Community and Choice

Housing Needs for People with Disabilities in Delaware

A joint report from:

Delaware Housing Coalition

and

Housing Sub-Committee of the Governor's Commission on Community Based Alternatives for People with Disabilities

April 2012

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A LETTER FROM THE HOUSING SUBCOMMITTEE CO-CHAIRS

With this report, *Community and Choice: Housing Needs for People with Disabilities in Delaware,* the state's affordable housing and disability communities culminate the first stage of a continuing effort to better understand the scope and nature of the housing needs for people with disabilities in the state, in order to provide more effective and appropriate responses.

The Housing Sub-Committee of the Governor's Commission on Community Based Alternatives for People with Disabilities and the State Council for Persons with Disabilities joined with the Delaware Housing Coalition over the past many months, making use of a renewed and enhanced sub-committee to serve as a working group for this report. Because the need is multifaceted and the data scattered, we have been engaged in an effort that has had many challenges. However, that is exactly why a workgroup of this sort was needed.

Among the estimated 108,500 people with disabilities in the State of Delaware, incomes are typically lower than among those without disabilities, with a higher overall percentage in poverty or at risk of falling into poverty, and a much higher need for housing assistance. The need for accessible, affordable housing is a major barrier to people with disabilities living in the community, and housing needs severely limit the options of people with disabilities choosing to live in the least restrictive setting of their choice. Independence, choice, and integration are critical and still overlooked issues which must be factored into the consideration of housing needs for people with disabilities.

There are many changes afoot which have promise of leading to better and more appropriate housing solutions for people with disabilities in Delaware. We have tried, along with the articulation of the need, to accurately describe some of those potential solutions. Our recommendations, organized by the areas of accessibility, affordability, community, and systems provide an outline of them.

We will continue to act, via the Housing Sub-Committee, to develop proposals and policies toward implementing such solutions. We will also work through the three-year statewide comprehensive community-based housing planning initiative, now in mid-course, that was begun by the Homeless Planning Council and the Delaware Housing Coalition, in order to raise the housing needs of people with disabilities to the level of a standard consideration in state and local planning.

We welcome your partnership in making the housing needs of people with disabilities better and more widely understood and encourage your participation in, and support of, our ongoing efforts.

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INTRODUCTION: THE NEED FOR A FRESH REVIEW

In the mid-2000s, the Housing Subcommittee of the Governor's Commission on Community Based Alternatives for People with Disabilities developed a strategic plan, as part of the overall strategic plan of the Commission, to improve affordable housing opportunities for persons with disabilities and remove this major hurdle to independent living and a community based model of care. The lack of clear, reliable data on the scope of housing needs among people with disabilities in Delaware was a challenge even then. In 2006-2007, the Delaware State Housing Authority and its consultants, Mullin & Lonergan Associates, worked closely with the Housing Subcommittee on the Special Populations section of its *2008-2012 Statewide Housing Needs Assessment*. This resulted in several steps forward and new information, but the state's housing community has still struggled with the need to better understand the scope and nature of the housing needs of people with disabilities in Delaware in order to provide appropriate responses. With multiple unique subpopulations, each with distinctive needs and their own network of service providers, advocates, and data sources, simply assembling the information that is available into a coherent whole is itself demanding.

To revisit this topic, the Housing Sub-Committee of the Governor's Commission on Community Based Alternatives and the Delaware Housing Coalition have joined together to make use of a renewed and enhanced sub-committee to serve as the study workgroup, which held its first meeting in February 2011. The Housing Sub-Committee's leadership worked to ensure participation, encouraged wide collaboration in the work, and provide guidance and insight. Delaware Housing Coalition facilitated the study and implemented the work plan (data gathering, research, analysis, report). Through the workgroup model, the sub-committee collected data, conducted focus groups and interviews, collectively reviewed research products, and discussed and refined the study's recommendations. The Delaware State Housing Authority (DSHA) provided assistance with data collection, research and analysis. The various divisions of the Department of Health and Social Services (DHSS) provided data, input and feedback on the report.

First of all, we need better raw data about disability housing needs (populations, immediate needs, long-term projections). This includes updating and revisiting primary data available in Delaware (providers, state and local agencies) and reviewing national data sources. Secondly, income poverty and disability interact in ways that mutually reinforce one another. So, a more careful analysis is required of the relationship between income poverty, disability, and specific housing needs. In the third place, there is a spectrum of disability housing needs, each of which requires different solutions and resources. People with disabilities are over-represented among the homeless, living involuntarily in shelters and institutions instead of a home of their own. The need for rental housing is aggravated by the need for higher rental subsidies, absence of support services, and lack of accessibility. Similarly, the needs of owner-occupants span a range of their own, from the need for retrofits to remain in the home or financial help to offset housing cost burdens, on the one hand, to homebuyer financial preparation, asset-building, universal design in general housing construction, and special lending products, on the other.

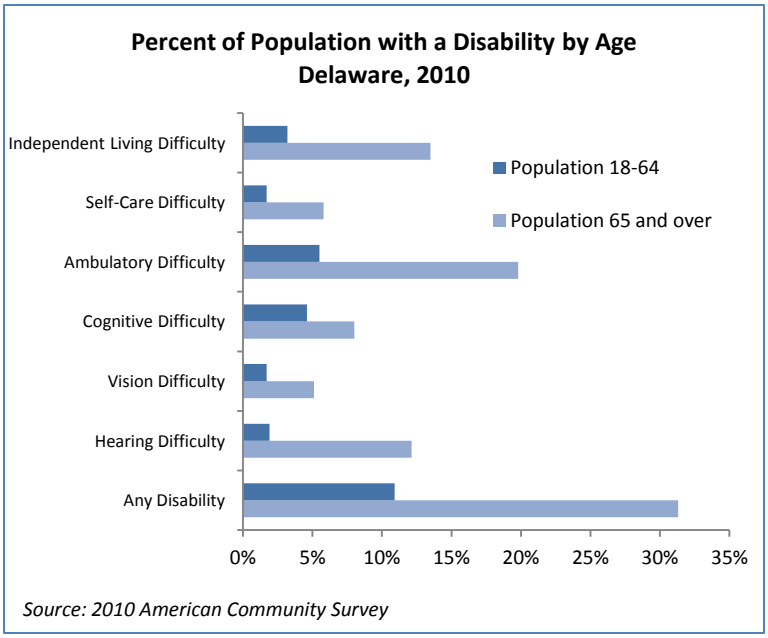
PREVALENCE OF DISABILITIES

Nationally, there are 36.4 million people with disabilities in the United States, or 11.9% of the population.[1] The prevalence of disabilities varies across surveys due to a variety of reasons, but is generally between 11% and 19% nationally. The Survey on Income and Program Participation (SIPP) estimated that in 2005, there were 54.4 million people in the United States with some level of disability and 34.9 million with a severe disability.[2]

Table 1: Measures of Disability Prevalence, United States

Source	Year	Population	U.S.	Delaware
U.S. Census	2000	Civilian noninstitutionalized population 16-64	9.7%	9.4%
Panel Study on Income Dynamics (PSID)	2001	Population 18-64 reporting any disability	14.7%	n/a
Survey on Income and Program Participation (SIPP)	2005	Total population reporting any disability	18.7%	n/a
		Total population reporting a severe disability	12.0%	n/a
American Community Survey (ACS)	2010	All (civilian noninstutionalized population)	11.9%	12.3%
		18-64	10.0%	10.9%
		65 or over	36.7%	31.3%
Current Population Survey (CPS)	2009	Civilian population 16 years and over	11.4%	n/a
Behavioral Risk Factor Surveillance Survey (BRFSS)	2009	Population in households, 18 and over	18.9%	18.4%
National Health Interview Survey (NHIS)	2009	Population over 18 reporting unable or limited in their ability to work due to a health condition	10.0%	n/a

The most frequent and current measure of disability prevalence available at the national and state level is the American Community Survey (ACS), which has replaced the previous "long form" of the decennial census in collecting detailed household and housing information. Using a series of six questions about sensory, ambulatory, cognitive, independent living and self-care difficulties, the 2010 ACS reports a disability prevalence rate of 11.9% nationally and 12.3% in Delaware for the civilian noninstitutionalized population, regardless of age. The ACS estimates that there are 108,444 Delawareans with disabilities. The prevalence rate varies widely by age group: 31% for individuals 65 and over, 10.9% for those 18-64, and 4.4% for those under 18.



ABOUT THE DATA

Sources of state-level information on disability prevalence and housing needs are both scarce, and the major sources have several drawbacks. The most available source used for most state-level data throughout this report is the American Community Survey (ACS). However, the ACS is a much smaller sample survey than the Census, and thus has margins of error that are sometimes quite large, especially when looking at estimates for smaller subpopulations and geographies. Released as single-year, 3-year, and 5-year estimates, the most reliable data for subpopulations and smaller geographies are in the 3 and 5-year releases. Unfortunately, information on disability had to be excluded from recent 3 and 5 year releases as the questions about disability were changed in 2007.[3] The 2008-2010 estimates released in late 2011 are the first multi-year estimates to include information on disability. Similarly, the population in group quarters or institutions was not included in earlier years of the ACS, so multi-year estimates do not yet include these populations. Most tables still exclude the institutionalized population.

On more detailed data items, three-year 2008-2010 estimates at the state level are used throughout this report. Margins of error can be high when looking at smaller subpopulations, so using the three-year estimates gives more reliable numbers for many of the items of interest for this report. In general, we refer only to the state level estimates as these have the least margin of error.

Another challenge is that different data sources use different measures for disability. Appendix A gives a list of the questions used by the most common sources. Sources with more detailed questions that allow for more nuanced analysis of particular populations, disabilities and needs, such as the Survey of Income and Program Participation (SIPP) and Panel Study of Income Dynamics (PSID) unfortunately are not available at the state level. Other data issues with other national sources are noted in the report where the data are presented.

POPULATIONS COVERED BY MAJOR SURVEYS

It is important to note the populations covered by the major surveys, especially when comparing them to each other and applying prevalence rates to Delaware's population for estimates. Most break out the working-age population (usually 18-64 or 25-64 years) from the population 65 and over. As the prevalence of disabilities increases significantly among older adults, this allows us to gauge the prevalence of disabilities among people who are likely to be employed, seeking employment, or heads of households supporting families and whose disabilities are likely to affect their efforts to do those and other activities.

In addition, most surveys also exclude disability measures for children, as some disabilities may either resolve or not emerge until older ages. Measures of difficulty with independent living –such as Instrumental Activities of Daily Living (IADLs) like shopping, visiting a doctor's office or running errands – are also not usually captured for individuals under 15 or 18 years of age, depending on the survey. Age categories in the published data from national surveys may not always align: specific ages covered are noted in tables and charts for the relevant data source.

All of the major national surveys with disability information used in this report (the National Health Interview Survey, American Community Survey, and Survey on Income and Program Participation) exclude the population in institutions. As this includes nursing homes and other long-term care settings, this may have some effect on the

prevalence of disability shown in these surveys. In 2006, the ACS was expanded to include the group quarters population, which includes institutionalized (correctional facilities, juvenile facilities, nursing facilities, in-patient hospice facilities, residential schools for people with disabilities, and hospitals with patients who have no usual home elsewhere) and noninstitutionalized (college/university student housing, military barracks, emergency and transitional shelters, and group homes) populations. However, the published data only include the noninstutionalized group quarters population. Thus, the 2008-2010 ACS estimates on disability prevalence used in this report only include the noninstitutionalized group quarters population. A 2008 report from the Census Bureau analyzed the differences in disability prevalence across these populations. In this analysis, Delaware was one of five states where the disability rates between the civilian noninstitutionalized and household populations were not statistically different.[4]

Table 2: Prevalence of Any Disability by Age and for the Total, Civilian Noninstitutionalized and Household Populations 5 Years and Over, United States and Delaware, 2006

Category	Civilian Noninstitutionalized Population (including noninstitutional group quarters)		Household Population		Total Population (Including all group quarters)	
	U.S.	DE	U.S.	DE	U.S.	DE
Age 5 years and over Any Disability	15.1	15.3	14.9	15.3	15.7	15.9
Age 16 years and over Employment disability	7.1	n/a	6.9	n/a	7.2	n/a
Age 16-64 years Any disability	12.3	n/a	12.2	n/a	12.6	n/a
Age 65 years and over Any disability	41.0	n/a	40.7	n/a	43.4	n/a
Source: U.S. Census Bureau, 2008						

The 2010 Census provides detail on the population in group quarters in Delaware. As of the 2010 Census, there were 24,413 individuals in group quarters in Delaware, 47.8% in institutional settings. In particular 4,591 people, or 19% of the total population in group quarters, were identified as living in nursing facilities or skilled nursing facilities in Delaware in 2010.

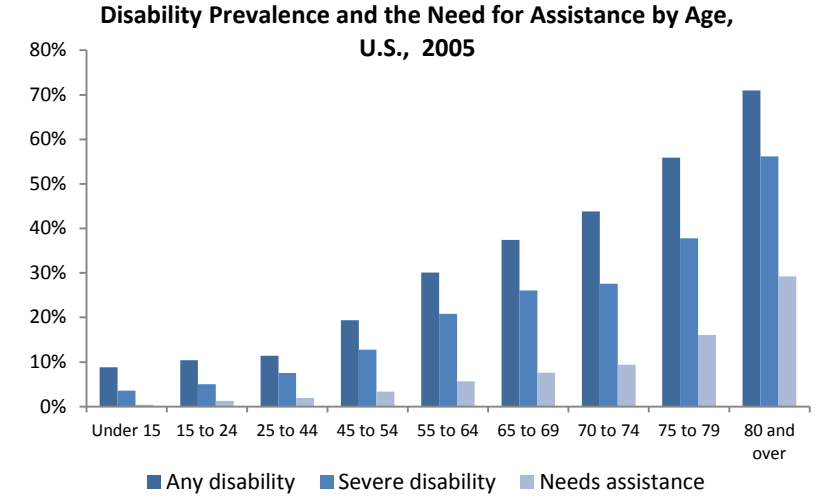
Table 3: Population in Group Quarters, Delaware, 2010

Category	Total	Under 18	18-64	65 and over
Total Group Quarters Population	24,413	769	19,532	4,112
Institutionalized Population	11,673	370	7,352	3,951
Correctional facilities for adults	6,457	n/a	n/a	n/a
Juvenile facilities	382	n/a	n/a	n/a
Nursing facilities	4,591	n/a	n/a	n/a
Other institutional facilities	243	n/a	n/a	n/a
Noninstitutionalized Population	12,740	399	12,180	161
College/University student housing	10,184	n/a	n/a	n/a
Military quarters	283	n/a	n/a	n/a
Other noninstitutional facilities	2,273	n/a	n/a	n/a
Source: U.S. Census Bureau, 2010 Census				

SEVERITY OF DISABILITY AND LIMITATIONS IN ACTIVITIES OF DAILY LIVING (ADLS)

Severity of disability is an important facet of the overall prevalence of disability in the population: people with more severe disabilities are more likely to experience poverty, long-term poverty, unemployment or inability to work, and more likely to need supportive services. Measures of severity can have large effects on estimates of prevalence and affect the need for assistance. According to a different national survey that includes more detail on type and severity of disability, across the entire population, 18.7% report any disability, and 12.0% report a severe disability.[5] 4.1% of those ages 6 and over report needing assistance with an Activity of Daily Living (ADL) or Instrumental Activity of Daily Living (IADL).

In most of the major national surveys that also have available state-level data or housing-related data, there is unfortunately little information available about the severity of disability and specific functional limitations that might relate to an individual's housing needs. Wherever more specific data are available, they are included in the relevant topic in the Delaware Data Review by Population section.



Source: Survey on Income and Program Participation (2005)

An important measure that cuts across disability populations is activities of daily living (ADLs). People with difficulty completing activities of daily living may need supportive services to assist with these activities. The American Community Survey reports on both "Self-care difficulty," defined as "difficulty dressing or bathing" and "Independent Living Difficulty," defined as "difficulty doing errands alone such as shopping or visiting a doctor's office." Independent Living Difficulty is only defined for adults over 18. Individuals may report more than one disability, so the number of individuals reporting self-care and independent living difficulty should not be added. In Delaware, an estimated 18,375 people have difficulty with self-care and 36,108 have difficulty with independent living.

Table 4: Population with Self-Care or Independent Living Difficulty, Delaware, 2008-2010

	Self-care Difficulty		Independent Living Difficulty	
	Number	**Percent**	**Number**	**Percent**
Under 18	1,165	0.8%	n/a	n/a
18 – 64	9,299	1.7%	18,360	3.4%
65 and over	7,911	6.5%	17,748	14.5%
All	18,375	2.2%	36,108	5.4%
Source: U.S. Census Bureau, 2008-2010 American Community Survey				

Rates in Delaware are similar to those reported in national surveys, and rates across national surveys are also similar. Other national surveys report on limitations in Activities of Daily Living (ADLs), defined as eating, dressing or bathing (similar to the ACS' measure "Self-Care Difficulty"), and Instrumental Activities of Daily Living (IADLs), defined as household chores and shopping (similar to the ACS' measure "Independent Living Difficulty"). Nationally, the National Health Interview Survey (NHIS) reports that about 4.4 million adults (2%) required the help of another person with ADLs and 9.2 million (4%) with IADLs.[6]

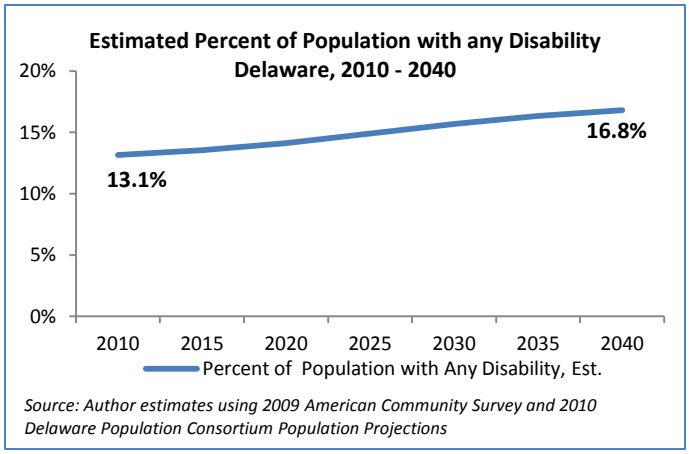
Table 5: Percent of Population with Limitations with ADLs/Self-care Difficulty or IADLs/Independent Living Difficulty, United States

	ADLs/Self-care Difficulty			IADLs/Independent Living Difficulty		
	ACS (DE)	**ACS (U.S.)**	**NHIS**	**ACS (DE)**	**ACS (U.S.)**	**NHIS**
Under 18	0.8%	0.9%	n/a	n/a	n/a	n/a
18 – 64	1.7%	1.8%	1.1%	3.4%	3.5%	2.3%
65 and over	6.5%	8.8%	6.4%	14.5%	16.2%	12.7%
All	2.2%	2.6%	1.9%	5.4%	5.6%	4.0%
Source: U.S. Census Bureau, 2010 American Community Survey; Centers for Disease Control and Prevention, 2009 National Health Interview Survey						

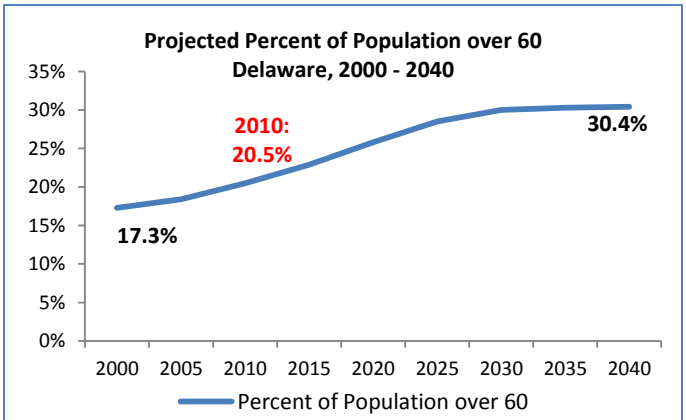
DISABILITY AMONG OLDER ADULTS

Disability prevalence and the likelihood that a disability will be severe and require a person to need assistance increases sharply among older adults. In Delaware, an estimated 10.9% of adults 18-64 had any disability in 2010; for those over 65, 31.3% had any disability.[7] Older adults are also more likely to have difficulty with ADLs or IADLs and require personal assistance with these activities: as seen in Table 4 above, 6.5% of those over 65 required personal assistance with ADLs and 14.5% required personal assistance with IADLs.

As the population ages, higher rates of disability among older age groups will slowly increase the overall percentage of the population living with a disability: the number of individuals with disabilities will grow faster than the population as a whole. From 2000 to 2010, the percent of Delaware's population over 60 increased from 17.3% to 20.5%; by 2040, 30% of the population will be over 60.[8] While the overall population will



Source: Author estimates using 2009 American Community Survey and 2010 Delaware Population Consortium Population Projections



Source: 2010 Delaware Population Consortium Population Projections

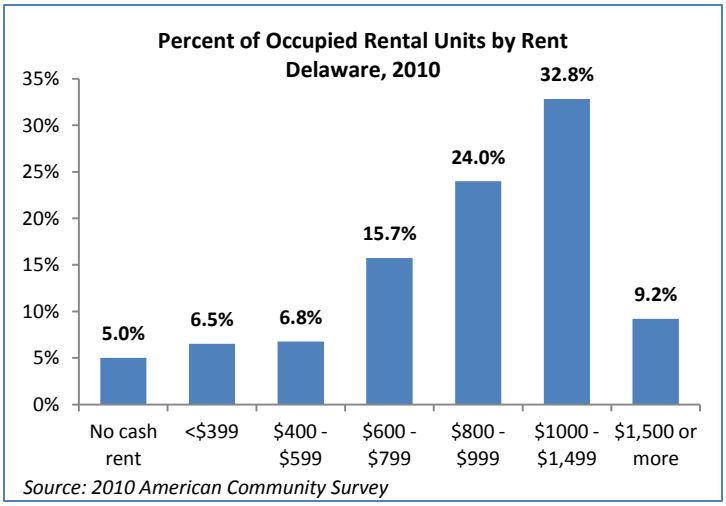
increase about 16% from 2000 to 2040, the population over 60 will increase 150%.

To create a general estimate of how this might affect disability prevalence in Delaware, we applied the 2009 rates of disability prevalence by detailed age group and sex reported by the American Community Survey in Delaware to the Delaware Population Consortium's 2010 Population Projection Series. The 2009 rate was held constant across the projections. Using this method, individuals with any disability are projected to increase from 13.1% of the population in 2010 to 16.8% of the population in 2040.

POVERTY AND HOUSING NEEDS AMONG PEOPLE WITH DISABILITIES

AFFORDABILITY CHALLENGES FOR ALL HOUSEHOLDS

The recent recession and persistently high unemployment hit lowest income households earliest and hardest, in an environment where the largest employment growth was already among lower-wage jobs in lower-wage industry sectors. The foreclosure crisis has also put upward pressure on rents as millions of households, with battered credit, lost savings and often unemployed, return to renting in a housing market that had added little multifamily rental stock through the homeownership boom years. Decreases in home prices are of little help to the most vulnerable households.



Source: 2010 American Community Survey

According to the 2010 American Community Survey, only 10% of rental units in Delaware had rents below $500, while over 40% have rents over $1,000 – the percentage of units renting for less than $500 dropped by more than half from 2000 to 2010 and the percentage renting for more than $1,000 quadrupled.

Fair market rents for a 2 bedroom apartment in Delaware range from $750 in Sussex County to $1,077 in New Castle: nowhere in the state can an individual earning minimum wage afford even an efficiency (0 bedroom) apartment. The gap between what an extremely low-income household can afford and the 2-bedroom fair market rent ranges from $286 in Sussex County to $474 in New Castle. The National Low Income Housing Coalition (NLIHC) estimates that 54% of renters in Delaware cannot afford the fair market rent on a 2 bedroom apartment.[9]

An estimated 42% of Delaware's renter households have income below 50% of median (very low income).[10] Of these 36,150 households, 75% (27,130) are cost burdened and 48% are severely cost-burdened. Among the state's poorest households, those with extremely low incomes (<30% of median), 62% (12,845 of 20,570) of renter households are severely cost-burdened. These households are the state's most vulnerable, most precariously housed and at risk of homelessness.

HUD's *Worst Case Needs* report shows a surge in worst case needs from 2007-2009; in this same time period, there was no increase in housing assistance in proportion to the surge in very low-income renters. Households are

considered to have worst case needs when they have very low incomes (below 50% of median), do not have housing assistance, and are either severely cost burdened or living in severely inadequate housing. In 2009 7.10 million households had worst case needs by this definition: 41.4% of very low income renter households.[11] Only 25% of very low income renter households reported having housing assistance.

For those without housing assistance, options are scarce due to a declining stock of affordable rental housing, the long-term loss of federally assisted housing, substandard housing conditions, and "mismatch" of renters to units. Nationally, higher income households occupy about 42% of the units that are affordable to extremely low-income renters, and 36% of units affordable to households from 30-50% AMI. Only 32 units of adequate, affordable rental housing are available every 100 extremely low income renters.[12] In Delaware, only about 12% of vacant for-rent units are affordable to extremely low income households. Worsening this situation, the country's stock of subsidized rental housing has declined steadily in recent years: since 1995, approximately 360,000 project-based Section 8 units have been lost, with another 10,000 – 15,000 lost every year, and annually, about 10,000 public housing units are lost to either demolition or sale.

In Delaware, as in the nation, there is a general scarcity of housing assistance for the most vulnerable households. Statewide, approximately 13,600 households are on public housing and Housing Choice Voucher waiting lists, mostly households with extremely low incomes.[13] As of 12/31/11, there were a combined 8,170 households on waiting lists at project-based Section 8 sites in Delaware (privately owned, federally subsidized sites), and over 3,000 households on waiting lists for Low income Housing Tax Credit (LIHTC) sites.[14]

INCOME AND POVERTY RATES

Earnings and household income are both lower for persons with disabilities, both at the national level and in Delaware. The 2008 Current Population Survey (CPS) showed an estimated household income of $32,000 for persons with disabilities, compared to $63,500 for those with no disability.[15] Looking only at earnings, the 2008-2010 ACS estimated that persons with a disability in Delaware had median annual earnings of $20,331, compared to $31,991 for persons with no disability. Nationally, persons with no disability had median earnings of $30,263 compared to $19,970 for those with a disability.

Table 6: Median Household Income, Civilian Noninstitutionalized Population, Delaware, 2008

	With a work limitation		Without a work limitation	
	Estimate	95% Margin of Error	Estimate	95% Margin of Error
Delaware	$32,000	± $7,264	$63,500	± $3,522
United States	$32,500	± $667	$60,200	± $393
Source: Current Population Survey, calculated by the Cornell University Rehabilitation Research and Training Center on Disability Demographics and Statistics				

Likewise, persons with disabilities are much more likely to live in poverty. In Delaware, 16.7% of all individuals with a disability were estimated to have poverty level income, compared to 10.5% for those with no disability.[16] However, this split is even greater for working-age people with disabilities (18-64): the poverty rate for this group is 19.7%, compared to 8.9% for working-age individuals with no disability. This is likely a low estimate, as the ACS does not include the population in group quarters or institutions; those with disabilities in institutions, especially the non-elderly, likely also have poverty-level income.

Table 7: Poverty Rates and Median Earnings by Disability, Delaware, 2008-2010

	With a Disability	With no Disability
Median earnings	$20,331	$31,991
Percent in poverty (<100% of poverty threshold)*	16.7%	10.5%
Percent in poverty or near-poverty (<200% of poverty threshold)	39.4%	24.9%
**Poverty thresholds used in the ACS are those set by the Census Bureau by household size and presence of children. For a one-person household under 65, the 2009 poverty threshold was $11,161. Source: U.S. Census Bureau, 2008-2010 American Community Survey*		

Poverty is even more widespread among people with severe disabilities. Those with a severe disability are far more likely to be in poverty: 27% of people 25 – 64 years old with a severe disability had poverty-level income compared to 12.0% of those with a non-severe disability and 9.1% of those with no disability.[17] In 2005, 41.5% of people 25 - 64with a severe disability had monthly household income below $2,000, compared to 20.4% of those with a nonsevere disability and 13.7% of those with no disability.

Poverty-level income itself is an inadequate measure of material hardship and need, as the level is so low: the federal poverty threshold for one person in 2009 was $11,161 (those under 65; for those over 65, $10,289)[18]. A family or person may have double that income and still face serious housing and other needs. Nationally, 36% of individuals with a disability are estimated to have income below 200% of the federal poverty level, making up 18% of persons with income below 200% of the poverty level.[19]

In Delaware, 18,434 people were estimated to have income below 100% of the federal poverty level and a disability in 2008-2010. When we expand our view of poverty to include households with income from 100-200% of the poverty level (for one person under 65, 100% in 2009 was $11,161; 200% was $22,322), the disparity between people with disabilities and those with no disabilities is even more stark. In Delaware, an estimated 39% of people with disabilities had income below 200% of the federal poverty level, compared to 25% of people with no disabilities. People with disabilities make up about 19% of those in poverty in Delaware.

Table 8: Percent of Population with a Disability by Poverty, Delaware, 2008-2010

	Population	With a Disability	Percent
Below 100% of Poverty Threshold* (2009: $11,161)	97,812	18,434	18.8%
Below 200% of Poverty Threshold (2009: $22,322)	230,789	43,442	18.8%
Over 200% of Poverty Threshold	631,594	66,937	10.6%
**Poverty thresholds used in the ACS are those set by the Census Bureau by household size and presence of children. For a one-person household under 65, the 2009 poverty threshold was $11,161. Source: U.S. Census Bureau, 2008 - 2010 American Community Survey Universe: Civilian noninstitutionalized population for whom poverty status was determined.*			

Among those who are homeless, about 35% of whom have a disability, incomes are often so low as to be practically negligible. The 2011 Delaware Point-in-Time study showed that 43% of individuals surveyed who were homeless had no income whatsoever, and 25% had income of less than $500 a month[20]. Many of these individuals count state General Assistance (approximately $90 a month) as their only income. 68% of individuals surveyed thus had income below $500 a month.

