



## Permanent Supportive Housing and Federally Qualified Health Centers: A Promising Partnership - Part I (of 3)

Permanent Supportive Housing providers are always searching for resources to help fund and/or provide supportive services to their residents. Recently, Federally Qualified Health Centers (FQHCs) have become partners with some supportive housing projects. FQHCs are the safety net providers of health care in this country. The goal of FQHCs is to maintain, expand and improve the availability and accessibility of primary and preventive health care services and related enabling services provided to low income, medically underserved and

vulnerable populations that traditionally have limited access to affordable services and face greatest barriers to care. FQHCs include community health centers, rural health clinics, migrant health clinics, clinics serving the homeless and public housing health clinics.

FQHCs are required to provide, either directly or through contracts, a full continuum of primary health services including: Adult Medicine; Pre-natal/OBGYN; Pediatrics; Oral Health; and Behavioral Health. They must also

provide enabling and support services which may include: Translation; Outreach; Eligibility; Facilitated enrollment; and Case management services. FQHCs must be governed by fully independent, community-based board of nine to twenty-five members. Consumers must constitute a majority of the board (51%) and reflect the demographics of the service area population. Non-user members must be representative of the community and should be selected for expertise in variety of areas.

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## U. S. Conference of Mayors Report on Hunger and Homelessness

To assess the status of hunger and homelessness in America's cities during 2007, The U. S. Conference of Mayors surveyed 23 major cities (including Chicago) whose mayors are members of its Task Force on Hunger and Homelessness. The survey sought information and estimates from each city on (1) the demand for emergency food assistance, emergency shelter and transitional housing; (2) the capacity to meet that demand; (3) the causes of hunger and homelessness; (4) efforts underway in

each city to combat these problems; (5) the economic or social conditions that exacerbate these problems; and (6) the outlook for 2008.

This year, the Conference of Mayors made several important changes to its Hunger and Homelessness Survey Questionnaire aimed at increasing the quality of the data collected and improving the accuracy of survey results. The revised survey is more

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**Headlines/Hotline on the Internet** - The Illinois Community Action Association publishes both Homeless Headlines and Homeless Hotline on the Publications page of its web site at [www.icaanet.org](http://www.icaanet.org). To receive both by email, send a blank email to: [headlines-hotline-subscribe@yahoo.com](mailto:headlines-hotline-subscribe@yahoo.com). (Self service only.)



# HHS Poverty Guidelines Update

*[This is an abridged version of the notice published on page 3971 of the January 23, 2008 Federal Register. The full version can be downloaded at <http://aspe.os.dhhs.gov/poverty/08fedreg.pdf>.]*

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U. S. C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update, at least annually, the poverty guidelines, which shall be used as an eligibility criterion for the Community Services Block Grant program. The poverty guidelines also are used as an eligibility criterion by a number of other Federal programs. The poverty guidelines issued here are a simplified version of the poverty thresholds that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI-U). The guidelines in this 2008 notice reflect the 2.8 percent price increase between calendar years 2006 and 2007. After this inflation adjustment, the

**2008 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA**

Persons in family	Poverty guideline
1 .....	\$10,400
2 .....	14,000
3 .....	17,600
4 .....	21,200
5 .....	24,800
6 .....	28,400
7 .....	32,000
8 .....	35,600

For families with more than 8 persons, add \$3,600 for each additional person.

guidelines are rounded and adjusted to standardize the differences between family sizes. The same calculation procedure was used this year as in previous years. (Note that these 2008 guidelines are roughly equal to the poverty thresholds for calendar year 2007 which the Census Bureau expects to publish in final form in August 2008.) The guideline figures shown represent annual income.

Due to confusing legislative language dating back to 1972, the poverty guidelines have sometimes been mistakenly referred to as the “OMB” (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty guidelines may be formally referenced as “the poverty guidelines updated periodically in the Federal Register by the U. S. Department of Health and Human Services under the authority of 42 U. S. C. 9902(2).”

Some programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non-Federal organizations that use the poverty guidelines under their own authority in non-federally-funded activities can choose to use a percentage multiple of the guidelines such as 125 percent or 185 percent.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

Note that this notice does not provide definitions of such terms as “income” or “family.” This is because there is considerable variation in how different programs that use the guidelines define these terms, traceable to the different laws and regulations that govern the various programs. ■

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## Homeless Headlines



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The **Illinois Association of Community Action Agencies** has published the monthly *Homeless Headlines* and the *Homeless Hotline* since 1991 under contract with the **Illinois Department of Human Services**.

