APPENDIX B

TO

SPECIAL NEEDS HOUSING TRUST FUND

UNDERWRITING FINANCING GUIDELINES AND FINANCING POLICY

MULTIFAMILY SUPPORTED HOUSING LENDING PROGRAMS

Social Services Plan

Developers/Sponsors proposing a special needs housing project must identify the target population and a service provider HMFA for the project. In addition, the service provider must provide a Social Services Plan that addresses the needs of the target population and the plan components outlined below. The Social Services Plan must meet the guidelines listed below unless it has been developed and approved in accordance with criteria established by either the Department of Human Services or the Department of Children and Families.
In the event that a Project Owner wishes to transfer to a new service provider, the owner must submit a request for transfer in writing, including the reasons for the request, to the Multifamily /Supported Housing and Lending Division with a revised Social Services Plan. All transfers must be approved by HMFA.

Social Services Plans are subject to the HMFA's approval. If the service provider is receiving funding from a State HMFA, the appropriate State Department, Division or HMFA funding the services must approve the Social Services Plan, any requested transfer of service provider, or comparable requirements, to the satisfaction of the State funding entity and provide evidence of approval to HMFA.

Social Services Plan

The Social Services Plan must include a description of the scope of social and support services to be provided for supportive housing projects, including a staffing plan and how the services will be delivered and funded. The services must be affordable and appropriate to the target population to the satisfaction of HMFA, available and accessible to the project's tenants and the social service provider must have the capacity to perform such services. The social services plan must address the target populations' support service needs and may include a range of services across a wide continuum of care and intensity appropriate to the target population(s). Appropriate and needed services must be supported by evidence-based practice, research and/or direct practice experience. Each special needs tenant does not have to utilize all of the services provided by the project; however, the services must be available. The social services plan shall address, but is not limited to, the following items:

i. A description of the targeted population(s), including criteria which will qualify proposed tenants for the supportive housing units and expected support services that are likely to be required.

ii. A description of the proposed services, including how services respond to need areas of tenants, how services will be funded, and service location (on site or in the community).

iii. The plan must describe the scope of services for the tenants/residents of the project, including the supportive and/or treatment services funding (see chart below), the staffing plan, and a plan for how the services will be delivered. The plan must address how the project will promote residential opportunities that are integrated into the neighborhood or the community. The plan must include, at a minimum, the following three services: 1) service coordination/ case management; 2) linkages to mainstream resources including entitlement programs; and 3) linkages to health care and treatment programs as needed. Services should be designed to assist individuals and families to maintain their housing and/or residential opportunity. A description must include how services will be coordinated or made available to all special need tenants, including a listing of referral sources.

Services Sources and Uses	**$ Per Year Total**
Case manager Salaries & Benefits	
Service Subsidies	
(add source)	
(add source)	
Service Funding Overview for the Building	
Service subsidy per tenant per year	$0,000
Tenant to case manager ratio	X: X
Case management salary range (annual)	$0,000 to $0,000

Tenant Selection & Involvement The plan must describe the population to be served and how the population will benefit from the project. The tenant selection policy must be described and referral sources identified. If the plan proposes to restrict occupancy to any group, an explanation of why it is necessary for the restriction(s) must be provided. A description of tenant/landlord relationships, including roles of the service provider and developer in tenant/landlord relationships, how

prospective tenants will be recruited, screened, and selected, and the plan for problem resolution to minimize evictions for supportive housing tenants.

Tenants living in supportive housing are the experts in understanding what quality supportive housing looks like. Tenants should be engaged throughout operations. Engagement with tenants should be authentic and meaningful. Engagement can take a variety of forms including but not limited to focus groups, informational interviews, listening sessions, tenant surveys, tenant councils, and tenant advisory boards.

Service Needs Assessment

The plan must indicate how the housing and supportive service needs of the tenants will be assessed, including the relevant assessment tools, and how these needs will be addressed. The services provided must be appropriate to the needs of the target population. Appropriate and needed services may be supported by evidence-based practice, research and/or direct practice experience.

Capacity & Commitment To Staff Training

The plan must describe and demonstrate capability and experience of the social service provider in providing housing and/or supportive and social services to the target population or a relevant special needs population.

On-going training and support to direct service staff is essential to successful supportive housing programs. In this section, describe the organization-wide training program, including but not limited to, onboarding, on-going training, and professional development opportunities for direct service staff and supervisors. Common training opportunities include: Housing First, harm reduction, trauma informed care, motivational interviewing, Homeless Management Information System (HMIS), case conferencing, addressing substance use, mental health 101, service planning, and working with landlords and property managers.

