

17	6%	I was convicted of a felony within the past 5 years.
26	10%	I was convicted of a felony more than 5 years ago.
30	11%	I have never been convicted of a felony.

24. Have you been unable to get housing in Ohio because of any financial reasons?

105	39%	Yes → <i>Please check all of the reasons you had trouble getting housing.</i>
11	4%	The landlord was unwilling to accept my payment source (such as Section 8 voucher).
13	5%	Where my income comes from
58	21%	My negative credit history
50	18%	I didn't have enough money for security deposit, and first and last months' rent.
48	18%	I could not find housing I could afford.
17	6%	I had no access to transportation to search for housing.
165	61%	No , I have not had trouble getting housing because of financial reasons.
13	5%	I had trouble getting housing for a different reason. <i>(please describe)</i>

- Drug and alcohol use
- Illness
- Prison record
- MRDD
- People don't understand the programs at CATF.
- Needed help with deposit
- Unpaid low rent at CMHA
- Unable to work/no income
- Not enough income to support myself
- Not a citizen and no income. Daughter leases apartment and pays rent for me.

25. Have you had other problems when trying to get housing in Ohio?

72	27%	Yes → <i>Please check all of the reasons you had trouble getting housing.</i>
5	2%	My race or ethnic background
13	5%	My sexuality: gay, lesbian, bisexual, or transgender
3	1%	The number of children or people in my family
25	9%	My HIV or AIDS status
10	4%	My disability or handicap
14	5%	My history of incarceration
9	3%	My alcohol or drug use
7	3%	My mental illness
8	3%	My appearance
1	<1%	My immigration status
1	<1%	I do not speak English well.
5	2%	I cannot read or understand the forms.
19	7%	I have had problems getting housing for a different reason: <i>(please describe)</i> <ul style="list-style-type: none"> • Buying a house due to low income • Financial reasons • Financial stability • No income • Not enough money • Weird credit • Dayton, OH had very little funding and a four-year waiting list • Told to get help in my own consortia by CATF HIV housing staff • I don't really have the knowledge to apply • My pets and the fact that I smoke • My pets, not enough income to support myself • Will not rent to mom and son • Physical health • Prison record
196	72%	No , I have not had any problems when trying to get housing.

Section 6: Housing Support Gaps

26. Do you need these housing services? Please check Yes or No for each.

95	35%	Lists of apartments or houses that you might be able to afford
62	23%	A staff member to take you around to look at apartments
44	16%	Help filling out housing applications and other forms
103	38%	Assistance with first or last month's rent or deposits
57	21%	Housing that will accept pets
102	38%	A person to help you with your housing if your situation changes
29	11%	Other kind of housing service: <i>(please describe)</i> <ul style="list-style-type: none"> • Two bedrooms for me and caretaker • Exact info on the Shelter Plus Care benefit qualifications • Help getting rid of stray cats • Help moving • Money for moving truck • Help with utilities • HOPWA funds • Housing with handicap access • I need low-income assistance at my new place • Short-term rental assistance • Lawn care, rooting • Roommate referral

27. Have you used or needed any mental health services or programs in the past six months? Please check Yes, No, or Need for each service.

	I have used this.		I have not used this.		I need this.	
HIV/AIDS support group	72	27%	150	55%	36	13%
Another kind of support group	29	11%	203	75%	16	6%
Mental health counselor or therapist	81	30%	148	54%	31	11%
Psychiatrist for medication to help with a mental illness	60	22%	181	67%	13	5%
Group home or apartment for people with mental illness	3	1%	242	89%	4	2%
Psychiatric hospital	8	3%	239	88%	3	1%
Other program	11	4%	230	85%	8	3%

Number of mental health services received:

145	53%	None
54	20%	One
32	12%	Two
24	9%	Three
11	4%	Four
6	2%	Five

28. Have you used or needed any of these kinds of alcohol or drug programs in the past six months? Please check Yes, No, or Need for each.

	I have used this.		I have not used this.		I need this.	
12-step program (AA, NA, CA)	32	12%	229	84%	5	2%
Drug and alcohol counseling program (no methadone)	25	9%	235	86%	7	3%
Methadone maintenance program	3	1%	256	94%	5	2%
Residential treatment or recovery program	9	3%	250	92%	6	2%
Other program	10	4%	248	91%	6	2%

Number of substance use services received:

228	84%	None
22	8%	One
13	5%	Two
5	2%	Three
4	2%	Four

29. Do you have to leave your county of residence to get medical or other services?

38	14%	Yes → <i>If so, what county do you go to for medical care or services?</i>
1	<1%	Cincinnati
2	1%	Dayton
3	1%	Fairfield
16	6%	Franklin
1	<1%	Hamilton
1	<1%	OSU or Maher
226	83%	No , I do not have to leave my county of residence to get medical or other services.

30. What are the most common types of transportation you use to get to appointments or to look for housing? Please check Yes or No for each.

128	47%	My car
75	28%	The car of a friend or family member
15	6%	Bicycle
85	31%	Walking
123	45%	Public bus
31	11%	Taxi
10	4%	Special transportation for people with disabilities
49	18%	HIV/AIDS agency
12	4%	Other social service agency van
61	22%	Volunteers or friends
19	7%	Other types of transportation

Section 7: Housing Preferences

31. For the next 12 months, do you plan to:

176	65%	Stay where you are
90	33%	Move to another place

32. If you had to move next month, would you plan to:

158	58%	Have a place of your own even if it means paying more rent
83	31%	Share a place with other people

33. If you had to move next month, would you plan to:

158	58%	Move in with family or friends
73	27%	Move into shared housing with other people who are living with HIV/AIDS in a building that was developed for people living with HIV/AIDS

34. If you had to move next month, would you plan to:

26	10%	Live in an apartment building where <i>only</i> people with HIV or AIDS live
218	80%	Live in an apartment building where different kinds of people live together, whether they have HIV or not

35. If you had to move next month, would you plan to:

126	46%	Live in a place where there are services available on-site throughout the day
120	44%	Live in a place with no services on-site

36. If suddenly you could no longer care for yourself, would you plan to:

112	46%	Move in with family or friends
133	54%	Move into a place or program with other people where your needs can be met

Section 8: Other Comments

Are there any other comments that you would like to share with us?

Respondents wrote in the following comments:

- Client will lose housing 6/25/04 due to foreclosure.
- Continue to survey HIV/AIDS consumers of needs and supportive services.
- Did not like question 34!
- Difficulties communicating with CATF about my housing situation and being heard, requested help with a list of places to look and was told to go to my own consortia. I want to live in Franklin Co where all my services are being provided. Living in my car and staying with people in Franklin and other nearby counties right now. Why can't I get help to stabilize in Franklin Co?
- Do you have a list of apts in that area there for people with HIV here in Columbus, OH. If so, can I have a copy of it?
- Due to cardiac problems I need to move to a one-level apt unit. I am on the 3rd floor now and it is hard.
- Get some help in Licking County – at the Task Force who know what's available – last couple women didn't know what they were doing.
- Having these services would be very helpful.
- Housing dept here did not treat me professionally or fairly.
- Housing with mental illness, HIV, and poverty is a problem.
- I'm at a crisis point. I've lost my Medicaid benefits; I think I'm going to lose my SSI. I'm not sure what I can do. The mess right now is aggravating depression and symptoms associated with HIV meds.
- I'm homeless three days a week and would like a place of my own some day.
- I am very happy that we have an agency here to help people like me with HIV. Please keep their funding so they can help others like me.
- I am very thankful for CATF and its staff and the Columbus Health Dept case worker, Linna, God Bless Them for their Help.
- I currently own my own home but may have to sell and rent due to drop in income, but bad credit history may really hurt my chances.
- I have a new apt but the place is not in my name, it's in my dad's name. I need help getting low income in my name. And change the lease to my name with my Health. I hope it can be done.
- I have not used housing yet. I am very secure at this time with the housing Amethyst provides thru Shelter Plus. But I am looking forward to my house.
- I hope and pray that CATF will help with housing.
- I hope one day soon they will find a cure for this devastating disease (HIV/AIDS).
- I hope that the results are shared with clients. I would like to see and read the results.
- I need help with some of the issues I have with utilities and previous bankruptcy issues.

- I owe the IRS back taxes. This has kept me from getting Section 8 housing.
- I realize each person needs help in their own way.
- I really need housing but can't pay rent at full prices.
- I suffer from PTSD and heart failure. I do need a safe, permanent place to have as home.
- I think Section 8 vouchers should be easier for people with HIV. Living with other people with HIV affects privacy issues.
- I wish CATF could meet every month to pay for my utilities.
- I wish there were some single family homes available for us. Because I was a home owner before. I had a brand new home.
- I would like to live on my own. My present situation (no income) prevents it.
- I would like to see more programs for housing for HIV/AIDS. It's hard to deal with this and at times we need to have our own/be alone.
- I would move but would have a really hard time because of money and a way to move my stuff.
- It is good to have assistance in every way possible.
- It would be nice to have more opportunities to move or live elsewhere.
- Just thank God there are people out there to help us.
- Need more housing in Columbus for more people.
- ODAP program difficulties with getting my medication.
- Please continue to do more of these services-related surveys.
- Please Help!
- Shelter Plus Care should be transferable to the Caregiver if s/he suffers from HIV/AIDS; if the current tenant passed away. This will prevent the caregiver from becoming homeless!
- Some of these questions have other answers in my situation.
- Some questions were tricky, but I filled it out to the best of my knowledge.
- Sure could use daily transportation bus passes to get out. Help with utilities and especially help with cable TV company.
- Thank you for all your help and assistance. The staff is wonderful, but I do know they are overworked and get no \$ for all the hours they work.
- Thank you for asking questions. Now you know. Have a nice day.
- Thank you for not making this form any longer and I appreciate the gift card and your support with my condition.
- Thanks to CATF for all your help.
- The CATF has been very supportive of my situation. Thank you.
- There are no services in Fairfield County. My needs are not met fully.
- This person has been homeless since release from prison 11/04² due to sex offense conviction.
- Updated list of low-income housing available not thru CMHA, available through RW Consortia, therefore available to more clients – quarterly would be nice.

