NEW PROJECTS

Bethesda House of Schenectady, Inc.

Coordinated Entry Expansion

Bethesda House is requesting expansion funds to bolster the Coordinated Entry program and ensure that it is appropriately staffed and supported. Coordinated Entry (CE) is a critical component of the homeless response system in Schenectady County and plays a vital role in the Schenectady CoC by ensuring that every individual or family, regardless of location, background, or circumstance, has equal access to the homeless response system through a systemic and collaborative process that streamlines access to a wide range of services and housing resources, offering a single, standardized pathway to assess needs, prioritize households, and connect them to the most appropriate interventions. Given the significant growth in complexity, expanded requirements for data analysis, timely reporting, performance monitoring, and system evaluation, and shifting CE grantee and sub-grantee roles, expansion funding is essential for strengthening CE oversight, increasing capacity for data analysis, enhancing assessment quality, improving system integration, and ensuring that CE can meet the growing and evolving needs of the community. Schenectady CE will implement a comprehensive public outreach and advertising strategy specifically designed to reach households experiencing homelessness with the highest needs by distributing multi-language flyers, posters, and resource cards at libraries, schools, food pantries, community centers, shelters, hospitals, and government buildings, maintaining updated CE information on agency websites, collaborating with media platforms to highlight CE access points and the CE hotline, conducting direct street outreach in parks, encampments, abandoned buildings, and other unsheltered locations with same-day appointments, training shelter staff on CE program services, and exploring avenues to develop a CE hotline method to increase accessibility. Expansion funding will support a standardized CE assessment process through continued implementation of a single assessment tool used at every access point to evaluate housing barriers, safety risks, and service needs, reduce assessor subjectivity through scripted questions and guidance, and ensure households are prioritized consistently based on CoC-approved policies, along with centralized training, certification, and quality assurance, enhanced CE responsibilities including program crosschecks, CE–DV integration, and CE list management, improved HMIS data analysis and system evaluation, and coordinated referral management through a centralized prioritization list, standardized referral pathways, and warm handoff requirements and follow-up protocols, ensuring participants are directed towards the most appropriate housing and services to meet their needs while increasing housing stability, reducing duplication, and delivering an effective and data-driven response to homelessness.

Cornerstone

Bethesda House is requesting funding for Cornerstone, a 7-bed, site-based transitional housing program serving single adults experiencing homelessness who are motivated to work toward long-term stability. The project will provide up to 24 months of safe, stable, service-rich housing for individuals with needs such as limited income, unemployment, behavioral health conditions,

trauma histories, and limited daily living skills. The project's goals focus on promoting safety, stability, self-sufficiency, and successful transition to permanent housing, achieved through comprehensive assessments, intensive case management, safety planning, life-skills training, employment assistance, and housing search and tenancy support. Participants receive on-site services from Residential staff and Licensed Social Workers, including counseling and skill-building, and benefit from coordinated partnerships with providers offering outpatient behavioral health care, substance use treatment, primary care, workforce development, benefits enrollment, and transportation coordination to ensure participants obtain and maintain housing in a manner that fits their needs. Participation in supportive services is required as a condition of residency, with each individual engaged in an individualized service plan developed through assessment and reinforced through ongoing case management, trauma-informed support, and required engagement in recommended behavioral health or substance use treatment. The project is supplemented by public and private resources, with staff assisting participants in accessing Medicaid, Medicare, SSI/SSDI (including SOAR), SNAP, and Temporary Assistance, while partnerships with healthcare providers, Schenectady County DSS, and community-based organizations expand access to medical care, employment programs, and income supports, maximizing resources and promoting long-term housing stability.

PathForward

Bethesda House is requesting funding for PathForward, an 8-bed, scattered-site transitional housing program serving single adults experiencing homelessness who are motivated to work toward long-term stability. The project will provide up to 24 months of safe, stable, service-rich housing for individuals with needs such as limited income, unemployment or underemployment, behavioral health conditions, trauma histories, and limited daily living skills. The program aims to promote safety, stability, self-sufficiency, and successful reintegration into permanent housing and the community through a coordinated service model that includes comprehensive assessments, intensive case management, safety planning, life-skills training, employment assistance, housing search and counseling, and access to medical, behavioral health, and social services. Participants receive on-site support through Bethesda House's integrated service model, including counseling from Licensed Social Workers and daily living support from Residential staff, while partnerships with community providers ensure access to outpatient behavioral health care, substance use treatment, primary care, job training, benefits enrollment, and transportation coordination to help participants obtain and maintain housing in a manner that fits their needs. Participation in supportive services is a condition of residency, with each individual required to adhere to an individualized service plan developed through assessment and reinforced through ongoing case management, trauma-informed care, and engagement in recommended treatment services. The project is supplemented by public and private resources, with staff assisting participants in accessing Medicaid, Medicare, SSI/SSDI (including SOAR), SNAP, and Temporary Assistance, and leveraging partnerships with healthcare providers, Schenectady County DSS, and community-based organizations to expand access to medical care, employment programs, food security, and financial supports, maximizing resources and promoting long-term housing stability.