Performance Measures & Eviction Prevention

The plan must include performance measures (including housing stability quality of life, consumer satisfaction, employment and education, and ability to live independently) and methodology for evaluation of tenant/resident housing and service outcomes being addressed. *Please refer to the following chart as an example of categories and common performance measure goals.*

Core Outcomes and Benchmarks

	Outcome Measure	Goal
Housing Stability	Current and exited tenants who remain(ed) in supportive housing for at least 12 months.	85%
	Tenants who exit to permanent housing (including other supportive housing).	75%
Income & Employment	Tenants who were employed in a part-time, fulltime, or transitional job.	12%
	Tenants who have increased their income or maintained their existing entitlement benefits (e.g. SSI/SSDI).	60%
Social & Community Connections	Tenants who report that they participated in one or more community organizations or activities.	60%
	Tenants who report that they have strengthened their social support network since moving into supportive housing.	75%
Overall Wellness	Tenants who have voluntarily utilized at least one supportive service in the last year.	70%
	Tenants experiencing a mental illness, who have a behavioral health care provider (or relevant services) in the community.	70%
	Tenants who have a primary health care provider in the community.	70%
	Tenants who self-report that they received the help they needed to take care of their health.	80%
	Tenants who self-report that their mental health has improved or stabilized.	70%
	Tenants who self-report that their physical health has improved.	70%
Tenant Satisfaction	Tenants who self-report that they are satisfied with their housing overall.	75%
	Tenants who self-report satisfaction with the location and safety of their housing.	75%
	Tenants who self-report that they are satisfied with the services that are available to them.	75%

Note: For any project that serves a homeless population the Sponsor/Owner must comply with the requirement that the project reports in the New Jersey Statewide Homeless Management Information System ("HMIS") administered by the HMFA.

The plan must describe an eviction prevention strategy. The strategy should guide all other actions, processes, and procedures relating to eviction prevention. The policies created under the eviction prevention strategy should be reviewed and revised on a regularly scheduled basis in collaboration with tenants. Eviction prevention strategies should focus on promoting stable tenants through tenant skill-building and proactive intervention. Strong eviction prevention strategies should develop standardized and clear processes, rules are written to appropriately serve tenants with the greatest need and vulnerability, integrate commonly used mitigation strategies into staff trainings, utilize multi-disciplinary approaches, and utilize referrals as needed for additional supports to prevent eviction.

Accessibility & Fair Housing

The plan shall include a description of the service provider's capacity and planned activities to address bi-lingual needs, cultural competency, and other special needs accommodations, including accessibility features for the tenants/residents of the project.

The majority of fair housing responsibilities fall upon the property manager, but there must be coordination between the service staff

and property manager to ensure that tenants' rights are protected. Service providers' main responsibility around fair housing is assisting tenants who are seeking reasonable accommodations and advocating for tenants' reasonable accommodation requests.

Tenant Rights

Protecting tenant rights is a responsibility of the service provider. In this section, describe how tenants' confidentiality will be maintained, how written policies will be created and enforced, physical environments will be secured (e.g. separate offices, closed doors, locked files) and how tenants will be informed of their legal rights. Many supportive housing providers utilize a Release of Information (ROI) to share information among a tenant's community providers. It is important to remember that tenants are not required to sign ROIs or authorization forms and that tenants may revoke their release or authorization at any time. Clearly communicating this information to tenants and the protections that come with tenant rights are very important.

Consumer Choice

The social services plan shall demonstrate how tenants will have the opportunity to participate in their individualized services plan, service goals and/or choice of services.

Executed Service Agreements

If the special needs housing project sponsor is not providing the social services, the sponsor must provide evidence of executed service provider agreement(s) and evidence of committed funding sources or documentation of how and by whom the supportive and/or treatment services will be paid.

Either party may terminate an executed Social Services Agreement with prior notice to the affected party and the HMFA. It is the responsibility of both the owner, in conjunction with the social services provider, to identify a new service provider, with the understanding that the Social Services Agreement will not terminate between either party until such time as a replacement provider is identified, established under an agreement and approved by the HMFA. The HMFA, Supported Housing and Special Needs Division must be notified immediately of intent to terminate a Social Services Agreement between an owner and service provider and the Agreement must be approved by the HMFA.

Service Fees

For projects targeting people who are very-low or low income, services included in the Social Services Plan must be provided at no out-of-pocket cost to the tenants/residents. This does not restrict third-party reimbursement, such as Medicaid.