² 11/04 is the date written in the comment area, although the survey was completed prior to 11/04.

- Would be great if this research helps provide more people with assistance. We need more housing options.
- Your program is doing a great job with helping me with my needs and my disease.

Appendix 5: HIV/AIDS Housing Planning in Central Ohio, 1989 to present

This section includes a timeline of HIV/AIDS housing planning activities from 1989 to the present, as well as the entirety of the most comprehensive plan completed prior to this one, the 1993 Vision 2000: Open Doors plan of the HIV/AIDS Advisory Coalition of Metropolitan Columbus.

HIV/AIDS Housing Planning in Central Ohio

The following timeline of previous plans and planning processes was compiled by Nina Lewis at the Columbus Health Department.

1989 to 1991	The <i>Columbus/Franklin County AIDS Community Plan 1989-1991</i> developed by the Columbus AIDS Community Advisory Coalition
October 1990	<i>Assessment of Housing Needs of HIV-Infected Persons: A summary of a study produced by David Dresser and Company, funded and supported by the United States Department of Health and Human Services, Health Resources and Services Administration (HRSA), Ohio Department of Health, and The Columbus Health Department</i>
November 1990	<i>The ARIS Project Report: The Development Plan for an AIDS Regional Information System for Central Ohio</i> , November 1990. Developed by The ARIS Project, the Needs/Resources Committee and the Planning/Allocation Committee, managed and produced by the Metropolitan Human Services Commission, National Capitol Systems, Incorporated, and Battelle Memorial Institute
November 1990	<i>Recommendations for Strengthening, Coordinating and Expanding Public and Private Mental Health and Substance Abuse Services for HIV Infected and Affected Persons</i> , November 15, 1990. Developed by The Mental Health, Substance Abuse and AIDS Task Force, Sandra L. Shullman, Chair for the Columbus AIDS Community Advisory Coalition
June 1993	<i>Vision 2000: Open Doors</i> , June 1993. Developed by the HIV/AIDS Advisory Coalition of Metropolitan Columbus Housing Task Force
July 1993	<i>Final Report: Central Ohio Regional AIDS Services Planning Project</i> . Prepared by Linda Crawford-Cloud, J.D., Project Director and submitted to Teresa Long, Columbus Health Department; Deborah Coleman, Columbus Health Department; Mary Lou Langenhop, HIV/AIDS Community Advisory Coalition (Chair); and George Ersek, the United States Department of Health and Human Services, Health Resources and Services Administration (HRSA), Division of HIV Services
July 1993	<i>HIV/AIDS Community Plan: Community Progress Report, Franklin County</i> , July 1993. Prepared and submitted by the HIV/AIDS Community Advisory Coalition of Metropolitan Columbus Planning Committee
January 2001	<i>The Financial Assistance Resource System of Central Ohio's HIV/AIDS Affordable Housing Continuum of Care, Performance & Evaluation Project</i> , June 2000. Commissioned the Columbus Health Department, written and submitted by Edie Milligan, President, Keeping Track, Inc.

Update of the Vision 2000 HIV/AIDS Housing Plan

The HIV/AIDS epidemic has changed greatly since the *Vision 2000: Open Doors* HIV/AIDS housing plan was developed in 1993. Primarily, the introduction of new medical treatments means that people are living longer and healthier lives with HIV. Because people are living longer and healthier lives, the total number of people living with HIV/AIDS in Central Ohio is now larger than ever before. A copy of the 1993 plan follows.

Appendix 6: Federal Financing Sources for Affordable Housing

This section contains information and resources on financing affordable housing.

The following information is intended to provide an introduction to some sources of financing for affordable housing. Housing Opportunities for Persons with AIDS (HOPWA) is a U.S. Department of Housing and Urban Development funding source dedicated for people living with HIV/AIDS. Because housing is expensive to develop and operate, especially when enriched with support services, and because people living with HIV/AIDS may have very little income available to pay for rent and services, HOPWA funds alone are not sufficient to develop and operate housing. Other sources of funding are required. People living with HIV/AIDS who have low incomes are eligible for mainstream programs for low-income people. Depending on the individual, they may also be eligible for programs for people with disabilities, for people who are homeless, and others. The following is not an exhaustive list, but highlights some of the larger programs and those most directly related to housing people living with HIV/AIDS. More information and resources on financing affordable housing are available through the AIDS Housing of Washington web site (www.aidshousing.org).

U.S. Department of Housing and Urban Development (HUD) Consolidated Plan Programs

HUD requires a single, consolidated submission process, including all of the planning, application, and performance assessment documentation for the following formula programs:

- Community Development Block Grants (CDBG)
- Emergency Shelter Grants (ESG)
- HOME Investment Partnerships Program (HOME)
- Housing Opportunities for Persons with AIDS (HOPWA)

The planning process is intended to help local jurisdictions develop a vision for housing and community development and to coordinate their activities. Local governments develop the plan in consultation with public and private agencies that provide supportive housing and social and health services, community members, and neighboring localities. The Consolidated Plan must indicate the activities that will be carried out in the coming year to address emergency shelter and transitional housing needs, homelessness prevention, the transition to permanent housing and independent living, and services for people who are not homeless but have supportive housing needs.

Information about each of the programs follows.

Community Development Block Grant (CDBG)

CDBG program funds may be used in a variety of ways to support community development, including the acquisition, construction, and rehabilitation of public facilities and housing. However, communities are not required to include housing when determining how they would like to use CDBG funds.

All CDBG-funded activities must address one of the three national objectives of the program:

1. Benefit low- and moderate-income people.
2. Eliminate or prevent slums or blight.
3. Meet other urgent community development needs, where existing conditions pose a serious and immediate threat to the health and welfare of the community, and no other financial resources are available.

Emergency Shelter Grants (ESG)

The ESG Program funds are designated to improve the quality of existing emergency shelters and transitional housing for homeless people, to help create additional emergency shelters, to pay for certain operating and social service expenses in connection with homeless shelters, and for homeless prevention activities.

The HOME Investment Partnerships Program (HOME)

Communities have the flexibility to use HOME funds for the housing activities that best meet local needs and priorities. Uses can include property acquisition, rehabilitation, site improvements, demolition, new construction, and tenant-based rental assistance. Assistance can take the form of loans, advances, equity investments, interest subsidies, and others. A portion (at least 15 percent) of HOME funds must be set aside for community housing development organizations (CHDOs), which are nonprofit organizations meeting certain HUD-established criteria.

Housing Opportunities for Persons with AIDS (HOPWA)

HOPWA is another program that comes under the Consolidated Plan process. HOPWA provides grant funds to state and local governments to design long-term, comprehensive strategies for meeting the housing needs of low-income people living with HIV/AIDS and their families. Participating jurisdictions have the flexibility to create a range of housing programs, including housing information services, resource identification, project- or tenant-based rental assistance, short-term rent, mortgage, and utility payments to prevent homelessness, housing and development operations, and support services. Ninety percent of HOPWA funds are awarded through formula grants, and the remaining 10 percent are awarded through a competitive grant program.

HOPWA Formula Grants

HUD awards 75 percent of HOPWA Formula Grant funds to eligible states and qualifying cities. Eligibility is based on the number of cases of AIDS reported by the Centers for Disease Control and Prevention as of March 31 of the year prior to the appropriation. Eligible metropolitan statistical areas (EMSAs) and states receive direct allocations of HOPWA funding when 1,500 cumulative cases of AIDS are diagnosed in a region. The remaining 25 percent of funds is allocated among metropolitan areas that have had a higher than average per capita incidence of AIDS.

HOPWA grantees may carry out eligible programs themselves, deliver them through any of their administrative entities, select or competitively solicit project sponsors, and/or contract with service providers.

HOPWA Competitive Grants

Competitive grants are awarded in the following categories:

- **Special Projects of National Significance (SPNS).** These projects are intended to be models for addressing the needs of low-income people living with HIV/AIDS and their families because of their innovation or ability to be replicated.
- **Long-Term Comprehensive Strategies for Providing Housing and Related Services.** Applications in this category can be submitted by state or local governments that are not eligible for HOPWA formula allocations during that fiscal year.

Homeless Assistance Continuum of Care

In order to encourage the integration and coordination of community homeless assistance, HUD combined three major homeless assistance programs—Supportive Housing Program, Shelter Plus Care, and Section 8 Moderate Rehabilitation Single Room Occupancy Program (SRO)—under the Continuum of Care planning and allocation process.