SafeHarbor

Bethesda House is requesting funding for SafeHarbor, a 10-bed, site-based transitional housing program serving single adults experiencing homelessness who are motivated to work toward long-

term stability. The project will provide up to 24 months of safe, stable, service-rich housing for individuals with needs such as limited income, unemployment or underemployment, behavioral health conditions, trauma histories, and limited daily living skills. The program promotes safety, stability, self-sufficiency, and successful reintegration into permanent housing through a coordinated service model that includes comprehensive assessments, intensive case management, safety planning, life-skills training, employment assistance, housing search and tenancy support, and access to medical, behavioral health, and social services. Participants receive on-site support through Bethesda House's integrated service model, including counseling from Licensed Social Workers and coaching from Residential staff, while partnerships with community providers ensure access to outpatient behavioral health care, substance use treatment, primary care, job training, benefits enrollment, and transportation coordination to help participants obtain and maintain housing in a manner that fits their needs. Participation in supportive services is a condition of residency, requiring adherence to an individualized service plan developed through assessment and reinforced through ongoing case management, trauma-informed care, and engagement in recommended treatment services. The project is supplemented by public and private resources, with staff assisting participants in accessing Medicaid, Medicare, SSI/SSDI (including SOAR), SNAP, and Temporary Assistance, and leveraging partnerships with healthcare providers, Schenectady County DSS, and community-based organizations to expand access to medical care, employment programs, food security, and financial supports, maximizing resources and promoting long-term housing stability.

YWCA of Schenectady

Stepping Stones

The YWCA is requesting funding for the Stepping Stones Program. The YWCA will operate 36 scattered-site units of supportive transitional housing (17 one-bedroom, 16 two-bedroom, 3 three-bedroom) for women and their children who are survivors of domestic violence meeting HUD's category 4 homelessness criteria, with an anticipated annual turnover of at least 25% serving approximately 45 households (around 72 individuals) during a one-year period. The program provides comprehensive, service-rich housing support with project goals of safety, stability, and self-sufficiency, including annual assessments, individualized housing and service plans, intensive case management, monitoring of progress, safety planning, housing search assistance, mediation with property owners, transportation, financial assistance for housing barriers, and access to wraparound supports such as childcare, food, clothing, and crisis intervention. Services are delivered through dedicated staff and partnerships with providers including Ellis Hospital, Schenectady Community Action Program, New Choices Recovery Center, Step One, Mobile Crisis, and YWCA programs, ensuring access to healthcare, counseling, workforce development, substance use treatment, childcare, and other supports necessary to obtain and maintain housing. Participation in support services is required as outlined in occupancy agreements, with case managers determining needs and requiring engagement in services necessary for stability. The project is supplemented with public and private resources, with case managers assisting participants in accessing Medicare, Medicaid, SSI, SNAP, TANF, WIC, and other benefits through coordination with the Department of Social Services, while trauma-informed, victim-centered

practices and staff with lived experience ensure ongoing safety planning, confidentiality, and participant-driven support toward long-term housing stability.

