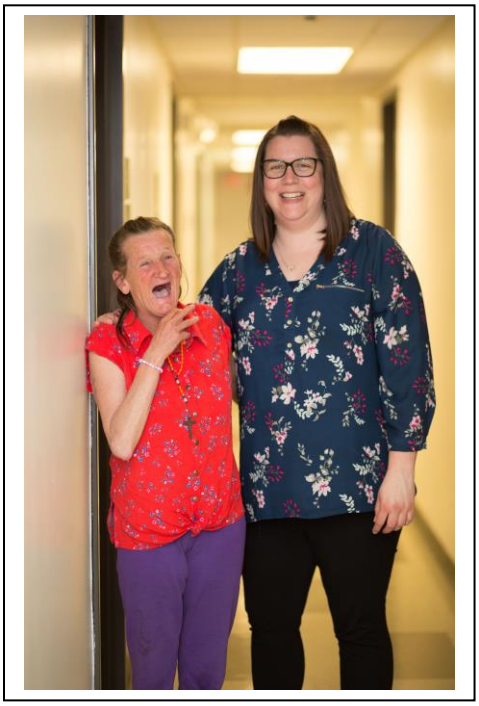
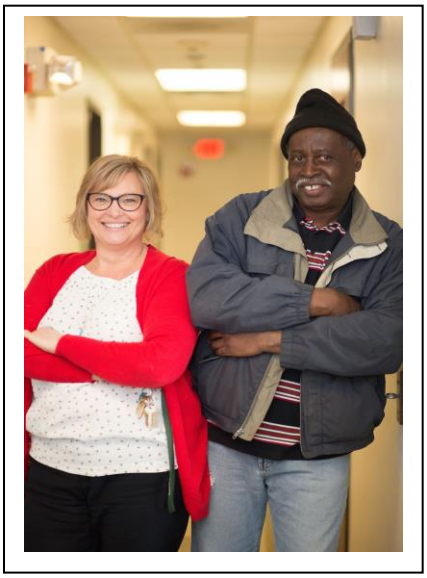
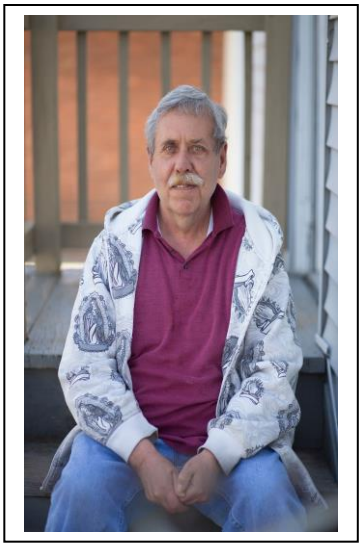
Bethesda House of Schenectady, Inc.

ANNUAL REPORT

2018 — 2019







From Top to Bottom, Left to Right
Kathy O, resident, Crystal T, staff
Melinda B, resident
Louise O, staff, Paul B, resident
Dave B, resident

Bethesda House is an interfaith ministry to the homeless, disabled, and economically disadvantaged citizens of Schenectady County. We strive to build a just, hospitable and inclusive community one person at a time, by affirming the dignity and addressing the needs of each guest that enters this

House of Mercy.

834 State Street, Schenectady, NY 12307, (518) 374-7873

www.bethesdahouseschenectady.org

“Generosity brings happiness at every stage of its expression. We experience joy in forming the intention to be generous. We experience joy in the actual act of giving something. And we experience joy in remembering the fact that we have given.” Buddha

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Special Thanks

The administration of Bethesda House of Schenectady, Inc. gratefully acknowledges the work of its Directors and staff, who are responsible for providing and gathering the necessary data and information to compile this annual report.

The support that Bethesda House receives from the interfaith community through generous contributions, in-kind items, and volunteer hours is immeasurable. The concept of Bethesda House was born out of the interfaith community's recognition of the tremendous needs of the homeless and disadvantaged population of our Schenectady community. Over the years, as the agency has grown and our needs have increased, we have never been left to stand alone. Bethesda House is deeply grateful for the on-going support and continued commitment to our shared vision of ending homelessness.