The Continuum of Care system includes four components: outreach to and needs assessment of individuals or families who are homeless, emergency shelters with supportive services, transitional housing with support services, and permanent independent or supportive housing to meet long-term needs. The establishment of a Continuum of Care system involves a community-wide or region-wide process involving nonprofit organizations (including those representing persons with AIDS and other disabilities), government agencies, other homeless providers, housing developers and service providers, private foundations, neighborhood groups, and homeless or formerly homeless individuals. It is very important for applicants to understand that funding for the Supportive Housing Program, Shelter Plus Care, and Section 8 SRO projects must be applied for within the context of the Continuum of Care process.

Supportive Housing Program (SHP)

SHP program funds are used to provide supportive housing, either as transitional housing for homeless people or permanent housing for homeless people who have disabilities, including people living with HIV/AIDS. In addition, SHP funds can also be used for safe havens, which provide specialized permanent housing for severely mentally ill homeless persons who have been unwilling to participate in support services, support services for people not living in supportive housing, and other innovative supportive housing models. SHP funds can be used for a range of activities from land acquisition to administrative expenses.

Shelter Plus Care

The Shelter Plus Care program provides rental assistance for permanent housing, linked with support services funded by other sources, to homeless and disabled people and their families. Activities under Shelter Plus Care include tenant-based rental assistance, project-based rental assistance, sponsor-based rental assistance, and Section 8 moderate rehabilitation assistance for single room occupancy dwellings.³

³ This differs from the Section 8 SRO program described next. Specifically, Shelter Plus Care SRO targets people who are homeless *and* have a disability, and Shelter Plus Care projects must include support services, while Section 8 SRO residents must be able to live independently.

Section 8 Moderate Rehabilitation Single Room Occupancy Dwellings (SRO)

Under the SRO program, HUD contracts with public housing authorities (PHAs) to enable the moderate rehabilitation⁴ of residential properties that, when completed, will contain multiple single room dwelling units. The PHAs make rental assistance payments to the landlords on behalf of the homeless individuals who rent the rehabilitated dwellings, covering the difference between a portion of the tenant's income (normally 30 percent) and the HUD-established Fair Market Rent (FMR) of the unit. The program does not provide financing for the rehabilitation work, but a portion of this cost is reflected in the rent.

Other HUD Programs

HUD has many other programs, but three are particularly relevant when developing housing for people living with AIDS: Supportive Housing for Persons with Disabilities (Section 811), Section 8 Rental Assistance, and Section 8 Housing Opportunities for Persons with Disabilities (Mainstream Program).

Supportive Housing for Persons with Disabilities (Section 811)

Nonprofit organizations can use Section 811 funds to construct, acquire, and/or rehabilitate supportive housing for very low-income persons with disabilities, including those with disabilities resulting from HIV-infection. The support services should address the residents' individual needs, provide optimal independent living, and provide access to the community and employment opportunities.

Section 811 funding is provided in two parts: a one-time capital advance, essentially a grant, to fund development, and ongoing project-based rental assistance that pays the difference between the tenant payment and the operating cost.

Section 8 Rental Assistance Programs

Section 8 Rental Assistance takes the form of certificates and vouchers which are administered by public housing authorities. Rental certificates and vouchers allow income-eligible households to find and obtain rental housing independently. Tenants typically pay 30 percent of their income, while the certificate or voucher pays the difference, up to the HUD-established Fair Market Rent (FMR) for the area. The primary difference between certificates and vouchers is that with a voucher, a tenant can pay more than 30 percent of their income if the cost of the unit exceeds the FMR.

Public housing authorities can also designate up to 15 percent of their vouchers to be project-based in new construction or rehabilitated housing. Project-based vouchers stay with a particular unit, so that income-eligible tenants can come and go, but the unit stays affordable. Tenants cannot take the vouchers away from the unit for use elsewhere.

Section 8 Housing Opportunities for People with Disabilities (Mainstream Program)

In Fiscal Year 1997, HUD moved a portion of the funds originally earmarked for the Supportive Housing for Persons with Disabilities (Section 811) to create this separate tenant-based program. This provides certificates and vouchers to persons with disabilities to allow for more housing choice.

⁴ HUD considers moderate rehabilitation to be a minimum of \$3,000 of rehabilitation work per unit.

Low Income Housing Tax Credits

Created in 1986, the Low Income Housing Tax Credit allows qualified owners of or investors in eligible low-income rental housing to reduce their federal income taxes on a dollar-for-dollar basis for a ten-year period, subject to compliance. Low-income housing developers use these credits to attract investors, who commit to funding a project in return for the tax credit.

Dollars of tax credit available are allocated to states based on population, equal to \$1.75 per capita in 2002 and adjusted for inflation thereafter. States administer their own competitive process for the credits. The Low Income Housing Tax Credit has become the primary federal resource for developing low-income housing. Tax credits funded approximately 1.2 million units through 2001, and contribute to the development of approximately 67,000 additional units per year.⁵

⁵ The Danner Company, *The Low Income Housing Tax Credit Program*. Available online: www.danter.com/taxcredit (Accessed: October 7, 2003).

Appendix 7: HIV/AIDS Housing Continuum

The housing needs of people living with HIV/AIDS cover a wide range, from one-time emergency utility assistance to nursing home care. Consequently, it is useful to think about housing opportunities along a continuum. The following text reviews each of the housing types in the HIV/AIDS housing continuum and offers ideas for addressing needs in each area.

It is important to understand that the wide range of housing needs for people living with HIV/AIDS and their families does not exist apart from other housing needs in a community. Generally, HIV/AIDS housing needs fall into an overall, community-wide housing continuum. This continuum, which provides a comprehensive way of evaluating a community's resources, divides housing needs and resources into the following categories, each of which is explained in detail in this section:

Emergency ↔ Transitional ↔ Permanent ↔ Specialized Care

Many of the best housing resources for people living with HIV/AIDS are provided by mainstream organizations that serve a wide variety of people. It is usually faster, cheaper, and more appropriate to draw on mainstream housing resources than to create new facilities and services just for people living with HIV/AIDS. Training other providers to understand the special needs of people living with HIV/AIDS can provide the same result as, and often more efficiently than, providing a new service tailored to specific needs. One effective strategy is to encourage mainstream housing providers to meet the needs of people living with HIV/AIDS through a range of nondevelopment mechanisms.

Emergency Housing Assistance

Emergency housing assistance is one-time or very short-term assistance provided to address an immediate housing crisis—often for people who are homeless or at imminent risk of becoming homeless. The primary goal of emergency assistance is to solve the immediate housing crisis; the assistance is usually one of the following:

- Emergency rent, mortgage, or utility payments to prevent loss of residence
- Hotel/motel vouchers
- Emergency shelter

Assistance to Remain in Your Home: Rent, Mortgage, or Utility Payments

Emergency housing assistance can be structured to specifically help households facing a crisis that could result in displacement from their housing. This assistance may take the form of a rent or mortgage payment or utility assistance, and may also include emergency repairs, weatherization, and other assistance that would forestall eviction, foreclosure, or uninhabitability of the residence. It is designed to address one-time crises, not ongoing needs. AIDS service organizations can administer this type of emergency assistance program directly or can contract with mainstream providers of similar services. Assistance with rent or mortgage payments can also be provided on a transitional or permanent basis, both of which are described under “Tenant-Based Transitional Assistance” and “Tenant-Based Rental Assistance” on the following pages.

When rent, mortgage, or utility payments work best: This type of assistance is most effective in communities where it is more likely that the financial crises faced by people living with HIV/AIDS can be overcome with short-term assistance. It is especially useful where a large percentage of those in housing need are homeowners, as is the case in most rural areas. Since it is much less expensive to keep people in their homes than to find or develop new ones, this can be a cost-effective form of assistance.

Advantages

- Preserving existing housing is much easier than developing new housing options.
- Multiple households can be served with less funding.
- Emergency housing payments are made just once or twice to each household and can be easy to administer.
- Remaining in his or her own home is the preferred choice of many people living with HIV/AIDS.

Disadvantages

- Many people living with HIV/AIDS need ongoing financial assistance, rather than short-term assistance, to remain in their homes.
- Emergency assistance does not result in long-term affordable housing units that will be available to people in need in the future.
- This approach does not address the needs of people who are homeless.

Hotel or Motel Vouchers

Hotel or motel vouchers are a form of emergency assistance given to homeless households that have no other alternative but living on the streets or in a substandard or inappropriate housing situation. Typically, vouchers are coordinated through case managers and provide homeless households with a motel room for a week at a time, with a maximum stay of about a month. Voucher providers negotiate agreements with local hotels or motels, and the hotels or motels bill the providers as rooms are used. Hotels or motels may offer discounted rates to nonprofit organizations.

When hotel or motel vouchers work best: Vouchers may be the only emergency housing option for small, rural communities that do not have enough homeless people to support the development and operation of a shelter. Vouchers may also be the best emergency option for people who are too sick to stay in an emergency shelter or for families who may not be able to stay together in a shelter. Hotel or motel vouchers work best when the local waiting lists for affordable housing are relatively short, and people are likely to have a place to transition to relatively quickly.