Schenectady Domestic Violence Coordinated Entry System

The YWCA is requesting funding for a new DV-CE program in Schenectady County. Schenectady County, and particularly the City of Schenectady, has an abnormally high rate of domestic violence, with the Department of Criminal Justice Services (2024) reporting the third-highest rate of domestic violence in New York State, 1,238 incidents recorded by the Schenectady City Police Department and 2,758 cases reported by the District Attorney's Office from 2020 to 2024. Additionally, a 2022 Housing Market Study by Asterhill Research Company identified a net need for approximately 3,254 beds for women victims of domestic violence within 60 miles of YWCA's main campus. Despite this need, YWCA NorthEastern NY is the only provider of domestic violence support services in Schenectady County, making it highly qualified to develop and operate the first CE in Schenectady County to focus on serving and tracking survivors of domestic violence in the NY-507 system and playing a critical role within the Continuum of Care by working in conjunction with all YWCA support services and appropriate housing programs to streamline the process of connecting survivors to stable housing, provide case management and program oversight by highly trained staff, and allow population data to be collected to provide better coordinated services. The project will implement an advertising strategy specifically designed to reach households experiencing homelessness with the highest needs by advertising the Domestic Violence Coordinated Entry System at the domestic violence shelter and within domestic violence support programs, having counselors and case managers provide information and make referrals, introducing the project to hospitals, urgent care centers, crisis care centers, and other critical access points, updating printed materials and the website to include CE information, disseminating information through partnerships including the Housing and Supportive Services Network and domestic violence task force, and strategically placing materials using accessible language to ensure the project reaches the households that need it the most. The project will implement a standardized assessment process by utilizing a standardized assessment form crafted through the CoC CE chapter, maintaining a system for anonymous entries into the CE database and follow-up processes, scoring all applications using the same standard scale, and referring applicants to the most appropriate housing programs based on their needs and population categories.

Schenectady Community Action Program, Inc.

TH30

Schenectady Community Action Program is requesting funding for their 30-bed Transitional Housing program. The program is designed to serve homeless households referred through the Schenectady CoC Coordinated Entry system, including single adults and families with children. Households may present with a range of needs, including limited income, barriers to employment, safety concerns, and lack of rental history. The program's goal is to reduce the length of time households remain homeless and support them in achieving permanent housing stability. Participants may remain in the program for up to 24 months, with services tailored to individual progress toward housing goals. SCAP provides a comprehensive package of services including rental assistance, security deposits, tenant rights and responsibility education, landlord/tenant mediation, habitability inspections, case management, and employment counseling. To ensure

each household can maintain housing stability, the program provides wraparound supports tailored to participant needs. These include transportation assistance, case management, access to behavioral health and medical services through partnered providers, childcare and family support, and referrals to educational/vocational programs. SCAP collaborates closely with partner organizations in the Schenectady community, including employment programs, health and mental health providers, legal services, and domestic violence agencies. Participation in case management and housing stability planning is required as part of the Transitional Housing program to ensure that participants engage with the supports needed to achieve and maintain housing. Households meet regularly with case managers, at minimum on a monthly basis, with case management intensity and frequency tailored to the level of an individual's or family's needs. Case managers work with participants to develop individualized housing and service plans, monitor progress, and address barriers to stability. The project is supplemented by a range of public and private resources, including referrals and assistance in enrolling participants in mainstream benefits such as Medicaid, Medicare, SSI/SSDI, SNAP, HEAP, and childcare subsidies. SCAP also helps households access community mental health programs, workforce development services, and other mainstream social service programs. These supplemental resources help increase income stability, improve health outcomes, and support long-term housing retention. To ensure long-term stability, a dedicated supportive housing case manager tracks outcomes and provides follow-up support for up to one-year post-exit to prevent housing loss and support successful transitions to permanent housing.

TH18

Schenectady Community Action Program is requesting funding for an 18-bed Transitional Housing program. The program is designed to serve homeless households referred through the Schenectady CoC Coordinated Entry system, including single adults and families with children. Households may present with a range of needs, including limited income, barriers to employment, safety concerns, and lack of rental history. The program's goal is to reduce the length of time households remain homeless and support them in achieving permanent housing stability. Participants may remain in the program for up to 24 months, with services tailored to individual progress toward housing goals. SCAP provides a comprehensive package of services including rental assistance, security deposits, tenant rights and responsibility education, landlord/tenant mediation, habitability inspections, case management and employment counseling. To ensure each household can maintain housing stability, the program provides wraparound supports tailored to participant needs. These include transportation assistance, case management, access lo behavioral health and medical services through partnered providers, childcare and family support, and referrals to educational/vocational programs. SCAP collaborates closely with partner organizations In the Schenectady community, Including employment programs, health and mental health providers, legal services, and domestic violence agencies. Participation in case management and housing stability planning is required as part of the Transitional Housing program to ensure that participants engage with the supports needed to achieve and maintain housing, Households meet regularly with case managers, at minimum on a monthly basis, with case management intensity and frequency tailored to the level of an individual's or family's needs. Case managers work with participants lo develop individualized housing and service plans, monitor progress, and address barriers lo stability. The project is supplemented by a range of public and private resources, including referrals and assistance in enrolling participants in mainstream benefits such as

Medicaid, Medicare, S81/SSDI, SNAP, HEAP, and childcare subsidies. SCAP also helps households access community mental health programs, workforce development services, and other mainstream social service programs. These supplemental resources help increase Income stability, improve health outcomes, and support long-term housing retention. To ensure long-term stability, a dedicated supportive housing case manager tracks outcomes and provides follow-up support for up to one-year post-exit to prevent housing loss and support successful transitions to permanent housing.