A Message from the Board President

Dear Friend,

The mission statement of Bethesda House clearly states that we welcome and help all who enter our house; this has always been very important to me. While it sounds so easy, in reality, it is complex and compelling. It brings to mind that "a journey of a thousand miles begins with a single step".

My relationship with Bethesda goes back a long way - from Liberty St. to State St., from employee to board member, board president, fundraiser and volunteer. During that journey I have observed our staff and management team with an extraordinary set of professional work skills. They work compassionately to listen and address the needs of a fragile population.

The agency has grown rapidly by not only increasing our programs, but expanding services to meet demands. Case in point, this year we have applied for a New York State HHAP grant that will allow us to shelter and monitor individuals that have recently been released from jail. We are also looking forward to expanding our Code Blue program.

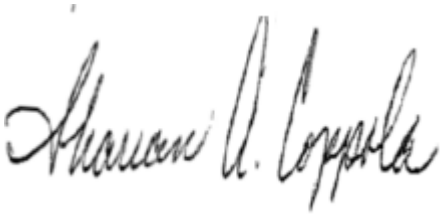
We have worked with the city administration and when this grant is awarded we will begin construction on building a new building to house these programs. We are anxiously awaiting the results of the HHAP process, which will be announced the end of October 2019.

No matter what we do ~ from helping someone with laundry, to finding permanent housing ~ it is a process; a process that involves people, patience, understanding, budgets and funding.

Every gift of time, talent and treasure is a building block that supports our mission and those we serve.

Help us with your gift of time, talent, and treasure, and be a part of our caring community.

Best regards,



Sharran A. Coppola, Board President
2011 - 2015, 2018-2019

Bethesda House at a Glance

"When we meet real tragedy in life, we can react in two ways- either by losing hope and falling into self-destructive habits or by using the challenge to find our inner strength" Buddha

Consumers Served

The numbers cited in the table below only begin to tell the story of the people we serve and the variety of services we offer. These figures represent thousands of hours of case management, social work- behavioral health, emergency services, life skills, and residential services.

Guests Served	Total 2018-2019	Total 2017-2018
Guests	56,175	54,180
Unduplicated Guests Receiving Services	7,606	6,064
First Time Guests	2,733	2,549
Homeless Guests	5,020	4,671

The numbers reflect cumulative totals of services provided.

Program Department Services	Total 2018-2019	Total 2017-2018
Consumer Choice Food Pantry — Meals Served	15,294	15,844
P.G. Wright Food Pantry – Meals Served	17,629	24,390
Clothing Room	1,095	1,008
Showers	3,867	1,726
Telephone	1,305	4,200
Hygiene Kits	1,395	*5,710
*Mailboxes	45,910	43,390
Daily Meal	32,264	35,142
Laundry	1,118	1,477
Lockers	7,015	6,570

*** Hygiene Kits correction 2017-2018 number should have been 1,150**

The numbers reflect cumulative totals of scheduled appointments.

Case Management Services	Total 2018-2019	Total 2017-2018
Housing, Permanent, and Emergency	5,713	3,509
Representative Payee	2,607	2524
Case Management Services	2,505	1,291
Emergency Services	1,375	1261
Referred for Income	857	701
Secured Income	195	233
Social Work	3,720	1,714
DSRIP 2 ED Triage: Transportation Program	285 / 4,680 trips	249 / 4,088 trips
DSRIP 3 Primary Care/Behavioral Health Integration	1,680	1,014
CASAC- DSS Assessments completed & 1 follow-up	813 / 1,626	800 / 1,600
Outreach Case Management: individuals / contacts	262 / 1,572	180 / 1,080
Health Home Care Coordination individuals / contact	277 / 57,616	0
Medical Care Program individuals / contacts	202 / 750	0
*Continuum of Care (COC) Coordinated Entry Referrals	811	480
*Continuum of Care (COC) Coordinated Entry Housed	229	271