Advantages

- Vacant hotel or motel rooms can usually be found immediately.
- This approach does not require the creation of any new housing resources.
- Hotel or motel vouchers can be simpler to administer; the administering agency is not responsible for managing a facility.

Disadvantages

- Hotel or motel vouchers can be an expensive way to provide temporary housing.
- Many hotels and motels will not agree to participate in voucher programs.
- Most hotels and motels do not offer cooking facilities, or refrigeration for medications.
- Individual members of families do not have privacy in hotel or motel rooms.
- Many hotels and motels used for this purpose are located in neighborhoods with drug trafficking and other criminal activities.
- Hotel or motel vouchers are not a long-term housing solution.

Emergency Shelter

Emergency shelter is basic, temporary, overnight sleeping accommodation. Stays at emergency shelters are often limited to less than 30 days. Emergency shelter can take any form; beds in dormitory-style rooms or mattresses on the floor of space that has a different daytime use (for example, church assembly room, public office building) are common examples. Some shelters offer private rooms for families, and many also provide a meal program. Typical shelter providers include community action agencies, the Salvation Army, and other faith-based service agencies.

When emergency shelters work best: Emergency shelters are best suited for population centers with a significant homeless population and numerous affordable transitional and permanent housing options. If a community has a significant homeless population and no emergency shelters, AIDS service organizations should work with other homeless service providers to assess whether local need would justify the development of a shelter. In communities with emergency shelters, an HIV/AIDS training program for shelter staff can help the existing resources to address the needs of people living with HIV/AIDS more effectively.

Advantages

- Emergency shelters offer an immediate response to housing crises.
- Many communities already have existing emergency shelters.
- Shelters are often cost-effective to operate.
- Shelters are often the first point of contact with services for the newly homeless.

Disadvantages

- The large numbers of people served, combined with conditions that may be unsanitary, encourage the spread of infectious diseases in shelters.
- Emergency shelters often require people to go elsewhere during the day, which can be a hardship for people living with HIV/AIDS.
- The shared living situation of most emergency shelters offers little confidentiality for people living with HIV/AIDS.
- Emergency shelters typically do not have accessible refrigerated storage for prescription medications or offer private bathroom facilities for managing health care needs.
- Mainstream shelter providers may lack sensitivity to issues faced by people living with HIV/AIDS.
- Few shelters are designed to accommodate families.
- Emergency shelter is not a permanent solution to housing problems.

Transitional Housing Assistance

Transitional housing assistance is of limited duration—usually from 30 days to 2 years—and is intended to help people transition from a housing crisis into a permanent, stable housing situation. Its goal is to provide temporary housing and services to help households develop the skills and locate the ongoing resources they need to succeed in permanent housing. Additionally, people with no or poor rental history can build a positive rental history while in transitional housing, increasing their access to permanent housing.

Transitional housing assistance is effective where consumers are likely to either become self-sufficient or transition to another permanent housing resource by the time it ends. Transitional housing assistance most often includes:

- Assistance with move-in and occupancy needs
- Tenant-based transitional housing
- Supportive transitional housing project

Assistance with Move-In and Occupancy Needs

Move-in/occupancy needs assistance encompasses anything that assists households in overcoming the one-time challenges of establishing a new residence. Typical assistance includes providing moving expenses, rent deposit, move-in kit (linens, cookware, dishes, flatware, cleaning supplies), furniture, appliances, utility hook-up fees, and basic life skills training. Move-in/occupancy needs assistance can be either in-kind assistance or cash payments.

When move-in and occupancy needs assistance works best: In communities in which homeless people are transitioning into permanent housing, a program to provide move-in and occupancy needs assistance is essential. Since all homeless people have similar move-in and occupancy needs, centralized assistance programs that are coordinated with other homeless service providers generally work the best.

Advantages

- Move-in assistance can be relatively inexpensive.
- These programs are easy to administer.
- Move-in and occupancy needs assistance can be donated or provided by volunteers.
- Local businesses may be willing to donate to these programs.

Disadvantages

- Many people living with HIV/AIDS need more than just move-in and start-up assistance.
- Where rent deposits are provided, they are often retained by landlords as cleaning fees or kept by departing tenants.

Tenant-Based Transitional Housing Assistance

Some communities offer tenant-based rental assistance programs on a transitional basis. These function much like the programs described under “Assistance to remain in your home” above, but offer housing assistance for a longer period of time than just one or two payments. These programs are often developed under the guidelines of the Housing Opportunities for Persons with AIDS (HOPWA) program for short-term, 21-week assistance, but may also provide housing assistance for as long as 2 years.

When tenant-based transitional housing assistance works best: These programs work best in communities where consumers will be able to transition to permanent housing assistance within the established time limit.

Advantages

- Tenants have more choices of housing location.
- Tenants can use this type of assistance in existing housing units; new units do not need to be developed.
- This type of assistance can prevent a person from becoming homeless while waiting to access permanent assistance.
- Tenant-based programs can be implemented relatively quickly.
- Tenant-based transitional housing assistance program operation is comparatively less complex than developing and operating a facility-based program.

Disadvantages

- Tenant-based programs do not create new long-term housing resources. The community has this resource only as long as funding continues to be available (unlike developing new permanent housing units).
- This type of program may not be appropriate for people who need more support services in order to remain housed successfully.
- Some landlords are unwilling to rent to people with housing assistance vouchers.
- Some communities do not have enough good-quality rental units available at Fair Market Rent levels.

Supportive Transitional Housing

Supportive transitional housing is temporary housing combined with support services designed to assist homeless families and individuals to overcome the problems that led to their homelessness and return to living in permanent, independent housing. The services provided through a transitional program may address substance use, mental health, life skills training, education, and family support, and may help establish relationships between consumers and service providers. Supportive transitional programs can also help people who have been incarcerated to reintegrate into the community.

Transitional housing is typically provided in a centralized facility, but it may also be provided in scattered sites. Since the transitional needs of homeless people living with HIV/AIDS are similar to those of other homeless people, HIV/AIDS service organizations can collaborate with mainstream transitional housing providers. See “Master Leasing” for information about another method for providing transitional housing.

When supportive transitional housing works best: Supportive transitional housing is most helpful in communities that have a significant homeless population, and is successful only when all of the necessary support services are funded and in place. Since transitional housing is intended to move people into successful permanent housing placements, it works best in communities that have a sufficient supply of affordable permanent housing to accommodate those moving out of the transitional program. Smaller, rural communities should focus on providing permanent housing opportunities before developing transitional housing.

Advantages

- People leaving good transitional programs are much more likely to maintain stability in permanent housing.
- Transitional models often require program participation and compliance as conditions of residency, which gives service providers leverage to ensure that tenants benefit from the services in the program.

Disadvantages

- The support services necessary for a good transitional program are expensive to provide.
- Transitional programs are not successful in areas that lack adequate affordable permanent housing options; people leaving transitional housing must be able to find permanent housing at the end of the transitional period.

Permanent Housing Assistance

The goal of permanent housing assistance is to create safe, stable, and decent housing opportunities. Permanent housing assistance includes any of the following:

- Support services designed to help people live independently, provided on an ongoing basis
- Tenant-based rental assistance
- Shallow rent subsidy (another form of tenant-based rental assistance)
- Provision of actual housing units through sponsor- or project-based assistance, including through:
 - Lease buy-downs
 - Set-asides in larger housing projects
 - Scattered-site condominium acquisition
 - Group homes/shared housing
 - Independent apartment development projects

Support Services

In some circumstances, an array of support services may be all that is necessary to stabilize people living with HIV/AIDS in permanent housing. Support services are most often offered as a complement to a housing situation; without ongoing support services, many people living with HIV/AIDS risk losing their housing. Services can include case management, home care, counseling, nutrition and meal services, crisis intervention, legal assistance, transportation, day health programs, mental health services, and substance use treatment services, and may be provided by an AIDS service network or through other service providers.

When support services work best: A range of support services is needed in every community, regardless of the adequacy of housing options. Support services should be an integral part of every housing solution. Where the local supply of affordable housing is adequate to meet the demand, ongoing support services may be all that is necessary to ensure stable, successful housing. The local AIDS service organization should have the capacity to serve people in their homes and should develop good referral arrangements with other service providers.

Advantages

- Support service provision can help tenants remain in their existing home.
- Neither capital funding nor a time-consuming development process is necessary.
- Existing providers in the community can partner and contribute their skills and knowledge.
- Local volunteer teams can provide many HIV/AIDS services.

Disadvantages

- People with extremely low incomes often require financial assistance in addition to support services in order to find and keep housing.
- Providing support services to people in widely scattered locations can be expensive.
- Securing funding for ongoing services is a challenge.

Tenant-Based Rental Assistance

Tenant-based rental assistance (TBRA) is ongoing assistance paid to a tenant (or his or her landlord) to cover the difference between market rents and what the tenant can afford to pay. Tenants find their own units and may continue receiving the rental assistance as long as their income remains below the qualifying income standard. Many TBRA programs are federally subsidized, administered by local public housing authorities, and governed by HUD's Section 8 regulations. Some are funded by other sources, such as HOPWA, or operated by AIDS service organizations and nonprofit agencies. Section 8 regulations require all units with Section 8 tenants to meet federal housing quality standards (HQS), and the subsidy levels are set at the difference between HUD's annually established Fair Market Rent for the appropriate unit size and 30 percent of the tenant's household income.