FEDERAL INCOME SUPPORTS

People with disabilities may need to rely on Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) as their main source of income, and disproportionately experience poverty and long-term poverty. In Delaware, the Social Security Administration (SSA) reports that 9,253 non-elderly adults with disabilities received SSI benefits in 2009.[21] This works out to an annual income of just over $8,000, well below the 2009 federal poverty threshold of $11,161. The standard SSI benefit of $698/month does not allow an individual to rent even an efficiency apartment anywhere in the state.

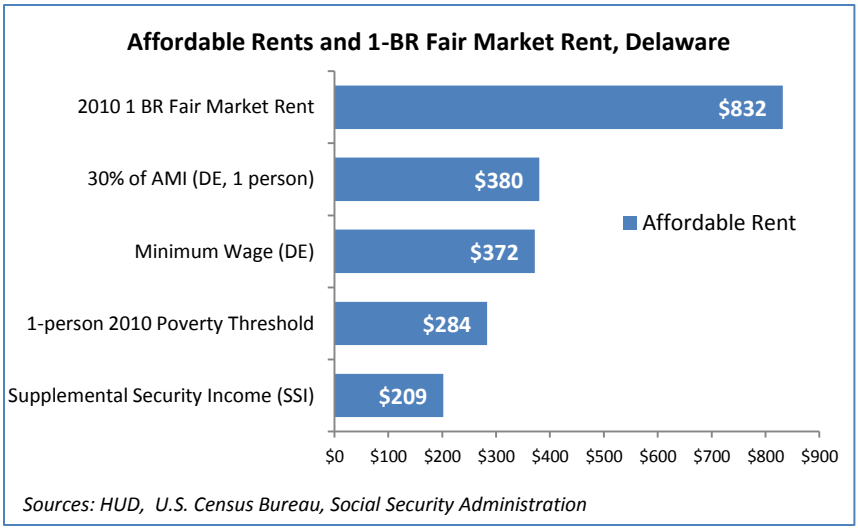


Table 9: SSI Recipients by Eligibility Category and Age, Delaware, 2009

	Category		Age		
	Aged	Blind and disabled	Under 18	18 – 64	65 or older
Delaware	15,384	14,082	3,577	9,253	2,549
Kent	3,431	3,211	748	2,215	468
New Castle	9,103	8,232	2,190	5,303	1,610
Sussex	2,850	2,639	639	1,735	471
Source: Social Security Administration, SSI Recipients by State and County, 2009					

Priced Out in 2010: The Housing Crisis for People with Disabilities reports that in 2010, approximately 4.4 million adults with disabilities between 18 and 65 relied on SSI as their main source of income and had annual incomes of less than $8,500.[22] Many of those in institutions, often funded by Medicaid, rely on SSI for their income and absolutely require a housing subsidy to live in the community. In many communities, including in all of Delaware, individuals relying on SSI for income would need to pay close to or even more than 100% of their monthly income to afford the fair market rent on a basic apartment. Across the nation, the average person on SSI needed to pay 112% of their monthly income to rent a 1 bedroom apartment.

For the 9,253 non-elderly adults with disabilities receiving SSI benefits in Delaware, the fair market rent on a 1 bedroom apartment would be 123% of their monthly income. As a percent of the median income, SSI is 17% of the one-person median income for Delaware.

LONG-TERM POVERTY

People with disabilities are far more likely to experience long term poverty (36 months or more of poverty-level income), and those in long-term poverty are far more likely to have disabilities, especially disabilities of long duration. The poverty rate for those with no work disability was 6%; for those with a work limitation only, 10%, but for those for whom their disability prevented work in all months of the year, the poverty rate was 32%.[23]

Annual poverty rates (households with annual income below the poverty level) are also 2 to 5 times higher among working-age people with disabilities compared to their counterparts without disabilities. As might be expected, poverty rates are generally higher for those with more severe disabilities. 6.08% of individuals 25-61 with no disability were in poverty, compared to 12.09% with some disability and 22.75% of those who had a severe disability.

Table 10: Annual Poverty Rates by Functional or Activity Limitation Status, Ages 25 to 61, United States, 1997

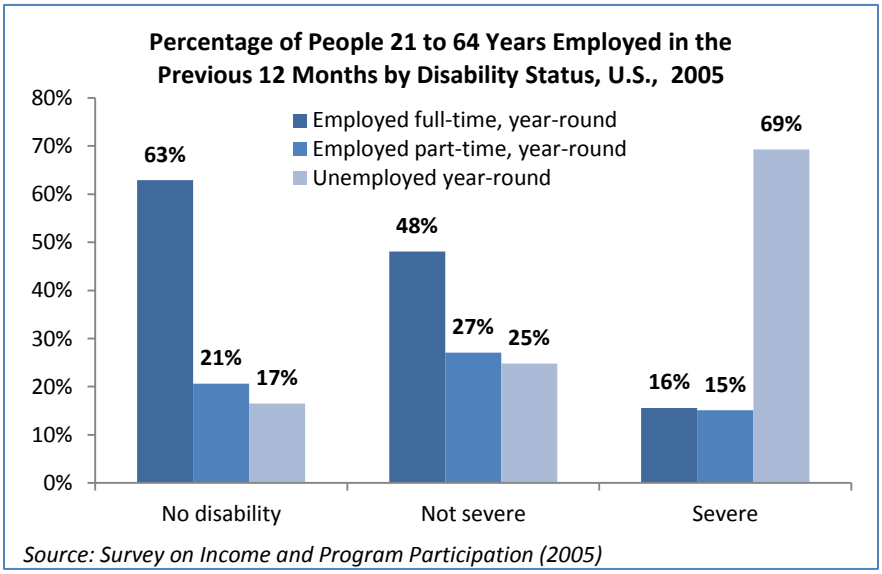
Disability	No Difficulty	Difficulty	Inability or Needs Assistance to Perform Activity (Severe Disability)
Sensory Limitation	7.43	16.84	23.55
Functional limitation	6.48	12.50	22.84
ADLs/IADLs	7.20	18.10	25.90
Any limitation	6.08	12.09	22.75
Source: She and Livermore, 2009			

Poverty-level income is compounded by higher costs for services and results in much higher rates of material hardships such as food insecurity among people with disabilities in poverty. In 1997, average annual out-of-pocket health care expenditures among working-age people with disabilities were about 3 times higher than that of their counterparts without disabilities.[24] Controlling for income and other demographics, people with work limitations were more likely than those without work limitations to experience more material hardships, at every level of income. About 40% of those in poverty reporting a work limitation in 1998, regardless of duration, experienced food insecurity compared to just 4% of those with incomes above 200% of the poverty level and no work limitation.[25]

People with disabilities living in poverty are much more likely than others living in poverty to experience material hardship. Further, people with more severe disabilities or disabilities of long duration are more likely to experience material hardship, even among people with income below poverty level. 21% of people with income below poverty level and a work limitation lasting more than 12 months reported not getting needed medical care, compared to 12% of people with no work limitation. 20% reported food insecurity with hunger, compared to 8% of people with no work limitation.[26]

Costs for transportation, medical care, attendant care and assistive technology may all make low income an even greater barrier to living independently in the community. She and Livermore (2007) used reports of material hardship in the Survey on Income and Program Participation to identify a poverty standard adjusted for people with disabilities: how much income would a person with a disability need to have an equal probability of experiencing material hardship as a person with no disability? Their analysis suggested a disability-adjusted poverty standard of $34,239 for a person with a work limitation lasting longer than 12 months.

Low asset limits in critical federal income support programs may also contribute to long-term poverty as they create barriers for people with disabilities to save and to make investments that may improve their circumstances long-term, including education, assistive technology, transportation and homeownership. Current asset limits for Supplemental Security Income, for example, have not been raised since 1989, at $2,000 per person or $3,000 per couple. While other important programs' eligibility and asset limits are controlled by states (for example, Medicaid and Supplemental Nutrition Assistance Program (SNAP)), low asset limits in these federal programs remain a major barrier. Delaware has eliminated asset tests in its Medicaid and SNAP (food stamp) programs.



Source: Survey on Income and Program Participation (2005)

EMPLOYMENT

It is often challenging for people with disabilities to acquire and maintain employment. When they are employed, it is more likely to be on a part-time basis and/or in lower-income occupational groups, and those in the labor market are far more likely to be unemployed. The Bureau of Labor Statistics' Current Population Survey (CPS) reports that 1/3 of workers with a disability were employed part-time, compared to about 1/5 of those with no disability.[27] Among working age adults (16-64), 35.2% of persons with a disability were in the labor force, with an unemployment rate of 15.6% in 2009, compared to 77.8% participation among persons with no disability and an unemployment rate of 9.2%.

2009 ACS estimates on disability and employment similarly show the disproportionate impact of disability on unemployment and labor force participation in Delaware. Persons with a disability made up 5.4% of employed persons in Delaware, but 13.6% of those who were unemployed and 28.7% of those not in the labor force.

Table 11: Labor Force Participation, Percent of Population Employed, and Unemployment Rate, Delaware, 2009

	Persons with a disability			Persons with no disability		
	Labor force participation rate	Percent of population employed	Unemployment Rate	Labor force participation rate	Percent of population employed	Unemployment Rate
All persons	22.4	19.2	14.5	70.9	64.5	9.0
16 to 64 years	35.2	29.7	15.6	77.8	70.7	9.2
65 and over	6.8	6.3	7.4	22.1	20.7	6.3
Source: Current Population Survey, calculated by Cornell University						

People with severe disabilities are often even more limited in their employment. 69.3% of people 21-64 with severe disabilities were unemployed year-round, compared to 24.8% of those with non-severe disabilities and 16.5% of those with no disability.[28] Only 15.6% of people with severe disabilities were employed full-time, year-round, compared to 62.9% of those with no disability. More than half (55.0%) of those with severe disabilities reported that their disabilities prevented them from working. When people with severe disabilities are able to maintain employment, still, their earnings are far less than their counterparts with non-severe or no disabilities: the 2005 SIPP reported median monthly earnings of $2,539 for those with no disability, $2,250 for those with a non-severe disability, and only $1,458 for those with a severe disability.

WORST CASE HOUSING NEEDS

Biannually, the U.S. Department of Housing and Urban Development releases a report on worst case housing needs as a measure of the nation's most critical housing needs. "Worst case needs" are defined as households with very low incomes (below 50% of the area median for their household size) who do not receive government housing assistance and are severely cost burdened (pay more than 50% of their income for rent), live in severely inadequate conditions (overcrowded or substandard), or both. In the past, issues with the main data source used to develop HUD's worst case needs studies led to serious concerns that the needs of persons with disabilities and their prevalence among households with worst case needs were underestimated. In 2011, HUD addressed these concerns with new data methods and released a supplement to its report focusing on the worst case housing needs of persons with disabilities.[29]

Table 12: Housing Conditions of Renter Households by Disability, United States, 2009

Households (1,000s)	Total	With Disabilities	Households with a Disability as Percent of Total
All households	111,861	9,293	8.3
Renter households	35,396	3,886	11.0
Owner households	76,465	5,407	7.1
Renter households			
Unassisted w/severe problems	8,085	1,059	13.1
Unassisted w/nonsevere problems only	8,229	815	9.9
Unassisted w/no problems	14,211	987	6.9
Assisted	4,871	1,025	21.0
Very low income	17,118	2,584	15.1
Worst case needs	7,095	987	13.9
Rent burden >50% of income	9,000	1,332	14.8
Rent burden 30-50% of income	8,240	986	12.0
Severely inadequate housing	998	149	14.9
Moderately inadequate housing	2,264	387	17.1
Crowded housing	1,499	183	12.2
Source: U.S. Department of Housing and Urban Development, 2009 Worst Case Housing Needs of People with Disabilities			

In 2009, an estimated 2.6 million very low income renter households included nonelderly people who reported having at least one of the six measures of disabilities (visual, hearing, cognitive, ambulatory, self-care, and independent living limitations). 987,000 of these households had worst case housing needs – 38% of all very low-

income renter households with disabilities. Renter households that include people with disabilities are more likely than those that do not include people with disabilities to have very low incomes, experience worst case needs, pay more than one-half of their income for rent, and have other housing problems such as living in inadequate or overcrowded housing. Other key findings of this report include:

- 66% of renter households with disabilities had very low incomes, compared to 46% of those without disabilities
- Ambulatory, cognitive and independent living limitations were the most prevalent limitations among households with worst case needs that included people with disabilities.
- 34% of renter households with disabilities had severe rent burden (>50% of income towards rent), compared to 24% without disabilities.
- Additionally, 619,000 households with worst case needs include elderly people with disabilities.

Although state-level data are not produced for the HUD Worst Case Housing Needs report, for this study, a state-level estimate of worst case rental housing needs was developed. This estimate is discussed in detail in the *Rental Housing Needs* section.

ASSISTED HOUSING WAITING LISTS AND OCCUPANCY

Households with disabilities and households with extremely low incomes (<30% of Area Median Income) are strongly represented on waiting lists for public housing and Housing Choice Vouchers. Statewide, 3,128 households on public housing authority (PHA) waiting lists (24%) are either elderly or include a person with a disability. Two of Delaware's larger PHAs (Wilmington and New Castle County) do not have open waiting lists, so the total number would likely be significantly higher if all waiting lists were open. In Table 13, it may be more useful to focus on the percentage of households than the number, as households may frequently be on the waiting list of more than one PHA.

Table 13: Total Public Housing and Housing Choice Voucher Waiting Lists, Delaware, September 2010

	Total	
	Number	**Percent**
Total households	13,215	100.0%
By income (Data missing for NCC)		
<30%	8,925	67.5%
30 - 50%	2,522	19.1%
50 - 80%	732	5.5%
By type		
Families with children	3,729	28.2%
Elderly and Disabled Families/Individuals (DSHA only; DSHA waiting list includes both together)	2,235	16.9%
Persons with Disabilities (WHA, DHA, NCC, NHA)	642	4.9%
Elderly (WHA, DHA, NCC, NHA)	251	1.9%
*Percentages may not equal 100% due to rounding and overlap among household types.		
**Some families with disabilities also have children in the family, which is included in the families with children count above.		
Source: Analysis of Impediments to Fair Housing Choice, July 2011. Data Collected September 2010		

Assisted housing (public housing, Housing Choice Vouchers, or privately owned housing with project-based subsidies) is highly effective in reducing worst case housing needs, especially among people with disabilities. Renter households that include people with disabilities are two times more likely to receive housing assistance than those that do not: about 37% of very low-income renter households with disabilities received housing assistance compared to only 23% of those without disabilities.[30] In the focus groups convened to inform this report, feedback from consumers identified the availability of some assisted housing, however limited, as the main positive they saw about housing for persons with disabilities. While it is in short supply, for those able to access it, it results in a major improvement in their quality of life.

At the state level, HUD's *Picture of Subsidized Households* data report that 32% of non-elderly households in public housing in Delaware and 22% with a Housing Choice voucher are either headed or coheaded by a person with a disability.[31] Across all HUD programs covered by this data source (See table), 28% of households under age 62 are headed or coheaded by a person with a disability, and 22% of households 62 or over.

Table 14: Percent of Subsidized Households with a Disability, United States and Delaware, 2008

	Delaware			United States	
	Total number of units	**% of Households <62 where either head of household or spouse/ cohead has a disability**	**% of households >62 where either head of household or spouse / cohead has a disability**	**% of Households <62 where either head of household or spouse/ cohead has a disability**	**% of households >62 where either head of household or spouse / cohead has a disability**
Public housing	2,676	32	48	30	42
Housing Choice Vouchers	4,735	22	56	32	59
Project-based Section 8 (incl. 202)	4,428	32	12	38	14
Other HUD multifamily programs	1,148	66	13	31	10
Section 236	78	16	3	22	15
All HUD programs	13,065	28	22	32	32

Source: HUD Picture of Subsidized Households Data, 2008
Note: Number of units as reported by this data source. For HUD-subsidized sites, this only includes subsidized units.

Kent and Sussex Counties have a substantial inventory of rental housing subsidized by the U.S. Department of Agriculture's Rural Development programs. These programs provide income restrictions as well as rental subsidies in some sites and units. Detailed information about occupancy by non-elderly households with disabilities is not available, but Rural Development's occupancy data for Delaware show clearly that households receiving assistance have extremely low incomes (average adjusted annual income of only $11,117 for all households) and are likely to be elderly (53%).

Table 15: USDA Section 515 and Section 514 Housing Occupancy Statistics, United States and Delaware, 2010

	United States	Delaware	
		Number	Percent
Total households	413,932	1,643	n/a
Average adjusted income	$11,364	$11,117	n/a
Households receiving Rental Assistance (RA)	267,665	1,251	76.1%
Average adjusted income for households receiving RA	9,388	10,014	n/a
Elderly households, total	59.0%	868	52.8%
Elderly households with disabilities	23.1%	455	27.7%
Very low income (<50% of county AMI)	93.6%	1554	94.6%
Source: USDA Rural Development Multi-Family Housing Occupancy Report, April 2010			

Local data from Delaware's public housing authorities (the Delaware State Housing Authority, Wilmington Housing Authority, Dover Housing Authority, Newark Housing Authority, and New Castle County) also reflect that a substantial percentage of households in public housing or with Housing Choice Vouchers have disabilities and/or are elderly. The following data are summarized from the 2011 *Analysis of Impediments to Fair Housing Choice* and were collected in September, 2010. As of this data, close to 80% of public housing residents and Housing Choice Voucher holders had extremely low incomes. 33% of households in public housing and 39% of voucher holders had a member with a disability.

Table 16: Public Housing Residents by Income and Household Type (DSHA, WHA and NHA) September 2010

	Public Housing Residents (DSHA, WHA, NHA)		Housing Choice Voucher Holders (DSHA, WHA, NAA, NCC)	
	Number	Percent	Number	Percent
Total Households	1,784	100.0%	4,341	100.0%
Households by Income				
Residents <30%	1,400	78.5%	3,423	78.9%
Residents 30 - 50%	293	16.4%	827	19.1%
Residents 50 - 80%	84	4.7%	89	2.1%
Households by Type*				
Families with children	932	52.2%	2,664	61.4%
Individuals/families with disabilities	590	33.1%	1,680	38.7%
Elderly (one or two persons)	380	21.3%	657	15.1%
Note: Dover Housing Authority data are not included here as resident household income and disability information was not available. *Percentages may not equal 100% due to rounding and overlap among household types. **Some families with disabilities also have children, which is included in the families with children count above.				
Source: Analysis of Impediments to Fair Housing Choice, July 2011. Data collected September 2010.				

HOMELESSNESS AMONG PERSONS WITH DISABILITIES

With higher rates of poverty and material hardship, it is not surprising that people with disabilities would be heavily represented among the homeless. Both national and local data show that a substantial percentage of people experiencing homelessness have a disability.

HUD's *2010 Annual Homeless Assessment Report to Congress* identified 649,917 individuals counted as homeless on various single points in time in January, 2010. This count excludes persons in permanent supportive housing who would otherwise be homeless: an additional 294,748 people. Of those 649,917, 17% (109,812) were chronically homeless. 26.2% of homeless adults reported having serious mental illness and 34.7% a substance abuse issue. 3.9% of adults reported living with HIV or AIDS.[32]

HMIS data for 1.59 million persons accessing homeless services showed that 36.8% of homeless adults had a disability. The HMIS definition of disability does include substance abuse, while some other measures of prevalence, such as the American Community Survey, do not.

Table 17: Previous Living Situation of Individuals using Homeless Residential Services, United States and Delaware, 2010

	United States	Delaware
Already homeless	**42.5**	**34.9**
Place not meant for human habitation	*16.5*	*9.3*
Emergency shelter or transitional housing	*26.0*	*25.6*
Some type of housing	**36.4**	**51.3**
Rented or owned housing unit	*9.3*	*18.0*
Staying with family	*14.8*	*20.5*
Staying with friends	*12.3*	*12.8*
Institutional settings	**13.2**	**8.2**
Psychiatric facility, substance abuse center, or hospital	*7.6*	*4.9*
Jail, prison, or juvenile detention	*5.3*	*2.9*
Foster care home	*0.3*	*0.4*
Other situations (hotel, motel, other)	**8.0**	**5.6**

Note: This table shows data for unaccompanied adults, unaccompanied youth, and multiple-adult households without children.
Source: HUD, 2010 Annual Homeless Assessment Report to Congress and Homeless Planning Council of Delaware

In Delaware, of 2,428 adults receiving services from agencies participating in the Homeless Management Information System (HMIS) in 2010, 257 (10%) listed either Addiction or a Disability as the reason for their homelessness, and 271 listed their employment status at program entry as disabled.[33] 904 adults (37.2%) were identified as having a disability of long duration. Prior to program entry, 13 individuals listed foster care home or foster care group home as their previous residence, 11 a psychiatric hospital or other psychiatric facility, 38 a substance abuse treatment facility or detox center, and 151 transitional housing.

The 2011 Point in Time study identified 1,405 people homeless on a single night in January, 2011. From this survey, it is estimated that 6,584 people in Delaware are homeless over the course of a year. The Point in Time study also identifies chronically homeless individuals. 119 persons, or 9.5% or the total individuals surveyed, were chronically

homeless, and 29% of individuals who were chronically homeless also reported a mental illness. Overall, 25% of the surveyed individuals reported severe mental illness, 20% chronic substance abuse, 10% a physical disability, and 2% a developmental disability.

Table 18: Persons Homeless by County, Delaware, January 2011 Point-in-Time

	Homeless Persons	Percent
Kent	204	14.5
New Castle	1028	73.2
Sussex	100	7.1
Unknown	73	5.2
Total	**1,405**	**100.0**
Source: Homeless Planning Council of Delaware, 2011 Point in Time Study		

DELAWARE DATA REVIEW BY POPULATION

Unfortunately, national level sources of information on housing needs of persons with disabilities are scarce, and needs are difficult to quantify. For this report, extensive local and state data on the population of persons with disabilities and, wherever possible, income, housing and other needs were sought and collected. At the state and local level, data are largely limited to registries and lists of consumers maintained by service providers such as state agencies and nonprofit organizations, and these do not always allow us to clearly measure housing needs. However, they are an excellent window into the population, with a variety of population-specific data fields and, in several cases, information on income, living arrangements, and service needs.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Intellectual and developmental disabilities include a wide range of chronic conditions that can include cognitive and/or physical limitations. Examples include Down Syndrome, cerebral palsy, Fragile X Syndrome, Autism Spectrum Disorders (ASD), and several degenerative disorders. People with intellectual or developmental disabilities (ID/DD) may face challenges in self-care, communication, learning, mobility, and may require assistance with activities of daily living.

Considering the wide range of conditions included, functional limitations and levels of assistance needed, it is especially challenging to identify the size of the population with ID/DD and subsequently, housing needs of this population. In 2010, the Social Security Administration (SSA) reported 4,146 beneficiaries in Delaware receiving Social Security Disability Insurance (SSDI) in the diagnostic categories of Autistic Disorders (436), Developmental Disorders (476), Intellectual Disability (2,608), and Organic Mental Disorders (626).[34] A December 2009 DDDS report lists 3,167 individuals on the DDDS total census, 842 in Residential Services, 71 at the Stockley Center and 2,073 served via Family Support Services. On average, 28 new applicants apply for DDDS services every month.

As of September 2011, the Division of Developmental Disabilities Services (DDDS) reported serving 1,923 individuals with ID/DD who were in a stable housing situation with parents or other caregivers, including 303 under the age of 18. Key points from these data include:

- 1,923 individuals receiving services in the community (stably housed with parents or friends);
- 303 under the age of 18;
- 1,623 over 18 and considered in need of affordable housing in order to live independently of their caregivers if they chose;
- Of the 1,623, 96% have income below 30% of the state median income (extremely low income), the other 4% are still below 50% of the state median income (very low income);
- Of the 1,623, only 2% (32) are over 65, suggesting most older individuals with ID/DD may be in institutional settings;
- All are estimated to need supportive services to live in the community;
- 167 (10.3%) would need wheelchair accessible units; and
- 6.0% would need sensory adaptations.

While we have information on the number of people receiving services, many people go uncounted – they may live at home with their families and receive no state services. In addition, DDDS provides services to those with an IQ of 70 or below, although other standards for ID/DD identify an IQ of 85 or below, leaving a potentially large population without supports. The long-lasting nature of intellectual and developmental disabilities present additional challenges. As individuals age, so do their parents, who are frequently primary caregivers. These individuals are at especially high risk for homelessness and/or abuse should anything happen to their caregivers. Many people who are currently stably housed with their families may need other housing and supportive services as their families age. DDDS registry reports run in December 2009 show 167 individuals aged 50-60 years living with their families, and 75 individuals aged 61 years or older living with their families. DDDS provides emergency placements in these situations, however, the need for these emergency placements and for long-term solutions for older people with ID/DD is likely to grow.

Table 19: DDDS Clients Aged 50 and Over, December 2009

	Aged 50-60	Aged 61 or over	Total aged 50 or over
High Risk	10	6	16
Intermediate Risk	9	10	19
Low Risk	148	59	207
Total	**167**	**75**	**242**
Source: DDDS Registry Reports (12/15/09 Run Date)			

Nationally, it is the ID/DD housing and care system where the transition to community based care has been most widely implemented and effective to date. Still, the national United Cerebral Palsy reports that there remain 162 large state institutions, housing 32,909 Americans. However, 6,189 fewer people are living in those institutions now than in 2005. Americans with intellectual and developmental disabilities are some of the most vulnerable Medicaid recipients and may have multi-faceted needs. These consumers make up just over 1% of all Medicaid recipients, but utilize 10% of Medicaid spending. Delaware is one of the top ten states for Medicaid spending for persons with ID/DD according to United Cerebral Palsy's *The Case for Inclusion* report.[35] The 2009 data in this report include:

- 87% of Delaware Medicaid recipients with ID/DD are receiving Home and Community based Services (HCBS)

- 76% of ID/DD Medicaid expenditures are on HCBS
- 83% of ID/DD expenditures on non-ICF/MR (As defined by Medicaid, intermediate care facilities for people with ID/DD – institutions with 4 or more people)
- 2,077 receiving services in their home or the family's home, 157 in 1-3 resident family foster care, and 847 in congregate care settings, mostly group homes.

Delaware also ranks 4th among the states in supporting meaningful work experiences, with 49% of individuals in supportive or competitive employment, compared to the national average of 21%.

People with developmental disabilities make up the majority of those with HCBS waivers and expenditures for this population tend to be higher than for other populations using HCBS services due to the overall higher level of care typically needed. As of federal FY 2009, HCBS waivers for people with developmental disabilities made up 80% of Delaware's total HCBS waiver expenditures. [36]

Table 20: HCBS Waiver Expenditures, Delaware, FY 2005 - 2009

	FY 2005	FY 2009	Change
HCBS Waiver Expenditures – ID/DD	$53,603,630	$89,329,061	66.6%
Total HCBS Waiver Expenditures	$70,734,741	$111,574,094	57.7%
ID/DD Waiver Expenditures as % of Total	75.8%	80.1%	
The federal fiscal year is used in this table. *Source: Medicaid HCBS Waiver Expenditures: FY 2004 through FY 2009. Thomson Reuters, 2010*			

The Division of Long-term Care Residents Protection reports that there are 147 licensed neighborhood homes for people with ID/DD in Delaware, with a total of 600 beds. These homes are defined as five or fewer residents. The vast majority of these beds, 417 (70%), are in New Castle County. The Arc of Delaware has 84 group homes throughout the state that can house 332 individuals with ID/DD: 27 of these have subsidies from the HUD Section 811 program to reduce operating costs. In addition, United Cerebral Palsy has three houses with a capacity of 16. In January 2012, DDDS reported supporting 554 beds in neighborhood homes for people with ID/DD.

Table 21: Licensed Group Homes and Beds for People with Developmental Disabilities, Delaware, 2011

	New Castle		Kent		Sussex		Total	
	Homes	Beds	Homes	Beds	Homes	Beds	Homes	Beds
Developmental Disabilities	100	417	19	76	28	107	147	600
Source: DHSS, Division of Long-term Care Residents Protection								

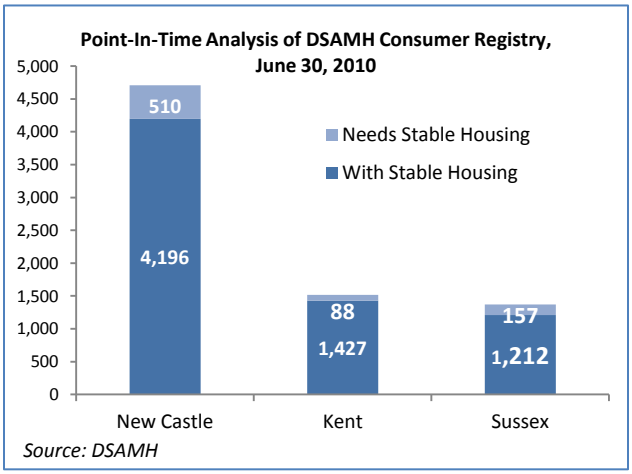
Nationally, there have been some programs supporting homeownership for people with ID/DD, to varying levels of success. The ARC of Delaware supports 14 individuals who are homeowners, but report challenges with maintenance, housekeeping, and the overall responsibility of homeownership. Homeownership for this population is very much a niche product dependent upon the unique situation of each individual and their support systems. Whether in homeownership or a rental unit, supportive services are essential for people living in the community, particularly financial management and credit review.