Residential Services	Total
Lighthouse total served including Veterans	20
Liberty Apartments total served	18
Beacon Scattered Sites	15

Home Connections	Total
Schenectady County DSS Referrals for Service	309
Individuals Stably Housed	72
Number of Males Referred for Housing	157
Number of Females Referred for Housing	152

Code Blue Emergency Shelter – 10/26/18 – 4/10/19	Total
Un-Duplicated Guests Served	207
Beds Utilized	1,350

Emergency Overnight Shelter	Total
Program Shelter Stay participants (unduplicated)	484
Total utilization of shelter stay beds	2,782
Total beds approved for shelter stay	4,031

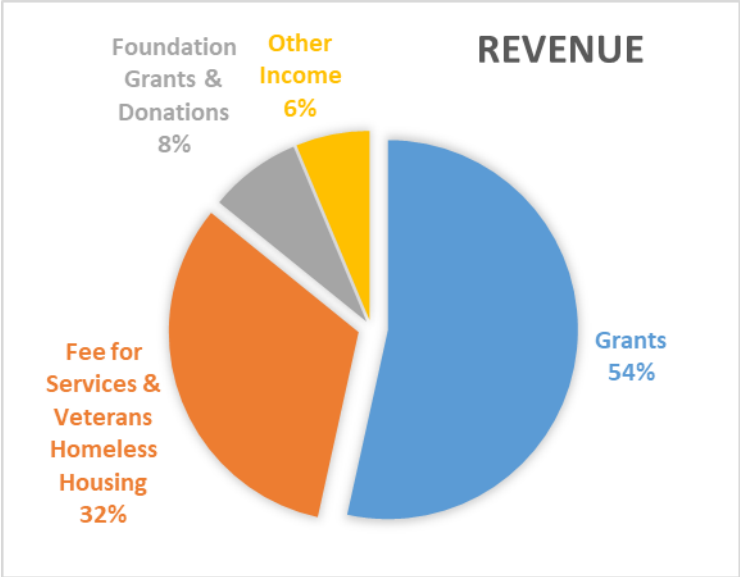
- *CoC is community-wide, includes 13 area providers.
- Consumers were referred to the agency from 16 area providers. Four thousand nine hundred and seventy-five (4,975) referrals were made for the following services: 390 Case Management, 309 Home Connections, 897 Emergency Services, 3,334 Social Work- Mental Health, and 45 Residential Services
- Case Management and Program staff referred 313 consumers to area providers to best meet the needs of the individuals.

*** Mailbox calculation: 85 (3+82) mailboxes, 3 general, 95 individual; 95 individuals use the general mailboxes; 82 individuals have their own mailbox, available to users 249 days a year; 96% utilization rate**

Revenue & Expenses

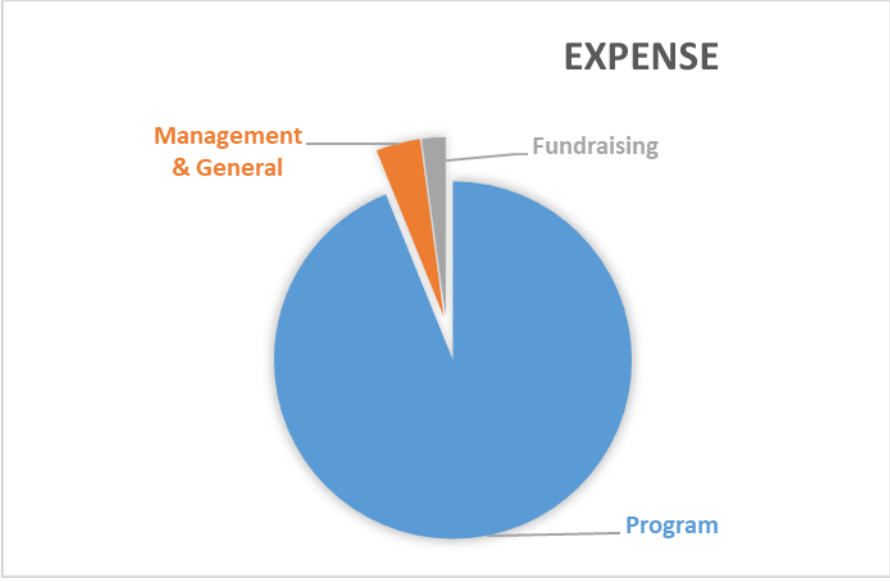
Revenue	Amount
Grants/Applied Income for Operations	1,401,844
Fee for Service & Veterans Homeless Housing	849,227
Foundation Grants & Donations	206,354
Other Income	164,985
Total Revenues	2,634,926