Many communities have established TBRA programs with HOPWA funds, which are often structured similar to Section 8. However, HOPWA, unlike Section 8, allows for local discretion regarding serving undocumented immigrants and people with criminal histories. Shallow rent subsidies are another form of tenant-based rental assistance, and are discussed below.

When TBRA works best: Tenant-based rental assistance programs work best when there is a partnership between an experienced local (or regional) housing authority willing to administer the subsidy, and an AIDS service organization willing to market the subsidies, prescreen tenants, and assist tenants in finding appropriate units. Where this partnership exists, TBRA can be effective in communities of any size. TBRA is best suited for communities with a surplus of units renting at or below Fair Market Rent levels, or renting for a relatively affordable price.

Advantages

- Tenants may choose where they live.
- Tenants pay only 30 percent of their income to rent.
- Tenants can use TBRA in existing housing units.
- TBRA programs can be implemented relatively quickly.
- TBRA programs can be implemented statewide, allowing for coverage of rural areas with few housing assistance providers.

- Some local housing authorities give Section 8 waiting-list preference to people with terminal illnesses or who have HOPWA rental assistance.
- TBRA programs do not require the same level of technical skills as housing development, and can therefore be more accessible to an AIDS service organization.

Disadvantages

- TBRA programs do not create new long-term housing resources. The community has this resource only as long as funding continues to be available (unlike developing new permanent housing units). When the funding runs out, existing tenants lose their subsidy and, potentially, their housing.
- Some landlords are unwilling to rent to people with TBRA vouchers.
- Often, available units that are both within the FMR cost limit and operated by property managers willing to accept TBRA are located in neighborhoods with drug trafficking and other criminal activities.
- Federal subsidies are subject to annual renewal.
- Funding for many other TBRA programs is limited to 3 to 5 years and can be very difficult to renew.
- Some communities do not have an adequate supply of good-quality rental units at Fair Market Rent levels.

Shallow Rent or Mortgage Subsidies

Shallow rent or mortgage subsidies are another way of providing assistance to a tenant. Instead of calculating the consumer contribution and benefit provided based on the tenant's income; however, shallow rent or mortgage subsidies are based on a smaller, fixed amount. For example, a program might provide \$100 to \$200 per month toward rent or mortgage payments, and the consumer would cover the remainder of monthly housing costs.

When shallow rent subsidies work best: Shallow rent or mortgage subsidies work best where consumers are close to being able to afford housing costs independently, and regularly need a small amount of assistance. Mortgage assistance is particularly helpful in areas where many consumers are homeowners, which is often the case in rural areas. Shallow rent or mortgage subsidies also work best where housing costs are staying fairly level; in an increasing-cost housing market, this kind of program can become ineffective or excessively costly.

Advantages

- Tenants may choose where they live.
- Tenants can often use shallow rent subsidies in order to remain in their current home.
- A larger number of people can be served when a lesser amount of assistance is needed for each.
- Shallow rent subsidy programs can be implemented relatively quickly.
- Shallow rent subsidy programs do not require the same level of technical skills as housing development, and can therefore be more accessible to an AIDS service organization.

Disadvantages

- Shallow rent subsidy programs do not create new long-term housing resources. The community has this resource only as long as funding continues to be available (unlike developing new permanent housing units).
- Shallow rent subsidies are inappropriate for people who need more assistance to remain stably housed.

Set-Asides in Other Housing Projects

Because of the time, energy, complexity, and risk involved in developing affordable housing, AIDS housing organizations should take on new development projects only after careful consideration of other available options. One of the best ways to secure affordable units without development is by negotiating set-asides for people living with HIV/AIDS in projects developed by affordable housing providers. This may be as simple as a referral agreement or may involve the contribution of capital (see lease buy-downs) or the negotiation of a master lease (see master leasing) to help lower rents. In the latter cases, the AIDS housing organization must find additional funding.

In exchange for the investment of public subsidy, affordable housing developers make a commitment to keep the housing affordable for the long term, usually 30 to 50 years. A project-based set-aside involves a housing developer or owner dedicating a specified number of units to serve a special needs population for a defined term, up to the life of the project. The AIDS housing provider and property manager establish terms for the set-aside in a legal agreement.

When housing set-asides work best: Set-asides work best in projects that are developed with rents already affordable to people living with HIV/AIDS. When this is not the case, AIDS housing organizations are most likely to interest mainstream housing developers in set-asides when they can bring a source of debt-free funding into the project that otherwise would not be included (for example, HOPWA). This additional funding allows the housing developer to reduce the amount of repayable financing and lower rents by lowering debt service requirements.

Advantages

- The burden of developing, owning, and managing housing is borne by experienced developers with property management capacity.
- Set-asides can ensure access to affordable housing more quickly than undertaking a new development project.
- If agreements are properly negotiated, set-asides can secure long-term commitments.
- Economies of scale are not required: a set-aside is economically efficient with even a single unit.
- Residents can integrate into the community.
- Setting aside some units for people living with HIV/AIDS may increase the competitiveness of the housing developer's funding applications.

Disadvantages

- Mainstream housing providers may have rules that disqualify the people who need assistance.
- Some areas lack housing providers willing to set aside units for people living with HIV/AIDS, and some providers, particularly housing authorities, have rules that preclude setting aside units for specific populations.
- Set-asides are effective only when the rent on the units is affordable to the people you want to serve.
- The need for affordable rental units in some areas is so great that housing providers may not be willing to enter into special set-aside agreements.
- AIDS housing providers need to make certain that the physical design of the units will meet the needs of their residents, and that property management staff will work well with the people living with HIV/AIDS who are to receive housing assistance.

Lease Buy-Downs

Buying down a lease is a way of securing long-term affordability without the obstacles and worries of housing development and ownership. In a lease buy-down, an AIDS service organization or other housing provider enters into a long-term lease agreement with a property manager, and establishes a rent reserve fund which will pay the difference between the market rent and the amount that residents can pay.

The rent reserve is funded at the outset at a level that will last through the term of the lease. The payment amount is calculated by taking the net present value of the difference between the tenant's rental income stream and the rental income stream required to sustain the unit. The term of the lease, the discount factor used to determine net present value, and the basis for the affordable rents are all matters of negotiation between the AIDS housing organization and the mainstream housing provider. The AIDS housing organization must provide the up-front payment from capital funding sources.

When long-term leases work best: When the existing affordable rents in a community are not affordable for a person living with HIV/AIDS, lease buy-downs may be the solution. Lease buy-downs work best in communities with mainstream housing providers or landlords who are willing to engage in long-term leases. These deals are most common between housing providers and AIDS housing organizations that have good, existing relationships. When a mainstream housing provider offers rents that are already affordable to the targeted population, a set-aside agreement (see set-asides) may be preferable to a long-term lease.

Advantages

- Long-term affordability is assured without ongoing rent subsidy.
- AIDS service organizations do not have to manage the property.
- Economies of scale are not required: leasing even a single unit can be economically efficient.
- Residents can integrate into the community, unlike when living in a facility solely dedicated to people living with HIV/AIDS.

Disadvantages

- Developing contractual agreements can be complicated, time consuming, and expensive.
- Some funders are uncomfortable participating in a project with a long-term lease; many prefer ownership.
- It may be difficult to find property managers willing to enter into a long-term lease.
- Some communities have very few rental housing units available.
- If the rent differential is large, the cost of a lease buy-down may be high.
- Mainstream housing providers may have rules that disqualify the people you wish to assist.
- Different funding sources require different commitment periods (up to 51 years).

Master Leasing

Master leasing can be used to provide either transitional or permanent housing. Using this strategy, the AIDS housing provider leases units—individually, as single-family homes, on a floor, or throughout an entire building—that are then leased at an affordable cost to people living with HIV/AIDS. Master leasing is typically for a shorter term than lease buy-downs (above), but should be for at least 5 years, if possible.

When master leasing works best: Master leasing works best in communities with an active market in residential rental properties in healthy neighborhoods. Support services should also be available that can meet the needs of residents in the leased location(s).

Advantages

- AIDS housing providers can secure units quickly with master leasing.
- Community acceptance issues can often be avoided by pursuing this strategy.
- Residents can integrate into the community.

Disadvantages

- An operating subsidy will likely be necessary for each unit for the term of the lease.
- Available, affordable properties are often in neighborhoods with drug trafficking and criminal activities.
- If it is necessary to displace residents in a building to be leased, relocation can be complicated and expensive.
- The condition of a leased building needs to be assessed carefully, and staff may be needed to handle interior maintenance issues.
- The lack of a centralized support-service space can be problematic.
- Staff need to cultivate and maintain relationships with the landlord.

Scattered-Site Acquisition

Acquiring scattered-site condominiums or single-family homes is a way for AIDS housing organizations to enjoy some of the benefits of ownership, with reduced management responsibilities. In this scenario, AIDS housing organizations raise capital funding to purchase condominiums or single-family homes in their community and lease the units to people living with HIV/AIDS.