SCAP Support Services for Homeless Families

Schenectady Community Action Program is requesting funding for a new SSO-Standalone project. This project is essential to assist families living in hotels and motels, sheltered by the Department of Social Services (DSS), in exiting homelessness and achieving self-sufficiency. Many of these families face multiple barriers, including limited access to stable housing, employment, childcare, and healthcare. By increasing supportive services, the project will provide intensive case management, housing navigation, and wrap-around supports such as childcare and employment linkages. Services will focus on rapid re-housing, income support, and housing stabilization, including identifying rental units, coordinating with landlords, arranging transportation, scheduling appointments, and addressing client-specific housing issues. This comprehensive approach is designed to reduce the average length of stay in shelter, decrease the number of families staying 30 days or more, and promote long-term housing stability and self-sufficiency. Service needs will be assessed using SCAP' s internal Self-Sufficiency Matrix, completed bi-annually, alongside HMIS data tracking to monitor progress across key domains such as housing stability, employment, income, and health. Assessments will include client feedback to ensure services are tailored to evolving needs. This data-driven approach allows staff to identify gaps, adjust individualized service plans, and measure outcomes in alignment with project goals. The project will employ a proactive, engagement-focused strategy to serve all eligible participants, including families with histories of unsheltered homelessness and those who do not traditionally engage in support services. Through collaboration with DSS, families will be connected to both on-site case management services and housing placement services. Case managers will provide individualized support, including rapid re-housing assistance, housing navigation, coordination with landlords, transportation, and scheduling appointments. Outreach will focus on trust-building to engage participants who may be hesitant to access services. The goal is to reduce shelter stays exceeding 30 days and promote faster transitions to stable housing. The project will be supplemented with resources from other public and private sources to enhance service delivery. Staff will assist participants in accessing mainstream benefits such as Medicaid, Medicare, Supplemental Security Income (SSI), and SNAP. Partnerships with local workforce development programs, childcare providers, and community-based organizations will provide additional supports. Leveraging these resources alongside HUD-funded services will strengthen housing stability, reduce reliance on emergency shelters, and improve overall self-sufficiency outcomes.

SCAP Sojourn House Expansion

Schenectady Community Action Program is requesting expansion funds to bolster the Sojourn House Transitional Housing program. SCAP's Sojourn House is a transitional housing program serving pregnant women and women with children who meet HUD' s homeless eligibility criteria. Participants enter from street homelessness, emergency shelters, or fleeing domestic violence. As the only transitional housing program of its kind in Schenectady County, Sojourn House remains an essential resource In a community where family-focused housing services are extremely limited. The program provides a safe, stable, and home-like environment with 24/7 staffing and can accommodate up to 7 families, with a total of 21 beds available. Sojourn House offers a range of on-site, services designed to help participants achieve permanent housing stability and improve overall well-being. Case management, therapeutic supports, and employment and education linkage and assistance are all provided on-site, and these services are supplemented through partnerships with community providers. Participants receive individualized case planning, housing search and navigation support, goal development, budgeting guidance, and assistance connecting to permanent housing opportunities. Transportation needs are addressed through bus passes and coordination with community transportation services to ensure access to childcare, healthcare, employment, and housing appointments. Safety planning is integrated into ongoing case management, particularly for participants who have experienced or are fleeing domestic violence. Therapeutic and behavioral health needs are met through coordinated care with mental health and substance use providers. The program also promotes positive parenting practices and supports continuity in children's education through active coordination with childcare providers, schools, and early childhood programs. In addition, all basic needs, including meals, clothing, hygiene items, and laundry facilities, are supplied on-site. Participation in case management and in services directly tied to achieving housing stability is required for continued program residency. Residents meet regularly with their case manager and are expected to actively engage in activities that support progress toward permanent housing, safely, employment or education, and increased self-sufficiency. The project is strengthened by extensive coordination with both public and private resources, including Medicaid and Medicare, SNAP, TANF, SSI/SSDI, WIC, employment and training programs through collaboration with the Schenectady County Department of Social Services. Partnerships like these ensure that families have access to the broad range of supports needed lo obtain and maintain stable housing after exiting the program.