Expense	Amount
Program	2,581,019
Management & General	109,667
Fundraising	58,337
Total Expense	2,749,023



In-Kind & Volunteers 2018-2019

Volunteer Hours	10,953
Value of Volunteer Hours	$247,673
Value of Donated Items	$193,386



Introduction

The administration and staff of Bethesda House of Schenectady, Inc. are pleased to present to you, our Board of Directors, referring agencies, consumers, regulatory and policy making agencies, and friends, this Annual Program Report for fiscal year July 1, 2018 to June 30, 2019. Accountability, to both the consumers we serve and the community that supports our mission, is important to Bethesda House of Schenectady, Inc. Fundamental to the principles and values of the interfaith communities, the staff of Bethesda House views our agency as a living body, which is always growing and learning. This report reflects some of the agency's experiences of 2018-2019. We are confident, as we reflect on this year, that we are better positioned to serve those who will come to us in the future because we are learning from our past.

During the 2018-19 funding year, the total number of guests that served increased 3.7% over the previous year (2017-18); and a 5.50% increase over the last two years. Existing programs were restructured to manage the increase in people served and new initiatives were incorporated which allowed for a greater depth of comprehensive services. New services include a Medical Care program staffed by a Registered Nurse and Medical Assistant along with onsite physician services by Ellis Medical Centers Residency Program Doctors, Outreach Case Manager, and Health Home~ Care Coordination services.

We continue to meet with individuals who, for the first time in their lives, need assistance; people who are aging, that have lived their lives on the streets and can no longer tolerate the cold; and people with unaddressed, complex medical and mental health needs which require immediate attention.

As we compiled the data for this report, we are mindful that we are presenting consumer related data and demographic information; we are providing the reader with outcome material that may or may not reflect the policy objectives of those who set policy. As an agency whose mission is "an interfaith ministry to the homeless, disabled, and economically disadvantaged citizens of Schenectady County, building a just, hospitable, and inclusive community, one person at a time, by affirming the dignity and addressing the needs of each guest entering this "*House of Mercy*", success takes on a much more subjective and individualized dimension than mere conformity to given policy objectives. If our consumers report that they are feeling more hopeful about the future, more prepared to deal with life's adversities, and more able to care for themselves and their families because of Bethesda House, we consider such an outcome a success. It is this success that drives the actions of our staff and inspires us to keep working on behalf of our consumers.

This Annual Program Report covers five service dimensions of the agency: Program Department: Day Program Drop-in Center/ Essential & Emergency Services, Case Management, Social Work – Behavioral Health, Residential Services, and Certified Alcohol and Substance Abuse Counseling (CASAC).

- Bethesda House's Program Department is comprised of a variety of individual services that meet the needs of Schenectady's homeless and working poor population. The goal of the combined day drop-in and essential services programs is to provide crisis management, harm reduction, and stabilization in the lives of the individuals who are experiencing the harshness and difficulties of life and who are hopeful to find guidance out of their despair.

  The Coordinated Entry Program, under the umbrella of the Program Department and in partnership with the Legal Aid Society of NENY, is designed to track the most vulnerable, homeless families and individuals in need of housing from the point of entry into the Continuum of Care tracking and wait-list system, to the moment when they secure housing.