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U.S. Department of Health & Human Services

Administration for Children & Families

## Basic Center Program Grants

Through the Basic Center Program, Family and Youth Services Bureau (FYSB) works to establish or strengthen community-based programs that address the immediate needs of runaway and homeless youth and their families. The central purpose of these programs is to provide youth with emergency shelter, food, clothing, counseling, and referrals for health care. Most Basic Centers can provide 15 days of shelter for up to 20 youth. There are exceptions for those jurisdictions that have different standards for licensing. The Basic Centers seek to reunite

young people with their families, whenever possible, or to locate appropriate alternative placements.

Currently, the U. S. Department of Health and Human Services' (HHS') Administration for Children and Families is accepting applications for its Basic Center Program. The program offers an alternative to runaway and homeless youth by providing appropriate shelter, counseling, and aftercare.

The application deadline is February 19, 2008.

**More Information** - <http://www.acf.hhs.gov/grants/open/HHS-2008-ACF-ACYF-CY-0063.html>

### Making the Connection

## Food Stamp Work Requirement

Contributor: DuPage Federation on Human Services Reform



*The authors of this column welcome your comments and questions. See contact information at the end of the article.*

Individuals who receive Food Stamps have always been required to meet some type of a work requirement. Most often it used to be simply agreeing to look for work and registering for work at the local Illinois Department of Employment Security. Prior to 1996 and Welfare Reform there were a few areas in Illinois that had in place a more stringent work

requirement for some Food Stamp recipients.

In 1996 when Welfare Reform legislation was signed, an enhanced work requirement was added for able-bodied adult food stamp recipients without dependents (ABAWDs). Welfare Reform legislation included a provision that limited ABAWDs to three months of food stamps during a set 36 month period unless the person met specific exemptions or fulfilled and verified work or training activities. This segment of the Welfare Reform legislation was not of concern to all of us because Illinois requested a waiver\* of this requirement from USDA and was approved. This waiver did not affect the pre-reform work requirements already in place. *In April of 2007, however, Illinois began implementing*

## HIV/AIDS Risk

Nurse.com, a website showcasing nursing and health news, featured the Centers for Disease Control and Prevention's (CDC) findings on how homeless or unstably housed people are at an increased risk of acquiring or transmitting HIV and experience an increase in adverse health affects if they already have HIV. The CDC journal AIDS and Behavior found that homeless or unstably housed persons were two to six times more likely to "have recently used hard drugs, shared needles, or exchanged sex [sic]" than similar low-income persons who were stably housed. Since housing assistance allowed people to achieve both physical and mental stability, drug and sexual risk behaviors associated with a lack of stability decreased, proving that the condition of homelessness, and not simply traits of homeless individuals, influences risk behaviors and healthcare utilization.

### Counties that Must Meet the Work Requirement

Adams	Livingston
Champaign	Madison
Coles	Marshall
DeWitt	McLean
Douglas	McDonough
DuPage	Mercer
Henry	Peoria
Jackson	Rock Island
Jasper	Sanagamon
Jersey	Tazewell
Lake	Woodford

*the 1996 Welfare Reform work requirements in Macon and Sanagamon counties. As of January 2, 2008 the work requirement is now expanded to include 20 more counties.*

What does this change mean to those of you live in these counties? It means that individuals aged 18 through 49 are not eligible for Food Stamps for more

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## Food Insecurity And Developmental Risk In Children

Researchers from Boston University School of Medicine (BUSM) and Boston Medical Center (BMC), in collaboration with researchers from Arkansas, Maryland, Minnesota and Pennsylvania, have found that children living in households with food insecurity, are more likely to be at developmental risk during their first three years of life, compared to similar households that are not food insecure. This study appears in the January 2008 issue of the journal *Pediatrics*.

The U. S. Department of Agriculture estimates that 16.7 percent of all U. S. households with children less than six years of age had food insecurity in 2005, reporting limited or uncertain availability of enough food for an active healthy life. In children aged less than three years, food insecurity has

been associated with poor infant health, and the likelihood of hospitalization.

The Children's Sentinel Nutritional Assessment Program (C-SNAP) interviewed caregivers from low-income households with children aged four to 36 months at five pediatric clinic/emergency department sites in Boston, Little Rock, Baltimore, Minneapolis and Philadelphia. The target child from each household was weighed and weight-for-age score was calculated.