When scattered-site acquisition works best: Scattered-site acquisition works best in communities that have an active market in affordable condominiums or single family homes, and where support service networks can deliver a range of services to widely dispersed populations.

Advantages

- Acquisition provides quick access to units, when compared to development.
- Scattered condominium sites can effectively meet scattered demand.
- In some communities, acquiring new condominiums is less expensive than building new apartment buildings with public money.
- A small number of units can be developed efficiently.
- The property management functions of the AIDS housing provider are minimized.
- Residents are integrated into the community.

Disadvantages

- Condominium homeowner associations may exercise control over leases, tenants, and the number of renters allowed in a development, and the AIDS housing provider needs to have staff that can manage relations with a homeowner association.
- Although homeowner associations cover general maintenance for the exterior of the property, the AIDS housing provider will need to handle complicated property management responsibilities, including tenant screening, rent collection, general maintenance of the unit, and unit turnover, across scattered sites.
- Many smaller communities do not have any condominium developments.
- Condominiums have monthly maintenance fees as well as special or emergency assessments over time, and these need to be planned for.
- Acquired housing may require ongoing operating subsidy to keep rents affordable.
- Condominiums offer less control than more traditional ownership.
- Some public lenders are wary of condominium acquisition.

Group Homes or Other Shared Housing Arrangements

Group living assistance can include anything from a group home owned by an AIDS housing organization to a housemate referral service. Many of the early HIV/AIDS housing projects were shared single-family houses, but high vacancy rates in such facilities in recent years due to medical advances in treating HIV have shifted the focus of new developments to independent units. A group home or other shared housing can either be purchased or leased by the AIDS housing organization.

In many areas, small group homes can be developed in single-family zones, which are more prevalent than multifamily zones. However, each community has its own land use laws that restrict the number of unrelated adults that may live together, and it is important to comply with local regulations. Group homes also require ongoing maintenance and attention to being a good neighbor in order to be successful.

When group homes work best: Group living situations are best in those communities where consumer preference surveys indicate sufficient demand for this type of accommodation. While group homes may be less expensive to operate when full than independent living units, empty beds can make them more expensive. Similarly, the costs of providing accompanying support services to people in need of mental health and/or substance use treatment services can exceed the cost savings of group housing.

Advantages

- Group homes can be less expensive to develop and operate than independent apartments.
- Community living provides supports to people living with HIV/AIDS.
- Group homes offer churches or civic organizations the opportunity to participate in HIV/AIDS housing by sponsoring individual rooms in a house.

Disadvantages

- Consumer surveys of people living with HIV/AIDS often indicate a preference for independent units over shared accommodations.
- If local demand for shared housing drops, it is very difficult to convert part of a shared house to a new use.
- Personality conflicts between housemates can be difficult to manage, especially when the residents have mental health and/or substance use issues.

- Some people are reluctant to live in an HIV/AIDS-only housing project.
- Confidentiality can be hard to maintain in a group living situation.
- Proper nutrition may not be maintained if the sponsor does not take some responsibility for assuring meal provision.

Independent Apartment Development Projects

Independent apartment projects can be developed by HIV/AIDS housing organizations specifically to meet the permanent housing needs of people living with HIV/AIDS, or to serve a mixed population that includes people living with HIV/AIDS. AIDS housing organizations can function as the developer, owner, manager, and service provider for the units, or they may contract out those functions to other, experienced organizations. The tasks involved in project development include researching the need, developing a program, acquiring a site, assembling an architectural and engineering team, raising capital financing, hiring a contractor, overseeing construction, renting-up the units, and beginning operations. A development project typically lasts 2 to 4 years, and the complexity of the project is usually determined by the size of the development and the mix of financing.

When independent apartment projects work best: Independent apartment projects work best in communities with a sufficiently large demand for HIV/AIDS housing units. AIDS housing organizations in communities with few people living with HIV/AIDS should consider master leasing, a lease buy-down, set-aside units, or scattered-site condominiums. Inexperienced housing developers should partner with experienced developers before undertaking a new development project because of the many skills and technical knowledge required.

Advantages

- Housing units can be developed to address specific needs.
- People with HIV/AIDS usually prefer independent apartment units to shared accommodations.
- Large development projects can increase an organization's capacity to raise private donations and grants.
- Project development creates long-term housing resources.
- Projects offer opportunities for AIDS service organizations to work with organizations that address other community service needs.
- This model offers the owner the most control.

Disadvantages

- Developing an independent apartment project is very expensive, complex, and time-consuming.
- Multifamily-zoned land can be hard to find in some areas.
- An AIDS housing project can attract community opposition.
- The number of units required to operate a building efficiently may be larger than the local demand for AIDS housing.
- Development projects may require ongoing operating subsidy to keep rents affordable for people with extremely low incomes.
- Some people are reluctant to live in an AIDS-only housing project.
- Development requires a long-term commitment to housing operation.

Specialized Care Facilities

Specialized care facilities include short- and long-term housing combined with services designed to assist people whose medical or behavioral health make independent living impossible. Specialized care facilities range from assisted living to skilled nursing to hospice care. Each of these facilities targets only a portion of people living with HIV/AIDS in a community, those with very specific medical or support service needs. All of these facilities can be either limited to those with HIV/AIDS or open to all whose support needs are similar. Although mainstream specialized care providers may not initially be equipped to serve those living with HIV/AIDS, spending time and money to adapt these mainstream resources is usually the fastest and most efficient way to address the specialized care needs of people living with HIV/AIDS as opposed to creating new facilities.

When specialized care facilities work best: Specialized care facilities work best in communities where there is a large concentration of people living with HIV/AIDS who require higher-end care. Because specialized care requires complex technical skills in both the provision of care and business management, and because it is highly regulated, specialized care facilities work best when an experienced specialized care provider is a partner.

Advantages

- Specialized care facilities can provide a high level of care for people whose medical or behavioral health does not allow them to live independently.

Disadvantages

- The need for skilled staffing makes specialized care facilities very expensive to operate.
- People who are living longer typically do not want to live in a group living situation if it can be avoided.
- Maintaining a specialized care facility for people living with HIV/AIDS is only possible in areas with a large concentration of people living with HIV/AIDS.

Appendix 8: Glossary of HIV/AIDS- and Housing-Related Terms

This glossary includes terms used in the plan and terms related to HIV/AIDS and housing.

AFFORDABLE HOUSING Housing is generally defined by the U.S. Department of Housing and Urban Development as affordable when the occupant is paying no more than 30 percent of their adjusted gross income for housing costs, including utilities. Affordable housing may refer to subsidized or unsubsidized units.

AIDS Acquired Immunodeficiency Syndrome. A person with HIV infection is diagnosed with AIDS when either a) they develop an opportunistic infection defined by the Centers for Disease Control and Prevention as an AIDS indication, or b) on the basis of certain blood tests related to the immune system.

ASSISTED LIVING Group residences that offer the delivery of professionally managed personal and health care services, including meals, 24-hour attendant care, social activities, assistance with bathing, dressing and transferring, dispensing medication, and health monitoring. Assisted living is intended for those who need some assistance in performing the activities of daily living but who do not need the high level of medical supervision provided by a skilled nursing facility. Assisted living facilities may be HIV/AIDS-specific, or they may serve people with many needs.

ASYMPTOMATIC HIV INFECTION Without symptoms. Usually used in the HIV/AIDS literature to describe a person who has a positive reaction to one of several tests for HIV antibodies but who shows no clinical symptoms of the disease.

AT RISK OF BECOMING HOMELESS Being on the brink of becoming homeless due to one or more of the following: having inadequate income or paying too high a percentage of income on rent (typically 50 percent or more), living in housing that does not meet federal housing quality standards, or living in housing that is seriously overcrowded. Also see Homeless Person.

BEDS The unit of measure when describing the overnight sleeping capacity or availability for shelters, skilled nursing facilities, hospices, board and care, adult family living, assisted living, and other such facilities.

CDC The Centers for Disease Control and Prevention, the lead federal agency for protecting health and safety. CDC serves as a national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities.

CASE MANAGEMENT The central component of HIV/AIDS care is case management. Case managers coordinate all the care a client receives from all providers in the community. Typically, case management services are provided by agencies separate from the housing providers. When a case management client resides in a residence, however, the residential staff members have the most frequent contact with the resident and often are responsible for the care coordination. Case management is also provided through other social service systems.

COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM (CDBG) A federal grant program, administered by the U.S. Department of Housing and Urban Development, authorized under Title I of the Housing and Community Development Act of 1974 and administered by state and local governments. CDBG funds may be used in various ways to support community development, including acquisition, construction, rehabilitation, and/or operation of public facilities and housing.

CONSOLIDATED PLAN A document written by a state or local government and submitted annually to the U.S. Department of Housing and Urban Development that serves as the planning document of the jurisdiction and an application for funding under any of the community planning development formula grant programs (Community Development Block Grant, Emergency Shelter Grant, HOME Investment Partnerships Program, and Housing Opportunities for Persons with AIDS). The document describes the housing needs of the low- and moderate-income residents of a jurisdiction, outlining strategies to meet the needs and listing all resources available to implement the strategies.