As with other populations, transportation and integration into community activities – work or day programs, or other activities, and adequate transportation to participate - are vital to avoid isolation and ensure a high quality of life in the community.

SUBSTANCE ABUSE AND MENTAL HEALTH

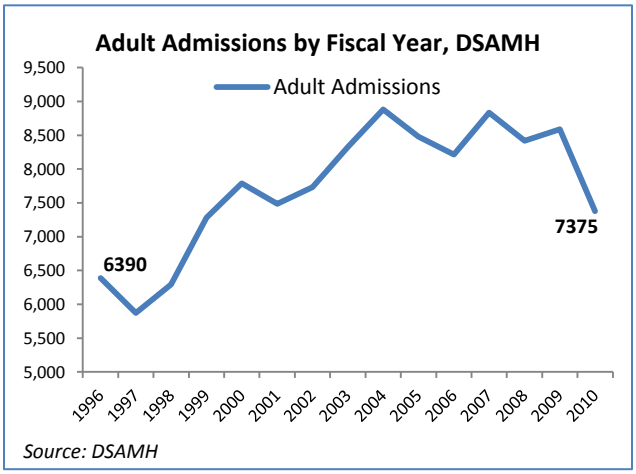
The American Community Survey data do not offer any specificity beyond the broad category "cognitive difficulty", which is not specific to mental health disorders. Many other national health or disability surveys similarly group intellectual or developmental disabilities with mental health disorders, so there is also a lack of national estimates to apply. Detailed information on the prevalence and extent of substance abuse and mental health issues at the local level is largely limited to local sources. In 2010, the Social Security Administration reported 1,292 SSDI recipients in Delaware in the diagnostic category "Mood disorders" and 832 in the category "Schizophrenic and other psychotic disorders".[37]

In FY 2010, DHSS' Division for Substance Abuse and Mental Health (DSAMH) served 13,995 clients (unduplicated within categories, clients may have used more than one service) with inpatient, community mental health, and substance abuse treatment.[38] Total DSAMH substance abuse adult admissions have climbed steadily over the 2000s, from 6,390 in FY 2003 to 8,590 in FY 2009, although dropping again to 7,375 in FY 2010.[39] DSAMH's substance abuse treatment caseload has also increased progressively: 3,950 as of June 30, 2010, up from 2,690 at the end of FY 2003.[40] As of June 30, 2010, the caseload in Delaware's community mental health system was 4,896.[41]



A point-in-time analysis of DSAMH's consumer registry on June 30, 2010 shows an active caseload of 8,402 statewide, 56% in New Castle County, 18% in Kent, 16% in Sussex, and 10% with county unknown. Some key findings include:

- By age, 94% (7,896) were between 18 and 64, 1% (64) under 18 and 5% (442) over 65.
- 276 (3% of total) were identified as veterans.
- 34% were employed full or part-time, 21% unemployed and seeking work, 19% unemployed and not seeking employment, and 15% (1,222) identified as disabled or unable to work.
- For primary source of income, 2,511 (30%) listed Social Security (238), SSI (855), SSDI (1,211), VA-Disability (26), General Assistance (155) or AFDC/TANF (26) as their primary source of income.



- 25% (2,066) of the total caseload in this point-in-time analysis relied on SSI or SSDI as their primary source of income; as noted earlier, both of these sources are not likely to provide enough to afford even the most basic, minimal housing anywhere in Delaware.
- While annual income information was only available for about 75% of clients, 54% of the total clients (4,557) had extremely low incomes – below 30% of the Area Median Income for their county of residence. An additional 9% (767) had very low income: below 50% of AMI.

The DSAMH point-in-time analysis also identified at least 882 individuals who could be considered in need of stable housing: those with a residential arrangement listed as a nursing home, corrections facility, other institution, other, homeless, or unknown. 251, or 3% of the total point-in-time caseload, were identified as homeless. 362 of the 882 had residential arrangement listed as unknown, it is likely that many of these were Front Door clients about whom little information was collected. Removing these 362 with unknown residential arrangement leaves 520 people in need of stable housing: residential arrangement of an institution, jail, or none/homeless. In addition, it is impossible to know how many individuals with more stable residential arrangements are not actually in stable housing: a private residence may be doubled up with a family member or living with a friend, adult foster care, or a boarding house.

Table 22: DSAMH Consumer Registry by Residential Arrangement, June 30, 2010 Point-in-Time Analysis

	Number	Percent
Private residence – unsupervised	6,557	78.0%
Private residence – supervised	376	4.5%
Adult foster care	65	0.8%
Boarding house	26	0.3%
Group setting/unsupervised	58	0.7%
Group setting/supervised	438	5.2%
Nursing home/ICF/SNF	3	0.0%
Corrections facility/jail	198	2.4%
Other Institution	15	0.2%
Other	53	0.6%
None/homeless	251	3.0%
Unknown	362	4.3%
Source: Division of Substance Abuse and Mental Health		

Of those identified as needing stable housing, 46% had mental health needs, 35% substance abuse, and 13% co-occurring mental health and substance abuse. The remaining 6% did not have information or were gambling addiction clients. This is fairly consistent with the overall caseload, 41% mental health, 44% substance abuse, 12% co-occurring mental health and substance abuse, and 3-4% either gambling or unknown. Clients with extensive unknown information may be walk-in community treatment center clients where the period of contact is brief and thus extensive case information is not collected.

While several fields of DSAMH's intake and annual assessment forms are housing-related, unfortunately these are often apparently not filled in. Still, the cases in which there is information offer interesting insight. 8% of the total caseload for which the question was answered (5,279) indicated that they had been homeless within the past 30 days and 6% within the past 12 months (this separate question had fewer responses, 1,897). Among those in the "Needs Stable Housing" pool, on these same questions, 41% of those with information (439 total) indicated that

they had been homeless within 30 days and 12% (91 total) within the past 12 months. Of the total caseload with responses to the question "How many places has the client lived in the past 90 days?" (1,877), 9.5% had 2 or more residential arrangements in the past 90 days. Of those for whom annual income information was available (284), 74% of those needing stable housing had income below 30% of the county Area Median Income.

Table 23: Individuals with Substance Abuse or Mental Health Conditions Identified as in Need of Stable Housing, DSAMH Point-in-Time Analysis, June 30, 2010

		Number
Needs stable housing		882
County	Kent	88
	New Castle	510
	Sussex	157
	Unknown	127
Income	<30% of AMI	209
	30 – 50% of AMI	8
	>50% of AMI	67
	Unknown	598
Modality	Mental health	406
	Substance abuse	306
	Co-occurring	116
Age	<18	47
	18 – 64	789
	65 or over	46
Homeless history	Homeless w/in 30 days	180
Veteran status	Veterans	30
Primary source of income	Social Security	11
	SSI/SSDI	94
	General Assistance	26
	Family/friends	39
	None	272
Note: Subheadings may not add up to total due to lack of data for some clients.		
Source: Division of Substance Abuse and Mental Health		

While the use of these data is hindered by the large number of "unknown" fields, the estimate of approximately 500 people with mental illness or substance abuse disorders in immediate need of affordable housing is our best possible estimate from a direct source at the moment covering the entire population. Working to narrow this to people with severe and persistent mental illness, we can look at discharge data from the Delaware Psychiatric Center (DPC) and information on chronic homelessness. In calendar year 2010, 344 people were discharged from DPC, an estimated 7% to homeless status (shelter or transitional housing, half of those discharged to transitional housing were estimated to be transitioning to homeless status). In FY 2010, 648 unduplicated clients were served at DPC: assuming 7% of clients in a given year would be homeless without housing support, 45 people would have needed housing assistance in FY 2010. Combining these with rough estimates based on the 2011 Point-in-Time Study, approximately 200 people with severe mental illness may need housing assistance over the course of a year, and there is likely duplication across these estimates and across years. As of June, 2011, two of the larger nonprofit service providers also had total waiting lists of 184 individuals (Connections: 112, NAMI-DE: 72).

Table 24: Estimates of Housing Need for Persons with Substance Abuse and Mental Illness, Delaware

Source/Population	Calculation	Estimate
DPC discharges	648 in FY 2010 Estimated 7% to homeless status	45
Chronically homeless with mental illness (HPC Point-in-Time Study)	6,584 homeless over course of a year 25% with mental illness (1,646) 9.5% chronically homeless (119, annual estimate 625) 29% of chronically homeless self-report mental illness (35, annual estimate 181)	181 chronically homeless with mental illness
Homeless with mental illness (HPC Point-in-Time Study)	6,584 homeless over course of a year 25% with mental illness (1,646)	1,646 homeless with mental illness over the course of a year
DSAMH point-in-time analysis	Consumers with residential arrangement of none/homeless, incarcerated, institution, or unknown (882 total) as of 6/30/2010. 362 "unknown" are likely to be short-term clients about whom little information is collected. This leaves 520 in need of stable housing as of the point-in-time, 251 immediately homeless.	520 in need of housing 251 homeless

As part of its settlement agreement with the Department of Justice, DSAMH has assembled data from the Homeless Management Information System (HMIS, now Community Management Information System), Delaware Criminal Justice Information System (DELJIS), and the Division of Medicaid and Medical Assistance to identify individuals with severe and persistent mental illness (SPMI) who are in the target population identified in the agreement. Early efforts in this area have resulted in the identification of approximately 5,000 Delawareans who meet the agreement's priority criteria:

- People who are currently at Delaware Psychiatric Center, including those on forensic status for whom the relevant court approves community placement;
- People who have been discharged from the Delaware Psychiatric Center within the last two years and who meet any of the criteria below:
- People who are, or have been, admitted to private institutions for mental disease (IMDs) in the last two years;
- People with SPMI who have had an emergency room visit in the last year, due to mental illness or substance abuse;
- People with SPMI who have been arrested, incarcerated, or had other encounters with the criminal justice system in the last year due to conduct related to their serious mental illness; or
- People with SPMI who have been homeless for one full year or have had four or more episodes of homelessness in the last three years.

Nineteen group homes with 156 beds for persons with mental illness are listed as licensed by the Division of Long-term Care Facilities Resident Protection. DSAMH reports a capacity of 161 beds in group homes and 171 in supervised apartments with 24-hour supervision. The inventory assembled for this report shows 170 units in group homes, 677 units of permanent supportive housing in a variety of forms (vouchers, scattered sites, supervised or staffed apartments, shared apartments), and 232 beds in residential treatment programs.

Table 25: Inventory of Assisted Beds for People with Substance Abuse/Mental Illness, Delaware, 2011

	Kent	New Castle	Sussex	Blank or Statewide	Total
Group home	62	75	33	0	170
Permanent supportive housing	29	306	51	60	446
Vouchers, permanent supportive housing	30	58	20	123	231
Residential treatment program	10	151	46	25	232
Total	**131**	**590**	**150**	**208**	**1079**

While not traditional permanent supportive housing, the Oxford House movement has also grown in Delaware. There are 35 of these peer-supported, self-run houses for people in recovery in Delaware. As these homes do not receive any supportive services and are self-run, they are not reflected in the above inventory.

As part of a 2011 settlement with the U.S. Department of Justice regarding providing services in the most integrated settings appropriate to consumers' needs, DSAMH must develop the capacity to serve 650 individuals with community placements by 2016. 150 of these placements were grandfathered in through units already available; 500 must be added. In addition, to prevent unnecessary institutionalization by the provision of community-based services, the settlement calls for the development of expanded peer support services; a statewide crisis system composed of mobile crisis teams, crisis walk-in centers, stabilization services, a 24-hour hotline and crisis apartments as an alternative to institutionalization; expanded supported housing and supported employment programs.

Delaware's mental health and substance abuse care systems have a well-developed network of group home and supervised apartments. As in the area of intellectual and developmental disabilities, these congregate settings have been advanced as priority housing options and alternatives to institutional care. However, these settings may not always be the least restrictive setting, and there is increased attention on developing tenant-based rental assistance programs to allow individuals to live independently in the community with supportive services. DSAMH's Eligibility and Enrollment Unit (EEU) works closely with providers to move clients to a lower level of care when it is appropriate; however, a lack of housing assistance may be a serious barrier to such transitions if tenant-based rental assistance or other subsidized units are not available. In the focus group held for consumers of substance abuse and mental health services, the lack of housing options and narrow focus on congregate situations was raised as a concern. While many appreciated the supports available in group situations, these settings can also raise numerous challenges, and consumers felt there was little opportunity to live independently and not enough of a "step" between congregate situations and full independence. At the same time, congregate or clustered settings offer critical peer support, and can help serve as a transition, especially when many people also report feelings of isolation and fear about being in the community.

HIV/AIDS

Delaware's AIDS incidence rate (14.8 per 100,000 residents) is among the highest in the nation, ranking 8th among the states.[42] The majority of HIV/AIDS cases are diagnosed among adults aged 30-39. Adults age 50 and older account for 12% of HIV/AIDS cases in Delaware and 16% of cases nationwide, but this percentage will increase as the population ages and life expectancy with HIV/AIDS has increased substantially in recent years. An additional 29% of persons living with HIV/AIDS are 40-49 years old.

Geographically, persons living with HIV/AIDS are distributed statewide fairly evenly with county-level population estimates. However, in New Castle County, persons with HIV/AIDS are heavily concentrated in the City of Wilmington, which comprises 14% of the county's population but is home to 43% of persons living with HIV/AIDS in the county. In 2009, 29% of all newly diagnosed HIV cases in Delaware occurred among minorities residing in the City of Wilmington.

Table 26: Individuals Living with HIV/AIDS by County of Residence, Delaware, 2011

	Living with HIV/AIDS	
	Number	**Percent**
Kent County	463	12.7
NCC	2,468	67.8
Wilmington Metro Area	*1,542*	*42.4*
Sussex County	689	18.9
Unknown	18	0.5
Total	3,638	100
Source: Delaware Department of Public Health, Delaware Monthly HIV/AIDS Report, October 2011		

Individuals living with HIV/AIDS are overrepresented among the homeless. Delaware's 2011 Point-in-Time study reported that 4% of surveyed homeless adults identified themselves as living with HIV/AIDS. This is similar to the national figure: the HUD *2010 Annual Homelessness Assessment Report to Congress* reported 3.9% of individuals counted in point-in-time studies nationally reported living with HIV/AIDS. In a 2011 consumer survey, 62% of participants in the Delaware HIV Consortium's Tenant-based Rental Assistance (TBRA) program reported that they were homeless prior to entering the program, and 79% reported that they would be homeless or at risk of homelessness without the rental assistance.[43] As of August 1, 2011, the Delaware HIV Consortium reported that there were 206 persons living with HIV/AIDS on the waiting list for the TBRA program. Typically there are up to 250 people on the list, and the wait time for assistance is approximately 4 years. In FY 2010, approximately 700 individuals received the AIDS Home and Community based Services (HCBS) Medicaid waiver in Delaware, up from 648 in FY 2006.[44]

In a focus group of people living with HIV/AIDS, members reported persistent housing discrimination. People living with HIV/AIDS have another layer of services and medical needs to coordinate and negotiate; it is easy for medical needs to be neglected in the face of homelessness and precarious housing. Many members of the group reported that staying current with the medical needs took second place when they were facing homelessness or losing their housing, especially if they were also responsible for other family members. The HIV Consortium's 2011 consumer survey also reflects this: 97% of respondents reported that tenant-based rental assistance helps them better

manage their health, and 98% reported having had recent contact with a case manager and utilizing Ryan White funded services.

In 2006, an extensive consumer survey was conducted by the Delaware HIV Consortium's Planning Council. 280 people living with HIV/AIDS were interviewed on their service needs and access. 24% of those interviewed reported service access issues related to affordable housing, with service access issues defined as either "used but still has unmet need" or "needed but couldn't get".[45] 30% reported that they lived with family when they preferred not to, in facilities, or on the streets – all situations in which an individual needs housing. 18% reported being homeless at least one night in the past 12 months.

In addition to specific housing needs, the consumer survey also reflected widespread needs in other basic areas, like dental care (35%), medications (20%), transportation (20%) and food (19%). 42% of those interviewed were unemployed and unable to work; 26% were able to work but still unemployed. Most tellingly, 64% had income below the federal poverty level. The top 5 supportive services identified by consumers as needed priorities were:

- HIV case management
- Help paying for household bills
- Transportation to medical appointments
- Help finding affordable housing; and
- Food programs.

Delaware's stock of permanent supportive housing includes 34 units for people living with HIV/AIDS, all in New Castle County. The Delaware HIV Consortium's statewide tenant-based rental assistance (TBRA) program typically serves about 125 households at a time, approximately 150 over the course of a year. About 70% of households live in New Castle County, the remaining 30% split between Kent and Sussex Counties.

SENSORY DISABILITIES

The 2008-2010 American Community Survey estimated 29,720 individuals in Delaware had a hearing difficulty and 20,172 had a vision difficulty. Both were much more common among persons 65 and older: 13.8% of the population 65 and over reported hearing difficulty and 6.9% reported vision difficulty, compared to 2.1% and 1.9%, respectively, for persons 18-64 years old. The ACS estimates for Delaware and the United States are similar.

Table 27: Percent of Population With Sensory Disabilities, U.S. and Delaware, 2008-2010

	Under 18	18 – 64	65 and over	Total
Hearing Difficulty				
United States	0.6%	2.1%	15.4%	3.4%
Delaware	0.8%	2.1%	13.8%	3.4%
Delaware – Number	1,558	11,268	16,894	29,720
Vision Difficulty				
United States	0.7%	1.8%	7.2%	2.2%
Delaware	0.7%	1.9%	6.9%	2.3%
Delaware - Number	1,370	10,398	8,404	20,172
Source: U.S. Census Bureau, 2008-2010 American Community Survey				

The Social Security Administration reported that a total of 589 disabled beneficiaries in Delaware received Social Security disability benefits because of blindness (376) or deafness (213) in 2010.[46] In March 2011, the DHSS Division for the Visually Impaired reported 3,028 individuals with varying levels of visual impairment or blindness on its registry, 70% of these legally blind, 26% severely visually impaired and 4% totally blind. By age group, 33% were 0 – 54, 28% 55 – 79 and 40% 80 or older. 13% of those for whom residence information was available (237 of 1,873) lived in a nursing home or assisted living facility. Of those for whom living arrangement information was available (1,917), 36% reported living alone.

Table 28: Consumers on DHSS Division for the Visually Impaired (DVI) Registry by Severity and County, March 2011

	Kent	New Castle	Sussex	Total	Percent
Totally blind	18	84	30	132	4.4%
Legally blind	380	1161	562	2103	69.5%
Severely visually impaired	170	411	212	793	26.2%
Total	568	1656	804	3028	100.0%
Percent	18.8%	54.7%	26.6%	100.0%	
Source: Division for the Visually Impaired (DVI)					

Table 29: Consumers on DHSS Division for the Visually Impaired Registry by Age, March 2011

	0-18	19-54	55-79	80 or over	Total	Percent
Totally blind	7	42	66	17	132	4.4%
Legally blind	159	452	608	884	2,103	69.5%
Severely visually impaired	163	166	169	295	793	26.2%
Total	329	660	843	1,196	3,028	100.0%
Percent	10.9%	21.8%	27.8%	39.5%	100.0%	
Source: DHSS Division for the Visually Impaired						

PHYSICAL DISABILITIES

Nationally, 5.2% of the population 18-64 years of age are estimated to have ambulatory difficulty in the 2008-2010 American Community Survey. This increases dramatically to 24.1% of adults 65 and over. The figures for Delaware are similar, 5.4% (29,791 people) of those 18-64 reporting ambulatory difficulty and 21.6% of adults 65 and over (26,368 people). Among all individuals over 18, 8.4% report ambulatory difficulty. This measure is, however, quite broad and includes many people who may need only limited accessibility features in their housing. Similarly, it may exclude many who have other physical difficulties. Even national sources on more specific functional limitations are scarce.

The National Health Interview Survey, conducted by the Centers for Disease Control and Prevention, includes several questions on difficulties in physical functioning: overall, 15% of adults had great difficulty with at least one of nine physical activities performed without help and without the use of special equipment (responding “very difficult to do” or “can’t do at all”).[47] The percentage rises rapidly among adults over 65. Among all adults over 18, the NHIS reports a prevalence of 15.2% of the population having any physical difficulty, compared to the ACS

reporting nationally 8.4% of those over 18 having ambulatory difficulty. The ACS question to determine ambulatory difficulty is whether the person has serious difficulty walking or climbing stairs.

Table 30: Percentages of Difficulties in Physical Functioning among Persons Aged 18 years and over by Age, United States, 2009

	All	18-44	45-64	65-74	75 or over
Physical activities that are very difficult or cannot be done at all					
Any physical difficulty	15.2%	6.0%	18.8%	27.9%	48.3%
Walk quarter of a mile	6.8%	2.0%	7.8%	13.1%	28.0%
Climb up 10 steps without resting	4.9%	1.3%	5.7%	9.1%	20.9%
Stand for 2 hours	9.1%	3.0%	11.3%	16.4%	32.6%
Sit for 2 hours	3.3%	1.9%	5.2%	4.2%	4.9%
Stoop, bend or kneel	8.8%	3.1%	11.4%	16.8%	27.8%
Reach over head	2.3%	0.7%	3.1%	3.8%	8.2%
Grasp or handle small objects	1.7%	0.6%	2.1%	3.5%	6.1%
Lift or carry 10 pounds	4.1%	1.3%	4.9%	6.9%	16.4%
Push or pull large objects	6.1%	2.2%	7.6%	10.6%	21.0%
Source: National Health Interview Survey, 2009					

Those who were poor (below poverty threshold) or near poor (100 - 200% of poverty threshold) as defined by the NHIS were far more likely to report physical difficulty with any of the nine activities, with 27.8% of poor adults and 22.5% of near poor adults reporting physical difficulty, compared to only 12.0% of those who were not poor (over 200% of poverty threshold).

To get at least some estimate of the number of people in Delaware with more severe physical disabilities that may require more accessibility features in their housing, we reviewed rates of wheelchair use from the 2005 Survey on Income and Program Participation (SIPP), conducted by the U.S. Census Bureau. Rate of use per 1,000 was applied to the Delaware population by age. The SIPP method estimates 10,472 individuals over 15 who use a wheelchair or similar device in Delaware, about 32,000 who use a cane, crutches or walker, and almost 69,000 who have difficulty using stairs.

Table 31: Estimate of Population using Mobility Devices, Delaware, 2010

	All over 15		65 years and Over	
	Rate	Estimate	Rate	Estimate
Total population	n/a	728,714	n/a	129,277
Difficulty using stairs	94.48	68,849	301.93	39,032
Wheelchair or similar device	14.37	10,472	52.04	6,728
Cane, crutches or walker	44.40	32,355	178.60	23,089
Rate per 1,000 from SIPP (2002) applied to 2010 Delaware population				
Source: Population: U.S. Census Bureau, 2010 Census; Rate: U.S. Census Bureau: Survey on Income and Program Participation (SIPP), 2005				

At every level of need, physical accessibility both in the home and public spaces is a major challenge for persons with physical disabilities, and is sorely lacking in both the general and assisted housing stock, even for those who may need only some accessibility features (such as a no-step entry). Focus groups and interviews all made this point repeatedly: even in the other focus groups not specific to physical disability, the need for basic accessibility across all types of housing was mentioned.

Using the 2005-2007 American Community Survey, HUD's CHAS data provides some estimates of persons with a mobility or self-care disability with housing problems at the state level by income.[48] In this data, a housing problem is defined as cost-burden, inadequate plumbing or kitchen facilities, or overcrowding. The vast majority of households with a housing problem are cost-burdened. By these estimates, there were 4,550 renter and 6,155 owner households with income below 50% of median and at least one member with a mobility or self-care disability, with close to 6,500 total having a housing problem. As this is a sample survey looking at a small subpopulation, these numbers should be approached with caution, but the trend is clear: lower income households, both homeowners and renters, who have at least one member with a mobility or self-care disability are very likely to have a housing problem. 72% of renter households and 75% of owner households with extremely low incomes and a mobility or self-care disability had a housing problem.

Table 32: Households with Mobility or Self-Care Disabilities with Housing Problems, Delaware, 2005-2007

	Total households	Households w/at least one member with a mobility or self-care disability	Percent of Households	Households w/at least one member with a mobility or self-care disability and a housing problem	Percent of all households with a mobility or self-care disability that have a housing problem
Renter households					
Total renter households	85,100	8,155	9.6	4,000	49.0
<30% AMI	19,470	3,125	16.1	2,260	72.3
30-50% AMI	15,140	1,425	9.4	975	68.4
50-80% AMI	18,850	1,580	8.4	490	31.0
>80% AMI	31,640	2,025	6.4	275	13.6
Owner households					
Total owner households	236,645	22,855	9.7	6,900	30.2
<30% AMI	13,625	1,935	14.2	1,445	74.7
30-50% AMI	21,090	4,220	20.0	1,780	42.2
50-80% AMI	35,685	4,785	13.4	1,765	36.9
>80% AMI	166,245	11,915	7.2	1,910	16.0
Source: HUD 2005-2007 CHAS Data					

The Division of Aging and Adults with Physical Disabilities estimates a need for housing assistance for approximately 650 people: a mix of current residents in private and state-run long-term care facilities to transition to the community referrals from Adult Protective Services and the Aging and Disability Resource Center. The majority of these are likely people with physical disabilities and/or who need assistance with ADLs or IADLs to live

independently. Most would need accessible units in addition to supportive services. More specifically, the estimate of 650 includes:

- 300 (Diversions and transitions from LTC facilities from FY 13 - 17)
- 100 (Transitions from DHSS LTC Facilities)
- 250 (Other referrals from APS, ADRC, and other sources from FY 13-17)

The lack of information about housing accessibility was also frequently mentioned in the focus groups, for both assisted and market-rate housing. While most multifamily sites have some fully accessible units, these units may often be occupied by persons who do not have a disability. People with a disability have a right to displace a non-disabled tenant to another non-accessible unit in order for them to occupy the accessible one; however, they may not be aware of this right. In addition, many units have some but not full accessibility, so thus are not subject to that requirement and the accessibility features may not be tracked or documented anywhere. In addition, a significant percentage of the rental housing in Delaware, as in the nation as a whole, is not in multifamily sites but single-family dwellings, which are even less likely to have basic accessibility features (no step entry, clear passage).

A central source of information about detailed accessibility features in rental housing, both assisted and market-rate, including current vacancy information, was often noted as a need.

YOUTH AGING OUT OF FOSTER CARE

As of December 31, 2010, there were 670 children in foster care in Delaware, down from 875 at the end of 2008 and 684 in 2009. By age group, 29% (196) were 5 years old or younger, 19% (127) 6-10 years, 25% (168) 11-15 years, and 27% (179) 16 or older. As of March 2011, DSCYF reported 211 youth aged 17 or over, with an average of 180 days left until they turn 18. Of these 211, 102 were 17.5 or older and thus aging out within the next six months from the date of report. At that time, there were also 97 youth aged 15 and 137 youth aged 16 currently in foster care, suggesting that the recent total of about 100 youth aging out every year is likely to continue for at least the next couple of years.

Youth in and aging out of foster care face immense challenges in the transition to independent living and, unfortunately, are at high risk of homelessness, substance abuse and mental health issues. Among those 18-24 years old currently participating in an Independent Living Program with the DSCYF, only 30% had graduated high school, and the unemployment rate for this group is 66 percent. 10% of individuals surveyed in the January 2011 Point-in-Time Study of homelessness in Delaware reported that they had some history with the foster care system; 11.7% of the 2,428 individuals who had contact with service providers reporting into the Homeless Information Management System (HMIS) in calendar year 2010 reported that they had ever been in the foster care system.

The inventory of housing assistance for transitioning youth has grown substantially in the past several years. West End Neighborhood House's Life Lines program has 22 beds for transitioning youth, the 801 shelter in Dover has an additional 6. The Murphey School, also in Dover, also offers extensions for youth aged 16-18 who are within one year of high school graduation. The largest source of housing assistance for this population will likely be the new State Rental Assistance Program (SRAP), which in its first year (FY 2012) anticipates serving 40-50 transitioning youth with housing vouchers.

Over a five year period, assuming:

- approximately 100 youth age out per year, 75 needing housing assistance;
- current capacity to serve approximately 75 via SRAP and Life Lines; and
- youth can remain in Independent Living programs and receive housing assistance until they are 24,

Approximately 300 units are likely needed to serve this population if the current rate of about 100 youth per year aging out continues.

PRIORITIZING HOUSING CHOICE AND COMMUNITY CARE

Four main factors call for improving access to community-based services and supports. First, people over 60 years of age will continue to grow as a percent of the overall population, which will lead to significant increases in demand for long term care and supportive services. The aging of the baby boomer generation and extensive in-migration of older households to retire in southern Delaware means that in 2010, 20.5% of the population in Delaware was over 60 years of age; by 2040, this is projected to increase to 30.5%. Older individuals, especially those over 75, are far more likely to need long-term services and supports.

Secondly, this aging population and increased demand for long-term services may herald financial crisis for public programs that are already overextended: the vast majority of long-term care services are paid for with public programs. Over decades, these systems have developed in ways that assume institutional care over supports to serve people in their homes. The median annual cost of a private room in a nursing home in Delaware is $89,060; 30 hours a week of home care may cost $32,760.[49] In 2009, Delaware ranked 50th among the states on the percent of Medicaid spending for older people and adults with physical disabilities going to Home and Community based Services (HCBS), at 13.2%.[50] Nationally, 36% of spending for these populations was directed to HCBS. Even if housing assistance is also required, serving people in their homes and communities can be considerably less expensive than facility-based care. Delaware recognizes that this dichotomy must change and the State must develop more community-based alternatives for Medicaid long-term services and supports in lieu of institutional care.