In the sample of 2,010 families, the researchers found 21 percent reported food insecurity. The results of the analyses revealed that children from food-insecure households, compared with those from food-secure households, were two thirds more likely to experience developmental risks. Household food insecurity, (with or without the report of family hunger), even in the presence of appropriate weight-for age, is an important risk factor for the health, development and behavior of children less than three years of age.

According to the researchers the clinical and public policy implications of this study are striking. "Providing nutritional and developmental interventions to young children and their families is a proactive step that might decrease the need for later, more extensive interventions for developmentally or behaviorally impaired children of school age," said lead author Ruth Rose-Jacobs, ScD, an assistant professor of pediatrics at BUSM and a research scientist at BMC.

"Interventions for food insecurity and developmental risk are available and overall have been successful. Linking families to the Food Stamp Program and/or the Supplemental Nutrition Program for Women, Infants and Children is an important intervention that should be recommended if indicated by risk surveillance or developmental screening," she adds.

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## Rural Homelessness Capacity Building

A new Rural Homelessness Capacity Building program launched this month will support the work of faith-based and community-based organizations serving homeless populations in rural America.

"Many small rural community organizations just don't have the funding, networks, and information they need in order to help their homeless neighbors," explained Moises Loza, executive director of the Housing Assistance Council, which created the new program.

"Through the Rural Homelessness Capacity Building program, they can access tools and resources that will enable them to better serve homeless people."

One-on-one technical assistance, audio web trainings, and online information will be available for rural homelessness provider organizations over the course of the three-year initiative.

Selected organizations working in high need communities will also receive for grants to pursue training opportunities, purchase equipment, or undertake other activities that will improve their ability to meet the needs of homeless people in their areas.

RHCB is funded by a Department of Health and Human Services Compassion Capital Fund grant.

The Housing Assistance Council is operating it with help from the National Alliance to End Homelessness.

**For more information about the program,** visit [www.ruralhome.org/rhcbindex2.php](http://www.ruralhome.org/rhcbindex2.php) or contact RHCB staff at 1-877-842-RHCB or [RHCBinfo@ruralhome.org](mailto:RHCBinfo@ruralhome.org). ■

## Homeless Headlines

### FQHC

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Because of their mission, FQHCs are eligible for a variety of reimbursement enhancements and cost savings programs not available to hospitals or physicians, such as higher Medicaid reimbursement and prescription drug discounts. They are also eligible for federal Healthcare for the Homeless (HCH) competitive grants to support otherwise uncompensated costs of providing primary care and enabling services to homeless individuals and families. FQHCs serve individuals with Medicare, Medicaid, private health insurance and the uninsured.

In Illinois, there are approximately forty-six FQHCs with hundreds of actual clinic sites. The Illinois Primary Health Care Association (IPHCA) is a non-profit trade association that serves as Illinois' sole primary care association. ([www.iphca.org](http://www.iphca.org)) A list of the clinic sites in Illinois is available at the Health Resources and Services Administration: <http://ask.hrsa.gov/pc/>.

### Partnerships With Supportive Housing Providers

Why would FQHCs and supportive housing providers enter into partnerships? Supportive housing provides a wide range of support to keep tenants in the building and out of institutions. FQHCs offer clinical services in community-based health centers, including psychiatric care, mental health counseling, substance abuse treatment and supports, healthcare coordination, and nutrition counseling. FQHCs and some supportive housing projects have similar staff: nurse practitioners, psychiatrists, nurses, nutritionists, and licensed social workers. FQHCs can send staff to housing sites or see tenants at clinic sites.

There are options to collaborate on different levels - FQHC clinics can be

located near a cluster of supportive housing buildings; an FQHC clinic could be co-located in a new supportive housing development; an FQHC could establish a satellite FQHC clinic; or individual specialized staff in the community could be reimbursed through an FQHC (like a Visiting Nurse model).

With these different models, services are offered either on-site at the housing provider or off-site at the clinic. Advantages of onsite services are that the services are more easily accessible for tenants with no waiting period for referrals, and follow-up and service coordination are easier. It may be easier to engage vulnerable tenants with complex health and mental health problems who may not be willing to go to clinics for care (at least initially). Services provided at the clinics, on the other hand, can give tenants a greater sense of independence, help them learn how to navigate service systems on their own and protect their personal privacy. In addition, more comprehensive health care services are usually available at clinics, compared to services that can be delivered at the housing site.