CONTINUUM OF CARE An approach that helps communities plan for and provide a full range of emergency, transitional, and permanent housing and service resources to address the various needs of homeless persons. The approach is based on the understanding that homelessness is not caused merely by a lack of shelter, but involves a variety of underlying, unmet needs—physical, economic, and social. Designed to encourage localities to develop a coordinated and comprehensive long-term approach to homelessness, the Continuum of Care consolidates the planning, application, and reporting documents for the U.S. Department of Housing and Urban Development’s Shelter Plus Care, Section 8 Moderate Rehabilitation Single-Room Occupancy Dwellings (SRO) Program, and Supportive Housing Program.

DEVELOPMENTAL DISABILITY Referring to a variety of disabilities which impact cognitive functioning and learning style. Sometimes referred to as mental retardation.

DISCRIMINATION Treating a person differently because they belong to, or are perceived to belong to, an identifiable group. Often discrimination is due to a person’s being from a different race, country, or religion, or because they’re female, have a family, are older, disabled, or are gay or lesbian.

DUALLY DIAGNOSED See Multiply Diagnosed.

EMA OR EMSA Eligible metropolitan (statistical) area. Geographic area based on population and cumulative AIDS cases, to receive federal funds through the Ryan White CARE Act and Housing Opportunities for Persons with AIDS (HOPWA) Program.

EMERGENCY HOUSING ASSISTANCE Emergency housing assistance is one-time or very short-term assistance provided to address an immediate housing crisis—often for people who are homeless or at imminent risk of becoming homeless. The primary goal of emergency assistance is to solve the immediate housing crisis. The assistance is usually one of the following: emergency rent, mortgage or utility payments to prevent loss of residence, motel vouchers, and/or emergency shelter.

EMERGENCY SHELTER Any facility with overnight sleeping accommodations, the primary purpose of which is to provide temporary shelter for the homeless in general or for specific populations of homeless persons.

EMERGENCY SHELTER GRANTS (ESG) A federal program administered by the U.S. Department of Housing and Urban Development that provides funds to local governments to help provide additional emergency shelters or improve the quality of existing emergency shelters and to help meet operating costs of essential social services to homeless individuals. Funds are provided to grantees through both a formula-based process for eligible metropolitan areas and urban counties and through a national competition for non-formula-eligible counties.

EXTREMELY LOW-INCOME An individual or family whose income is between 0 and 30 percent of the median income for the area, as determined by the U.S. Department of Housing and Urban Development.

FAIR HOUSING ACT The Federal Fair Housing Act prohibits, among other things, the owners of rental housing from discriminating against potential tenants based on race, sex, national origin, disability, or family size.

FAIR MARKET RENT (FMR) Rents set by the U.S. Department of Housing and Urban Development (HUD) for a state, county, or urban area that define maximum allowable rents for HUD-funded subsidy programs. HUD calculates FMR to be at the 40th percentile of recent moves, excluding apartments built within the past two years, meaning that 40 percent of recent movers paid less, and 60 percent paid more.

FAMILY For purposes of the plan and local policy interpretation, and in keeping with HOPWA regulations, the term “family” encompasses nontraditional households, including families made up of unmarried domestic partners. A family is a self-defined group of people who may live together on a regular basis and who have a close, long-term, committed relationship and share responsibility for the common necessities of life. Family members may include adult partners, dependent elders, or children, as well as people related by blood or marriage.

FEDERAL EMERGENCY MANAGEMENT ADMINISTRATION (FEMA) An independent agency reporting to the President and tasked with responding to, planning for, recovering from, and mitigating disaster. FEMA administers the Emergency Food and Shelter Program as mandated by Title III of the McKinney-Vento Act. Also see McKinney-Vento Act.

GROUP HOUSING/SHARED LIVING Two or more single adults, or families with children, sharing living arrangements in a house or an apartment. Generally, individuals each have a bedroom and share a kitchen, bath, and housekeeping responsibilities. The group facility may provide a limited range of services and be licensed or unlicensed.

HAART Highly Active Anti-Retroviral Therapy. The preferred term for potent anti-HIV treatment. This means a combination of drugs (usually three or more) to combat HIV. Usually more than one class of drug is included in a HAART regimen. Includes protease inhibitors, and is often referred to as combination therapy or the “cocktail.”

HARM REDUCTION A set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies for safer use, from managed use to abstinence. Harm reduction strategies meet drug users “where they’re at,” addressing conditions of use along with the use itself.

HIV Human Immunodeficiency Virus. The virus that causes AIDS. HIV disease is characterized by a gradual deterioration of immune functions. During the course of infection, crucial immune cells, called CD4+ T cells, are disabled and killed, and their numbers progressively decline. People infected with HIV may or may not feel or look sick.

HOME HOME Investment Partnerships Program. A program administered by the U.S. Department of Housing and Urban Development providing grants for low-income housing through rental assistance, housing rehabilitation, and new construction.

HOMELESS PERSON According to the U.S. Department of Housing and Urban Development, a homeless person is an individual or family who 1) lacks a fixed, regular, and adequate night-time residence, or 2) has a primary night-time residence that is a) a publicly supervised or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); b) an institution that provides a temporary residence for individuals intended to be institutionalized; c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. Individuals paying more than 50 percent of their income for housing are also considered at such high risk for homelessness that they are included in the definition of homeless for some federal programs. The term “homeless individual” does not include any individuals imprisoned or otherwise detained under an act of federal or state law.

HOPE VI HOPE VI, or the Urban Revitalization Program, a program administered by the U.S. Department of Housing and Urban Development, funds rehabilitation and/or replacement of distressed public housing units and support services. Through the end of FY 2001 the program has awarded \$4.8 billion to 146 communities in 37 states since 1993.

HOPWA Housing Opportunities for Persons with AIDS. A U.S. Department of Housing and Urban Development program which pays for housing and support services for people living with HIV/AIDS and their families. Created by an Act of Congress in 1990.

HOSPICE A support and care provided to people in the last phases of a terminal illness so that they may live as fully and comfortably as possible. Hospice focuses on alleviating pain and discomfort, improving the quality of life, and preparing individuals mentally and spiritually for their eventual death.

HOUSING COST BURDEN The extent to which gross housing costs, including utility costs, exceed 30 percent of gross income, based on data published by the U.S. Census Bureau.

HOUSING COST BURDEN, SEVERE The extent to which gross housing costs, including utility costs, exceed 50 percent of gross income, based on data published by the U.S. Census Bureau.

HOUSING UNIT An occupied or vacant house, apartment, or a single room (SRO housing) that is intended as separate living quarters.

HOUSING QUALITY STANDARDS (HQS) Standards set by the U.S. Department of Housing and Urban Development (HUD) to ensure that all housing receiving HUD financial assistance meets a certain level of quality. HQS requires that recipients of HUD funding provide safe and sanitary housing that is in compliance with state and local housing codes, licensing requirements, and any other jurisdiction-specific housing requirements.

HRSA Health Resources and Services Administration. HRSA is an agency of the U.S. Department of Health and Human Services that works toward providing health care to low-income, uninsured, isolated, vulnerable, and special needs populations through a number of programs including: Ryan White CARE Act, Rural Health Initiative, and other community-based health initiatives.

HUD U.S. Department of Housing and Urban Development. HUD is a cabinet-level agency designed to advocate for the housing needs of people with low incomes through programs for public housing, special needs housing, and first time homebuyers.

INFORMATION AND REFERRAL Assistance to individuals who are having a difficult time finding and/or securing housing.

LOW-INCOME FAMILY Family whose income does not exceed 50 percent of the median income for the area, as determined by the U.S. Department of Housing and Urban Development (HUD), with adjustments for smaller and larger families. HUD may establish income ceilings higher or lower than 50 percent of the median for the area on the basis of findings that such variations are necessary because of prevailing levels of construction costs or Fair Market Rents, or unusually high or low family incomes.

LOW INCOME HOUSING TAX CREDIT PROGRAM Formula allotment of federal income tax credits administered by states and distributed to nonprofit and for-profit developers of and investors in low-income rental housing. Since its creation in 1986 by the Tax Reform Act, more than a million units have been funded nationwide, utilizing the equivalent of more than \$3 billion dollars in funding annually.

MASTER LEASING A housing strategy in which a sponsor agency leases housing units from private or nonprofit housing landlords and subleases the units to individuals and families that meet the sponsor agency's eligibility criteria. This housing option is used mainly as transitional housing. In a transitional housing master leasing scenario, subleases with individuals and families can include stipulations for duration of tenancy and responsibilities of tenancy, such as a requirement to participate in support services.

MCKINNEY-VENTO ACT The primary federal response targeted to assisting homeless individuals and families. The scope of the Act includes: outreach, emergency food and shelter, transitional and permanent housing, primary health care services, mental health, alcohol and drug abuse treatment, education, job training, and child care. There are nine titles under the McKinney-Vento Act that are administered by several different federal agencies, including the U.S. Department of Housing and Urban Development (HUD). McKinney-Vento Act Programs administered by HUD include: Emergency Shelter Grant Program, Supportive Housing Program, Section 8 Moderate Rehabilitation for Single-Room Occupancy Dwellings, Supplemental Assistance to Facilities to Assist the Homeless, and Single Family Property Disposition Initiative. Also see: Emergency Shelter Grants, Federal Emergency Management Administration, Shelter Plus Care, Section 8 Moderate Rehabilitation for Single-Room Occupancy Dwellings, and Supportive Housing Program.