In addition, numerous surveys, both national and local, reflect people's desire to remain in their communities as long as possible. People want services to support them in their homes and to remain in their homes as long as possible. Further, many measures of quality of life are far improved when high-quality services are delivered in peoples' homes and communities rather than institutional settings.

Finally, systems not only *should* be built around community-based care and the assumption that people canlive in the community with appropriate supports, they *must* prioritize care in the community. In 1999, the U.S. Supreme Court rejected the state of Georgia's appeal to enforce institutionalization of individuals with disabilities in a 6-3 ruling in the case *Olmstead v. L.C*. While the process of deinstitutionalization was in progress in many states, this ruling brought attention to the sometimes slow pace, significant number of individuals still in institutions nationwide, and ongoing preference for institutional settings for persons with disabilities who could live in less restrictive settings. The 'integration mandate' of the Americans with Disabilities Act requires public agencies to

provide services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The Olmstead case upheld the ADA's integration mandate, and thus, like the ADA, applies to all qualified disabilities.

As background on the Olmstead decision and its implications, one type of discrimination forbidden by the Americans with Disabilities Act (ADA) is the needless segregation of people with disabilities. It requires state and local governments to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." (28 C.F.R. § 35.130(d)). Referred to as the ADA's "integration mandate", this means that publicly funded programs for people with disabilities thus must deliver services in ways that do not discriminate, such as by needlessly keeping people with disabilities away from the mainstream of their communities. People must be able to receive services in the most integrated setting possible considering their needs: the "most integrated setting" is one that "enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."

While group homes and other congregate settings may not be institutions, the day-to-day routines, rules and systems of these programs may result in segregation. Supportive housing – integrated throughout the community, with the option for people to live independently while still receiving the support they need – is usually a far more integrated setting and an option that is currently limited on the continuum of housing for people with disabilities in Delaware. While congregate and clustered settings in the community, with the benefits they offer of peer support and sense of community, should remain an option for those who prefer them, we need to similarly ensure there are independent settings available as well.

Settlement Agreement between State of Delaware and U.S. Department of Justice

While this report reviews needs and provides general recommendations for people with disabilities in Delaware, people with serious mental health conditions are at the center of a recent Settlement Agreement between the United States Department of Justice (USDOJ) and State of Delaware, signed on July 15, 2011. This Settlement Agreement is the result of an extensive investigation by the USDOJ which resulted in multiple findings and subsequent negotiations to revise Delaware's service delivery system for people with serious and persistent mental illness (SPMI).

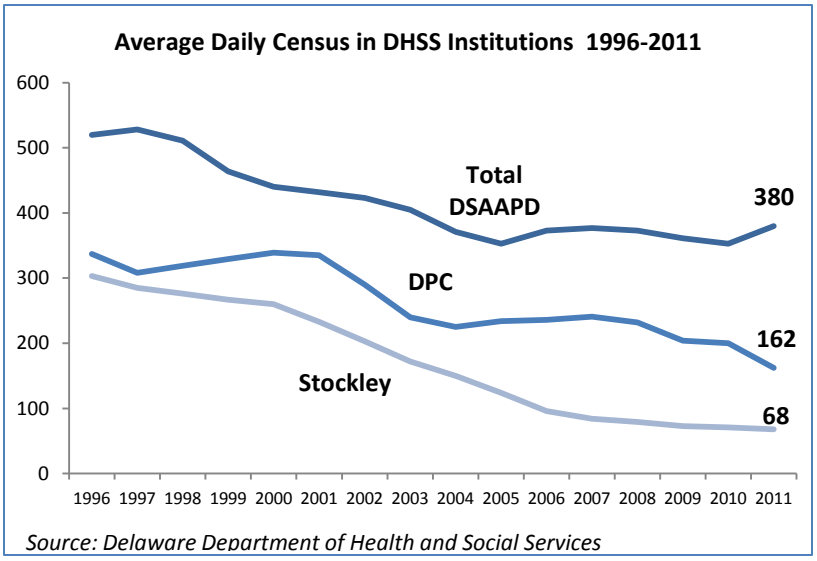
The USDOJ findings were based on the federal Americans with Disabilities Act and Olmstead legal decisions and the Agreement mandates that the State meet both of these federal standards. Specifically on the subject of housing, the State is required to identify 650 newly funded and integrated housing units over the next four years. The Agreement's Implementation Timeline (p. 13) states:

E. Supported Housing

1. By July 11, 2011, the State will provide housing vouchers or subsidies and bridge funding to 150 individuals. Pursuant to Part II.E.2.d, this housing shall be exempt from the scattered-site requirement.
2. By July 1, 2012 the State will provide housing vouchers or subsidies and bridge funding to a total of 250 individuals.
3. By July 1, 2013 the State will provide housing vouchers or subsidies and bridge funding to a total of 450 individuals.
4. By July 1, 2014 the State will provide housing vouchers or subsidies and bridge funding to a total of 550 individuals.
5. By July 1, 2015 the State will provide housing vouchers or subsidies and bridge funding to a total of 650 individuals.

PRIORITIZING COMMUNITY CARE IN DELAWARE

In recent years, DHSS and its divisions have been working steadily to reduce institutional bias and the number of beds and individuals in state-run facilities. The Delaware Psychiatric Center (DPC) and mental health and substance abuse care systems have been particularly in focus. Since FY 2003, the average daily census at the DPC has reduced from 240 to 183 in FY 2010. In July 2011, DHSS announced a five-year strategy to expand community services, housing, supported employment opportunities and a statewide crisis team, agreed upon with the U.S. Department of Justice at the conclusion of their three year investigation into conditions in the DPC. As part of this agreement, the population at the DPC must be further reduced to 125. In fall 2011, DSAMH was developing an RFP to facilitate the discharge of individuals who have been institutionalized, most for more than five years. A contracted service provider will provide full services for these consumers, everything excluding significant physical health care emergencies: housing, preventative health care, and any periodic in-patient services.



Source: Delaware Department of Health and Social Services

DHSS initiatives to prioritize community care and transition people living in institutions to the community have resulted in significant declines in the number of people in state-supported institutions. Since 1996, the average daily census for all DHSS long-term care facilities (Governor Bacon Health Center, Delaware Hospital for the Chronically Ill, and the Emily P. Bissell Hospital), excluding the Delaware Psychiatric Center and Stockley Center, fell from 520 to 380 in 2011, close to 30%. Over that same time period, the average daily census at the DPC fell from 337 to 162 (-52%) and at the Stockley Center, from 303 to 68 (-78%).

From FY 2012 – 2014, DHSS intends to further reduce the number of beds in public long-term care facilities by 114 beds spread across three facilities, with the primary reduction at the Delaware Hospital for the Chronically Ill. In total, 92 residents will be impacted, with the majority being moved between buildings as wings or buildings are closed. 18 will be transitioned into homes in the community with appropriate support.

Other initiatives linked to prioritizing community care in mental health services include the expansion of peer specialist programs and a partnership between DSAMH's Mobile Crisis service and local hospitals. In this partnership, Mobile Crisis was granted access to their Emergency Departments to evaluate consumers with psychiatric and substance abuse crises. The important first contact helps to reduce the number of involuntary commitments and create immediate links to community behavioral health services. As of fall 2011, DHSS reports being on target for all milestones for the first year of the settlement agreement with the Department of Justice.

While public attention has focused on the Delaware Psychiatric Center, the move to reduce the use of institutions is Department-wide and affects other state-run long term care facilities as well. As of 2010, 3 state run nursing homes remained in operation, with 591 beds, down from 816 in 1999.[51] However, these facilities had a 2009 occupancy rate of only 64% compared to about 90% in private nursing homes. Residents of state-run nursing homes are much more likely to have Medicaid as a source of payment, 81% in 2010 compared to 53% for private facilities. Medicare was a source of payment for 18% of residents in private nursing home facilities, but less than 1% in public facilities. Statewide, 14% of assisted living residents had Medicaid as a source of payment in 2010.

Table 33: Percent of Assisted Living and Nursing Home Residents with Source of Payment Medicaid or Medicare, Delaware, 2010

	Assisted living residents w/ source of payment Medicaid	Nursing home residents w/source of payment Medicaid		Nursing home residents w/source of payment Medicare	
		Public	Private	Public	Private
Kent County	20%	n/a	57.6%	n/a	17.0%
New Castle County	9%	n/a	51.5%	n/a	19.0%
Sussex County	18%	n/a	54.8%	n/a	17.0%
Delaware	14%	80.7%	53.0%	0.5%	18.0%
Source: University of Delaware Center for Applied Demography & Survey Research, Delaware Nursing Home Utilization Statistics, January – December 2010.					

New admissions to state-run nursing homes were also far more likely to be people under age 65, although the overall number of admissions was quite low, at 44 (out of 119 total) admissions in 2009. Individuals under 65 made up 37% of admissions to public facilities and 14% of admissions to private facilities. Statewide, 1,549 admissions to and 1,458 discharges from nursing homes in 2010 were individuals under 65.

Table 34: Nursing Home Admissions and Discharges, Individuals under age 65, Delaware, 2010

	Admissions <65	Percent of Total Admissions	Discharges <65	Percent of Total Discharges
Kent County (private facilities)	217	16.0%	223	15.9%
New Castle County (private facilities)	832	13.0%	750	12.1%
Sussex County (private facilities)	456	14.0%	446	13.5%
Total private facilities	1,505	13.7%	1,419	13.0%
Total public facilities	44	37.0%	39	33.3%
Delaware (all facilities)	1,549	13.9%	1,458	13.2%

In December 2010, Delaware made changes to its Medicaid Home and Community-Based Waiver programs, administered by the Division of Services for Aging and Adults with Physical Disabilities. These changes provide more service options for consumers and streamline service delivery: consolidating the previous Assisted Living Waiver, Acquired Brain Injury Waiver, and Elderly and Disabled Waiver in an amended Elderly and Disabled Waiver. In the new waiver program, personal care service options are expanded to include personal assistance services agencies and personal care attendants as well as home health agencies. Other initiatives at the Division of Medicaid and Medical Assistance (DMMA), such as the Diamond State Health Plan (DSHP) and Program of All Inclusive Care for the Elderly (PACE) programs are intended to further increase HCBS options and enhance the LTC delivery system.

Table 35: Institutional and Home and Community Based Waiver Expenditures and Recipients, Delaware, FY 2006-2010

	FY 2006	FY 2010	Change
Expenditures			
All Long-term Care Expenditures	$263,238,982	$335,951,563	27.6%
Total Institutional Expenditures	$180,702,791	$226,350,974	25.3%
Total HCBS Waiver Expenditures	$82,536,192	$109,600,589	32.8%
HCB Expenditures as % of Total	31.4%	32.6%	
Non-DD Long-term Care	$175,128,346	$218,795,119	24.9%
Total Institutional Expenditures	$156,487,835	$197,293,115	26.1%
Total HCBS Waiver Expenditures	$18,640,511	$21,502,004	15.4%
HCB Expenditures as % of Total	10.6%	9.8%	
ID/DD Long-term Care	$88,110,637	$117,156,444	33.0%
Total Institutional Expenditures	$24,214,956	$29,057,859	20.0%
Total HCBS Waiver Expenditures	$63,895,681	$88,098,585	37.9%
HCB Expenditures as % of Total	72.5%	75.2%	
Clients			
All Long-term Care			
Total Institutional Clients	2,253	2,671	18.6%
Total HCBS Waiver Clients	2,749	2,932	6.7%
Non-DD Long-term Care			
Total Institutional Clients	2,105	2,544	20.9%
Total HCBS Waiver Clients	1,974	2,056	4.2%
ID/DD Long-term Care			
Total Institutional Clients	148	127	-14.2%
Total HCBS Waiver Clients	775	876	13.0%

Total Clients is Average monthly clients by date of original payment.
All figures reflect total federal and state funds.
HCBS Waiver includes DDDS Waiver, Elderly & Disabled Waiver, and AIDS Waiver.
Source: Delaware Department of Health and Social Services

From FY 2006 to 2010, DHSS statistics on Medicaid costs show a reduction in the number of people receiving services in institutions and an increase in the number of individuals with home and community based waivers, with waiver expenditures increasing in proportion to overall long-term care expenses in Delaware. Over that time period, HCBS waiver expenditures increased from 31.4% to 32.6% of total Medicaid Long Term Care expenditures.

By population, services for people with intellectual/developmental disabilities are far more likely to be delivered in the community. In FY 2010, 75% of Medicaid Long Term Care expenditures for this population were spent for community-based care via the HCBS DD Waiver. This includes care for approximately 1,000 people. Of non-DD Long-term Care expenditures, 10% were spent on community-based care in FY 2010; this includes care for approximately 4,600 people.

As in the above example of Mobile Crisis interventions in emergency room visits with psychiatric or substance abuse crises, a key strategy of prioritizing community care is preventing unnecessary institutionalization in the first place when community placement is feasible, preventing readmissions, and reaching people with prevention and other services to avoid late-stage interventions that are more likely to result in institutional care. To reduce the census in long-term care facilities, new potential admissions must also be reduced. In February 2011, as part of its

Aging and Disability Resource Center (ADRC) initiative, DHSS implemented a diversion program to provide community support to individuals who have been referred for long-term care. Through January 2012, 162 of 192 (84%) clients referred for admission to public long-term care facilities had been connected to community-based services and assisted to remain in the community. Admissions have been reduced from 10.2 per month to 3.8 per month as of the last quarter of 2011.

THE COST OF CARE

Analysis conducted during the development of the new Delaware State Rental Assistance Program (SRAP), which was funded in FY 2012 with $1.5 million for the creation of approximately 150 vouchers for supportive housing for persons with disabilities, mirrors national findings that integrated supportive housing is typically much less expensive than institutional care. Housing an individual in a state-run long-term care facilities costs an estimated $157,300; estimated community costs for housing and supportive services are $46,400. Even in a private long-term care facility, if an individual is covered by Medicaid, state and federal costs are an estimated $96,900. Facilities like the Delaware Psychiatric Center are especially expensive; estimated annual costs for one person are $203,500, compared to approximately $61,500 for housing and services in the community.

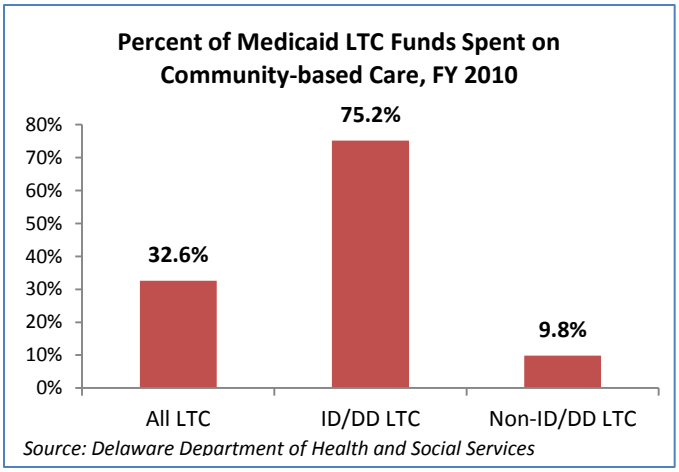


Table 36: Estimated Institutional and Community Cost Estimates, Delaware, 2010

	Institutional Costs	Community Costs
Long-term Care Facilities (Public)	$157,300	$46,400
Long-term Care Facilities (Private)	$96,900	$46,400
Delaware Psychiatric Center	$203,500	$61,500
Source: Delaware Department of Health and Social Services, 2010		

In general, the cost of serving a Medicaid consumer in their home or community is much less than the average cost of nursing home-based care (although community-based care for some individuals, depending on their support needs, can exceed the cost of institutionalization). The typical estimate is that a person who is able to be served in their home can average less than half the costs of institutional care. One study indicated a 63% reduction in per person spending for a nursing facility waiver program compared to institutionalization.[52] Expressed other ways, for the annual cost of one nursing home stay, two to three people can be served in their home or community.

A survey conducted in December 2008 of 1,000 Delaware residents age 35 and older found the following opinions and concerns:

- 42% thought it likely that either they or their family member will need LTC services in the next five years.
- 50% are not very or not at all confident in their ability to afford the annual $81,000 cost of a nursing home in Delaware.

- 51% of respondents with incomes less than $50,000 a year say they plan on relying on government programs to pay for their LTC.[53]

In December 2009, the percentage of all nursing facility residents for which Medicaid was the primary payor was just under 57%, representing about 2,421 Medicaid residents.[54] The 2,421 Medicaid nursing facility residents translates into a 1.8% prevalence rate of institutionalization among Delaware's elderly age 65 and older.

Assuming a constant rate of institutionalization, by year 2030, the number of nursing home residents paid by the DMMA will increase to 4,626. On an annualized cost basis, this translates into well over $150 million more in new Medicaid-funded nursing home stays or a combined total of over $320 million spent on nursing homes per year. This also assumes the annual cost of nursing home services remains static at $70,000; it may be more realistic to assume the cost of care will gradually increase over time and, thus, push institutional spending to even higher levels.

As the need for supportive services and care increases, the cost savings of transitioning to a model that prioritizes community care can be reinvested in expanding community services and serving more individuals. This transition does not always result in immediate or visible cost savings, as reducing census in long-term care facilities means that revenues from Medicaid that supported those beds are also reduced; it may also take substantial reductions before facilities, facility costs, and staff may be reduced. The greatest advantage is in the avoidance of future costs: building a community-based system of care that prioritizes remaining in the community will help avoid further expansion of institutional settings and the higher costs associated with institutional care.

MONEY FOLLOWS THE PERSON INITIATIVE

The Money Follows the Person demonstration grant program was created in 2005 to assist states in rebalancing their long-term care systems and help Medicaid enrollees who have lived in long-term care institutions for at least three months transition from institutions to community based care. Community residences are defined as homes, apartments, and small group homes with four or fewer unrelated individuals. 43 states and the District of Columbia are now participating. Delaware's MFP program began in 2008. Since then (as of 12/31/11), 60 individuals have transitioned from institutions to the community. The lack of affordable housing has been a major barrier to transitions, frequently the only barrier, and demand for the program is high. In calendar year 2011 through 6/8/11, Delaware's MFP program had 63 new referrals and 58 people waiting to be discharged and in the pipeline to transition – waiting on housing. An additional 81 referrals had been assessed and reviewed by the nurse and transition care team, and these individuals will also all likely be in need of housing. Nationally, while older adults living in nursing facilities made up the majority of those eligible for MFP in 2007 (75%), the largest group of MFP participants through June 2010 has been people with physical disabilities under age 65 who had lived in nursing homes.[55]

By the end of 2010, almost 12,000 people had transitioned from institutions to the community through MFP nationally.[56] With the Affordable Care Act health care reform initiative, Money Follows the Person was extended an additional five years through 2016. To date, national evaluation suggests that post-transition outcomes in the MFP program are positive. Two 2011 reports from Mathematica Policy Research using data on outcomes for MFP participants in 25 states who transitioned before March 2010 show that:

- In the year after returning to the community, about 85 percent of MFP participants had remained in the community, 9 percent had been reinstitutionalized, and another 6 percent had died.
- Reinstitutionalization tended to occur in the first three months after transition.
- Compared to institutionalized people who would have been eligible for MFP and transitioned to home and community based care in 2006 – before the program began – MFP participants were more likely to be under 65 with a physical or developmental disability than to be elderly.
- MFP participants with developmental disabilities were most likely to have remained in the community (94.8%), compared to participants who were elderly (75.4%) or non-elderly and with physical disabilities (83.8%).

Table 37: Community Living Arrangements of MFP Participants Ever Enrolled Through June 2010, by Targeted Population, U.S.

	All MFP Participants (number)	Targeted Population (percentage)				
		Elderly	Physical Disabilities	Intellectual Disabilities	Other	Unknown
Totals	7,729	26.7	36.1	25.1	2.5	9.6
Type of Qualified Residence						
Home	2,048	47.7	32.4	3.0	7.3	12.9
Apartment	1,870	18.9	34.0	10.6	6.8	29.7
Assisted living	680	14.1	10.4	5.0	4.2	3.1
Group Home	2,010	8.4	8.9	75.0	7.8	16.7
Unknown	1,121	11.0	14.2	6.4	74.0	37.6
		100.0	100.0	100.0	100.0	100.0

Source: Mathematica Policy Research, Money Follows the Person Demonstration: A Profile of Participants. 2011

In addition to the Money Follows the Person program, in 2011 DHSS began engaging in assessments of residents in all five of its facilities to gauge their desire to live in the community, appropriate settings and their need for housing and supportive services. DSAAPD estimates that over 100 residents transitioning from these facilities will need housing in the next several years, in addition to 50 individuals estimated to need housing annually by MFP and an additional 60 people who will need housing in order to avoid admission to state long-term care facilities.

DELAWARE AGING AND DISABILITY RESOURCE CENTER

In 2003, a national initiative to create Aging and Disability Resource Centers (ADRCs) was launched. In 2009, Delaware received a three-year grant from the Administration on Aging to develop and implement at statewide ADRC; in 2010, the Delaware ADRC began operations and was formally established through state law. The ADRC is the cornerstone of Delaware's plans to prepare for the rapid growth of the older population and the anticipated expansion of service needs and promote the use of home and community-based long-term care services as an alternative to institutional care.

Aging and Disability Resource Centers serve as a single point of entry for accessing information about long term care services and supports for consumers and caregivers; a high functioning single point of entry system like an

ADRC is one of the key dimensions of a high performing long term care system identified in a recent report by the AARP.[57] On this facet of care, the functionality of an ADRC or single point of entry, Delaware ranked 7th among the states on a composite score encompassing formal marketing, range of services provided, service planning, transition services, and others.

Operated by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD), the ADRC offers information and assistance with available resources, options counseling to help people decide what services would be best for them, and service enrollment support to find and enroll in the services they need. It also provides support to hospital discharge planners to improve and increase hospital-to-home transitions. These transition points are especially critical as "people are vulnerable to breakdowns in care and poor communication among service providers at these times."[58] Options counseling and service enrollment support are offered to people in their homes, nursing facilities, hospitals and other locations; the ADRC call center has staff available by phone and email. In 2012, the ADRC plans to expand call center support to 24-hour service.

Since its launch, the ADRC has already experienced high demand. From October 2010 – October 2011, the ADRC responded to over 28,000 phone calls and emails and in just October 2011, provided in-person support to 161 people in their homes, nursing homes or hospitals.

RENTAL HOUSING NEEDS

CHALLENGES QUANTIFYING NEEDS

Coming to a summarized number of units of accessible rental housing and rental assistance needed in the state is extremely challenging. With numerous variables in the type of need, and little available information about inventory, a straightforward gap analysis comparing the available inventory to identified needs is not possible.

Identifying needs is challenging as there is limited reliable, detailed data available beyond that collected by service systems such as the Department of Health and Social Services. These of course do not include all people with disabilities in Delaware, and especially when it comes to physical disabilities, information is limited. Sources of data like the American Community Survey use fairly general questions that do not include any information about the severity of a disability or need for accessibility features, and in addition, disability fields are not cross-tabulated with many other fields of interest, such as tenure and detailed income fields. There is no easy way to define how many people in Delaware require accessible housing, and, more importantly, how many people in Delaware need accessible housing and do not currently have it, or that same information specific to affordable accessible housing.

Collecting information on accessibility within the existing housing stock is similarly challenging. There are no national or local sources tracking accessibility features in the existing housing stock. At best, we have local information on the number of fully accessible units in subsidized or income-restricted rental housing, but even that is incomplete.

Still, by assembling local data and using national data to make some estimates for Delaware, we are able to get some sense of the population in need and the scope and nature of those needs.

NEEDS

WORST CASE RENTAL HOUSING NEEDS IN DELAWARE

Biannually, the U.S. Department of Housing and Urban Development releases a report on worst case housing needs as a measure of the nation's most critical housing needs. "Worst case needs" are defined as households with very low incomes (below 50% of the area median for their household size) who do not receive government housing assistance and are severely cost burdened (pay more than 50% of their income for rent), live in severely inadequate conditions (overcrowded or substandard), or both. These households are precariously or unsafely housed, and at high risk for homelessness.

Although the data source for HUD's *Worst Case Needs* report, the American Housing Survey, does not allow state-level reporting, for this study we have replicated an estimate of worst case housing needs in Delaware: very low income renter households with severe housing problems (severe cost burden, overcrowding, or inadequate kitchen or plumbing facilities) who are not receiving housing assistance. The vast majority of these households (approximately 95% in Delaware from the 2006-2008 data) have severe cost burden as their housing problem.

To create these estimates, percentages of very low-income renter households with disabilities from national sources are applied to state-level numbers of very low-income renter households with severe housing problems. Statewide, approximately 12,800 households have either project-based or tenant-based housing subsidy, leaving 23,366 very low income renter households with no housing subsidy. HUD's 2006-2008 CHAS data estimate that 18,235 very low-income renter households in Delaware have severe housing problems: we can safely assume that these households do not have a housing subsidy as severe cost burden is the housing problem in almost all cases and inadequate plumbing or kitchen facilities are unlikely in federally subsidized housing. A distressing statistic from these data is that statewide in Delaware, approximately 78% of very low-income renter households that do not have a housing subsidy, have severe housing problems.

Table 38: Estimate of Worst Case Housing Needs, Delaware, 2006-2008[59]

	Kent	Sussex	New Castle	Delaware
Total renter households	15,810	16,115	54,365	86,290
Very low income (VLI) renter households (<50% AMI)	5,840	6,205	24,105	36,150
Estimate - VLI renter households with housing subsidy	2,312	2,419	8,053	12,784
Estimate: VLI renter households with no housing subsidy	3,528	3,786	16,052	23,366
VLI renter households with severe housing problems (worst case needs)	3,375	2,990	11,870	18,235
Percent of VLI renter households with no housing subsidy that have severe housing problems	95.7%	79.0%	73.9%	78.0%
Estimate: VLI renter households with a nonelderly member with disabilities with severe housing problems	**844**	**748**	**2,968**	**4,559**
Note: Severe housing problems include cost burden over 50% of household income, inadequate kitchen or plumbing facilities, or overcrowding.				
Source for renter household and housing problem data: HUD 2006-2008 CHAS data				

Recent research from the National Low Income Housing Coalition (NLIHC) comparing rates of disability prevalence and housing needs in the American Housing Survey (AHS), the data source used in HUD's *Worst Case Needs* report, and the American Community Survey (ACS), show that despite efforts to coordinate survey questions on disability, the ACS still shows higher rates of disability than the AHS, from 38 to 99% higher for the six different disability questions, and the disparity tends to be highest for nonelderly renters.[60] Thus, in the above estimate, we applied a percentage of very low income renter households with disabilities from the ACS to the Delaware number of very low-income renter households with severe housing problems. This estimate suggests there are approximately 4,500 very low-income renter households with severe housing problems with disabilities in Delaware.

Considering these data inconsistencies, even though recent adjustments to HUD's *Worst Case Needs* reports have improved the quality of data on worst case needs among households with disabilities, the national number of 987,000 nonelderly very low income renter households with worst case housing needs and disabilities is likely still an underestimate. Comparison figures estimated with the American Community Survey are 1.31 million, and adjusting for the higher rates of disability prevalence shown in more detailed national surveys like the National Health interview Survey (NHIS) and Survey of Income and Program Participation (SIPP) suggest the number may be closer to 2 million.[61] A subsequent multivariate analysis attempting to create state-level estimates using AHS data and ACS geography suggests that 61% of adult nonelderly households with disabilities in Delaware have worst case housing needs, or approximately 5,000 households: in line with the estimate of 4,559 produced in Table 37.

SUMMARY OF DELAWARE LOCAL DATA

It is difficult to summarize the diverse housing needs of people with diverse disabilities into one number or even one table. For purposes of this report, we are most concerned with the number of people or households in need of affordable accessible rental housing or rental assistance. In addition, by population these estimates may come from widely different sources and reflect different levels of need: one estimate may be of people actually homeless, one of people who are housed but need rental assistance with supportive services to live independently. The following table summarizes the data on needs gathered from local sources for this report.

The below table suggests a total need for assistance for approximately 1,950 individuals or households. These are conservative estimates, as the case of the DSAMH point-in-time analysis is a good example. While 882 DSAMH clients were identified as in need of stable housing in that analysis, over 2,000 listed SSI or SSDI as their primary source of income. These individuals are highly likely to be precariously housed, cost-burdened and in need of rental assistance, or doubled-up with family or friends when they would prefer to and could live independently. DDDS is currently serving 1,923 people with intellectual or developmental disabilities who are currently stably housed with family or friends, but as their families age, many of these people may also need housing assistance. DDDS estimates 150 people may be at risk due to aging caregivers and need housing assistance in the near future.

In addition, we have very limited information about people with disabilities who may be similarly precariously housed in the community or in private nursing homes and able to transition to the community. The estimated need from LTC facilities suggests a need for at least 650 either assisted accessible units or market-rate accessible units with tenant-based rental assistance. 250 of these are estimated to be referrals from Adult Protective Services, the Aging and Disability Resource Center, or other sources.