The potential benefits to partnering with FQHCs for housing providers are that they would have a formal holistic continuum of care for tenants from one provider, who comes with its own funding, rather than piecemeal services. The housing provider would not be responsible for financing services provided by FQHC. The FQHC Medicaid reimbursable services could replace a percentage of the overall supportive services budget, with potentially a decrease in on-going need for government contracts, grants or other fundraising for services. And, perhaps most importantly, supportive housing residents would have ready access to a clinic that meets their primary health, mental health and substance abuse needs.

For FQHCs, they would have a concentrated patient population with chronic health issues to expand their patient base. Many tenants are or should be Medicaid eligible and the turnover in supportive housing is very low, ensuring the patients would remain served by the clinic. The community receives both stable affordable housing and quality health care services. Both the supportive housing provider and the clinic are able to develop strong working relationships thereby increasing effectiveness and efficiency.

Some of the challenges with such partnerships are that the housing provider will not control a contract for these services nor have the ability to hire or fire FQHC staff if unsatisfied with its performance. The FQHC may not be able to provide enough mental health, substance abuse and other enabling services to justify much of a reduction in supportive services staff or costs to the housing provider.

For these partnerships to succeed, permanent supportive housing providers should select a site that assures that the health clinic providers will see a significant number of patients (if services will be provided at the housing site); ensure there is a strong cooperative arrangement with staff in the permanent housing site to identify and contact residents who need health services and get them to the appointments; and the housing provider should know the payer mix - the proportion of residents who have Medicaid, Medicare or no insurance - before engaging with the health clinic to give them an idea of whether or not it makes sense to explore the partnership.

CSH and the National Health Care for the Homeless Council (NHCHC) have collaborated on a project to identify and document those community health clinics and healthcare for the homeless grantees that have partnerships with permanent supportive housing providers; to identify policy

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### FQHC

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opportunities and obstacles encountered in financing and delivering health care in permanent supportive housing; to document and share promising practices in permanent supportive housing; and to recommend strategies for increasing the capacity of FQHCs to participate in supportive housing. NHCHC convened a national working group and issued a report, with recommendations, in November 2007. A quote from the report sums up the project:

“The premise of the National Health Care for the Homeless Council, the Corporation for Supportive Housing, and the Permanent Supportive Housing Working Group is that housing is health care — because housing stability itself improves health and makes health and social services easier to deliver and more effective. For this reason, we contend, Health Centers serving homeless people are ideal participants and leaders in supportive housing initiatives.”

A copy of the report is available at: [www.csh.org/index.cfm?fuseaction=page.viewPage&pageID=4076&nodeID=81&noheader=1](http://www.csh.org/index.cfm?fuseaction=page.viewPage&pageID=4076&nodeID=81&noheader=1).

There are several examples in Illinois of FQHCs and supportive housing partnerships. In the next issue of Homeless Headlines, you will read about a rural FQHC that has an expansive geographic reach that works with several permanent supportive housing providers.

CSH will be convening an Illinois working group to share best practices in this area. If you are interested in participating in this group, please contact Sue Augustus at [sue.augustus@cs.org](mailto:sue.augustus@cs.org).

### Conference of Mayors

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rigorous, relying less on open-ended responses and more on data-driven ones. Among the report’s major findings are the following:

- The major causes of hunger in survey cities are poverty, unemployment and high housing costs. The hunger crisis is exacerbated by the recent spike in foreclosures, the increased cost of living in general, and increased cost of food.
- Sixteen cities (80 percent) reported that requests for emergency food assistance increased during the last year. Among fifteen cities that provided data, the median increase was 10 percent.
- Cities also reported that they are not meeting the need for emergency food assistance. Across the survey cities, 17 percent of all people in need of food assistance and 15 percent of households with children are not receiving it. Nineteen cities expect demand for food assistance to increase in 2008.
- The most common cause of homelessness among households with children is the lack of affordable housing. Among households with children, other common causes of homelessness are poverty and domestic violence. Among single individuals, the most common causes are mental illness and substance abuse.
- During the last year, members of households with children made up 23 percent of persons using emergency shelter and transitional housing programs in survey cities, while single individuals made up 76 percent. Only one percent of persons in these programs were unaccompanied youth.
- Six cities reported an increase in the overall number of homeless persons accessing emergency shelter and transitional housing programs during the last year. Ten cities cited a specific increase in households with children. Seven cities reported a decrease in the number of individuals accessing

emergency shelter and transitional housing programs.