Community Residences

Applicants proposing to create a residential program that will be a licensed group home(s) to serve a client population of the

	Department of Human Services (DHS) and/or the Department of Children and Families (DCF) must provide evidence that the project will be able to meet all appropriate DHS or DCF licensing requirements. Additionally, the applicant will be required to provide a letter of support from the appropriate DHS Division indicating that the project will have the necessary funding sources for building operations and the provision of services.
Other Housing Opportunities	Applicants proposing to create other housing or residential projects that will be licensed by the Department of Community Affairs or the Department of Health must provide evidence that the project will be in compliance with all appropriate licensing requirements.

SAMPLE SOCIAL SERVICES PLAN

This example social services plan includes:

- Promotion of residential opportunities that are integrated into the neighborhood/community
- Target Population
- Support Services
- Description of Proposed Services
- How Services Respond to Resident Needs
- Bi-lingual & Cultural Competency & Other Special Needs Accommodations
- Service Location
- List of Referral Resources
- Consumer Choice
- Tenant Selection Plan
- Performance Measures
- Service Fees

I. Promotion of residential opportunities that are integrated into the neighborhood/community

Provide background on developer's history in providing residential opportunities for low-income marginalized populations, the service provider's background and capacity and how this project will be integrated into the neighborhood and general community.

II. Target Population

<Developer> and <Service Provider > will target current unsheltered families for its <development> set aside units. The population will include unsheltered families from emergency shelters, transitional housing sites, safe havens as well as those families who are "doubled up" with family members/friends. According to NJ's Department of Community Affairs' Office of

Homelessness Prevention, the primary cause of homelessness in the state is that individuals/families are asked to leave their shared residence. These primary and secondary causes of homelessness in the state may be reflective of individual/family issues of low wages related to unaffordable housing costs, complex, dysfunctional and/or abusive family histories/relationships, and limited family support systems.

III. Required Support Services

Given **<Service Provider >** history of supporting previously unhoused families, we expect that families living at **<development>** will require extensive wraparound services to adjust to and sustain them in achieving and maintaining housing stability. Services will be targeted to parents as well as children who, more than likely have histories of trauma related to the experience of homelessness and childhood experiences, physical/emotional abuse from intimate partners and financial impoverishment. **<Service Provider >** expects that families will require ongoing case management services to provide linkages to financial/employment/benefits resources, supportive/clinical counseling, academic and developmental support for children, kinship programs, in addition to advocacy with local and community-based social and physical/behavioral healthcare resources as well as advocacy with internal leasing staff around residents' tenancy.

Moreover, many parents (and children) who have experienced homelessness may present with behavioral health issues, namely, substance use and mental illness. Family members may have received limited treatment or no treatment at all due to their formerly homeless status. Some family members may not be adherent to mental health or substance use treatment. The **<Service Provider >** service coordinator will assess the family's individual behavioral health needs and connect family members to local behavioral health resources provided that the individual is accepting of treatment options.

<Service Provider > also anticipates that formerly unhoused children will be coping with a myriad of social, emotional, academic and developmental issues. Parents and children will need support in managing issues such as below-average academic achievement, bullying, truancy, poor socio-emotional management, trauma/PTSD, mental illness, substance use and physical/intellectual development issues.

The **<Service Provider >** service coordinator will receive training on a trauma-informed approach to practice and will apply trauma-informed techniques and skills in their relationship with residents. **<Developer>** will ensure that all **<property management>** staff, including leasing and maintenance staff, are trained in trauma-informed care.

We also anticipate that residents will require assistance with changing their mailing address, procuring furniture and household supplies, and registering their children with the school system and daycare providers. In some cases, families may need help with referrals/connections to the court system and other legal supports.

IV. Description of Proposed Services

<Service Provider> will hire a services coordinator who will maintain responsibility for providing a breath of comprehensive social services to all special needs families residing at **<development** . **<Service Provider>** will seek to employ a bilingual services coordinator with at least one year of experience of social service provision to unhoused families and/or low-income families. If feasible, **<Service Provider>** will prioritize hiring a licensed-clinical services coordinator who can provide clinical counseling to family members. The services coordinator will receive ongoing supervision from **<Service Provider>** Social Service Department Head.

The service provision provided to our formerly unhoused families will be tailored to their specific needs. The service coordinator will initially focus on engaging with families to build a relationship of support based on trust. We anticipate that families in special units may need some time to establish trust with our service coordinator given the many providers that may have cycled in and out of their lives.