Table 39: Summary of Local Data on Housing Needs

Population	Need	Source
People with HIV/AIDS	250 on TBRA waiting list	Delaware HIV Consortium
People with Intellectual/Developmental Disabilities (ID/DD)	150 individuals estimated at-risk due to aging caregivers	DHSS: Division of Developmental Disabilities Services (DDDS)
Substance Abuse/Mental Health	882 DSAMH consumers in need of stable housing (nursing home, corrections facility, other institution, unknown, or homeless) 406: Mental Health 306: Substance Abuse 116: Co-occurring MH/SA 54: Unknown	DHSS: Division of Substance Abuse and Mental Health (DSAMH) point-in-time analysis
Elderly and Adults with Physical Disabilities	300 (Diversions and transitions from LTC facilities from FY 13 - 17) 100 (Transitions from DHSS LTC Facilities) 250 (Other referrals from APS, ADRC, and other sources from FY 13-17) *Likely all (650) fully accessible units*	DHSS: Division of Service for Aging and Adults with Physical Disabilities (DSAAPD)

Estimates from HUD's CHAS data (Table 31 above) show 2,260 extremely low-income (<30% AMI) renter households and 1,445 owner households with at least one member with a mobility or self-care disability with a housing problem (cost burden, overcrowding or substandard conditions) in Delaware. Expanded to include very low-income households (<50% AMI), there are 3,235 renter households and 3,225 owner households with income below 50% AMI, at least one member with a mobility or self-care disability, and a housing problem in Delaware.

Youth aging out of foster care are an additional high-risk population; estimates of the number of youth expected to be aging out of the foster care system provided by the Department of Services for Children, Youth and their Families suggest a need for approximately 300 units of rental assistance.

DEMAND FOR ASSISTED ACCESSIBLE UNITS

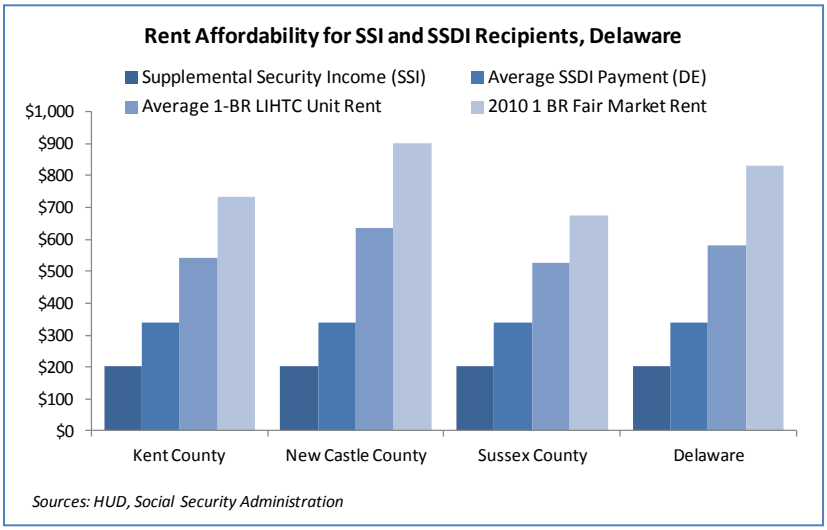
Caseworkers and advocates regularly report great difficulty locating accessible affordable rental housing. However, rental housing owners and developers also report vacancies and difficulty filling fully accessible units. Some sample review of data from people in the Money Follows the Person (MFP) program suggest that the issue may be more one of a need for subsidy and a mismatch in unit locations and sizes.

The Division for Medicaid and Medical Assistance (DMMA) provided the study working group with summary data on 110 current or former residents of long-term care facilities who either had or were attempting to transition to living in independent housing, approximately a 50% mix of people who had transitioned and those who had not yet. Some summary notes about the population:

- 62% were seeking either an efficiency or one bedroom unit.
- 66% had Supplemental Security Income (SSI) listed as their only source of income ($674/month); the rest relied on SSDI with a few having additional income from pensions or worker's compensation.
- The majority – 65% - were seeking units in New Castle County, with about 17% each seeking units in Sussex or Kent Counties.

The large number of people seeking smaller units and relying on SSI as their only income suggests that some of the problem may be related to the size and affordability of available units, not purely a need for fully accessible units. In non-elderly rental housing sites, efficiency and one-bedroom apartments are rare as they are not highly popular with the target market. In addition, new rental housing construction in the past two decades has been more concentrated in Kent and Sussex Counties: these sites are likely to have more accessible units. However, as new sources of federal project-based subsidy have been almost nonexistent for many years, new family sites are also unlikely to be subsidized. This is especially true in New Castle County, much of which is not eligible for subsidies provided by USDA Rural Development, the only remaining source of new project-based subsidy for family projects.

The extremely low incomes of most people attempting to transition out of long-term care facilities suggest that a source of rental assistance is an absolute necessity. As can be expected, demand among all households is very high for all sources of rental assistance, both project-based subsidies (waiting lists at sites with federal subsidies) and tenant-based subsidies (the Housing Choice Voucher program). A household may wait many years for a Housing Choice Voucher, and waiting lists at sites with project-based subsidies are similarly very long. People with disabilities are seeking rental assistance in a system already taxed beyond its limits to provide assistance.



Supplemental Security Income (SSI) provides a small source of income for those who are over 65, blind or disabled adults or children. If a person has no other income, they may receive the maximum benefit of $674 a month ($1,011 for a couple if both are eligible).They may also not have any cash assets over $2,000. If the consumer is in a long-term care facility paid for by Medicaid, the monthly benefit is only $30. Delaware offers a state supplement to SSI for residents of long-term care facilities: as of 2010, 554 adults and 62 children received this federally administered supplement of $140 a month.

Many people with disabilities receive the Social Security Disability Insurance (SSDI) and/or Supplemental Security income (SSI) programs for income support. The national average SSDI benefit in 2009 was $1,064; in Delaware, the average SSDI payment in 2010 was $1,128, with 27,704 individuals 18-64 receiving benefits. Individuals who receive SSDI may also receive SSI, but the monthly benefit is reduced. In 2010 in Delaware, 2,887 people between 18-64 years of age were receiving SSI and SSDI, with an average SSDI benefit of $500/month and average SSI benefit of $210/month.[62]

All of the people in the MFP program rely on SSI, SSDI or a combination of the two for their income: while benefits may vary slightly, they are clearly living on extremely limited incomes and their ability to afford even affordable rental housing is very limited. At the maximum SSI benefit of $698, a person could only afford a rent of $209 a month, leaving only $490 for all other expenses. Even at the average SSDI benefit of $1,128, a person can only afford a rent of $338. All of these people would need rental assistance – not simply an affordable unit, but either a project-based or tenant-based subsidy - to live independently in the community. In all three counties, individuals with incomes in this range would be below 30% of Area Median Income (AMI) for a one-person household.

Table 40: Affordable Rents and Average LIHTC Rents

	Affordable Rents			Number of Units and Average Rent: Unsubsidized LIHTC Sites							
	SSI ($698)	SSDI (Avg DE Benefit: $1,128)	30% of Area Median Income	0 BR		1 BR		2 BR		3 BR	
				Rent	Units	Rent	Units	Rent	Units	Rent	Units
Kent	$209	$338	$326	n/a	0	$542	208	$662	667	$773	159
New Castle	$209	$338	$422	$398	231	$635	714	$731	905	$885	322
Sussex	$209	$338	$322	n/a	0	$528	200	$640	603	$749	109
Delaware	$209	$338	$380	$398	231	$582	1,122	$683	2,175	$822	590
Source: Social Security Administration, DSHA											

To further evaluate the need for rental assistance, average rents for unsubsidized LIHTC sites were calculated. These are sites where rents are restricted to affordable levels and tenants must meet income restrictions, but generally are targeting households at 50 or 60% of Area Median Income (AMI). There are very few unsubsidized LIHTC efficiency apartments, all in New Castle County with an average rent of $398. Statewide, the average rent for an unsubsidized income-restricted 1 bedroom apartment is $582, far out of reach of anyone relying on SSI, SSDI, or with income below 30% of AMI. For 2 bedroom units, the average rent for an unsubsidized LIHTC unit is $683 statewide. Households with incomes dependent on SSI, SSDI or generally below 30% of AMI would, in almost all cases, need some form of tenant-based rental assistance to even be able to afford a LIHTC unit that did not already have a project-based subsidy.

ACCESSIBILITY IN THE RENTAL HOUSING STOCK

ACCESSIBILITY REQUIREMENTS FOR RENTAL HOUSING

Most requirements for accessibility are applied only to multifamily or multifamily rental housing. Section 504 of the Rehabilitation Act of 1973 requires that a minimum of 5% of housing units financed or subsidized with federal

funding be fully accessible to Uniform Federal Accessibility Standards (UFAS). An additional two percent must have features for those with sensory disabilities, although these features are mobile and can be transferred between units. Public Housing Authorities (PHAs) are required to regularly assess the need for accessible units; more than 5% may be required if greater need is determined by the PHA by a Section 504 Needs Assessment. Section 504 also includes accessibility requirements for PHA administrative offices, application offices, and other non-residential facilities.

The Fair Housing Amendments Act (FHAA) of 1988 moved beyond Section 504 to require designated access features in multifamily units (four or more units under one room, excluding townhomes) first occupied after March 13, 1991, regardless of any public financial assistance, the form of tenure, or whether the units will be used by people with disabilities or not. All ground floor and elevator accessible units must be accessible, with:

- An accessible building entrance on an accessible route;
- an accessible route into and through the unit;
- accessible public and common areas;
- doors usable by a person using a wheelchair throughout the unit;
- electrical and other controls at reachable levels;
- reinforcements in bathroom walls; and
- adequate space in kitchens and bathrooms to allow for a wheelchair.

HUD recognizes ten "Safe Harbors" for compliance with fair housing and accessibility requirements – construction standards for compliance with the Fair Housing Act's design and construction requirements, although ANSI is the predominant standard as it is the standard used by most local building codes.

For publicly funded sites, some statutory and regulatory provisions overlap others. Where there is a conflict, the most stringent provision applies including any state or local laws/regulation/codes which may be more stringent than Federal requirements. All projects, regardless of funding source, are required to meet the accessibility standards outlined in the Americans with Disabilities Act (ADA) of 1990, which provides for accessibility in public accommodations and commercial facilities. Public accommodations includes all new construction effective January 26, 1993 and impacts any rental office, model unit, public bathroom, building entrances, or any other public or common use area.

At the local level, projects are required to be reviewed by the Delaware Architectural Accessibility Board. All housing is subject to state and local building codes, which use ANSI (American National Standards Institute) standards, which cover accessibility. While Uniform Federal Accessibility Standards (UFAS) are one standard for accessibility required for Federal and federally-funded facilities, the State of Delaware has not elected to adopt UFAS as the State's standard. In Delaware, the ICC/ANSI A 117.1-2003 is utilized and provides technical requirements for accessibility.

To summarize, the key accessibility requirements for multifamily housing are:

1) Regardless of funding source, all ground floor and elevator-accessible multifamily units constructed for first occupancy after March 31, 1991 must have basic access features;

2) Publicly funded multifamily housing must also have at least 5% of units constructed to be fully accessible and 2% of units for sensory impairments;
3) Public and commercial areas of all sites must be accessible as required by the ADA; and
4) In Delaware, the ICC/ANSI, the building code used in all three Counties, is used to provide technical standards for accessibility for the above requirements.

ACCESSIBLE ASSISTED RENTAL HOUSING INVENTORY

As described above, 5% of housing units financed or subsidized with federal funding must be fully accessible and 2% with sensory accessibility features. Public housing is also subject to the Section 504 requirement that 5% of units be fully accessible and 2% with sensory accessibility features. The 2011 statewide *Analysis of Impediments to Fair Housing Choice* collected data on accessibility in public housing, which showed 119 Section 504-accessible public housing units in Delaware plus 10 additional sensory disability-accessible units. Sensory accessible units are mobile and not required to be permanent fixtures. The *Analysis of Impediments* recommended that all PHAs in the state with public housing units conduct new Section 504 Self-Evaluations, Needs Assessments, and Transition Plans to evaluate and address the need for accessible units.

Table 41: Section 504 Accessible Public Housing Units, Delaware, 2010

	Total Public Housing Units	Mobility Accessibility	% of Total Units	Sensory	% of Total Units
Delaware State Housing Authority	508	27	5.3	4	0.8
Wilmington Housing Authority	1,816	69	3.8	6	0.3
Dover Housing Authority	280	16	5.7	unknown	n/a
Newark Housing Authority	98	7	7.1	0	0.0
Total	**2,702**	**119**	**4.4**	**10**	**0.4**
Source: Analysis of Impediments to Fair Housing Choice, July 2011. Data Collected September 2010					

Section 504 also applies to sites developed using other federal funding sources, such as the Low Income Housing Tax Credit (LIHTC), project-based subsidized Section 8 or 202 sites, and USDA Rural Development. Sites constructed since the enactment of the FHAA in 1991 are also subject to its requirements for basic accessibility in all first-floor and elevator-accessible units in multifamily sites. Understandably, the numerous and overlapping standards can lead to some confusion in the general housing community about the definition of accessibility.

Statewide, an estimated 234 privately owned assisted affordable rental units are fully accessible. This information is, unfortunately, unreliable. Some older sites may have fewer than 5% of accessible units, and accessible units in older sites may also not meet current accessibility standards. When sites are fully rehabilitated using the LIHTC or other programs, they are brought up to current accessibility requirements and standards. In addition, numerous sites, especially ones built more recently, may have units that are not fully accessible but do include some accessibility features. As this is not required, the number of these units is far more difficult to track. An estimated 850 units in Delaware's assisted housing stock have some other accessibility features.

Table 42: Accessible Units in Assisted Housing Inventory, Delaware 2010

	Total Units	Fully Accessible Units		Units with some accessibility features[2]	
		Number	Percent	Number	Percent
Assisted housing[1]	**11,331**	**234**	**2.1%**	**854**	**7.5%**
Family	*7,333*	*179*	*2.4%*	*564*	*7.7%*
Elderly	*3,998*	*55*	*1.4%*	*286*	*7.2%*
Notes *1: Privately owned, federally subsidized or income restricted housing. Programs include Rural Development, LIHTC, HOME, and the Housing Development Fund (HDF).* *2: Accessibility features may include wide doors, open counters, bath rails, front appliance controls, sensory accessibility features, no-step entry or elevator access, and adaptable features.*					
Sources: Assisted Housing: Delaware State Housing Authority					

In 2010, Delaware State Housing Authority added incentives for multifamily projects applying for funding through the LIHTC program to include additional fully accessible units beyond the required 5%. This has proved very successful, with the incentive resulting in an additional 26 units in the 2010 funding cycle and extra 17 units in the 2011 cycle. Over the two years, the incentives have increased the percentage of accessible units from the required 5% to 14% of units across the two years to date. As attention to the need for accessible units continues to improve, and developers respond to incentives and market demand, the number and percentage of accessible units in Delaware's assisted housing stock will continue to increase. However, these sites are largely still in the financing or construction phases, so we do not yet know how well or quickly these fully accessible units have leased once the site is placed in service. In new construction sites or rehabilitated sites where the number of fully accessible units is being increased, the accessible units listed in Table 44 below are not yet included in the inventory in Table 41.

Table 43: Fully Accessible Units funded by Low Income Housing Tax Credit (LIHTC), Delaware, 2010-2011

	Total Units	Required Fully Accessible Units	Actual Fully Accessible Units	Percent
2010	355	20	46	13.0%
2011	168	9	26	15.5%
Total	523	29	72	13.8%
Source: Delaware State Housing Authority				

ACCESSIBLE MARKET-RATE OR UNASSISTED RENTAL HOUSING

Accessibility of market-rate housing is a concern as well: tenant-based rental assistance programs rely on the ability to find units in the private market, although quite a few voucher holders do live in income-restricted (LIHTC or other) sites that do not have project-based rental assistance. Statewide, there are approximately 4,500 Housing Choice Vouchers and the new State Rental Assistance Program is expected to serve 150-200 people in FY 2012: all of these households seek housing in the general rental market.

As the cost of reasonable accommodations or modifications are the responsibility of the tenant, PHAs report that most voucher holders start out seeking units that already have the accessibility features they need, and only rarely

do voucher holders need to make reasonable modifications. A common reasonable accommodation offered by PHAs is, if a consumer has a voucher for a 1 bedroom unit but finds a 2 bedroom unit with the accessible features they need, to adjust their voucher to 2 bedrooms in order to secure the unit with the needed features. Allowing a unit with a rent over the voucher payment standard is another reasonable accommodation. Voucher holders frequently find accessible units in Low Income Housing Tax Credit (LIHTC) sites. In these sites, all built or rehabilitated since 1990 and with at least 5% accessible units, accessible units are often available and rents are typically within the allowable voucher payment standard. Other new multifamily sites may also have accessible units, but higher rents.

As discussed earlier, all multifamily housing built after March 13, 1991 is subject to the design and construction requirements of the Fair Housing Act (1988), regardless of funding source. However, the vast majority of existing rental housing was built before 1991: 75% of rental housing in Delaware was built before 1990, and only 42% of the rental housing stock in Delaware is in buildings with 5 or more units.[63] Almost 40% of Delaware's rental housing stock is single-family attached or detached homes.

In April 2011, the study workgroup worked with the Delaware Apartment Association to conduct an online survey of its members about accessibility. While the response was not extensive, it was an interesting snapshot. 10 responses covered 21 sites and 2,800 units. All of the responses were in New Castle County. Of the 2,800 units covered, 77, or 2.7%, were reported to be fully accessible (to ADA or Section 504 standards). A frequently cited concern among managers has been that it is difficult to fill vacancies in accessible units; they may have trouble finding households who need the accessibility, and households with no members with disabilities do not want or like the features. Responses to an open-ended question about this on the survey were split, several cited having no trouble filling vacancies in accessible units, others said they were either frequently vacant for a long period or usually had at least one accessible unit available at all times. Responses also noted that their sites had units with some limited accessibility features, particularly wide doorways and hallways, handrails or grab bars in bathrooms, and lever door handles.

There is little data available on the extent of accessibility features in unassisted rental housing. In addition, a large percentage of the rental housing stock in Delaware is in the single-family housing stock: 39% of rental units in Delaware are in single attached or detached homes, and an additional 6% are mobile (manufactured) homes.

Table 44: Renter-occupied housing units by type of structure, Delaware, 2008-2010

Type of Structure	Units	Percent
1, attached or detached	34,842	39.2%
2 to 4	11,590	13.1%
5 to 9	9,751	11.0%
10 or more	27,166	30.6%
Mobile home or other (Boat, RV, Van)	5,422	6.1%
Total	88,771	100.0%
Source: U.S. Census Bureau, 2008-2010 American Community Survey		

In addition, a significant percentage of the rental housing stock in Delaware is older: 75% of the rental stock in Delaware was built before 1980. Older multifamily sites are be less likely to have accessible units and units with no-step entries.

Table 45: Renter-occupied units by year built, Delaware 2008-2010

Year Built	Units	Percent
Built 2000 or later	11,193	12.6%
Built 1990 to 1999	11,322	12.8%
Built 1980 to 1989	13,942	15.7%
Built 1970 to 1979	14,543	16.4%
Built 1960 to 1969	12,138	13.7%
Built 1950 or earlier	25,633	28.9%
Total	88,771	100.0%
Source: U.S. Census Bureau, 2008-2010 American Community Survey		

We can at best make some rough assumptions about the extent of accessibility in Delaware's overall rental housing stock. Assuming that 3% of rental units which are in structure of 5 or more units are accessible to either ANSI standards or with some mix of accessibility features would suggest an estimated 1,107 fully accessible rental units in the state.

Table 46: Estimate of Accessible Multifamily Rental Units in Delaware

	Units	Percent of Renter-Occupied Stock
Total Renter-occupied units	88,771	100.0%
Units in structures with 5 or more units	36,917	41.6%
Assumption: 3% of rental units in structures of 5 or more units are fully accessible	1,107	1.2%
Assumption: 10% of rental units in structures of 5 or more units have basic access	3,691	4.2%
Source for base numbers: U.S. Census Bureau, 2008-2010 American Community Survey		

This estimate, however rough, suggests a woefully inadequate number of fully accessible units compared to the likely need. A particular challenge, especially in affordable multifamily sites, may be that first-floor units with basic access features as required by FHAA have no requirements to be set-aside for people with disabilities. Only the 5% of units required by Section 504 to be fully accessible carry lease restrictions requiring a person without a disability to move to another vacant unit if the fully accessible unit is needed by a person with a disability.

TENANT-BASED RENTAL ASSISTANCE

In 2007, the Delaware Interagency Council on Homelessness (DICH) identified a need for 1,000 beds of tenant-based rental assistance for people who are chronically homeless or at risk for chronic homelessness, with mental health or substance abuse disabilities.[64] Since then, attention to tenant-based rental assistance (TBRA) programs has increased, especially as there is renewed focus on developing a community-based system of care for people with disabilities. This was reflected in the recent development and creation of the State Rental Assistance Program (SRAP), first funded in FY 2012 to provide approximately 150 units of rental assistance to people exiting institutions or at risk of institutionalization and who need rental assistance and supportive services to live independently in the community.

In addition to SRAP, Connections Community Support Programs (Connections CSP) manages approximately 230 tenant-based rental assistance vouchers for people with substance abuse or mental health disabilities and the Delaware HIV Consortium assists approximately 125 people with HIV/AIDS with its TBRA program, for an estimated total of about 505 units of tenant-based rental assistance specific to people with disabilities in Delaware. In FY 2013, an increased budget request for the SRAP program would allow it to expand to serve approximately 300 people.

Table 47: Tenant-based Rental Assistance for People with Disabilities in Delaware

	Units (Estimated)
State Rental Assistance Program (SRAP)	150
Delaware HIV Consortium TBRA Program (HIV/AIDS)	125
Connections CSP (Substance Abuse/Mental Health)	230
Total	**505**

Other tenant-based rental assistance programs for special populations are active in Delaware, but are not necessarily specific to people with disabilities. The Family Unification Program (FUP) provides rental assistance to families that would otherwise be separated (children in foster care) where affordable housing is the main barrier to family unification, and the HUD - Veterans Affairs Supportive Housing (VASH) Program, operated by the Wilmington Housing Authority, provides rental assistance for 25 homeless veterans.

HOMEOWNERSHIP NEEDS

There is even less information available about the extent of accessibility features across the single-family and owner-occupied housing stock, usually limited to the (already limited) surveys of people with disabilities responding about accessibility features in their own homes. As the population ages, and as middle-aged households take on caring for aging parents and other family members, it is likely that general demand for accessibility features in the overall housing market will grow. To date, however, there seems to be a disconnection between peoples' desire to "age in place" and remain in their communities as long as possible and their understanding of – and demand for – the features and services that will make that possible. In a 2008 AARP survey, 75% of Delawareans over 35 said they felt it was "extremely" or "very" important to remain in their current residence as long as possible; among adults over 65, this was 85%.[65] With this level of desire to remain in the community, it is surprising that builders and developers report not seeing extensive demand for accessibility features, even as options. As a community, we have built and largely continue to build homes and communities that are not conducive to aging in place. The survey also suggests, however, that people may overestimate their ability to stay in their current home without modification: only about 1 out of 5 people claimed a need to make major repairs or modifications to their home to enable to stay in them as they age.

As the population ages, as noted earlier, and disability rates increase with age, there will be substantial increase in the number of persons with intermittent or long-term disabilities. Using data on the average lifespan of units, the average length of residence for households occupying those units, and the projected proportion of households with at least one disabled resident, it is possible to roughly estimate the probability that a newly built single-family detached housing unit will house at least one disabled resident. A 2008 analysis found that 21% of households will

have at least one disabled resident in 2050, using physical limitation (long-lasting mobility impairments) as the measure of disability, and 7% when using the measure of self-care (Activities of Daily Living - ADLs) difficulty.[66] There is a 60% probability that a newly built single family detached unit will house at least one disabled resident during its expected lifetime using the first measure (physical limitation), and a 25% probability using the self-care/ADLs measure. When visitors are accounted for, the probabilities rise to 91% and 53%.

DEMAND FOR ASSISTANCE WITH ACCESSIBILITY MODIFICATIONS

There are an estimated 6,155 homeowner households with at least one member with a mobility or self-care disability with income below 50% of AMI (very low income) in Delaware; another 4,785 with income from 50-80% of AMI (low income).[67] These approximately 11,000 homeowner households with low incomes likely have limited ability to invest in major accessibility renovations if needed.

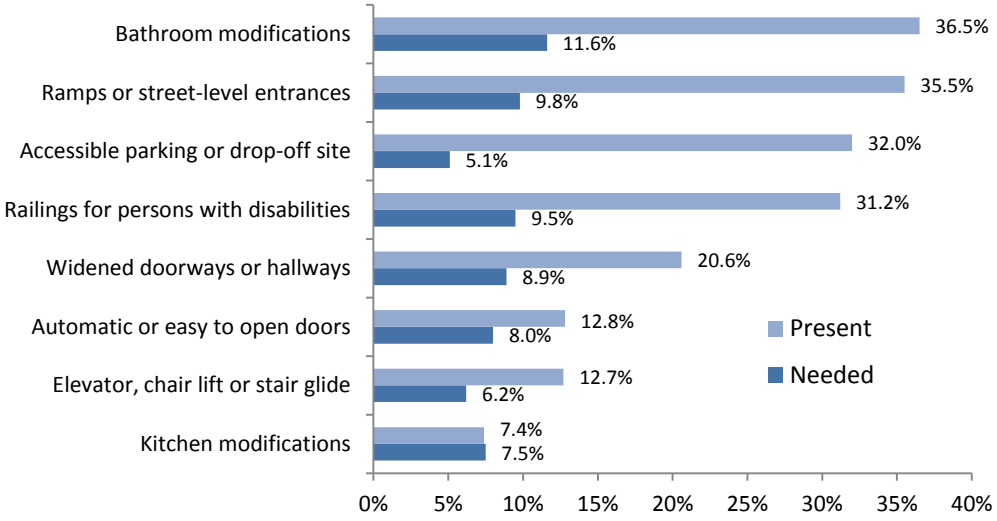
Households with at least one member with a mobility or self-care disability make up 17% of very low-income homeowner households in Delaware, and more than half (52%) of these households have housing problems (cost burden, overcrowding or substandard conditions).[68] Quality of life, the ability to get around inside and into their homes, and ability to live independently for as long as possible could doubtless all be improved for many of these households with accessibility modifications and/or other housing assistance.

For households who own their home and have a member with a disability, or elderly households, modifications may be needed either at purchase or after, and are often costly if they are extensive and include a bathroom or entrance. In the NHIS-Disability Supplement, respondents were asked about features that make it possible for people with mobility impairments and users of wheeled mobility devices (wheelchairs or scooters) to get around in their homes. About one third of people who reported using wheelchairs or scooters live in homes that are entirely on one floor, compared to 44% of people with disabilities who do not use any mobility devices. Most people with disabilities live in homes with a bedroom, bathroom and kitchen on one floor: 78.4% of wheelchair users and 88.5% of scooter users.[69]

A 2003 analysis of this data showed that unmet need for home accessibility features is substantial: about 13% of wheelchair users reported needing automatic or easy-to-open doors and elevators, lifts, or stair glides, and 50% of people who use wheelchairs must use steps or stairs to get into their home.[70] About half reported difficulty entering or exiting their homes – often due to steps and stairs, but can also include narrow doorways or steep or irregular entryways. These data also report that about 40 percent of wheelchair users use a walker, and 35 percent also use a cane, so they may be able to negotiate these barriers. Still, no-step entries would surely improve mobility and safety for these users as well.

Assuming similar percentages of needed home accessibility features apply to the estimate of 10,472 wheelchair users in Delaware in Table 30, over 1,000 households in Delaware may need ramps or street-level entrances; 1,200 bathroom modifications; 650 stair glides; and 900 widened doorways or hallways.

Not surprisingly, then, demand for assistance with home modifications in Delaware is high, and waiting lists for assistance programs are long. DSAAPD reports that the wait time for assistance through their programs, which have a lifetime limit of $15,000 of assistance, is usually about a year. For general home rehabilitation assistance, Community Development Block Grant (CDBG) funds administered by the counties is the most common source, and have extensive waiting lists several years long. These programs can and sometimes do also provide assistance for accessibility modifications, usually small modifications when larger rehabilitation projects are being done. These are frequently not tracked with much detail, as HUD only allows the modification to be reported as an accessibility modification if the home is brought up to full Section 504 accessibility, which is not usually the case. Loan programs are also available but are less widely used, as most households cannot afford to make payments on a loan and need grant assistance. For this report, programs offering home rehabilitation or accessibility modification assistance were surveyed.



Source: LaPlante, 2003, data from National Health interview Survey - Disabiility Supplement

Table 48: Rehabilitations and Accessibility Modifications in Delaware Homeowner Rehabilitation Programs

Program	Number	Time Period
New Castle County Architectural Accessibility Program Other CDBG rehabs occasionally include small accessibility modifications, usually for elderly homeowners.	23	FYs 2009, 2010 and 2011 YTD through April
DSHA Home Rehabilitation Loan Program (HRLP)	No recent loans for accessibility: small program of usually 10-15 loans per year	FYs 2009 and 2010
DSHA CDBG and HOME-funded Rehab (administered by Kent and Sussex Counties)	Four year sample of CDBG rehabs from Sussex County showed 20 (6%) of 236 rehabs included some accessibility modification	FYs 2007 - 2011
Milford Housing Development Corporation (MHDC) RC& D Project Emergency rehab needs, occasionally will do some accessibility modifications if necessary and related to the other work (such as replacing a tub, adding grab bars, etc.)	36 wheelchair ramp installations or extensive repairs 8 bathroom tub/shower conversions 5 entry doors widened Approximately 300 repairs annually overall	4 quarters from April 1, 2010 – March 31, 2011
Rural Development 504 Program	Most are elderly, about 50% include some accessibility modifications. About 10 total annually.	n/a
DSAAPD Home Modification Program	64 completed and 23 pending as of April, 2011, with a waiting list of 74.	FY 11 YTD as of April
Division of Vocational Rehabilitation	85 households assisted with home modifications in FY 2010. Projecting to serve 110 in FY 2011	FY 2010
Colonial Paralyzed Veterans Association	47 accessibility modifications (30 ramps, 17 bathrooms, doors, railings or stairglides)	2009 and 2010
City of Wilmington	45 homes rehabbed for elderly owners 21 with some accessibility modifications 9 on current waiting list, 4 for accessibility needs	

The housing rehabilitation programs are frequently assisting households with accessibility modifications as part of their work. These programs overwhelmingly serve elderly and very low-income homeowners, and this assistance is in very high demand. MHDC provides emergency rehabilitation assistance to approximately 300 homeowners per year, 75% with income below $15,000, approximately 40% elderly, and 25% with a head of household with a disability. For larger or non-emergency needs, many households join the CDBG waiting lists. While waiting for CDBG assistance, many individuals may be living without modifications they need as they wait – increasing their risk for a fall or other injury. There appear to be opportunities to improve coordination among housing rehabilitation and accessibility modification programs in the state, and for housing rehabilitation programs to improve their recording of accessibility modifications they perform.