SCAP Street Outreach

Schenectady Community Action Program is requesting funding for a new SSO – Street Outreach project. SCAP's SSO Street Outreach project is essential because individuals living outdoors or in places not meant for human habitation often experience the most significant obstacles to accessing services and exiting homelessness. Many have longstanding medical, behavioral health, or financial challenges and are disconnected from traditional service systems. Field-based outreach is often the only effective way to engage these individuals and connect them to sheller, treatment, and permanent housing pathways. SCAP' s participation in the Schenectady HUB reinforces the effectiveness of this model. From January 2023 through November 2025, outreach teams engaged 205 unsheltered individuals and successfully linked 85% of them to needed services and supports. This project builds on that success to ensure that individuals living in unsafe or unstable locations receive timely, coordinated assistance. SCAP staff work alongside the Schenectady Police Department, the Office of Community Services, and other county partners to conduct joint

outreach to encampments, abandoned buildings, parks, and other public spaces. SCAP then provides case management to help individuals access treatment programs or move into transitional or permanent housing. This established partnership ensures that outreach efforts are coordinated, efficient, and responsive to community needs. The outreach strategy focuses on regular in-person contact, accessibility, and clear pathways to services. Outreach staff conduct "boots on the ground" efforts throughout the county, checking on individuals living outdoors and offering basic supplies, information, and direct connections to services. Staff coordinate immediate access to shelter, medical care, behavioral health providers, or crisis stabilization services. Outreach workers also assist with documentation, benefits enrollment, housing applications, and other practical steps that support long-term stability. By maintaining consistent contact and providing reliable follow-through, the project supports individuals who may be reluctant or unable to seek services on their own. Individuals are assisted in securing Medicaid or Medicare coverage, SSI or SSDI benefits, and SNAP or TANF assistance as appropriate through partnership with Schenectady County Department of Social Services. Participants are connected to supportive housing programs and rental assistance opportunities available through Coordinated Entry and county housing partners. Together, these resources create a comprehensive support system that enables unsheltered individuals to stabilize, access services, and transition into permanent housing.

Safe Inc., of Schenectady

Development of Independent Skills Program Expansion

Safe, Inc. is requesting expansion funds to bolster the current Development of Independent Skills program. Safe Inc. of Schenectady will hire a F/T case manager, P/T case manager and a P/T Psychiatric Nurse Practitioner (PNP) to work with young adults who are unsheltered, in a hotel/motel paid for by DSS, or in a homeless shelter. This would take place in Safe lnc.'s drop-in center where these young adults will be able to grab a snack, meal/drink, grab clothing (if needed), do laundry, take a shower, get lists of food pantries/meal sites and meet with a case manager and a PNP who can provide assessments that may support the young adults accessing services. Staff will work these young adults and help them to navigate the different resources available, whether it is referrals to treatment centers and/or mental health facilities that will ultimately help lead them to employment opportunities, and once employed, it will lead to housing opportunities, which will help these young adults achieve self-sufficiency. Annual assessments for these young adults will be a collaborative process using interviews, standardized tools and surveys, to understand changing needs, focusing on strengths to develop individualized service plans, and may include medical/functional evaluations from the PNP and feedback directly from the young adults. The project will be supplemented with resources from other public or private sources through strategies such as partnerships, shared location of services, and helping program participants to enroll in eligible mainstream benefit programs.

New Choices Recovery Center

Supportive Transitional Engagement Program (STEP)

New Choices is requesting funding to support a new Transitional Housing project. The Supportive Transitional Engagement Program (STEP) is a scattered site program that intends to assist

individuals and families in establishing housing stability by providing housing and case management to program participants for a maximum of 24 months. The STEP program will serve 9 units and 12 individuals. Applicants with a substance use diagnosis will be selected from the Coordinated Entry list and contacted for an interview. New Choices Recovery Center will inform applicants that they are required to develop service plans and actively work toward the goals they have identified. New Choices currently partners with Schenectady County DSS, Workforce Development, SCAP, Bethesda House, City Mission, CDTA, and many other agencies within our community. Our partnerships with the named parties will allow New Choices to make referrals for employment services, treatment, furniture, food and other barriers to housing easier to navigate. Participants will engage in support services, and monthly support services sheets will be due monthly to their case managers. Participants who are not in compliance with the support service requirements will be reminded that it is a condition of their program participation, and that continued noncompliance may result in termination of assistance. Program participants will be supplemented with other resources such as treatment for substance use or mental health, assistance with access to health insurance employment services, transportation, and other referrals necessary to ensure that they are ready for housing independence within 24 months of admission to the STEP project.