<Service Provider> will develop a holistic strengths-based resident intake/assessment tool that documents demographic information as well as:

- information related to the family's residential history,
- parent(s) employment status/history
- physical/emotional/psychosocial status and needs of parents and children
- strengths and resilience indicators
- financial security/resources
- current informal and formal support involvement
- trauma/physical violence history of parent(s) and children
- functional status
- foster care involvement, if applicable
- child intellectual/socio-emotional development status/milestones,
- academic level of children in household/academic achievements
- food security
- status/history of child protective services
- what matters to family/priority needs from the parents' perspective/self-identified goals
- cultural practices/preferences
- group activity preferences

The assessment tool will inform the service coordinator and the family of the strengths and issues that should be noted and addressed in the documented care plan. The service coordinator and the family will jointly discuss and decide the follow-up necessary to address identified needs and goals and the person(s) responsible for follow-up action within a defined timeframe. The service coordinator will utilize motivational interview techniques to discover what goals matter most to the resident and their confidence level in achieving their goals. The service coordinator will also maintain responsibility for remaining in contact with the family on a weekly basis to assist with any transition needs and assist the family in becoming acclimated to and integrated within the larger **<development>** community.

Participation in the assessment process will be optional and residents will be assured that accepting or declining participation will have no impact on their housing status.

In addition to the initial assessment, **<service provider>** services coordinator will also be responsible for documenting all contact with residents either by phone, email or home visit. The services coordinator will utilize the case management system to document all contacts and interventions with and on behalf of residents.

Regarding assessment of children, **<service provider>** has extensive experience assessing and providing educational support to children and youth. *Provide service provider's background that is relevant to population being served.* **<Service Provider>** staff utilize the *Holistic Student Assessment* (HSA) tool, which is a data-driven tool to promote social-emotional development in young people. The tool provides a social-emotional portrait of the unique strengths and challenges of young people. The **<service provider>** services coordinator will utilize the HSA tool to determine the social-emotional development status of children residing at service coordinator **<development>**. I

Reassessments with families will occur, at a minimum, on an annual basis or event-based basis such as, for example, when a report is made to DC&P or in the event of any significant change in the resident's, as well as their children's, lives.

At a minimum, monthly follow-up, through in-person contact, will be made with families to ensure that there are no unmet needs and to check on the progress of the family in sustaining housing stability and achieving their expressed goals. Families experiencing ongoing instability or those who are experiencing complex physical, psychosocial, emotional or behavioral issues will be contacted in person, at minimum, on a weekly basis.

The service coordinator will also be responsible for collaborating with leasing staff to ensure that there are no issues pertaining to missed rent payments or with residents' maintaining their property in an acceptable manner. Any issues of hoarding, property destruction, non-rental payment, etc. with be discussed with the resident so that interventions can be targeted to proactively avoid the possibility of eviction. **<Provider>** services coordinator will collaborate with property management staff so that the resolution of these issues involves a team approach.

Based on its long history of providing affordable housing to families, **<developer>** is well aware of the healthy tension that can exist between property management staff and social services staff. In most instances, social service staff must adhere to the role of advocate on behalf of residents which may be in conflict with the role of leasing staff. **<Developer>** supports the respective roles of both leasing and social service staff and encourages each to collaborate with each other to mitigate these tensions.

Establishing positive relationships with community-based providers is critical to ensuring that resident needs are addressed in a timely, efficient and effective matter. Collaboration and cooperation with other social services and healthcare providers can go a long way in avoiding "turf" issues and in ensuring that staff from different agencies and organizations work well jointly in meeting residents' needs. The <**provider**> services coordinator will be responsible for

developing these relationships through outreach, participation in community provider webinars, seminars and trainings, in attendance at provider meetings and in participation in relevant community coalitions.

The services coordinator will also maintain responsibility for planning and coordinating activities that bring the families together. These activities will be based on residents' preferences expressed through a community-wide survey that will be administered by the services coordinator.

V. How Services Respond to Resident Needs

<Provider>'s ability to effectively assist residents in meeting their needs is directly contingent upon our service coordinator's ability to establish a trusting relationship with residents. Many of the **<development>** residents who will live in special needs units may have long histories of accessing social service, healthcare, child welfare and legal systems, and, as a result, have legitimate trust issues with systems' providers. Establishing a trusting relationship with residents is dependent upon the service coordinator's ability to approach the relationship with residents based on authentic engagement, openness, recognition of the strengths the resident brings, and a willingness to understand and value what matters to the resident.