ELDERLY HOMEOWNERS

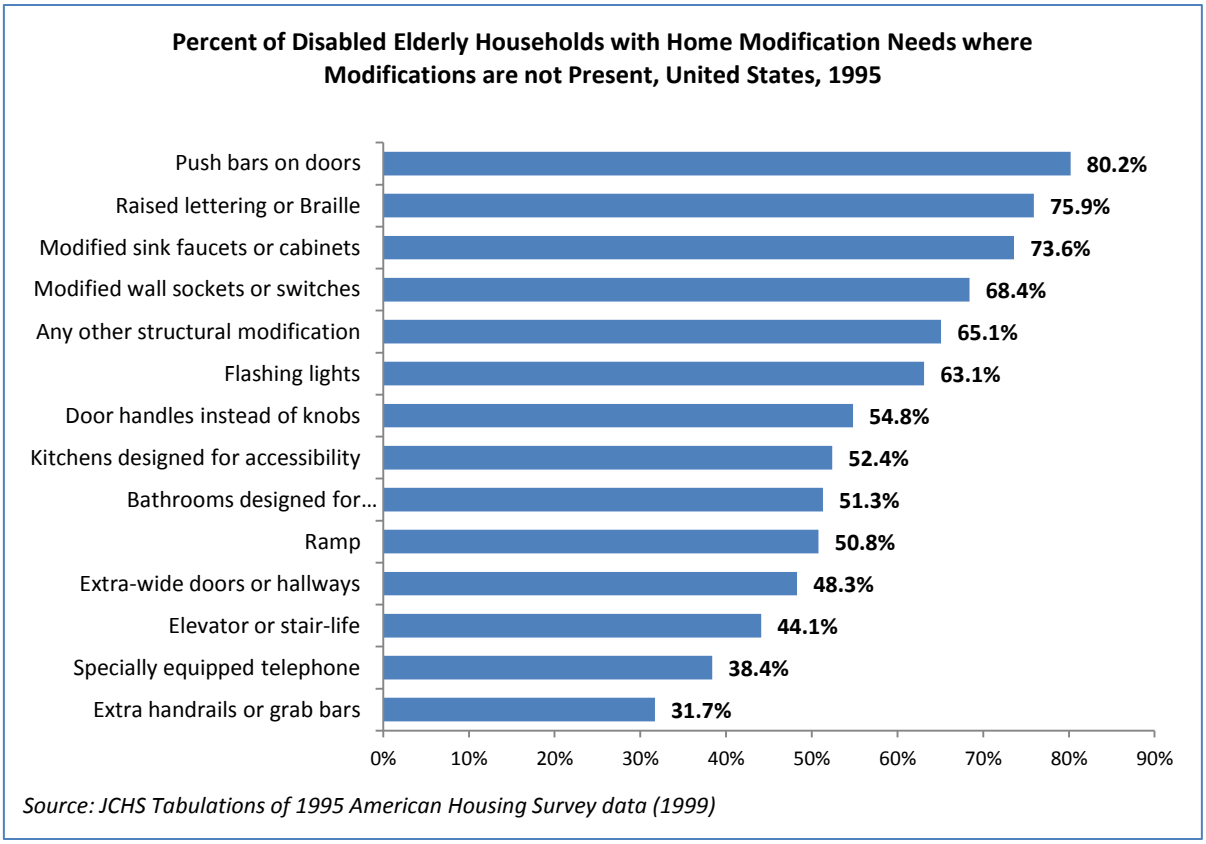
Especially for elderly households, the lack of accessibility features in their home can lead to unnecessary institutionalization, sometimes due to injuries from falls. DSAAPD program staff notes that other income issues can create barriers to accessibility modifications, even with assistance: it's not uncommon for building permits for accessibility modifications to be denied due to back taxes, for example. Accessibility modifications may understandably be a low priority compared to other pressing material and medical needs.

The 1995 American Housing Survey included a special supplement on home modifications, and tabulations of these data by the Joint Center for Housing Studies break these out by type.[71] Overall, 8.0% of elderly households with disabilities reported needing special modifications, equipment, or the assistance of another person around the home because of a physical limitation: this percentage is similar to the prevalence reported in other national surveys of older adults needing personal assistance with ADLs/IADLs. Among elderly (65 or over) households with disabilities who expressed needing home modifications, about 50% of households who needed accessible kitchens, bathrooms, ramps, doors or hallways had them. Overall, only about half of elderly households with disabilities have the modification that they explicitly state they need.

While state-level data on homeowners with disabilities are not available by age, disability, tenure and income all together, we know from other tabulations that the elderly are strongly represented among low-income homeowners and low-income homeowners with housing problems. 52% of homeowner households in Delaware with very low incomes (<50% of median) have at least one member who is 62 or over.[72] Of these 17,690 very low income homeowner households with at least one elderly member, 50% (8,830) are cost-burdened, 61% of them severely: paying more than 50% of their income towards housing costs.

Table 49: Elderly Very Low Income (VLI) and Cost-burdened Owner-occupied Households, Delaware, 2006-2008

	Households
Total owner-occupied households	239,460
Very low-income (VLI) owner-occupied households	34,300
Percent of all owner-occupied households	*14.3%*
Very low-income elderly owner-occupied households	17,690
Percent of all VLI owner-occupied households	*51.6%*
Very low-income cost-burdened owner-occupied households	27,710
Percent of all VLI owner-occupied households	*80.8%*
Very low-income elderly cost-burdened owner-occupied households	8,830
Percent of all VLI owner-occupied cost-burdened households	*31.9%*
Very low-income elderly severely cost-burdened owner-occupied households	5,420
Percent of all VLI elderly cost-burdened households	*61.4%*
Source: HUD 2006-2008 CHAS data	



Considering the high prevalence of disabilities and increased need for assistance with ADLs and IADLs among older adults, it is likely that many of the estimated 17,690 very low-income homeowner households with members over 62 have disabilities and potentially accessibility and service needs. As a rough measure, applying prevalence rates for people over 65 from the 2008-2010 American Community Survey for Delaware to these data on very low-income elderly homeowner households suggest approximately 6,200 very low-income elderly homeowners any disability in Delaware, 3,800 with ambulatory difficulty, 1,150 with self-care difficulty and 2.600 with independent living difficulty. Considering that the prevalence of disabilities is typically higher for lower-income households, the actual number may be higher. These households are likely to have a need for minor or major accessibility modifications as well as probable general home maintenance and rehabilitation needs.

Table 50: Estimates of Very Low Income (VLI) Elderly Homeowner Households with Disabilities, Delaware

	Households	
Very low-income (VLI) elderly owner-occupied households	17,690	
	Rate	**Estimate**
With any disability	34.8%	6,156
With an ambulatory disability	21.6%	3,821
With a self-care disability	6.5%	1,150
With an independent living disability	14.5%	2,565
Source: Households: HUD 2006-2008 CHAS data; Rates: U.S. Census Bureau, 2008-2010 American Community Survey		
Note: Individuals can report more than one disability, so the estimates should not be totaled.		

BASIC ACCESSIBILITY NEEDS ACROSS THE POPULATION AND HOUSING STOCK

As the population ages, and disability rates increase with age, there will be substantial increase in the number of persons with intermittent or long-term disabilities. Nationally, an estimated 21% of households will have at least one disabled resident in 2050, using physical limitation (long-lasting mobility impairments) as the measure of disability, and 7% when using the measure of self-care (Activities of Daily Living - ADLs) difficulty. There is a 60% probability that a newly built single family detached unit will house at least one disabled resident during its expected lifetime using the first measure (physical limitation), and a 25% probability using the self-care/ADLs measure. When visitors are accounted for, the probabilities rise to 91% and 53%.[73]

There are too many flexible variables and too little reliable, detailed data both about specific needs and the existing housing stock to estimate a certain number or percentage of new housing units in Delaware which must be accessible and at what level. However, the available data can lead us to several broad conclusions:

1) As the population ages, the likelihood that a housing unit will house people with disabilities, either temporarily or long-term, increases significantly;

2) Accessibility features are a vital support for all people to age in place and live independently and in the community as long as possible: by 2040, 30% of Delaware's population will be over 60; and

3) With many varying levels of physical disability and functional limitations, full accessibility may not be needed by all, but the greatest majority of people may find benefit from basic access (visitability) and universal design features that can be supplemented with additional modifications as necessary: no-step entries, wide doors and hallways, one accessible bathroom and bedroom.

ASSET BUILDING OPPORTUNITIES

As discussed earlier, there are numerous links between disability, especially severe disabilities, and unemployment, low earnings, poverty, and material hardship. People with disabilities, particularly severe disabilities, are especially likely to be in poverty long-term. Asset limits for critical income support programs remain fairly low, further inhibiting people with disabilities' ability to build assets.

For many households, homeownership is the most tangible opportunity to develop assets. People with disabilities may also benefit from investing in assistive technology, which can be expensive depending on their needs; modifications to a home they already own; purchasing a vehicle with modifications; or, like anyone else, being able to invest in education, starting a small business, or homeownership. However, many people with disabilities are starting out in such a financially precarious state and with such low incomes that there may be numerous steps before they can consider or achieve homeownership or other major investments or purchases.

Low-income people face barriers to accessing the financial mainstream, these may be even more pronounced for people with disabilities with the additional challenges they may face with transportation, communication, and accessibility. A 2007 survey of taxpayers with disabilities found that 30% reported no savings or investments at all, compared to 12 percent of taxpayers without disabilities.[74] They are also less likely to even have a bank account: a Government Accountability Office (GAO) report found that more than half of Supplemental Security income (SSI)

payments were made by check principally because the recipients did not have a bank account for direct deposit. Two-thirds of SSI recipients reported being unbanked: having no relationship with a traditional bank.

Asset-building programs have gained momentum as strategy to help people escape poverty but have often not considered the unique needs of people with disabilities. Attention to the need for asset-building strategies and supports for people with disabilities has only increased in the past few years and formal research and program evaluation efforts to document best practices are in their infancy. Research has shown that people with disabilities save successfully in IDA programs, although they are able to save slightly less (in terms of an average net monthly deposit) than their counterparts without disabilities. People who participated in asset-specific financial education in conjunction with their IDA program were found to save more. Preliminary research suggests that extra outreach to people with disabilities and specialized education programs as well as identification of physical access and participation barriers is important.[75]

To help people with disabilities to develop assets (of which homeownership may be one opportunity), needs are similar to those for all people with low incomes. These include:

- Raising asset limits for income and other support programs for people with disabilities;
- Improving access to the financial mainstream for banking, saving and investing;
- Expand IDA programs and include other major purchases that may be important for people with disabilities, such as assistive technology or modified vehicles;
- Offer financial coaching and case management to help consumers weave asset-building programs together and use them successfully.

OTHER ISSUES

FOCUS GROUP FEEDBACK

From April – May 2011, the study working group hosted six focus groups to gather feedback from consumers and others to inform this report. Groups included:

- Aging and Physical Disabilities
- Intellectual/Developmental Disabilities
- Substance Abuse/Mental Health
- HIV/AIDS
- Housing Developers and Service Providers
- Foster Youth

Volunteer facilitators asked a series of general open-ended questions (see Appendix C for script) about housing for people with disabilities, barriers to housing, the housing system in Delaware, and sources of information about housing. There was also opportunity for open discussion. The groups were generally very well attended and included many consumers as well as advocates and service providers. The groups proved a valuable source of information for the report and provided feedback that influenced the review of needs but especially the report's

recommendations. While much of the feedback was specific to the population, themes did emerge across many of the groups.

In Delaware's housing system and the housing system for people with disabilities, focus group participants reported seeing a lack of coordination, and that the systems are exceedingly difficult for consumers to navigate. Multiple waiting lists and confusing and varying eligibility criteria were particularly noted. While participants frequently commented that the existing subsidized housing for people with disabilities is incredibly valuable and improves the housing situation and security of many with disabilities in Delaware, the system also does not acknowledge the importance of integration as well as accessibility and affordability.

In regards to accessing information about housing, a frequently repeated comment in almost all focus groups was the fragmented system for information: there is no one person or place to explain all the options and point people in the right direction the first time. Consumers frequently just get a barrage of phone numbers and lists of organizations to sort through on their own. Luck and word of mouth from others often finally connect people to the programs they need and are eligible for.

Persistent stigma associated with disabilities, especially HIV/AIDS and substance abuse and mental health disabilities, was noted as a major barrier as housing discrimination and source of income discrimination continue.

The critical need for subsidies, either project-based or tenant-based, to reach extremely low incomes was a strong point among developers and service providers. There is limited development capacity for the development of specialized projects, and a key part of the problem is developers not understanding the market for housing for people with disabilities, or its size and depth. This includes both more specialized housing, like permanent supportive housing, as well as the overall need for basic accessibility features in new housing. To set aside units for people with disabilities, supportive services, a source of subsidy, and a reliable source of referrals all must come together for it to "work" for a developer, and these are not areas where they tend to have existing expertise.

Some common items noted in response to a question about what could be done differently in Delaware included:

- **Increase options** – there should be a full continuum of housing opportunities. There is a lack of new options and housing initiatives in Delaware, and some creative options have not been explored. Congregate or clustered settings with peer support and independent apartments with tenant-based rental assistance should both be options. Consumers must have meaningful choices: to live independently, with family, with roommates, etc. Choices are meaningful when all are realistic, feasible options with sufficient supports.
- **Improve coordination** among PHAs to benefit consumers, especially unifying and opening waiting lists. Accessing, getting on and monitoring multiple waiting lists and policies is a major challenge to consumers.
- **Aging in Place** - Think more broadly and strategically about "aging in place" and increasing general (and perceived) demand for universally designed/adaptable/visitable homes. We tend to think about it in terms of helping people remain in the homes they have via modifications and services, but we must also think about aging in place in terms of creating housing that is designed to facilitate aging in place.
- **Matching people to units** – Managers report that they have difficulty filling units; consumer advocates report that they cannot access accessible units. Access to real-time information on available units with accessibility and other detail is needed, as is a steady stream of referrals if units are set-aside.

- **Transportation** – transportation and isolation can be major challenges in more rural areas for group homes and all community housing situations.

Finally, three major themes across all the groups were:

1) Accessibility and the supports required to live in the community are fluid and unique to the individual. A range of responses is required to meet a range of needs: young to elderly, different combinations of needs, different levels of service needs, different living situations;
2) Choices for consumers should include a variety of housing settings and situations. Congregate or clustered settings which can provide informal peer support and independent apartments with tenant-based rental assistance should both be options. People must have meaningful choices: to live independently, with family, with roommates, etc. Choices are meaningful when all are realistic, feasible options with sufficient supports.
3) Moving to living independently can be a major adjustment for individuals too, with new responsibilities, new concerns, and household needs. Supporting people to transition to or remain in the community is not as simple as just getting them into housing, but providing long-term support and ensuring that housing and services are designed in such a way as to make living in the community realistic, sustainable, and beneficial to the consumer.

FAIR HOUSING ISSUES AND DISCRIMINATION

In 2005, paired testing in the Chicago metropolitan area conducted as part of a HUD report on discrimination found that people who were deaf or used wheelchairs when searching for housing to rent faced significant discrimination.[76] People who used the TTY relay system to inquire about advertised rental units were refused service in one out of four calls. For testers using wheelchairs, one in every four disabled testers was told about fewer units than similarly qualified testers with no disabilities and both received far less information about the application process. One in six housing providers refused a request for a reasonable modification that they tester said they would pay for and 19% of those with on-site parking refused to make the reasonable accommodation of providing a designated accessible parking space for a wheelchair user. In addition, wheelchair users were denied the opportunity to inspect any units in three of ten visits.

It should be no surprise, then, that the most common basis of fair housing complaints nationally is disability, alleged in 44% of complaints filed under the Fair Housing Act and substantially equivalent state and local laws in 2009.[77] The most common alleged issues are discrimination in the terms or conditions of the sale or rental of property (55% of complaints), refusal to rent (24%), and failure to make a reasonable accommodation (22%). In Delaware as well, disability is the most frequent alleged basis of discrimination, followed by race. 139 (42%) of 327 complaints from January 2000 – August 2010 in Delaware were disability related.[78] About one third of the total cases were located in the Cities of Wilmington or Dover. The Community Legal Aid Society (CLASI) also receives complaints regarding alleged violations of the Fair Housing Act: between January 2009 and October 2010, CLASI received 337 complaints alleging discrimination, 163 (48%) of these disability-related. 61 (82%) of the 74 cases settled through CLASI over this time period involved alleged discrimination on the basis of disability.

RECOMMENDATIONS

Through the collection of national and state data and the qualitative feedback from the focus groups, the working group identified four major areas (Accessibility, Affordability, Community Care, and Systems) where there are barriers to housing for people with disabilities in Delaware and recommendations to address and improve each.

1. **Accessibility: Increase the availability of and access to rental and homeownership opportunities with accessibility features.**
   - 1.1. Improve real-time information on available accessible and affordable units for consumers.
   - 1.2. Reduce fair housing barriers to affordable and accessible housing.
   - 1.3. Establish a common vocabulary and set of standards for accessibility features in the affordable housing industry.
   - 1.4. Increase the prevalence of basic access features in all new homes.
   - 1.5. Expand and coordinate resources for accessibility modifications for homeowners and homebuyers.
2. **Affordability: Increase the availability of and access to affordable housing for people with disabilities.**
   - 2.1. Increase the availability of Low Income Housing Tax Credit (LIHTC) properties to people with disabilities, especially those with extremely low incomes.
   - 2.2. Expand incentives for basic access and universal design features in affordable housing.
   - 2.3. Continue to invest in permanent supportive housing.
   - 2.4. Improve asset-building opportunities for people with disabilities.
3. **Community: Build a community-based system of care with a range of housing options.**
   - 3.1. Prioritize community-based care by redirecting resources from institutional care to community-based services and providing for housing needs.
   - 3.2. Ensure a range of housing options, meaningful choices and adequate supports for people to live and receive care in the community.
   - 3.3. Continue to develop and implement diversion and transition strategies to prevent institutionalization and reduce readmissions.
   - 3.4. Implement the Delaware policy statement *Exemplary Practices in Discharge Planning*, especially at all state-operated institutions and prisons, to improve connections to permanent housing and prevent subsequent homelessness.
   - 3.5. Improve community planning to benefit community quality of life for all residents and foster real integration for people with disabilities.
4. **Systems: Improve the affordable housing and disabilities services systems that serve people with disabilities.**
   - 4.1. Continue to build connections between the affordable housing and disabilities services systems.
   - 4.2. Improve triage assessment of consumers' housing needs and statewide collection of data about these needs.
   - 4.3. Foster and improve coordination among the state's Public Housing Authorities (PHAs), both among themselves and with providers of services to people with disabilities.
   - 4.4. Improve the housing system's communication with consumers and develop more accessible, centralized, user-friendly sources of information.
   - 4.5. Facilitate input about disability housing needs into the various housing and disability planning processes.

1. INCREASE THE AVAILABILITY OF AND ACCESS TO RENTAL AND HOMEOWNERSHIP OPPORTUNITIES WITH ACCESSIBILITY FEATURES.

1.1 IMPROVE REAL-TIME INFORMATION ON AVAILABLE ACCESSIBLE AND AFFORDABLE UNITS FOR CONSUMERS.

Multifamily site managers and developers report problems filling accessible units, but consumers and advocates report difficulty in finding accessible and affordable units. To help bridge this information and communication gap, ideally, Delaware should develop:

a) An online housing registry that could bring together real-time information on accessibility and availability of units. Beyond accessibility information, this could also be a general affordable housing resource, as no such real-time information on vacancies is currently available in Delaware. Key searchable information should include vacancies and waiting list information, location, and accessibility features. Ideally, site managers use the website as a marketing tool and maintain current information about additional items of interest to potential renters such as security deposits, pet policies, utilities included in rent, and others.

   Some state housing finance agencies require participation by monitored/financed sites in such registries, and market sites could be recruited to participate. There are vendors that offer the development and maintenance of these websites as a service, a few states have developed their own. They are typically partnerships between several state agencies.

b) Real-time information on households/individuals who need housing from the Department of Health and Human Services (DHSS). DHSS is working on having an agency-wide list of individuals waiting/looking for housing to be updated monthly.

PROGRAM PROFILE: MASSACCESS HOUSING REGISTRY

The MassAccess Housing Registry site is maintained by the Citizens Housing and Planning Association (CHAPA), a nonprofit umbrella organization for affordable housing and community development activities in Massachusetts. Its costs are supported by the Massachusetts Rehabilitation Commission, a division of the Massachusetts Office of Health and Human Services providing services to people with disabilities. CHAPA and the MRC worked with a Boston-based consulting firm to develop the site; ongoing maintenance and updating of information are provided by CHAPA. As part of this, CHAPA offers ongoing training to property managers, landlords, service providers and caseworkers.

The site includes listings for homeownership and rental housing opportunities. Property managers and landlords can log in directly to list units. A variety of basic and advanced search functions are available, including location, number of bedrooms, availability, accessibility features, affordability, and subsidies.

1.2 REDUCE FAIR HOUSING BARRIERS TO AFFORDABLE AND ACCESSIBLE HOUSING.

Fair housing remains a barrier to securing and maintaining affordable and accessible housing for people with disabilities. People with disabilities continue to face stigma and its effects in almost all areas, and discrimination in housing persists.

There is an ongoing need for consumer and landlord education on tenant rights and fair housing laws. Multifamily site managers report that many accessible units are occupied by households without disabilities, but it is not clear how informed people are on their right to identify themselves as someone with a disability in order to receive fair housing accommodations. Similarly, the public and housing providers need to be educated about the need for accommodations for persons with disabilities. Education and training on fair housing responsibilities should be tailored to specific audiences, such as multifamily managers, landlords, elected officials and local government leaders and staff. The Division on Human Relations and its partners should continue and expand fair housing training in the state.

Source of Income discrimination is a common fair housing issue for people with disabilities (SSI, SSDI, housing assistance like HOPWA). Adding Source of Income as a protected class in the state's fair housing laws would benefit this population. While the City of Wilmington's fair housing code protects "economic status", it is not enforced. Well over 100,000 families, people with disabilities and senior citizens rely heavily on some form of non-wage income in Delaware (2005-2009 American Community Survey): non-wage income includes any lawful subsidy or benefit, such as SSI, SSDI, TANF, child support, and other federal and state or local public assistance or rental assistance. Source of income discrimination protection can be very important to protect voucher holders, improve voucher placement rates, and improve housing opportunities for households relying on federal, state or local income supports or rental assistance. At least 11 other states and many other jurisdictions protect source of income. Fair housing advocates and legislators should consider and advance legislation to add source of income as a protected class in the state's fair housing laws.

For people with substance abuse or mental health disabilities, registry as a sex offender creates additional barriers as it precludes their consideration for publicly subsidized housing. The Delaware Interagency Council on Homelessness (DICH) worked with the Department of Corrections to develop a process to assess low-risk sex offenders, which would allow for case-by-case assessments of these individuals rather than a blanket prohibition that prevents any consideration of them. Implementation of this assessment process would improve housing options for people with disabilities who are low-risk registered sex offenders and may be currently institutionalized, homeless, or at high risk for institutionalization or homelessness. There may be opportunities to improve access for other offenders as well via similar partnerships.

1.3 ESTABLISH A COMMON VOCABULARY AND SET OF STANDARDS FOR ACCESSIBILITY FEATURES.

Throughout the course of our community outreach for this study, we received repeated comments as to the major challenge posed by confused and differing understandings of key terms. Different agencies and developers use terms differently and sometimes inconsistently. This is particularly an issue for "visitability" (referred to as basic access in this report) and "universal design", where no clear regulated standards exist. For adaptability and accessibility, HUD's

504 or UFAS standards apply. Adaptability is also frequently confused, and people often say or label units as "accessible" when they may have just a few specific features. Further, all projects are subject to local building code, which in all three of Delaware's Counties use ANSI standards. ANSI standards for accessibility exceed 504 and UFAS accessibility standards.

There is a need for clear definitions of various levels of accessibility everyone in the state can refer to: Universal Design, basic access/visitability, adaptability, accessibility. It might be ideal for a statewide entity like DSHA to set its own standards for UD and basic access that would likely be adopted by many other funders and could be a statewide point of reference, like DSHA's Minimum Construction Standards. Indeed, the lack of such national or local standards is likely the main barrier to increased incentives for accessibility features that improve livability and visitability without reaching the full accessibility as described by Section 504, UFAS, or ANSI. Several states have identified their own construction standards and manuals for universal design and visitability: for example, both Florida and Virginia have universal design manuals which provide specifications for what meets that designation, and Oregon mandates and defines visitability (basic access) in their construction standards.

PROGRAM PROFILE: STATE MODELS USING INCENTIVES TO INCORPORATE UNIVERSAL DESIGN AND VISITABILITY IN AFFORDABLE RENTAL HOUSING

Several states offer some incentives for the addition of optional universal design and/or visitability features in their LIHTC Qualified Allocation Plans (QAP)s or construction standards. Some examples include:

Florida: All units must be visitable. Florida's QAP offers 10 points (13% of total points) for additional optional universal design and/or visitability features in at least 20% of units. The HFA has a Universal Design and Visitability Manual listing required and optional features for family and elderly new construction and rehabilitation sites.

Indiana: Indiana's QAP requires 6% fully accessible units in new construction (over the usual 5% for rehabilitation projects). The QAP also offers different points levels (up to 4 out of 200 points total, 2.0%) for picking 1-4 universal design features from each of 3 columns.

Maine: Maine offers 4 points (5% of total points), 2 for each 10% of units above the minimum that meet the requirements of "Voluntary Pledges" in Maine Housing's Design and Construction Manual.

Wisconsin: Wisconsin's QAP offers 32 points (8% of total points) for listed universal design features in at least 20% of units.

Virginia: Virginia's QAP includes 6 points (0.5% of total points) for specific universal design features in elderly units. 15 (1%) points are available for 100% of units in an elderly site constructed to meet VHDA's Universal Design Standards, 15 points multiplied by the percentage of units meeting this requirement in non-elderly developments. Project sponsors must use a UD-certified architect approved by the housing finance agency.

Pennsylvania: Pennsylvania's QAP offers 10 points (7% of total points) for sites proposing double the required number of fully accessible units.

Maryland: Maryland's QAP offers 6 points (2% of total points) in a subjective "Development Quality Criteria" category that includes Universal Design.

1.4 INCREASE THE PREVALENCE OF BASIC ACCESSIBILITY FEATURES IN ALL NEW HOMES.

Across the population, the most widespread need is not always for fully accessible units, but units with basic accessibility features that allow for basic access and essential needs. While there are already requirements for fully accessible units in publicly funded rental sites and visitability/basic access in all first-floor multifamily units, there are no requirements at all for the type of housing that makes up the vast majority of the housing stock – single family attached and detached homes. There are two separate approaches with different goals:

1) To ensure some (5%) fully accessible units are built and set aside for people with disabilities in multifamily rental sites constructed with public funds and first-floor units in multifamily sites, regardless of tenure, must have basic access features.
2) To ensure that as many homes as possible, across the entire housing stock, are initially built to be as accessible as possible for everyone by incorporating a few key features to ensure basic access: one no-step entry, at least 32 inches of clear passage through the entire first floor, and at least a half-bathroom on the first floor.

Additionally, either a bedroom on the first floor or a room that can be used as a bedroom can also be included as a basic access feature. Basic accessibility features will meet the needs of many with physical disabilities, ensure visitability from friends and family with disabilities, and account for needs that arise from temporary disabilities. In single-family homes, retrofitting costs for entryways, clear passage and basic bathroom facilities can be very costly to retrofit.

There are several examples of both mandates and voluntary programs to increase the number of homes built with basic access or visitability features. From a production standpoint, mandatory programs are far more successful in producing units than voluntary programs, although mandatory programs are often strongly opposed by related industry groups and subsequently difficult to enact. In some states and jurisdictions, a compromise has been applying a mandate only to homes built with public support or financing. However, depending on the size of the jurisdiction and how much new construction of single-family homes are developed with federal funds, this approach typically affects very few homes compared to overall development in a community.

Other voluntary programs offer incentives such as fee waivers or streamlined permitting, or certificates that help prospective homebuyers identify homes built to certain accessibility standards. Others, such as California's statewide requirement, simply mandate that developers offer a set of accessibility features as options to homebuyers to ensure they are available and increase the likelihood that buyers will choose to include them.