Support Services Community Outreach Project

New Choices Recovery Center is requesting funding for a new SSO – Street Outreach project. New Choices Recovery Center will provide Support Service Only through Street Outreach to individuals and families experiencing homelessness. New Choices Support Services Community Outreach project is necessary to assist people exiting homelessness and increase self-sufficiency, because it will provide assistance and guidance to housing stability. New Choices will provide services and funds to assist applicants to secure units, pay utilities, and moving costs. Through intensive Case Management and street outreach participants will be referred to community treatment, employment, and mental health services. New Choices Recovery Center has a history of partnering with law enforcement and first responders to engage with sheltered and unsheltered homeless individuals through our work with Schenectady Police Department and the HUB. New Choices Recovery Center also participated in the Schenectady Community meeting for "Adults at Risk" of homelessness. New Choices Recovery Center is a walk-in friendly resource to help individuals access emergency shelter, mental health and substance treatment, and housing. New Choices Recovery Center houses families and has a long history of assisting families with reunification and positive community participation that has allowed them to increase their ability to live independently. New Choices will partner with the Schenectady County HUB program to provide street outreach to sheltered and unsheltered individuals. New Choices will hire a Case Manager to provide intensive support services such as referrals to treatment, childcare, education, housing and employment search resources; as well as funds for securing housing, utilities, and moving costs to assist individuals to secure housing and increase independence. Applicants will be informed that engagement in support services and actively working on a service plan are requirements of the program participants. Through community partnerships with agencies such as The City Mission, Department of Social Services, OASAS, Workforce Development and others New Choices Recovery Center will assist participants to apply for benefits, SSI, health insurance, employment and other community services to assist them with housing stability. The purpose of requiring participants to

secure other resources is to increase the likelihood of independence without ongoing housing or rental assistance.

RENEWAL PROJECTS

Bethesda House of Schenectady, Inc.

Bethesda House - Pathways to the Future

Grant PIN: NY0801
Project Description:
Bethesda House requests continued funding to support Pathways to the Future's 4-bed, 4-unit housing program that is dedicated to chronically homeless (CH) single adults. BH serves the most challenging-to-serve individuals, often barred from other agencies due to problematic behaviors. Referrals are through the Coordinated Entry System.

The supportive housing team comprises experienced and skilled personnel in residential services, case management, social work, and medical care. The medical team consists of physicians from Ellis Medical Center, who provide on-site services bi-monthly. Collectively, they address social determinants of health (SDOH) and assist each program participant in attaining independence, self-sufficiency, and a sense of future.

The program's goal is to ensure participants have access to safe, clean housing as a foundation for rebuilding their lives. Program staff assist in connecting participants to counseling, therapy, and treatment programs tailored to their individual needs. A primary focus for staff is linking participants to healthcare providers, preventive care, chronic disease management, and providing education on budgeting, nutrition, cooking, and daily living skills.
Program participants with no income or receiving DSS TA engage with staff to either find employment or get approved for SSI/SSD; staff are SOAR trained.

BH monitors health improvements, overall well-being, social interactions, success in reconnecting with family, employment, and volunteer work. Based on similar successful BH initiatives, it is estimated that 75% (3 out of 4) will maintain stable housing for 12 months, and 100% for two years.

BH staff partners with area providers, utilizing services such as Mohawk Opportunities and RSS, to connect residents to the Health Home – Care Management Agency; SMHA, the Glen Eddy or other relevant housing agencies, SCAP for ongoing education and paperwork, and Ellis Medical Center.

Bethesda House - Liberty House

Grant PIN: NY0097
Project Description: Bethesda House requests continued funding to support Liberty House's 2-bed, 2-unit housing program that is dedicated to chronically homeless (CH) single adults. BH serves the most challenging-to-serve individuals, often barred from other agencies due to problematic behaviors. Referrals are through the Coordinated Entry System.

The supportive housing team includes experienced and skilled staff in residential services, case management, social work, and medical care. The medical team features doctors from Ellis Medical Center, who are on-site twice a month. Together, they address SDOH and assist each program participant in achieving independence, self-sufficiency, and a sense of future.