- Disability is more prevalent among homeless singles than among adults in households with children. Rates of disability (mental illness, substance abuse, HIV/AIDS, physical and developmental disabilities) were approximately three times greater for singles than for adults in households with children.
- The average length of stay for persons in emergency shelter and transitional housing decreased from 2006. Cities reported that for households with children, the average length of a single was 5.7 months in 2007. For singles, the average length of a single stay was reported as months. In 2006, cities reported that an average length of stay was 8 months for both populations.
- Cities also reported that they are not meeting the need for providing shelter for homeless. Twelve cities (52 percent) reported that they turn people away some or all of the time.

You can view the full report at <http://usmayors.org/HHSurvey2007/hhsurvey07.pdf>.

## Homeless Headlines

### Work Requirement

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than 3 months in a set 36-month period (Illinois' fixed period is 01/01/06 and ends 12/31/08) unless they can prove they are:

☞ Working 80 hours per month or earn wages of at least the Federal minimum wage times 80 hours (\$5.85 x 80 = \$468) this can include in-kind income such as working the required number of hours in exchange for payment of rent; or

☞ Participating and complying with an approved activity under the Food Stamp Employment and Training Program. (Approved activities can be Basic Education if no high school diploma or GED, Vocational Training (short term and requires prior approval as part of an employment plan), Work Experience or Earnfare (Activities must be 80 hours not including study time) or

☞ Participating in a work program as a requirement to receive assistance from a local governmental unit; or

☞ Performing community work for the number of hours required (this can be self initiated and be with a local church or community organization)

A person is *exempt* from the work requirement if they are:

☞ Included in a FS case with children under age 18; or

☞ Physically or mentally unable to work (this includes temporary health problems such as a broken bone, or chronic illnesses when a person receives SSI, SSDI) or

☞ Pregnant; or

☞ A student, enrolled at least half-time (students of higher education must meet student eligibility requirements see state policy in chapter PM-03-04-03-b); or

☞ Responsible for care of an incapacitated person; or

☞ Participating in a drug addiction or alcoholic treatment and rehabilitation program; or

☞ Receiving Unemployment Insurance; or

☞ Residing in an exempt locale.

So what can you do to assist your clients if you live in one of the affected counties? I strongly recommend that the 3 month period is not exhausted. You want to make sure your clients are engaged in one of the above activities as soon as possible (unless exempt). If exempt you want to make sure the exemption is verified and claimed immediately.

1. You can help to identify clients who are exempt from participation due to a medical condition. Obtain a doctor's note saying the person is not able to work as early as possible. This does not have to be a long detailed report, just a statement on the doctor's letterhead or prescription pad.
2. Agree to be a community service site for your client. Let your local IDHS office know that you will be willing to have your client's do their community service hours with your organization. You already see the client, and for the homeless, they are already coming in for services, so why not. Just be ready to provide a written note that verifies how many hours your client volunteered.
3. Ensure your clients become engaged in activities at your local Employment and Training Center and that there is a way to document the hours attending programs.

This new policy does have a very positive benefit. Individuals are able to request additional help from the state that historically was limited to only

TANF clients. That help is supportive services such as help with transportation costs, minor car repairs up to \$300, help with insurance and license plates, initial employment expenses, help with minor school expenses, etc. Supportive services may be able to be provided to someone who is participating in an approved Food Stamp employment and training activity. A customer is eligible to receive supportive service payments in advance to enable him to take part in the FSE&T program or to start work. You want to make sure your clients ask for this help within 30 days of starting employment or training.

If you want to read the full policy for yourself, you can go to [http://www.dhs.state.il.us/page.aspx?item=34640#a\\_toc18](http://www.dhs.state.il.us/page.aspx?item=34640#a_toc18). For more information about supportive services see the state policy chapter at PM 21-06-00.