The state of Delaware and jurisdictions within the state should consider incentive programs to increase the number of homes built for basic access or visitability. We understand there are various regional differences and challenges in the type of foundation commonly used and other considerations, but we should encourage builders, advocates and local officials to work together to identify creative solutions to these challenges while still developing homes with accessibility features to meet the needs of the state's population. In particular, basic access should be incorporated in proposals to provide incentives for projects that meet other goals, such as access to transportation, affordability, and mixed income or mixed use development.

Improved understanding of the need for accessible housing both within the housing industry and among consumers would also likely increase the prevalence of basic access features in new homes. The vast majority of new homes are

not built with even the most basic access features, and are often not even available options. However, households are also not demanding these features, despite numerous extensive surveys reporting that people overwhelmingly desire to remain in their homes as they age and a high likelihood that a new home will be occupied by someone with either a temporary or permanent disability in its useful life.

From the focus groups and interviews, we heard that developers do not have a good sense of the scope of demand for housing among persons with disabilities, both in rental housing and for universally designed, visitable and fully accessible homes in general. The complexity of the market may seem overwhelming, and without a clear understanding of what the demand is, developers cannot respond.

To improve understanding about the demand for housing with accessibility features and people with disabilities as a sizeable market now and in the future, affordable housing and disability advocates should establish communication with the development and real estate industries to improve understanding of the disability housing market and conducting outreach to developers on the need and demand. This could include venues such as co-hosting educational events with industry groups like the Delaware Association of Homebuilders, Delaware Association of Realtors, Delaware Apartment Association and others as well as a presence at other real estate-related events and groups in Delaware.

Finally, we should engage in consumer education to help increase demand for universally designed and visitable homes. In surveys, individuals report strong desires to age in place and strong support for a range of housing options that allow people to remain in the community, but this to date has not translated into strong demand for these types of homes. This is the demand that market-rate developers will respond to, to start including universal design features as standard and options in new construction, and considering basic access in site design.

PROGRAM PROFILE: AUSTIN, TEXAS S.M.A.R.T.HOUSING™ PROGRAM

In 2000, the city of Austin, Texas launched its S.M.A.R.T.Housing program (Safe, Mixed Income, Accessible, Reasonably Priced, Transit Oriented) to offer incentives for developers to incorporate a number of socially responsible features in new development.

Single-lot, infill and new subdivision development are all eligible, as are both single-family and multifamily projects. Projects participating in the S.M.A.R.T.Housing program can receive fee waivers, fast-track review and permit processing, and density bonuses. In cases of extreme challenges, waivers of the no-step entry requirement are available. From April 2000 – 2008, 2,700 homes were developed through the program.

Austin defines “reasonably priced” as affordable to households at 80% of Area Median Income spending no more than 30% of their income on housing. Only a percentage of the units in a project must meet “reasonably priced” guidelines, but visitability standards are applied to all units. The S.M.A.R.T.Housing Program requirements for single-family homes include:

- No-step entrance with an accessible route
- Clear passage on all first-floor interior doors and hallways
- Lever handle hardware
- ½ bathroom on first floor with reinforced walls for grab bars
- Accessible electrical switches, plugs and thermostat controls.

1.5 EXPAND AND COORDINATE RESOURCES FOR ACCESSIBILITY MODIFICATIONS FOR HOMEOWNERS AND HOMEBUYERS.

There is an ongoing need for accessibility rehab assistance, as well as value in improving the coordination among housing rehab programs (like those funded by federal Community Development Block Grant (CDBG) funding) and accessibility-specific rehab programs operated by non-housing agencies. Housing rehab programs are often performing some accessibility modifications, and households getting accessibility modifications from accessibility-specific programs may have other housing rehab needs. Recommendations in this area include:

a) Consider opportunities to improve coordination between housing rehab and accessibility rehab programs. The partnership between CDBG and the Weatherization Program in Kent and Sussex Counties, where Weatherization addresses windows, doors and related items and CDBG addresses other needed repairs, may be a good model to evaluate.

b) Expand resources for housing rehab and accessibility rehab programs.

c) Identify sources of assistance for homebuyers at the point of purchase, including ranging up to moderate income. This may be a small niche need, but families with accessibility needs looking to purchase a home are often very limited by the available stock. A loan that could be used at the point of purchase to make modifications would be a useful resource.

d) Review and develop standard building requirements for accessibility items (like ramps) between the counties and municipalities. Operators of rehab programs complain about very different and sometimes burdensome requirements varying from county to county, which can significantly impact costs.

e) Many single-family homes are vacant, distressed, or entering the rental housing stock due to the foreclosure crisis and struggling housing market. As we seek ways to keep homes in active use and reduce vacancies, we should explore incentives to encourage investors to rehabilitate single family homes for accessible rentals.

As the result of the implementation of the Diamond State Health Plan Plus (DSHP Plus) initiative on April 1, 2012, individuals eligible for Medicaid who are enrolled in the Elderly and Disabled Medicaid Waiver will transition to a managed care system of delivering long-term care services. The new benefit package will include home modifications to help people remain in their homes. Many individuals who need wheelchair ramps and are currently on waiting lists will get them more quickly through DSHP Plus; this may also be an opportunity to coordinate accessibility needs with other home rehabilitation needs.

Government jurisdictions funding housing rehabilitation and accessibility modifications and nonprofit service providers of both rehabilitation and accessibility modifications should come together to examine their program offerings, eligibility requirements, funding, and needs for their services to explore new ways to coordinate and improve services to consumers.

2. INCREASE THE AVAILABILITY OF AND ACCESS TO AFFORDABLE HOUSING FOR PEOPLE WITH DISABILITIES.

2.1 INCREASE THE AVAILABILITY OF LOW INCOME HOUSING TAX CREDIT (LIHTC) PROPERTIES TO PEOPLE WITH DISABILITIES, ESPECIALLY THOSE WITH EXTREMELY LOW INCOMES.

For the past two decades, the federal Low Income Housing Tax Credit (LIHTC) program has been the nation's main vehicle for providing financing for the new construction and rehabilitation of affordable rental housing. 10-year tax credits are allocated to the states based on their population; states complete and release an annual Qualified Allocation Plan (QAP) which governs how the credits are awarded. Developers who are awarded credits then sell those credits for equity that contributes to making the housing affordable. Then, the housing must remain affordable for a 15-year Compliance Period and subsequent 15-year Extended Use Period. However, the program targets households at 50 – 60% of Area Median Income, and it is very challenging to create housing for lower-income households using the LIHTC without another source of rental subsidy. Units in LIHTC sites with other sources of project-based subsidy, not set aside for people with disabilities, are in extremely high demand and may be difficult for people with disabilities to access.

On some occasions, the LIHTC has been used to support projects targeted to people with disabilities. However, the development of set-aside, non-integrated units for people with disabilities is no longer an appropriate strategy. The settlement agreement between the State of Delaware and the U.S. Department of Justice does not permit the clustering of people with known disabilities in non-integrated housing, which not only prevents the further development of such housing but also may challenge the viability of some already existing affordable clustered housing. In the future, set-aside housing for people with disabilities should be fully integrated into typical housing in multifamily developments.

One broad strategy to increase the availability and affordability of LITHC sites to people with disabilities and extremely low incomes is to enact policies requiring, or strongly encouraging, the integration of units for persons with disabilities. These units need not all be fully accessible but ideally should all be subsidized. There are numerous models nationally for successfully encouraging the development and set-aside of units for persons with disabilities. Successful programs also develop the structures to ensure that a steady stream of referrals are available, that consumers are connected to any supportive services they need to live independently, and units are affordable to the target population.

There are many ways this can be structured, and many models available. Some states simply require that a percentage of all units be set aside for people with disabilities with extremely low incomes, and expect developers to identify how to make the units affordable or make available some state-level source of project-based subsidy for those units. Instead of a requirement, some states simply provide incentives for developers to include and set-aside affordable units. In either case, most also require a Memorandum of Understanding between the developer and a local agency who will be responsible for providing referrals and ensuring that residents have services.

PROGRAM PROFILE: USING THE LOW INCOME HOUSING TAX CREDIT TO REACH PEOPLE WITH DISABILITIES AND EXTREMELY LOW INCOMES

In recent years, many states have expanded their efforts to use the LIHTC to create housing for households with disabilities and extremely low incomes, particularly integrated into regular multifamily projects. Several states (Alaska, Pennsylvania, North Carolina, Michigan, Minnesota and Massachusetts) require a set-aside – usually 10% - of units for persons with disabilities and/or extremely low incomes in all projects. Others simply provide incentives via points or set-asides in their QAP for projects that commit to set-aside a certain percent of units for these populations. There are many variables, including if and how the units are made affordable to extremely low income levels, partnership requirements for referrals and services, and additional accessibility requirements. Many use a "Local Lead Agency" model, where projects are required to have a partnership with a local lead agency that will handle referrals and ensure supportive services. Some examples include:

North Carolina: A National Model

North Carolina's efforts to provide integrated housing for people with disabilities have been a national model. Since 2002, over 2,200 integrated units of supportive housing have been created. The North Carolina QAP requires that 10% of units to be targeted to persons with disabilities or the homeless. Project based subsidies for set-aside units are available through the state's Key Program. Applicants must demonstrate a partnership with a local lead agency (to coordinate referrals and services) and a targeting plan that must be reviewed and certified by the North Carolina Department of Health and Social Services.

Connecticut: Incentives and Provisions for Extra Support

Connecticut's QAP allows applicants to request up to a 5% increase in developer fee for projects where at least 15% of units are targeted to special needs populations, to provide services or an internal rent subsidy. Points are available based on the percentage of units that the project has set-aside, units affordable to households below 25% of Area Median Income, or sites where the applicant commits to give priority to recipients of housing assistance and services funded through the Connecticut Supportive Housing PILOTS Initiative (a program similar to Delaware's SRAP).

Pennsylvania: A Mandate and Partnership

Pennsylvania's QAP requires that 10% of units be affordable to households at 20% of Area Median Income, and half of these units must be accessible. The developer must have an agreement with an agency to provide referrals and services. The QAP also allows developers of projects setting aside units for persons with disabilities to increase their developer fee up to 5% to fund an internal rent subsidy or services. In addition, the HFA has a partnership with the state Office of Mental Health and Substance Abuse Services (OMHSAS) and has dedicated $50 million in capital and operating subsidy for integrated units for this population. Tenants must be consumers of OMHSAS services, and the projects use a Local Lead Agency model through County-based mental health departments to provide referrals and services.

Upcoming changes to the federal Section 811 program, which was previously used almost exclusively for the development and housing subsidies for group homes and apartments only for people with disabilities, will further emphasize integration and coordinating support for special needs units with mainstream affordable housing development programs at the federal level. As part of these changes, new resources will be available for housing finance agencies and nonprofit developers to integrate subsidized units for persons with disabilities in multifamily developments.

A new stream of competitive funds would allow housing finance agencies (HFAs) to use project-based Section 811 subsidies in new or rehabbed multifamily sites financed through the LIHTC, HOME, or housing trust funds. This program is expected to be available in 2012: to apply, state housing finance agencies must demonstrate extensive partnerships with the state Medicaid agency to ensure referrals and services.

Nationally, nonprofit developers will also be able to apply directly to HUD for new Section 811 subsidies to provide project-based subsidy for up to 25% of units in a site for new projects. Delaware's LIHTC Qualified Allocation Plan (QAP) should encourage developers to pursue this option, although should consider limiting the maximum percentage of units to 20%, the level identified as a maximum in the State of Delaware's recent settlement with the Department of Justice.

Again, in both of these scenarios, Delaware's housing and disability services systems must be prepared to ensure that people get the support they need to live independently and that residents and rental assistance if necessary are available to ensure units can be filled.

PROGRAM PROFILE: SECTION 811

Section 811 is a critical HUD program that assists the lowest income people with long-term disabilities to live independently in the community by providing affordable housing linked with voluntary services and supports. Historically, this has been limited to group homes and other communal settings, such as independent living apartments where 100% of units are targeted to people with disabilities. Over the 20 years since its creation, Section 811 has created over 30,000 units for people with disabilities, with a median income of $9,204. Delaware has approximately 300 Section 811 subsidized units.

Over the past decade, the Section 811 program has become less effective, creating fewer than 1,000 new units per year through an outdated law that did not reflect best practices in disability or supportive housing policies (Technical Assistance Collaborative). The Frank Melville Supportive Housing Investment Act of 2010, passed in December 2010, made substantial changes to modernize the program. The legislation also authorizes $300 million in funding for each fiscal year from 2011 to 2015. The reformed Section 811 program is expected to dramatically increase production by providing stronger incentives to leverage other sources of capital for 811 units and authorizing state housing finance agencies to create integrated supportive housing units in affordable rental housing developments with Section 811 Project Based Rental Assistance. The legislation also permanently transfers Section 811 funded vouchers to the Housing Choice Voucher program and ensures that other Housing Choice Vouchers appropriated by Congress for non-elderly people with disabilities continue to be used for that purpose.

In the new Section 811 program, the Capital Advance/PRAC option remains available for group homes and independent living apartments, but two new options are created and will be prioritized:

Multifamily Capital Advance/PRAC Option: Nonprofit developers may apply to HUD for Section 811 Capital Advance gap financing and renewable PRAC for up to 25% of units in a multifamily project. Processing authority for this program may be delegated to the states from HUD field offices.

Housing Finance Agency (HFA) Model: HFAs may apply to HUD for Section 811 PRAC funds, for 5 year renewable contracts. HFAs then select projects to include Section 811 units, with criteria for eligible projects. As above, no more than 25% of units in a property may be set-aside. HFAs must have a written agreement with their state's Health and Human Services/Medicaid agency on the target populations, outreach and referral methods, and supportive service commitments. This will provide operating subsidies for PRAC units where capital advance funds are not needed: the goal of this new program is to take advantage of units that are already made affordable to 50 or 60% of AMI with LIHTC, HOME, or state housing funds.

For more information, visit the Technical Assistance Collaborative's online resource center on Section 811.

2.2 EXPAND INCENTIVES FOR BASIC ACCESS AND UNIVERSAL DESIGN FEATURES IN AFFORDABLE HOUSING.

Broader, more flexible, levels of accessibility allow for the greater use of units by households with various accessibility needs, short-term accessibility needs, and visitation by friends and family with disabilities. Funders should add incentives for different levels of accessibility – such as livability ("universal design") and basic access ("visitability") – not just full-Section 504-compliance.

In 2010, the Delaware State Housing Authority added five points (out of 135) to its Qualified Allocation Plan (QAP), for utilization of Low Income Housing Tax Credits, in order to reward applications that proposed to increase the percentage of units built to full accessibility standards beyond the required 5% to 10, 15 or 20%. In that year, all of the successfully ranked projects sought these points, for a total of 46 out of 355 units developed fully accessible (13%). Response in 2011 was similarly strong. In addition to the 5% fully accessible requirement for all projects, Delaware law requires that all first-floor multifamily new construction units with state funding be adaptable to full accessibility.

While the above incentives for additional fully accessible units have been successful, the QAP and most other affordable housing funding programs in Delaware do not currently include incentives for the inclusion of other basic access or additional universal design features. We would encourage public and private funders to consider incentives to encourage additional basic access and universal design features to meet the needs of households that do not require full accessibility but could benefit from some additional accessibility features and to improve access and functionality for all households. In addition, basic access should be considered not only for typical rental and homeownership units, but also permanent supportive housing and other situations, and developers should be allowed to budget and pay for these modifications.

2.3 CONTINUE TO INVEST IN PERMANENT SUPPORTIVE HOUSING.

Best practices in the provision of housing for people who are homeless call for a focus on permanent supportive housing as the primary means to reduce and end chronic homelessness. Permanent Supportive Housing balances the provisions of affordable housing with access to services that help people regain their ability to live independently and become self-sufficient. As reflected in the Delaware Interagency Council on Homelessness (DICH)'s ten-year plan to end chronic homelessness (2007), additional investment in new housing should be targeted to permanent supportive housing as opposed to adding to the state's system of emergency shelters and transitional housing programs. Permanent supportive housing allows us to focus our resources and services on preventing and ending homelessness for Delawareans.

Similarly, federal strategies are focused on permanent supportive housing for individuals and families who are chronically homeless or at risk for chronic homelessness. Most recently, the federal government has called for an increase in services related to homelessness prevention, diversion, and rapid re-housing, as appropriate, for other populations.

Even as the state increases its attention to community-based housing models, there will still be a need and a role for permanent supportive housing that focuses on those with the most complex challenges. Delaware should continue to prioritize permanent supportive housing as one of our important responses to homelessness, including investing in its development and ensuring operating and/or rental subsidies to support it. There is also some existing housing stock which is affordable and accessible – developed using the model program described below - that may be at risk. The terms of the state's settlement agreement with the U.S. Department of Justice preclude the use of congregate housing, even when tenants have rights of tenancy and their own units within a congregate arrangement. The housing and disability communities need to look for ways to preserve this housing stock for other populations who could benefit from using it.

PROGRAM PROFILE: SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

DIRECT ACCESS TO HOUSING (DAH) PROGRAM

The Direct Access to Housing Program (DAH) emerged from a City-sponsored planning process in San Francisco that brought together consumers, providers, and local policy makers to address the critical need for safe, affordable housing for people with mental illness, particularly those exiting institutions in the mental health, substance abuse, and criminal justice systems. DAH is an initiative of the Housing and Urban Health (HUH) unit within the Community Programs Division of the San Francisco Department of Public Health. HUH funds and controls access to housing units that are master leased from private owners and infused with supportive services and professional property management.

Established in 1998, the DAH program provides permanent housing with on-site supportive services for approximately 600 formerly homeless adults, most of whom have concurrent mental health, substance use, and chronic medical conditions, in nine Single Room Occupancy (SRO) hotels and one licensed residential care facility.

Finding appropriate housing for individuals who have few family or community connections is a major challenge for staff of these public or community-based organizations. Without access to a stable residential environment, the trajectory for chronically homeless individuals is invariably up the "acuity ladder" causing further damage and isolation to the individual and driving health care costs through the roof. The DAH program was developed in an attempt to reverse this trajectory through the provision of supportive housing directly targeted toward "high-utilizers" of public health system. DAH is a "low threshold" program that accepts single adults into permanent housing directly from the streets, shelter, acute hospital or long-term care facilities. Residents are accepted into the program with active substance abuse disorders, serious mental health conditions, and/or complex medical problems.

Outcomes: The main goal of the DAH program is to provide housing to a group of people that have rarely, if ever, maintained stable housing as adults. Since opening the first DAH site in 1998, almost two-thirds of the residents have remained housed in the DAH program. Of the remaining one-third of the residents who moved out of the program, half moved to other permanent housing. Use of healthcare services and resources has also been tracked as a measure of success for the program. While overall healthcare use remained fairly consistent in terms of outpatient visits, the most expensive and crisis-level situations - emergency department use and inpatient episodes were both reduced significantly after housing placement.

2.4 IMPROVE ASSET-BUILDING OPPORTUNITIES FOR PEOPLE WITH DISABILITIES.

Many people with disabilities, facing poverty or very low incomes, have few opportunities to develop assets and to purchase a home. Homeownership is one of the key tax-advantaged means lower income households use to build assets and save. However, the services and systems to support asset-building and home purchase are also not always well-connected to disability services systems, and certainly people with disabilities can and might like to purchase a home. Beyond buying a home, asset-building has many other benefits, and people with disabilities may need or choose to use their savings for many other purposes: education, small business, accessibility modifications for existing homeowners, or purchase of major assistive technology items. Homeownership counseling and financial literacy programs should all ensure they are actively marketing to and reaching people with disabilities with their services.

Asset limits for key support programs such as Social Security and Medicaid are a major barrier to asset development for people with disabilities. Individual Development Account (IDA) savings are usually excluded from these asset limits. Existing IDA programs should allow people with disabilities to save for other major investments, such as a modified vehicle, home modifications, communications or other assistive technology. The Delawareans Save IDA program matches savings up to $1,500 per person or $3,000 per household, at $1.50 for each $1.00 saved. Homeownership, education and training and small business investments are all eligible savings goals. CFED's Assets & Opportunity Scorecard lists DE's IDA policy as weak or minimal, mainly due to the lack of state funding for IDA programs.[79] In addition, the Delawareans Save program, like many IDAs, does not allow some expenses that might be beneficial for people with disabilities and ultimately allow them to increase their incomes and savings, such as assistive technology or a modified vehicle.

The IRS estimates that $1 billion in Earned Income Tax Credit (EITC) refunds go unclaimed by taxpayers with disabilities annually. Among low-income filers, taxpayers with disabilities also access free tax preparation services at a lower rate (1.6%) than taxpayers with no disability (3.5%).

Ultimately, asset-building opportunities for people with disabilities will remain severely limited until changes in asset policies in the federal income support programs occur. There currently two large related policy proposals, the SSI Savers Act, which would raise asset limits for SSI to $5,000 per individual and $7,500 per couple, index the limits to inflation, and exclude some funds in qualified tuition programs, education savings accounts, and IDAs; and Achieving a Better Life Experience (ABLE) Act of 2009, which would create new tax-advantaged ABLE accounts to allow people with disabilities and their families to save for investments and their care while maintaining eligibility for crucial benefits. [80]

At the state and local level, efforts to improve asset-building opportunities for people with disabilities include:

- Improving access to financial literacy, credit repair, asset-building, homeownership counseling and tax preparation programs for people with disabilities;
- Developing specialized loan and savings programs to assist people with disabilities to purchase assistive technology they need;
- Expanding financial case management/coaching services to include specialized assistance to help people with disabilities weave together the various work incentive and asset-building programs while maintaining eligibility for the federal income supports they need.

3. BUILD A COMMUNITY-BASED SYSTEM OF CARE WITH A RANGE OF HOUSING OPTIONS.

3.1 CONTINUE TO PRIORITIZE COMMUNITY-BASED CARE BY REDIRECTING RESOURCES FROM INSTUTIONAL CARE TO COMMUNITY-BASED SERVICES AND PROVIDING FOR HOUSING NEEDS.

People can and should have choices about their environment, activities, services, work, socialization, and employment: systems must provide services in the least restrictive setting possible. While the process of deinstitutionalization has been long in progress nationwide, it has sometimes been at a slow pace, with significant numbers of people remaining in institutions nationally and ongoing preference for institutional settings and systems that continue to steer people to institutional care. Creating permanent change means transforming systems to truly prioritize community care and building collaboration across disciplines, sectors and departments.

Providing services to people in their homes and the community not only improves quality of life, but also can reduce costs. Institutional care is exceedingly expensive, and a growing and aging population will mean a growing number of people with disabilities, including those who need extensive supportive services. This is happening as demands on federal and state budgets are especially high. But over time, as systems are more permanently reformed to prioritize community services and resources can be redirected, serving people in their homes and communities will allow us to meet growing needs and serve more people while containing costs.

DHSS has already taken many steps towards the development and strengthening of community-based systems of care for people with disabilities in Delaware. This includes:

- Changes to Medicaid managed care and waiver programs to increase the use of home and community based services (HCBS);
- The Money Follows the Person program, a joint program of DSAAPD and the Division of Medicaid and Medical Assistance to expand nursing home to community transition efforts that was recently extended through 2016;
- Development of the Delaware Aging and Disability Resource Center (ADRC) as a one-stop access point for aging and disability information and resources, options counseling and service enrollment support;
- Efforts to reduce the census in state-run long-term care facilities, including an independent assessment of the current residents of the five facilities operated by DHSS and a successful diversion program to reduce future admissions by helping people referred for LTC to remain in the community; and
- Numerous initiatives in the Division of Substance Abuse and Mental Health (DSAMH) to expand and enhance Delaware's community mental health services, including expanding Mobile Crisis Services and walk-in centers, supported employment, expand Assertive Community Treatment (ACT) and Intensive Case Management (ICM) teams, and changes to oversight of psychiatric hospitalizations.

Across DHSS, these initiatives should be continued to support community-based care for people with disabilities and maximum independence and integration in the community.

Finally, community-based care may mean different resources, strategies, and housing options for different populations. For people with developmental and intellectual disabilities, supports for families, family caregivers, and long-term plans for care as families age is especially critical. For people with substance abuse and mental health disabilities, developing the capacity of the state's community mental health system and assessing systems for institutional biases to prevent unnecessary institutionalization, reduce readmissions, and prevent late-stage interventions more likely to result in institutionalization are important strategies. For all populations, building a community-based system of care must include planning and providing for housing needs and housing assistance, whether through tenant-based assistance, housing assistance added to the package of services from current community-based care providers, or other methods appropriate for different populations.

3.2 ENSURE A RANGE OF HOUSING OPTIONS, MEANINGFUL CHOICES AND ADEQUATE SUPPORTS FOR PEOPLE TO LIVE AND RECEIVE CARE IN THE COMMUNITY.

A beneficial housing system will offer a diversity of forms. In particular, housing strategies for persons with disabilities should ensure a continuum of housing options and choices, from supports that allow living with family, to independent living in community, to congregate settings, or seeking homeownership when appropriate. There is no one size fits all, and a range of different housing options must be available and affordable in order for people with disabilities to have meaningful choices about their housing situation.

Three key strategies to ensuring a range of housing options are to 1) continue to expand tenant-based rental assistance programs; 2) identify new models to build a continuum of housing options for people with disabilities; and 3) ensure a full range of community supports to create and sustain successful transitions to community care.

Tenant-based Rental Assistance (TBRA)

Delaware should continue to expand programs providing rental assistance for households to rent units in the private market. Model programs in Delaware have been very successful to date, including the Delaware HIV Consortium's longstanding TBRA program for people living with HIV/AIDS and vouchers for people with substance abuse and mental health disabilities managed by Connections and supported through the Continuum of Care. The successful development and implementation of the State Rental Assistance Program (SRAP) should continue this trend. While SRAP was funded to serve 150 households in FY 2011, the need for the program far outstrips available resources. As of February 2012, DHSS has a pool of 95 SRAP applicants who are still in need of assistance and have not yet been submitted to DSHA because DHSS has nearly exhausted the number of vouchers reserved for their clients. TBRA will be in even higher demand as DHSS and the homeless assistance system continue to work to help people with disabilities to live in the community, transitioning people who are currently in long-term care facilities or congregate settings.

New Models

To ensure a continuum of housing options and settings, the housing and disability services systems should consider new models to broaden the housing opportunities available for people with disabilities and ensure the opportunity to live in the least restrictive and most integrated setting possible. Supports for shared housing and roommate matching in particular are tools that people with disabilities and advocates identified as potentially useful. Actions to support

these may include developing programs to link potential roommates and ensuring that various program guidelines allow for roommate or shared housing situations.

In the Community Living Program model being implemented by United Cerebral Palsy in Delaware, individuals share a home but live very independently: arranging their own personal care and transportation services and choosing how they spent their time in employment or volunteer activities. Instead of the round-the-clock staffing often seen in group homes, a part time house manager will assist with the maintenance of the house, resolving issues, and be a resource for residents as necessary. It is initially targeting individuals transitioning from institutions.

Supports for New Renters

Another aspect of prioritizing community care is recognizing the full range of supports needed for a successful and sustainable transition. For people with disabilities who have never – or not for a long time – lived independently, acquiring and maintaining rental housing (applications, security deposits, lining up resources, utilities, basic household needs, and navigating transportation) can be just as challenging as moving to homeownership and require ongoing support in managing new responsibilities and addressing new concerns.

There are some existing examples and recent steps in this area in Delaware. The Assertive Community Treatment (ACT) model employed by DSAMH and service providers in the substance abuse/mental health field in Delaware includes these services, and in late 2011 DHSS engaged in two new contracts with nonprofit service providers to provide housing placement services to 180 DHSS clients statewide. Additionally, the case management provided through the Money Follows the Person (MFP) program provides a model of intensive case management that includes assistance locating, securing and transitioning to rental housing. DHSS, DSHA and service providers should explore the possibility of a network of housing case managers to offer housing counseling for rental housing similar to homeownership counseling.

PROGRAM PROFILES: ROOMMATE MATCHING AND LISTING SITES AND SERVICES

FindMyRoommate

FindMyRoommate is an online matching service for people with disabilities who are looking for roommates with whom to share housing and companionship, and possibly paid services and natural supports. It can be used by people with disabilities independently or with a support person.

People who are looking for a place to live and people who have a home they want to share can create listings where they describe what they have or what they are looking for. The site offers a closed email system to facilitate initial contacts between people listing and responding to listings. The service does not directly match roommates, but provides the means for people to locate each other.

To date, FindMyRoommate has listings services for Minnesota, Connecticut and Indiana, it is available to states on an annual subscription basis. States may customize the terminology, search features and other aspects of the site for their state.

Housemate Match

Housemate Match is a program of the Marcus Jewish Community Center of Atlanta (Georgia). The service pairs older adults who have room in their homes with adults who are seeking a roommate.

HMM connects two people who are looking to combine personal and financial resources. HMM provides rooms to rent for those who prefer to share a home rather than living alone and for those who choose to remain in their home and age in place. This service is more direct: people who are interested, begin by scheduling an interview with a housing counselor, who helps check references, verify income, and match roommates. They may be homeowners or renters who wish to share space: Homeowners must be seniors, and home seekers must be adults with some type of income. Rent and payment arrangements are made between the individuals.

In 2005, Housemate Match also added an In-Home Caregiving program, which specifically addresses the needs of homeowners requiring non-medical caregiving services in their homes in exchange for reduced rent. Services may include things such as transportation, light housekeeping, and meal preparation, and caregivers are screened and have reference and background checks.

3.3 CONTINUE TO DEVELOP AND IMPLEMENT DIVERSION AND TRANSITION STRATEGIES TO PREVENT INSTITUTIONALIZATION AND REDUCE READMISSIONS.