The program's goal is to ensure participants have access to safe, clean housing as a foundation for rebuilding their lives. Program staff assist in connecting participants to counseling, therapy, and treatment programs tailored to their individual needs. A primary focus for staff is linking participants to healthcare providers, preventive care, chronic disease management, and providing education on budgeting, nutrition, cooking, and daily living skills.

Program participants with no income or receiving DSS TA engage with staff to either find employment or get approved to receive SSI/SSD; staff are SOAR trained.

BH monitors health improvements, overall well-being, social interactions, success in reconnecting with family, employment, and volunteer work. BH staff partners with area providers, utilizing services such as Mohawk Opportunities and RSS, to connect residents to the Health Home – Care Management Agency; SMHA, the Glen Eddy or other relevant housing agencies, SCAP for ongoing education and paperwork, and Ellis Medical Center.

Bethesda House – Coordinated Entry Schenectady Co.

Grant PIN: NY1034
Project Description: Bethesda House requests continued funding to support the CoC CE system. All CoC-funded programs are required to participate in the CE system. The referral and housing placement process ensures all households experiencing homelessness will receive rapid and appropriate assistance. Schenectady CoC's Coordinated Entry System operates as a "no wrong door" approach. The system ensures client centered services are allocated as effectively as possible and are easily accessible no matter where people are present.

CARES of NY, Inc.

Schenectady County of the Capital Region HMIS

Grant PIN: NY0106
Project Description: CARES requests continued funding to support an HMIS program for CoC NY-507. This is a data collection program that holds client level data. Participation in the HMIS is a requirement for all recipients of CoC and Emergency Solutions Grant funds.

Schenectady County CoC Planning Project

Project Description: CARES is requesting funding to support the operations of the CoC. Proposed funds will support coordination and facilitation of the CoC's processes; including strengthening the current CoC system, assisting with the development and implementation of a coordinated assessment system, conducting project evaluation and monitoring, conducting an annual gaps analysis and Point-in-Time Count, participating in the Consolidated Plan, and preparing and submitting the CoC's application to HUD.

New Choices Recovery Center

Shelter Plus Care

Grant PIN: NY0102
Project Description: New Choices Recovery Center requests continued funding to support a 59 bed Permanent Supportive Housing (PSH) program. New Choices Recovery Center's Shelter Plus Care program is a scattered site program that provides rental assistance and Case Management services to individuals and families who are experiencing homelessness. The target population is heads of households who have recent substance use diagnoses. The program strives to serve, at a minimum, 59 households and 78 individuals, with 15 of those households being dedicated to chronically homeless individuals. The Shelter Plus Care Program operates aims to promote self-sufficiency by reducing barriers to access services, assisting program participants to secure housing, and providing support services, with the long-term goal of stabilized permanent housing. The New Choices Shelter Plus Care program received 120 referrals and successfully housed 100 applicants. Discharges from the New Choices SPC program yielded 87% of positive outcomes due to increased employment, transfers to Section 8, and family reunification of program participants.

The Shelter Plus Care Program provides rental assistance and case management to program participants. New Choices has reallocated $100,000 of rental assistance to create a support service line to meet the increased service needs of our participants. New Choices has assisted with transportation costs, household and hygiene supplies, and utility deposits to help our participants obtain and maintain stability. New Choices SPC program is unable to meet every need, so they work with local churches, small businesses, Schenectady and other County Departments of Social Services, the SUD clinic, and specified members of the participant's support network to coordinate services to prevent re-entry to homelessness. Case managers meet with program participants to assess their needs and from that assessment, both parties develop an individualized service plan. The Case Manager and program participant then review the progress of the service plan goals. Participants are assisted with services such as employment training, vocational training, childcare, transportation and other services to assist participants with becoming self-sufficient. The Occupancy agreement states that participants must agree to support service participation.

SAFE Inc. of Schenectady

Development of Independent Skills Program

Grant PIN: NY0105
Project Description: SAFE Inc. of Schenectady requests continued funding for their support services program. The Life Skills Program (LSP) will serve 55 individuals ages 18-35 who are homeless or at-risk of homelessness that suffer from mental illness, substance abuse, and/or a physical disability. The LSP will teach individuals the necessary life skills needed to maintain safe stable housing while addressing their mental, physical, educational and/or employment issues through intensive case management and referrals. Of the 55 individuals served, 48 will enter and remain in permanent safe affordable housing and will also increase their skills and/or income to achieve greater self-determination.

The Life Skills Case Manager (LSCM) formulates an individualized service plan for each participant by entering them into Coordinated Entry (CE), help them enroll in an educational/vocational program, help enroll them into counseling, participate in life skills groups, provide safety planning, and referrals for support groups.