MEDIAN FAMILY INCOME (MFI) The amount, as determined by HUD, which divides an area's income distribution into two equal groups, one having incomes above this amount, one having incomes below. MFI is based on the most recent U.S. Census family income data and is adjusted annually for inflation. HUD and the U.S. Census Bureau consider a family to be a household comprised of related individuals. For example: A family is a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

MEDICAID A program jointly funded by the states and the federal government that provides medical insurance for people who are unable to afford medical care. The program focuses mainly on the needs of the elderly, people with disabilities, and children.

MEDICARE A federal program under the Social Security Administration that provides health insurance to the elderly and disabled.

MENTAL ILLNESS A serious and persistent mental or emotional impairment that significantly limits a person's ability to live independently.

MODERATE INCOME An individual or family whose income is between 50 percent and 80 percent of the median income for the area, as determined by the U.S. Department of Housing and Urban Development (HUD), with adjustments for smaller or larger families. HUD may establish income ceilings higher or lower than 80 percent of the median for the area on the basis of findings that such variations are necessary because of prevailing levels of construction costs or Fair Market Rents, or unusually high or low family incomes.

MULTIPLY DIAGNOSED To be diagnosed with HIV/AIDS and also have histories of other disabilities. This term generally refers to people who are HIV-positive and have chronic alcohol and/or other drug use problems and/or a serious mental illness. The terms “dually diagnosed” and “triply diagnosed” are also used.

OPERATING COSTS (in relation to housing) Distinct from capital costs and support services costs. Operating costs include property taxes, insurance, maintenance, and repair.

PERMANENT HOUSING Housing which is intended to be the tenant’s home for as long as they choose. In the supportive housing model, services are available to the tenant, but accepting services cannot be required of tenants or in any way impact their tenancy. Tenants of permanent housing sign legal lease documents.

PERSON WITH A DISABILITY HUD’s Section 8 program defines a “person with a disability” as: a person who is determined to: 1) have a physical, mental, or emotional impairment that is expected to be of continued and indefinite duration, substantially impedes his or her ability to live independently, and is of such a nature that the ability could be improved by more suitable housing conditions; or 2) have a developmental disability, as defined in the Developmental Disabilities Assistance and Bill of Rights Act.

PROJECT-BASED RENTAL ASSISTANCE Rental assistance that is tied to a specific unit of housing, not a specific tenant. Tenants receiving project-based rental assistance give up the right to that assistance upon moving from the unit. Also see Rental Assistance, Shallow Rent Subsidy, and Tenant-based Rental Assistance.

PROTEASE INHIBITORS A group of anti-retroviral medications for people living with HIV/AIDS. Protease inhibitors act by preventing the replication of HIV in the body and are often prescribed in combination with other HIV medications. Also see HAART.

RENTAL ASSISTANCE Cash subsidy for housing costs provided as either project-based rental assistance or tenant-based rental assistance. HOPWA short-term rental assistance is available for up to 21 weeks. HOPWA long-term rental assistance is provided for longer than 21 weeks. Due to HOPWA regulations, rental assistance cannot be guaranteed for longer than three years. Ryan White funds can be used for short-term, transitional, or emergency housing defined as necessary to gain or maintain access to medical care. Also see Project-based Rental Assistance, Tenant-based Rental Assistance, and Shallow Rent Subsidy.

RYAN WHITE CARE ACT Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. A program of the Health Resources and Services Administration (HRSA) providing funds for health care and supportive services for people living with AIDS. Created by an Act of Congress in 1990. Also see HRSA.

SCATTERED-SITE HOUSING Individual units scattered throughout an area, such as condominiums and single family homes in different complexes or neighborhoods, creating dispersed and integrated housing options.

SECTION 8/HOUSING CHOICE VOUCHER PROGRAM A federal program operated by local housing authorities providing rental assistance to low-income persons and administered by the U.S. Department of Housing and Urban Development. Under the Section 8 Housing Voucher program, the local housing authority determines a standard amount of rental assistance an individual or family will receive. The tenant would pay the difference between the amount of assistance and the actual rent, which may require the tenant to spend more than 30 percent of their income on rent. The Section 8 voucher program is a tenant-based program, meaning the subsidy is specific to the tenant as opposed to the unit.

SECTION 8 HOUSING OPPORTUNITIES FOR PERSONS WITH DISABILITIES (MAINSTREAM PROGRAM) The Mainstream Program, created in 1997 and administered by the U.S. Department of Housing and Urban Development, utilizes up to 25 percent of the funds originally earmarked for Section 811 to a separate tenant-based rental assistance program for persons with disabilities. Also see Section 811.

SECTION 8 MODERATE REHABILITATION FOR SINGLE-ROOM OCCUPANCY DWELLINGS This program provides Section 8 rental assistance for moderate rehabilitation of buildings with SRO units (single-room occupancy dwellings). The program, administered by the U.S. Department of Housing and Urban Development, is designed for the use of an individual person. Units often do not contain food preparation or sanitary facilities. A public housing authority makes Section 8 rental assistance payments to the landlords for the homeless people who rent the rehabilitated units.

SECTION 811 Provides grants to nonprofit organizations for acquisitions, new construction, and/or rehabilitation of rental housing with support services for very low-income persons with disabilities. The program is administered by the U.S. Department of Housing and Urban Development and includes a capital advance and project-based rental assistance payments.

SHALLOW RENT SUBSIDY Short-term or ongoing cash subsidy for housing costs provided as either project-based rental assistance or tenant-based rental assistance. Typically, shallow subsidies are for a set amount and are not related to the percentage of income paid to rent. Also see Project-based Rental Assistance, Rental Assistance, and Tenant-based Rental Assistance.

SHELTER PLUS CARE A national grant program administered by the U.S. Department of Housing and Urban Development providing rental assistance, linked with support services, to homeless individuals who have disabilities (primarily serious mental illness, chronic substance abuse, and disabilities resulting from HIV/AIDS) and their families.

SKILLED NURSING FACILITY A nursing home or facility providing 24-hour care from nurses and aides.

SRO Single-Room Occupancy. Refers to studio apartments which provide very limited cooking facilities and typically have shared bathrooms. They are often in rehabilitated hotels, and can be used for emergency, transitional, or permanent housing.

SOCIAL SECURITY DISABILITY INSURANCE (SSDI) A federal government benefit for individuals who are medically disabled and have worked for enough years to be covered under Social Security.

SPECIAL NEEDS HOUSING Housing for people who require specific accommodations and/or support to access and maintain housing. Special needs housing may target the elderly; the disabled, including people living with HIV/AIDS; and those with histories of homelessness, mental illness, and substance use issues.

SUBSIDIZED RENTAL HOUSING Assisted housing that receives or has received project-based governmental assistance and is rented to low- or moderate-income households. Subsidized rental housing does not include owner-occupied units, nor does it include Section 8 certificate/voucher holders in market-rate housing.

SUBSTANCE USE ISSUES The problems resulting from a pattern of using substances such as alcohol and drugs. Problems can include: a failure to fulfill major responsibilities and/or using substances in spite of physical, legal, social, and interpersonal problems and risks.

SUPPLEMENTAL SECURITY INCOME (SSI) SSI is a federal government benefit for individuals who are 65 or older, or blind, or have a disability and earn a low income.

SUPPORTIVE HOUSING Housing, including housing units and group quarters, which include on- and off-site support services.

SUPPORTIVE HOUSING PROGRAM (SHP) Provides grants to develop housing and related support services for people moving from homelessness to independent living. Program funds help homeless people live in a stable place, increase their skills or income, and gain more control over the decisions that affect their lives. Funding may be used for capital costs, facility operations, and support services.

SUPPORT SERVICES Services provided to individuals to assist them to achieve and/or maintain stability, health, and improved quality of life. Some examples are case management, medical or psychological counseling and supervision, child care, transportation, and job training.

SYMPTOMATIC HIV INFECTION Any perceptible, subjective change in the body or its functions that indicates disease or phases of disease, as reported by the patient. When referring to a person who is HIV-positive, this indicates a person who is sick and/or shows medical symptoms of the disease, but does not have an AIDS diagnosis.

TANF Temporary Assistance for Needy Families, a program administered by the U.S. Department of Health and Human Services. TANF, which replaced and is sometimes referred to as welfare, provides assistance and work opportunities to families with low incomes by granting states the federal funds and guidelines to administer their own welfare programs.

TENANT-BASED RENTAL ASSISTANCE A form of rental assistance in which the assisted tenant may move to a different housing unit while maintaining their assistance. The assistance is provided for the tenant, not a specific housing unit. Also see Project-based Rental Assistance, Rental Assistance, and Shallow Rent Subsidy.

TRANSGENDER Individuals whose sense of gender identity does not match their physiological sex, including those who have changed or are in the process of changing their sex from male to female or female to male.

TRANSITIONAL HOUSING A project that is designed to provide housing and appropriate support services to homeless persons to facilitate movement to independent living within 24 months, or a longer period approved by the U.S. Department of Housing and Urban Development (HUD). For purposes of the HOME program, there is not a HUD-approved time period for moving to independent living.