A key strategy of prioritizing community care is preventing institutionalization in the first place and reducing subsequent readmissions. Systems should be structured to quickly redirect people at risk of institutionalization to the least restrictive community based setting and connect them to the necessary supports to ensure they can remain in the community as long as possible. These efforts have already proved very successful: in February 2011, DHSS implemented a diversion program to provide community support to individuals who have been referred for long-term care. From February to September 2011, 115 out of 139 individuals (83%) who had been referred for long-term care were able, with connections to services, to remain in the community. Continuing to expand such programs and ensuring that all populations are covered will help people with disabilities to remain in the community as long as possible and avoid unnecessary institutionalization by connecting them with appropriate supports.

For the elderly and people with physical disabilities, transitions between care settings and at hospital discharge are points when people are particularly vulnerable. Care Transitions Delaware is undertaking major initiatives to strengthen transitions between care settings to improve health outcomes and promote individual choice. DSAAPD is partnering with hospital and other organizations to build upon existing discharge planning strategies to reduce hospital readmissions and prevent unnecessary nursing home placements.

For people with psychiatric and substance abuse crises, avoiding involuntary commitment is a strategy to help people avoid entering the cycle of institutionalization. Hotlines, mobile crisis teams and walk-in crisis centers all allow people in crisis to receive services without being removed from their homes or community. In a new partnership, DSAMH's Mobile Crisis services have partnered with some local hospitals to evaluate consumers with psychiatric and substance abuse crises in their Emergency Departments to reduce the number of involuntary commitments and create immediate links to community behavioral health services. Assertive Community Treatment (ACT) teams also provide a range of coordinated services to people in their homes and communities, and have been found to reduce hospitalization rates and durations of stays and in assisting people to access mainstream resources to secure and sustain housing and employment. ACT teams have been the center of Delaware's mental health service delivery system since 1988, but there is a need for more funding and services, as well as a need to ensure that diversion strategies and coordinated services to support community care are in place for all populations.

3.4 IMPLEMENT THE DELAWARE POLICY STATEMENT *EXEMPLARY PRACTICES IN DISCHARGE PLANNING,* ESPECIALLY AT STATE-OPERATED INSTITUTIONS AND PRISONS, TO IMPROVE CONNECTIONS TO PERMANENT HOUSING AND PREVENT SUBSEQUENT HOMELESSNESS.

The 2007 Delaware Interagency Council on Homelessness (DICH) 10-Year Plan to End Chronic Homelessness identified the lack of consistent and applied formal discharge policies and procedures as a major barrier to preventing and ending homelessness. The plan recommended a collaborative group come together to review and strengthen discharge and aftercare planning strategies to ensure that appropriate linkages with housing and community-based care are in place to prevent subsequent homelessness. As stated in the 10-Year Plan, "No person should leave a hospital, nursing home, or residential treatment program without an identified transitional or permanent place to live (not an emergency shelter), the necessary entitlements or employment income to pay for it, and the supportive services needed to sustain it."[81]

In 2008, a joint committee of the Delaware Interagency Council on Homelessness and Commission on Community based Alternatives for People with Disabilities followed through on this recommendation and produced a Delaware policy statement, *Exemplary Practices in Discharge Planning*. While the development of uniform policies was a major step forward, efforts to ensure statewide implementation are ongoing. Implementing effective, uniform discharge planning is a critical task to preventing unnecessary repeat institutionalizations, homelessness, and ensuring that people are transitioned to stable, permanent housing with the supports they need to remain in the community. It is especially important that these standards are implemented in state-supported institutions and prisons, which are most likely to be serving people at high risk of homelessness.

3.5 IMPROVE COMMUNITY PLANNING TO BENEFIT COMMUNITY QUALITY OF LIFE FOR ALL RESIDENTS AND FOSTER REAL INTEGRATION FOR PEOPLE WITH DISABILITIES.

Integration into the community means more than just the physical location of a home. It must include access to public or private transportation that is accessible, within reasonable range of a person's home, and affordable, and allow for involvement in community activities such as work, volunteer and civic engagement, recreation, worship and shopping.

Transportation can be particularly challenging and isolating, and connections to transportation are especially important for housing for persons with disabilities. Transportation is a critical and expensive variable which can undermine an affordable housing opportunity. People with disabilities are among those (also including the elderly, children, and the poor) who are effectively disenfranchised by habitual automobile-oriented planning and development. When housing is not wisely located in areas with convenient public transportation this exacerbates all the problems that may make daily life difficult for people with disabilities.

Beyond transportation, for community-based solutions to work, there must be adequate community. People with disabilities and their allies recognize unresolved conflicts between goals, such as independent living, on the one hand, the need for support, on the other, without which life can be accompanied by a tremendous sense of isolation and anxiety. Compact, mixed use development can provide for more walkable neighborhoods, convivial streetscapes, and a diversity and energy that are welcoming and reassuring, helping to foster human contact and mutual aid. The National Council on Disability identifies the following features for livable communities:

- Provides affordable, appropriate, accessible housing;
- Ensures accessible, affordable, reliable safe transportation;
- Adjusts the physical environment for inclusiveness and accessibility;
- Provides work, volunteer and educational opportunities;
- Ensures access to key health care and support services; and
- Encourages participation in civic, cultural, social and recreational activities.

The Poverty and Race Research Action Council also provides a checklist for affirmatively furthering fair housing in programs such as the Department of Housing and Urban Development (HUD)'s new Sustainable Communities Initiative. Among the recommendations are:

- Develop a regional fair share housing plan with target numbers for each municipality, based on HUD's worst case needs housing study, since this is the "most basic way of applying fair housing principles to a comprehensive regional plan." (The current Fair Share Housing Measure developed by the Delaware Housing Coalition is based on the these needs.)
- Ensure strong income targeting in all housing allocations so that affordable housing is targeted to higher opportunity communities and new transit or economic development areas.
- Encourage inclusionary principles, setting aside low income units, in new planned transit oriented development as "the most reliable way to ensure equitable location of low income housing"
- Direct limited housing development and preservation funds to affirmatively further fair housing, requiring "new low income housing assets in low poverty, high opportunity areas with high achieving schools, preferably in locations reasonably well served by public transportation and free from adverse environmental impacts such as air, water and noise pollution from industrial facilities, major highways, bus depots, etc. and contamination due to prior or adjoining land uses.

Community planning and design that successfully incorporate these features contribute to quality of life for all residents, not only people with disabilities.

4. IMPROVE THE AFFORDABLE HOUSING AND DISABILITIES SERVICES SYSTEMS THAT SERVE PEOPLE WITH DISABILITIES.

4.1 CONTINUE TO BUILD AND IMPROVE CONNECTIONS BETWEEN AND WITHIN THE AFFORDABLE HOUSING AND DISABILITIES SERVICES SYSTEMS.

Efforts to expand rental housing opportunities for people with disabilities must focus on prioritizing integrating people and affordable units into the community. A blend of tenant-based and project-based rental assistance strategies will ensure both that vouchers are available for people to choose their own homes as well as that affordable units are set-aside for people with disabilities in typical multifamily developments.

A key part of both of these strategies is the development of connections and communications between the disability services and housing systems. To function effectively, these programs must ensure that people who choose to live in the community receive the supportive services and housing assistance they need from these two diverse systems in a coordinated way. In addition, at the most basic level, we have to be sure that there are units for people to live in, and, when developers set-aside units for people with disabilities, that there are people to live in the units. This requires a high level of partnership and interaction between a number of agencies: the partnership between DSHA, DHSS and the Department of Services for Children, Youth and their Families (DSCYF) in the implementation of the new State Rental Assistance Program (SRAP) is an excellent example of these initiatives.

PROGRAM PROFILE: DELAWARE STATE RENTAL ASSISTANCE PROGRAM (SRAP)

SRAP was developed as a partnership between the Delaware State Housing Authority, Department of Health and Human Services, and Department of Services for Children, Youth and their Families. The program provides rental assistance to low-income Delawareans who require affordable housing and supportive services to life safely and independently in the community. Target populations include people living in state-run long-term care facilities, kids exiting foster care, and homeless individuals and families. A key advocacy point for the program has been the cost savings associated with helping people to live stably in the community as opposed to institutions or moving in and out of service systems: these families and individuals are often in the state's care ultimately due to a lack of affordable housing. Providing rental assistance via SRAP is estimated to cost $8,000-$10,000 per household annually.

With its experience in the administration of the federal Housing Choice Voucher (Section 8) program, DSHA administers the rental subsidies (reviewing applications, approving participants, inspecting rental units, making payments to landlords, annual tenant recertification and ongoing compliance), and DHSS, DSCYF and their partners and contractors screen and refer applications to DSHA and fulfill the program's supportive services component through the provision of home-based care.

SRAP was first funded in the 2011 legislative session to begin operation in FY 2012, with $1.5 million in funding expected to serve 150-200 households. In August 2011, the program became operational. DSHA and its partners supporting SRAP are requesting an increase to $3 million for the program in FY 2013.

4.2 IMPROVE TRIAGE ASSESSMENT OF CONSUMERS' HOUSING NEEDS AND STATEWIDE DATA COLLECTION ON THESE NEEDS.

Improving discharge policies and initial housing needs assessment at intake and annual recertification is a homelessness prevention strategy. Members of the study working group have worked together and with DHSS to reformat a model federal housing needs assessment matrix into one that can be used in Delaware. Ideally, this assessment should be incorporated into the intake process across all key DHSS divisions. Expanded assessment of consumers' housing needs at initial intake should improve quality of services and improve identification of individuals who are precariously housed and at risk of homelessness.

If implemented uniformly across all DHSS Divisions, the new assessment form could be an incredibly valuable source of information on housing needs**.** Currently, the DHSS Divisions all use different registry systems tailored to their population. They may have extensive housing information or little to no housing information; or they may have fields for housing questions that are often not recorded. Uniform questions and measures across all Divisions will greatly improve the availability and quality of data about the housing needs of DHSS' clients. Implementation of the new assessment form across DHSS will be challenging, but is vital to both improving services and improving the data available on housing needs long-term. Beyond DHSS, a uniform housing assessment could also be implemented in all systems and institutions which frequently serve people with disabilities, including the Department of Corrections (DOC) and Department of Services for Children, Youth and their Families (DSCYF).

For some populations, peer support programs may also be a source of ongoing qualitative information about housing needs. Peer-operated resource centers which provide supports to people with mental health and substance abuse problems are regularly in touch with people who need housing, have lost their housing, and other housing issues. These programs, staffed and managed by people who themselves have disabilities, have their 'ear to the ground' regarding the needs of people with similar problems in ways that service providers might not.

In addition, to facilitate future efforts to assess the housing needs of people with disabilities, the state should improve the collection and maintenance of information about the baseline inventory of housing targeting specific populations. While DHSS Divisions maintain information about housing where they provide assistance, some populations have large networks of supportive housing that is not assisted by DHSS and thus little or no information on the entire inventory may be available. An assessment of existing resources is a critical part of assessing needs; information about the existing inventory of supportive housing should be easily accessible and maintained. We encourage DSAMH, DSAAPD and DDDS to develop, maintain and centralize inventory information for their target populations.

4.3 FOSTER AND IMPROVE COORDINATION AMONG THE STATE'S PUBLIC HOUSING AUTHORITIES (PHAS), BOTH AMONG THEMSELVES AND WITH PROVIDERS OF SERVICES TO PEOPLE WITH DISABILITIES.

Efforts to improve coordination and interchangeability among DE's Public Housing Authorities (PHAs) on their waiting lists and eligibility requirements would benefit consumers. This was a repeated comment in almost all focus groups: it is extremely challenging to navigate and get transportation to get on multiple waiting lists, understand different eligibility requirements and monitor one's status on multiple lists.

Public housing authorities are critical partners in the effort to prevent and end homelessness and critical providers of housing for people with disabilities and low incomes. A main recommendation from the U.S. Interagency Council on Homelessness is that PHAs review and streamline their administrative policies and procedures to reduce barriers and improve access for people with disabilities and who are homeless. This may include things like reducing background and credit checks, how communication with people without a permanent mailing address is handled, documentation requirements, waiting list management, and sharing information across public agencies. In Delaware, a very small state with five public housing authorities where many households are willing to take a unit wherever they can, reviewing and streamlining policies and procedures is not only important for each PHA but across all PHAs. Improving the portability of vouchers across Delaware's PHAs, a recommendation in the 2011 *Analysis of Impediments to Fair Housing Choice*, is also an important improvement to benefit consumers.

Coordination with service providers may also improve access and service to consumers. For example, allowing people with disabilities who are transient to list their service provider's address and phone number as a point of contact may improve notification when they reach the top of the waiting list. Currently, if attempts to reach them by phone or mail are unsuccessful, people go to the bottom of the list. For people with disabilities who are housed, using their service provider as a kind of emergency contact who can step in to resolve problems before they result in eviction may also help people to remain housed once they do get assistance. As another example, DHSS has recently engaged with the Wilmington Housing Authority in a pilot diversion program to assist residents at risk of being evicted due to housekeeping issues, frailty and late rent issues. WHA will contact DHSS when residents who are elderly are having housekeeping or rent issues potentially leading to eviction. A DHSS contractor will do an assessment to determine the resident's needs and connect the resident to services to prevent eviction.

The study working group understands that some of these are large, challenging, and long-term issues, but given the size of the state and small number of public housing authorities, improved coordination to benefit consumers and potentially also improve efficiency in the delivery of services is an important endeavor.

4.4 IMPROVE THE HOUSING SYSTEM'S COMMUNICATION WITH CONSUMERS AND DEVELOP MORE ACCESSIBLE, CENTRALIZED, USER-FRIENDLY SOURCES OF INFORMATION.

Delaware's housing system is difficult for consumers to navigate (multiple waiting lists, eligibility requirements, etc.) and to even get there, consumers face a fragmented system for information: there is no one to explain all the options and point people in the right direction the first time. Those who are successful usually end up finding the right program through long trial and error, word of mouth, or luck. Many specific populations have their own resource directories, which have different or incomplete housing information, and housing-specific directories can be so comprehensive that they leave people adrift in options.

Three key resources on housing and services are the DSHA Housing Services Directory, the Delaware 211 website and phone system, and DSAAPD's new Aging and Disability Resource Center. A cooperative initiative to ensure these resources share and report the same timely information and give people as much detail as possible about potential providers and eligibility requirements. For example, the 211 website is not searchable by County; both the 211 website and ADRC give little detail about what services different providers offer and listings should be reviewed for appropriateness. DSHA's Housing Services Directory includes very comprehensive and annually updated housing

information, but it is a static publication, not a searchable website. We recommend the providers of these various directories and referral services work to improve coordination and links between their services.

4.5 FACILITATE INPUT ABOUT DISABILITY HOUSING NEEDS INTO THE VARIOUS HOUSING AND DISABILITY PLANNING PROCESSES.

The Housing Subcommittee of the Governor's Commission on Community-based Alternatives, which has served as the working group for this report, should be kept active as a venue to continue communication between the disability and housing systems. It should also be a central location to facilitate input about the housing needs of people with disabilities and priorities for meeting those needs into the many planning processes in both the housing and disability systems. Each field alone has numerous different planning processes, including:

- Comprehensive Plans created by Counties and municipalities to guide land use, which include a Housing Element on housing needs;
- 5-Year Consolidated Plans and annual Action Plans created by HUD-funded jurisdictions (the Delaware State Housing Authority, New Castle County and Cities of Wilmington, Newark and Dover)
- Annual Plans developed by the five public housing authorities (PHAs);
- Strategic plans and other plans developed by Divisions in the Department of Health and Social Services (DHSS), such as the State Plan on Aging; and
- Strategic plans developed by nonprofit service providers and affordable housing providers;

All plans should be strongly encouraged to include elements, where relevant, to advance the priorities and recommendations in this report to:

- Increase the availability of and access to rental and homeownership opportunities with accessibility features;
- Increase the availability of and access to affordable housing for people with disabilities;
- Build a community-based system of care with a range of housing options; and
- Improve the affordable housing and disabilities services systems that serve people with disabilities.

APPENDIXES

APPENDIX A: QUESTIONS USED TO IDENTIFY DISABILITY IN MAJOR NATIONAL DATA SOURCES

Current Population Survey (BLS Employment Data)

In the CPS, persons are classified as having a disability if there is a response of "yes" to any of these questions. The disability questions appear in the CPS in the following format:

This month we want to learn about people w ho have physical, mental or emotional conditions that cause serious difficulty with their daily activities. Please answer for household members who are 15 years and older.

- Is anyone deaf or does anyone have serious difficulty hearing?
- Is anyone blind or does anyone have serious difficulty seeing even when wearing glasses?
- Because of a physical, mental or emotional condition, does anyone have serious difficulty concentrating, remembering or making decisions?
- Does anyone have serious difficulty walking or climbing stairs?
- Because of a physical, mental or emotional condition, does anyone have difficulty doing errands alone such as visiting a doctor's office or shopping?

http://www.bls.gov/cps/cpsdisability_faq.htm

American Community Survey (2008 and later)

Source: Review of Changes to the Measurement of Disability in the 2008 American Community Survey. Matthew W. Brault, U.S. Census Bureau, 2009.

http://www.census.gov/hhes/www/disability/2008ACS_disability.pdf

The American Community Survey and U.S. Census exclude the group quarters population, which includes college dormitories, prisons, long term care facilities and other institutions.

- Is this person deaf or does he/she have serious difficulty hearing?
- Is this person blind or does he/she have serious difficulty seeing even when wearing glasses?
- Because of a physical, mental or emotional condition, does this person have serious difficulty concentrating, remembering or making decisions?
- Does this person have serious difficulty walking or climbing stairs?
- Does this person have difficulty dressing or bathing?

- Because of a physical, mental or emotional condition, does this person have difficulty doing errands alone such as visiting a doctor's office or shopping?

2000 Census

Source: Disability and American Families, 2000. Qi Wang, U.S. Census Bureau, July 2005.

http://www.census.gov/prod/2005pubs/censr-23.pdf

Does this person have any of the following long-lasting conditions:

a. Blindness, deafness, or a severe vision or hearing impairment?

b. A condition that substantially limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting or carrying?

Because of a physical, mental or emotional condition lasting 6 months or more, does this person have any difficulty in doing any of the following activities:

a. Learning, remembering or concentrating?

b. Dressing, bathing or getting around inside the home

c. Going outside the home alone to shop or visit a doctor's office? (answer if this person is 16 years old and over)

d. Working at a job or business? (answer if this person is 16 years old and over)

2009 American Housing Survey (HUD Worst Case Needs)

1) Are you deaf or have serious difficulty hearing?

2) Are you blind or have serious difficulty seeing, even when wearing glasses?

3) Because of a physical, mental or emotional condition, does anyone in this household have serious difficult concentrating, remembering or making decisions?

4) Does anyone in this household have serious difficulty walking or climbing stairs?

5) Does anyone in this household have serious difficulty dressing or bathing?

6) [For all household members 15 years old and older] Because of a physical, mental or emotional condition, does anyone in this household have difficulty doing errands alone such as visiting a doctor's office or shopping?

APPENDIX B: GLOSSARY OF ACCESSIBILITY TERMS

Accessible: Accessible features are permanently fixed in place and noticeable. An accessible housing unit might include items such as wide doors, lower countertop segments, or grab bars in the bathroom, for example. Publicly-financed affordable housing is subject to several different accessibility requirements which may vary depending on the funding source. These may affect the percentage of units and the specific construction standards. Construction standards for accessibility are usually exceeded by American National Standards Institute (ANSI) standards, those used in the building code for all three counties in Delaware. In this report, "fully accessible" is used to denote a unit built to the most stringent accessibility requirements applicable to the site.

Adaptable: Adaptable features are those that can be adjusted in a short time by unskilled labor without involving structural or material changes. Adaptable units look the same as other units in the building except that accessible features can be easily added to match an individual's needs. Examples of adaptable features include counter tops or closet rods that are supported by adjustable supports rather than built into the wall at a fixed level, or removable panels on under-sink cabinets that can allow for wheelchair access. In a multifamily site, units constructed with basic access features to comply with the requirements of the Fair Housing Amendments Act (1988) could be considered adaptable: they have a no-step entry, basic space to allow for someone who uses a wheelchair to maneuver, and reinforced bathroom walls to allow for grab bars.

Assistive Technology: Assistive technology includes devices for personal use created specifically to enhance the physical, sensory, and cognitive abilities of people with disabilities and to help them function more independently. Examples of assistive technology include flashing doorbells or TTY technology for people with auditory impairments.

Basic Access: Basic accessibility is similar to the concept of visitability described below. It includes the most basic features to allow someone with a disability to enter and have basic use of a home: one no-step entrance, 32 inch door clearance through the first floor, and at least a half-bathroom. Additional modifications can then be made to suit the person's specific needs, but these most basic features will generally ensure a person with a mobility disability can get into a home and have basic use of its facilities. These are the most necessary and some of the most expensive to correct with home modifications. Some local policies or incentives on basic access may also include placement of electrical controls at reachable levels, reinforced bathroom walls to allow for future placement of grab bars, and specific amounts of space in bathrooms and kitchens.

Universal Design: Universal design incorporates the characteristics necessary for people with physical limitations into the design of common products and building spaces, making them easier and safer for everyone to use and more widely marketable and profitable. An example of universal design is the use of lever handles on doors. As opposed to doorknobs which can be difficult for people with limited use of their hands, lever handles are useable by all people. Universal design features improve the livability of a home for all users, with or without disabilities.

Visitability: Visitability refers to homes designed to meet the accessibility needs of both its residents and any anticipated guests with disabilities. Bathrooms with doors wide enough to accommodate wheelchair users is an example of a visitable feature. Generally, visitability refers to three key features: an accessible, wide no-step entrance, at least 32 inches clear passage space through interior doors, and at least a half-bathroom on the first floor with space

to accommodate a wheelchair. These features make the home vistable to guests with disabilities while also allowing the resident to stay in the home over time as the resident's physical needs change.

Source: Adapted from the Technical Assistance Collaborative

APPENDIX C: FOCUS GROUP PROTOCOL

Facilitator	Welcome and introduction of facilitator and observer.
Facilitator	Description of focus group process and structure.
Facilitator	Remind participants that they may refuse participation at any time and are under no obligation to respond to any questions that make them feel uncomfortable.
Participants	Questions and clarification of information overview provided.
Facilitator	Announce that audio tape is about to be turned on. Remind participants not to mention any names. If names are mentioned accidentally, they will be deleted from the tape and will not appear in any transcripts. Once transcribed, tapes will be erased.
Observer	Start audio tape recording.
Facilitator	Lead introductions of each participant. State first name only.
Facilitator	Lead the group through the following topics starting with open-ended questions, and using more directed questions to clarify responses by group members:
	What is the first word that comes to mind when you think of housing for people with disabilities?
	How high of a priority is housing for people with disabilities?
	What are the positives about housing in Delaware for people with disabilities?
	What are the biggest barriers for people with disabilities in obtaining housing in Delaware?
	How would you describe the housing system in Delaware?
	How would you describe the housing system for people with disabilities?
	Where do people with disabilities obtain information on housing?
	If you could identify one thing to do differently or in a better way to increase housing for people with disabilities --- what would it be?
Facilitator	Is there anything that we should have talked about but did not? (This would also be a time for the facilitator to pose questions suggested by participants on the registration form.)
Facilitator	Thank participants for taking part in the focus group. Solicit and respond to any questions.
Facilitator	Provide contact information should participants have any further questions at a later time.
Facilitator	Adjourn.

Focus Groups:

- Aging and Physical Disabilities – April 20, 2011 (10 participants)
- Intellectual/Developmental Disabilities – April 20, 2011 (15 participants, est.)
- Substance Abuse/Mental Health – May 19, 2011 (25 participants)
- HIV/AIDS – April 28, 2011 (10 participants)
- Developers/Providers – May 24, 2011 (6 participants)
- Foster Youth – May 18, 2011

APPENDIX D: KEY HOUSING TERMS

(substantially drawn from the Homeless Planning Council's Glossary of Housing Terms)

***Affordable Housing**:* Housing is "affordable" when the occupant(s) pays no more than 30% of their total income on rent and utilities; or, if the occupant(s) owns their own home, they pay no more than 35% of their total income on their mortgage payment, insurance, taxes and utilities.

Area Median Income (AMI): Usually, the state or county-level Area Median Income figures set annually by the Department of Housing and Urban Development (HUD) for use as income limits in related programs.

***Chronically Homeless Person** (As defined by HUD):* An unaccompanied homeless individual with a disabling condition or a family with at least one adult member who has a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. A disabling condition is defined as: (1) a disability as defined in Section 223 of the Social Security Act; (2) a physical, mental, or emotional impairment which is expected to be of long-continued and indefinite duration, substantially impedes an individual's ability to live independently, and of such a nature that the disability could be improved by more suitable conditions; (3) a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act; (4) the disease of acquired immunodeficiency syndrome or any conditions arising from the etiological agent for acquired immune deficiency syndrome; or (5) a diagnosable substance abuse disorder. The term —homeless‖ in this case means a person sleeping in a place not meant for human habitation (e.g., living on the streets), in an emergency homeless shelter, or in a Safe Haven as defined by HUD.

Cost-burden: A household spending 30% or more of their income for rent. A household is considered "severely cost burdened" when they are spending 50% or more of their income for rent.

***Extremely Low Income (ELI)**:* Is defined as at or below 30% of the area wide median income.

Homeless (*as defined by HUD*): As defined by the McKinney Act (42 U.S.C 11302), a homeless person is a person sleeping in a place not meant for human habitation or in an emergency shelter; and a person in transitional housing for homeless persons who originally came from the street or an emergency shelter. The programs covered by this NOFA are not for populations who are at risk of becoming homeless. The definition of homeless person from the HEARTH Act will not be in effect for the FY2010 CoC Competition.

***Housing Choice Vouchers (HCV)**:* A HUD program, usually administered by local housing authorities, that provides rental assistance. A household with a voucher usually has to pay only 30% of their income for rent and utilities. The vouchers cover the remaining housing costs.

Housing First: A consumer-driven housing model that offers permanent housing to those without homes. It is based on the belief that helping people access affordable permanent housing should be the central goal in ending homelessness. Housing First has an immediate and primary focus on quick access to and sustainability of permanent housing, and often is offered simultaneously with support services. The housing is not time-limited, and is not contingent on compliance with services or regulations.

Low Income: Households whose incomes are between 51% and 80% of the area median income (AMI), as determined by HUD, based on family size.

Moderate Income: Households whose incomes are between 81% and 120% of the area median income (AMI), as determined by HUD, based on family size.

Public Housing Authority (PHA): There are five in Delaware – Delaware State Housing Authority, Dover Housing Authority, New Castle County Housing Authority, Newark Housing Authority, and Wilmington Housing Authority.

Permanent Supportive Housing (*As defined by HUD - in terms of their programs*): Permanent housing for homeless persons with disabilities is another type of supportive housing. It is long-term community-based housing, which includes supportive services for homeless persons with disabilities. The intent of this type of supportive housing is to enable this special needs population to live as independently as possible in a permanent setting. The supportive services may be provided by the organization managing the housing or coordinated by the applicant and provided by other public or private service agencies.

Safe Havens: offer low-demand, indefinite-length-of-stay, supervised housing alternatives for persons with substance use and/or mental health conditions who need a place to stay that does not tie compliance with rules or service expectations to the maintenance of housing.

Section 811: A HUD program that provides capital grants and project-based rental assistance to non-profit sponsored housing developments for people with disabilities. It allows persons with disabilities to live as independently as possible in the community by increasing the supply of rental housing with the availability of supportive services. The program also provides project rental assistance, which covers the difference between HUD-approved operating costs of the project and tenants' contribution toward rent.

Supplemental Security Income (SSI): A federal financial benefit program sponsored by the Social Security Administration (SSA), available to financially needy individuals with disabilities who have been qualified by SSA as having a disability, which prevents them from engaging in productive employment.

Supportive Housing: Housing with services that enable participants to live more independently than they would otherwise be able to. The types of services depend on the needs of the residents. Services may be short term, sporadic, or ongoing indefinitely.

Accessibility	Affordability	Community	Systems
Increase the availability of and access to rental and homeownership opportunities with accessibility features.	**Increase the availability of and access to affordable housing for people with disabilities.**	**Build a community-based system of care with a range of housing options for consumers.**	**Improve the affordable housing and disabilities services systems that serve people with disabilities.**
Improve real-time information on available accessible and affordable units for consumers.	Increase the availability of Low Income Housing Tax Credit (LIHTC) properties to people with disabilities, especially those with extremely low incomes.	Prioritize community-based care by redirecting resources from institutional care to community-based services and providing for housing needs.	Continue to build connections between and within the affordable housing and disabilities services systems.
Reduce fair housing barriers to affordable and accessible housing.	Expand incentives for basic access and universal design features in affordable housing.	Ensure a range of housing options, meaningful choices and adequate supports for people to live and receive care in the community.	Improve triage assessment of consumers' housing needs and statewide collection of data about these needs.
Establish a common vocabulary and set of standards for accessibility features in the affordable housing industry.	Continue to invest in permanent supportive housing.	Continue to develop and implement diversion and transition strategies to prevent institutionalization and reduce readmissions.	Foster and improve coordination among the state's Public Housing Authorities (PHAs), both among themselves and with providers of services to people with disabilities.
Increase the prevalence of basic access features in all new homes.	Improve asset-building opportunities for people with disabilities.	Implement the *Exemplary Practices in Discharge Planning,* especially at all state-operated institutions and prisons, to improve connections to permanent housing and prevent subsequent homelessness.	Improve the housing system's communication with consumers and develop more accessible, centralized, user-friendly sources of information.
Expand and coordinate resources for accessibility modifications for homeowners and homebuyers.		Improve community planning to benefit community quality of life for all residents and foster real integration for people with disabilities.	Facilitate input about disability housing needs into the various housing and disability planning processes.

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