Intake and orientation to the property will be conducted by the service coordinator to help to ease the family's transition to **<development>**. At this point, the service coordinator will begin to establish relationships with parents and their children and will maintain daily contact to proactively address any move-in issues.

<Provider> case management services will respond to resident needs by synthesizing, through the formal assessment process, the strengths and needs of each individual resident family member and by developing, in concert with residents, a plan to address those needs.

Referrals and follow-up calls made to community agencies will serve to connect residents with needed employment, financial and benefits assistance and childcare subsidies. The **<provider>**service coordinator's linkages to community resources will also assist residents with obtaining furniture and household goods, food, clothing and other basic necessities.

Based on **<provider>** history of providing housing and social services to low-income families, **<provider>**anticipates that previously unhoused residents will need support with accessing financial resources in order to maintain their housing and achieve stability. **<Provider>** service coordinator will link residents to financial benefit programs and will assist residents with seeking employment that provides a livable wage. **<Provider>** also expects that residents may need assistance with securing affordable transportation to their places of employment.

<Provider> recognizes that some families' unhoused history may have resulted from a history of substance use. **<Provider>** service coordinator will also assist residents with accessing treatment programs that will address substance use issues. The service coordinator will assist families with referrals to outpatient drug treatment programs, medication assisted programs and/or 12-step recovery programs and will monitor family members' progress with maintaining sobriety.

VI. Bi-lingual & Cultural Competency & Other Special Needs Accommodations

<Service Provider> serves clients of all cultural and racial backgrounds: the staff is familiar with providing services to people of many cultural, racial and linguistic backgrounds. **<Service Provider>** will continue to be responsive to the needs of the community to ensure that culturally competency and linguistically accessible services are offered. **<Service Provider>** will refer residents to service providers that have demonstrated an understanding of residents' cultural backgrounds and communication systems to support their empowerment, autonomy, self-respect and community integration. Supportive services staff is available to communicate with clients who do not speak English as a first language.

The hiring of staff will take into consideration the potential needs, linguistically and cultural, of those referred to the program. The Service Coordinator will be expected to bring the program experience in the delivery of services to individuals with physical disabilities, and will understand and respect the importance of culture in the lives of the program residents and the larger community. This will include not only attention to the "cultural competence" in the staff's understanding of cultures different from that of the staff person, but also the cultural impact of their experiences being a person with physical disabilities. Staff will be mindful of cultural complexities in their own developing an evolving cultural competence as they work with true respect and responsiveness in each and every encounter with each person served. Knowing and understand the culture of neighborhoods and communities will also be important to developing the cultural competence of staff.

VII. Service Location

The **<provider>** services coordinator will be based onsite at the **<development>** property in the Community building.

VIII. List of Referral Resources

The <**provider**> services coordinator will establish referral relationships with the following community-based agencies and organizations:

- *List relevant referral services. If the set-aside units are for people who are formerly homeless, the local continuum of care (CoC) should be listed.*

IX. Consumer Choice

Foundational social work values reflect a respect for consumer self-determination. Engagement and contracting with consumers allows them to participate in identifying what goals for their lives most matter to them and to determine how best to achieve their goals. Research has indicated that goals are best achieved when individuals determine them, are motivated, have confidence in achieving them and receive the support that they determine they need. **<Provider>** staff are committed to consumer self-efficacy.

Moreover, **<Provider>** staff values consumers' ability to participate in the development of programs and services that are implemented and initiated for them. Resident input and feedback is critical to the success of any programmatic initiatives. **<Provider>** uses survey tools to gauge resident interest in participating in various activities and seeks feedback from residents to develop programs that mirror resident preferences and interests.

X. Tenant Selection Plan

<Development> is a Tax Credit Property with one-, two- and three-bedroom apartments/townhouses.

To consider **<Development>** as your home, this is the Selection Criteria you must meet:

- IDENTITY AND AGE VERIFICATION

  All applicants must be at least 18 years of age. A document verifying the age of each household member will be required. Acceptable age verification documents: Birth certificate, Baptismal Certificate, Valid Passport, Social Security Administration Benefit Letter that includes birth date, Naturalization Certificate.