#### (Endnote)

\* Most waivers have been granted for cities and counties whose unemployment rate over a 24-month period exceeds the national average for that period by at least one-fifth. (Thus, if the national unemployment rate is five percent for a given two-year period, USDA will grant a waiver for an area where the unemployment rate exceeds six percent.) USDA also has granted waivers based on some other criteria, including data showing adverse labor conditions on impoverished Indian reservations and data showing a local unemployment rate in excess of 10 percent. (Retrieved January 14, 2008 from: <http://www.cbpp.org/12-8-00fa1849.htm>). On 12/20/07 USDA shows Illinois had been approved for a waiver in limited areas based on insufficient employment and an Unemployment rate of >20%) <http://www.fns.usda.gov/fsp/rules/Memo/PRWORA/abawds/abawds.pdf>

*The DuPage Federation on Human Services Reform, a non-profit 501(c)(3) organization focused on advocacy and planning in DuPage County, Illinois and designer and trainer of Making the Connection: A Guide to Accessing Public Benefits. The DuPage Federation is affiliated with Northern Illinois University, Regional Development Institute. Questions can be directed to [knelson@dupagefederation.org](mailto:knelson@dupagefederation.org) or [cking@dupagefedertion.org](mailto:cking@dupagefedertion.org)*



# Headlines Directory

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<http://www.communitychange.org>

## Center on Budget and Policy Priorities

820 First Street, NE, Suite 510  
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<http://www.cbpp.org>

## Chicago Coalition for the Homeless

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Fax: (312) 435-0198  
<http://www.enteract.com/~cch/index.htm>

## Coalition of Citizens With Disabilities in Illinois

300 E. Monroe, Suite 100  
Springfield, IL 62701  
Telephone: (217) 522 7016  
Fax: (217) 522-7024  
TDD: (217) 522-7016  
<http://www.imw.net/~ccdi/>

## Corporation for Supportive Housing

203 N. Wabash, Suite 410  
Chicago, IL 60601  
Phone: (312) 332-6690  
Fax: (312) 332-7040  
Email: [il@csh.org](mailto:il@csh.org)  
[www.csh.org](http://www.csh.org)

## Food Research and Action Center

1875 Connecticut Avenue, NW, # 540  
Washington, D.C. 20009  
Telephone: (202) 986-2200  
Fax: (202)986-2525  
[foodresearch@frac.org](mailto:foodresearch@frac.org)

## Housing Action Illinois

11 E. Adams, Suite 1501  
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## Housing Assistance Council

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<http://www.ruralhome.org>

## Illinois Coalition Against Domestic Violence

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## Illinois Department of Commerce and Economic Opportunity

620 E. Adams, CIPS-3  
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Fax: (217-782-1206  
<http://www.commerce.state.il.us/>

## Illinois Department of Human Services

Homeless Services and Supportive  
Housing  
400 W. Lawrence, 2C  
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Fax: (217) 524-6029  
<http://www.state.il.us/agency/dhs/>

## Illinois Food Bank Association

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## Illinois Housing Development Authority

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Fax: (312) 836-5286  
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## National Alliance to End Homelessness

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## National Coalition for Homeless Veterans

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## National Coalition for the Homeless

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Fax: (202) 737-6445  
<http://nch.ari.net/>

## National Community Reinvestment Coalition

727 15<sup>th</sup> St., NW, #900  
Washington, D.C. 20005  
Telephone: (202) 628-8866  
Fax: (202) 628-9800

## National Law Center on Homelessness & Poverty

918 F Street NW #412  
Washington DC 20004  
Telephone: (202) 638-2535  
Fax (202) 628-2737

## National Low-Income Housing Coalition & National Low Income Housing Information Service

727 15th St NW, 6th Floor  
Washington, D.C. 20005  
Telephone: (202) 662-1530  
Fax: (202) 393-1973  
E-mail: [info@nlihc.org](mailto:info@nlihc.org)  
<http://www.nlihc.org>

## National Rural Housing Coalition

601 Pennsylvania Avenue, NW  
Suite 850  
Washington, D.C. 20004  
Telephone: (202) 393-5229  
Fax: (202) 393-3034  
<http://www.nrhweb.org>

## Rural Development

2118 W. Park Ct, Suite A  
Champaign IL 61821  
Telephone: (217)403-6222  
Fax: (217)403-6231

## Southern Illinois Coalition for the Homeless

P.O. Box 955  
801 N. Market  
Marion, IL 62959  
Telephone (618) 993-0094  
Fax: (618) 993-4013

## Supportive Housing Providers Association

3417 North Monticello  
Chicago, IL 60618  
Telephone: (773) 588-0827  
Fax: (773) 267-1294  
[supportivehsg@aol.com](mailto:supportivehsg@aol.com)

## U.S. Department of Housing and Urban Development

Office of Community Planning and  
Development  
77 W. Jackson 24th Floor  
Chicago, Illinois 60604-3507  
Telephone: (312) 353-1696  
Fax: (312) 353-5417  
<http://www.hud.gov/local/chi/chihome.html>