Safe's LSCM holds a weekly group to address basic life skills that everyone in the group can apply to their daily living (i.e., cooking/baking, budgeting/financial planning, opening a bank account, resume building, mock interviews, utilizing community resources, etc.)

Schenectady Community Action Program, Inc.

SCAP - Sojourn House

Grant PIN: NY0110
Project Description: Schenectady Community Action Program requests continued funding for their 7-unit Transitional Housing (TH) program in Schenectady County. This is a transitional housing program that supports women and their children and for pregnant women that meet HUD's homeless eligibility criteria. Individuals may come from street homelessness, emergency shellers, or fleeing domestic violence. Sojourn House continues to be the only Transitional housing program of its type in Schenectady County. Sojourn House offers a safe, welcoming, and home-like environment for women and children. The program is staffed 24/7, It remains an essential resource in Schenectady County where family-focused homeless services are limited and most often require specific disabling conditions to quality.

Sojourn operated at a 76% utilization rate and supported 72 participants (total of 34 women and 38 children) throughout this reporting period. 65% of participants during this reporting period had positive outcomes to permanent housing. The average length of stay for participants that exiled the program 76 days (approximately 25 months.) On-site services include case management, therapeutic supports, and employment assistance, all aimed at achieving the program goal of permanent housing stability. Families are also supported in building social and economic networks, while continuity of education for children is actively encouraged and maintained The program promotes pos five parenting practices. as well. All meals are provided and hygiene products and clothing resources are available to residents.

Service Coordination. SCAP participates fully in the CoC Coordinated Entry Process. Participants are connected will community resources to ensure ongoing support and long-term stability. SCAP coordinates with Department of Social Services and New choices. A key objective of Sojourn House is to help women and their children develop support systems to lead to permanent housing placement and housing stability. Following program discharge. a case manager continues to monitor families' housing stability for up to a year, helping to address challenges and prevent setbacks.

SCAP – PHP16

Grant PIN: NY0104
Project Description: Schenectady Community Action Program requests continued funding for their PSH program in Schenectady County. This project provides 16 units of housing and comprehensive support services to homeless families with a diagnosed mental illness, substance abuse, or HIV/AIDS condition who live in scattered site apartments. HUD funding pays for rental subsidies and case management.

The program accommodates diverse family compositions, including nontraditional and multi-generational households, providing flexibly to meal varied needs. PHP operates 16 scattered-site apartments with leases established between SCAP and landlords for renewable one-year terms. PHP families reside in these apartments as subtenants. PHP achieved a utilization rate of 103% during the reporting period and a 96% retention rate for primary participants. By providing ongoing rental subsidies, PHP allows primary participants to focus on improving and maintaining their heath. The program provides comprehensive services including case management, therapeutic support, and employment assistance to ensure housing stability and foster independent living.

The program supports educational goats for both adults and children, addresses health needs to strengthen family dynamics, and promotes healthy parenting practices. Families can be referred through any community provider, and SCAP participates fully in the CoC Coordinated Entry process. Participants are connected with community resources to ensure ongoing support and long-term stability. SCAP coordinates with Hometown Heath, Ellis Mental Health Clinic, and Northern Rivers as community resources. A key objective of PHP is to help families develop social and economic support systems following episodes of homelessness, with comprehensive services ensuring housing stability and fostering independent living.

City of Schenectady

YMCA Schenectady - S Plus C DUP09A 10 Unit

Grant PIN: NY0107
Project Description: The City of Schenectady requests continued funding to support their Permanent Supportive Housing (PSH) program. This project serves ten men ages eighteen and up who are Schenectady County Residents and are currently homeless with a disability. Each YMCA resident receives a room and case management services. All the men of the Shelter plus Care

program are connected to an outpatient provider to address their disability. The case managers at the YMCA have weekly conferences with the clinical provider to ensure attendance and the follow through of the clinical requirements at the Residence Program.

YMCA Schenectady - S Plus C DUP09B 20 Unit

Grant PIN: NY0108

Project Description: The City of Schenectady requests continued funding to support their Permanent Supportive Housing (PSH) program. This project serves twenty men ages eighteen and up who are Schenectady County Residents and are currently homeless with a disability. Each YMCA resident receives a room and case management services. All the clients are connected to an outpatient provider to address their disability. The case managers at the YMCA have weekly conferences with the clinical provider to ensure attendance and the follow through of the clinical requirements at the Residence Program.