- HOUSEHOLD COMPOSITION / UNIT ELIGIBILITY MUST FALL INTO THESE CATEGORIES

OCCUPANCY GUIDELINES

APARTMENT SIZE	MINIMUM OCCUPANTS	MAXIMUM OCCUPANTS
ONE BEDROOM	ONE	TWO
TWO BEDROOM	TWO	FOUR
THREE BEDROOM	THREE	SIX

HOUSEHOLD MEMBERS INCLUDE: All persons who consider the apartment their primary residence. For example: children under joint custody must reside in the apartment at least 50% of the time or children away in foster care who will be returning to the household, members temporarily in the hospital or nursing home, unborn children, children being adopted or a future spouse or roommate.

- YOUR ANNUAL INCOME MUST fall within the State established -HUD income levels and family size. Total Household income must fall within the Philadelphia-Camden-Wilmington, PA-NJ-DE-MD MSA income levels. The income limits are updated annually and can be found at https://www.nj.gov/dca/hmfa/developers/lihtc/compliance/incomelimits.shtml. The annual income is the full amount, (GROSS), before any payroll deductions for all adults **NOT** the take home pay or net income. Adults are persons over the age of 18 years.

ANNUAL INCOME is inclusive and not limited to: employment, self-employment, tips, commissions, income from assets, Social Security and other benefits, payments in lieu of earnings, i.e., unemployment, disability compensation, worker's compensation and severance pay., child support/alimony, gifts, military pay, student financial assistance, etc.

If your annual income is lower than the required minimum income level for the specific number of household members for the specific bedroom size; you will not be eligible for an apartment. Tenants should not pay more than 35% of their monthly income for rent including Utility Allowance. The only time this doesn't apply is if you can prove that you paid higher rent in the previous 12 months.

If your annual income exceeds the maximum income requirements for the specific number of Household members and bedroom size, you will not be eligible for an apartment.

Violence Against Women Reauthorization Act of 2013 ("VAWA")

VAWA protects qualified tenants, participants, and applicants, and affiliated individuals, who are victims of domestic violence, dating violence, sexual assault, or stalking from being denied housing, evicted, or terminated based on acts of such violence against them.

APPLICATION DECISION

If An Application is Declined: Applicants will be notified in writing of any application denial and given fourteen (14) days to respond in writing to request a meeting to discuss the rejection. Within 5 days after the scheduled meeting, written results regarding the appeal decision will be mailed to the applicant. All application fees are non-refundable.
If An Application is Cancelled: If for any reason you withdraw your application or notify us that you have changed your mind about renting an apartment, all application fees are non-refundable.
Failure to Execute the Lease: In the event that you fail to sign the Lease Agreement after application approval, all said fees and deposits are non-refundable.

SPECIAL NEEDS SET ASIDE UNITS

<Development> has **(X)** units set aside for applicants with Special Needs. These reserved units will be occupied by applicants referred to us by contracted supportive housing agencies located in **X** County. Specific to the special needs set aside units; exceptions may be considered related to the credit screening criteria

SECTION 8 PREFERENCE

Applicants with confirmed Section 8 certificates or vouchers shall have occupancy preferences, provided that they meet all of the other requirements of the Tenant Selection Plan.

REASONABLE ACOMMODATIONS

1. A reasonable accommodation is a structural change made to an existing unit occupied by a person with a disability (and disability is typical defined as an individual with a physical or mental impairment that substantially limits one or more major life activity) in order to afford such a person, the full enjoyment of the premises.
2. A reasonable modification is a change, exception, or adjustment to a rule, policy or practice used in running a community.

XI. Performance Measures

<Service provider> will use several methods to measure social service performance and the effectiveness of service provision. Anonymous resident satisfaction surveys will be administered to residents on a bi-annual basis to ascertain whether residents are satisfied with the quality of social service provision and the timeliness of response to social service needs. Feedback will also be solicited online, when possible, and through paper surveys, about resident satisfaction with community program initiatives and activities for both the children and adults living in the community.

The services coordinator will also use data collected through the social services assessment form and survey forms to measure progress with residents achieving their identified goal(s). Assessment domains pertaining to job attainment, job retention, academic achievement, quality of life, life satisfaction etc. will be measured and data will be analyzed to evaluate how to work with residents to improve outcomes.

The service coordinator will also employ the PDSA (Plan, Do, Study, Act) method in measuring the success of social service interventions. The service coordinator will collaborate with the family in planning the behavior/situational change that the family identifies (PLAN) and will support the family as they work to implement the change; for example, seek employment, engage tutoring services, etc. (DO). The service coordinator will jointly evaluate whether the family's efforts were successful (STUDY) and if unsuccessful, jointly decide on a difference course of action for success (ACT).

XII. Service Fees

There will be no fees for services to any resident. Third party reimbursement, such as Medicaid, is not restricted.