  The Program Department has more than one contract source. The City of Schenectady, NYS Office of Temporary Disability Assistance (OTDA)'s Solutions to End Homelessness Program (STEHP), Department of HUD, Regional Food Bank, Concern for the Hungry, DEC Emergency Food Program, and private foundations and donors all support the services offered by this department.

- The Case Management Department provides a variety of services to the homeless and to those who are at risk of becoming homeless. The goal for each homeless individual who walks through our door is to first manage the crisis and then to proceed toward the overall goal of moving individuals out of the cycle of homelessness and poverty. All Case Managers are available to any guest who is in need of our emergency/essential and housing services. Case Managers complete an initial assessment to determine the needs of our guests and to offer the appropriate services including, but not limited to: counseling, guidance, assistance with basic needs through our Day Program/Essential & Emergency Services Department, housing and income stability, referrals to other agencies for drug and alcohol addiction treatment, referrals for mental and medical health treatment, as well as networking with other agencies to provide services that Bethesda House does not provide. Case Managers can also assist a guest with rental and/or utility assistance and employment assistance.

The Case Management Department has more than one contract source. The City of Schenectady, NYS Office of Temporary Disability Assistance (OTDA)'s "Solutions to End Homelessness Program "(STEHP), Schenectady County DSS, and private donors support the services offered by this department.

- Our Social Work Department provides mental health services to the agency's guests and residents, processes intakes, completes mental health assessments, and initiates referrals to area mental and physical health providers. Long-term counseling and support is available. Bethesda House has implemented two separate programs designed to support the reduction of Emergency Department utilization and Integration of Primary Care and Behavioral Health services. 2018-2019 new initiatives include the Medical Care program and the St. Peters Health Partners Health Home program.

  Bethesda House has a student internship program; graduate level students from University at Albany, Fordham University, and Simmons College (Boston, MA), as well as undergraduate students from Siena, the College of St. Rose, and Ellis Medical Center Nursing Program, are supervised by our Licensed Social Workers. Interns benefit from a hands on learning experience working with our community's homeless and impoverished citizens who are substance users, mentally ill (who typically self-medicate with illegal drugs), who are experiencing trauma, and are struggling with other chronic crisis driven issues.

  The Social Work Department has more than one contract source. NYS OMH through the Schenectady County Office of Community Services, Schenectady County (under the Home Connections program), Delivery System Reform Incentive Payment (DSRIP) and Alliance funding both through the Alliance for Better Health Care, and Department of Health through St. Peters Health Partners Health Home program.

- Bethesda House has operated under the "Housing First" model since 1998. In 2002, when the Agency opened its first residential program, to current, the concepts of the "Housing First" model are practiced. Staff work diligently with residents to overcome life challenges and to help provide a safe, comfortable, and welcoming home for everyone to enjoy and find solace.

  Housing First ~ which is to provide housing first for the chronically homeless population, and then combine that housing with supportive treatment services in the areas of mental and physical health, substance abuse, education, and employment.

  Residential programs include the Lighthouse - seven beds, Liberty Apartment - sixteen beds, and the Beacon - eight scattered-site apartments are permanent supportive housing for chronically homeless adults with a history of untreated, severe, and persistent mental illness and other disabling conditions. We provide advocacy, housing, and a safety net for our residents. Staff address the needs of the whole person focusing on self-respect, personal growth, and discovery of an individual's strengths.

  The Lighthouse Program's additional three beds are transitional housing beds for veterans. Agency staff work closely with Albany Veterans Administration staff, providing a safe and stable setting while the veterans begin treatment and work on financial stability; long-term services are secured after completion of our program.

  The Residential Services Department has more than one contract source. The Department of HUD, NYS Office of Temporary Disability Assistance (OTDA) "NYS Supportive Housing Program" (NYSSHP), Veterans Administration, and private donors support the services offered by this department.

- The Certified Alcohol and Substance Abuse Counseling (CASAC) program performs drug and alcohol assessments, re-assessments, and/or drug screenings as referred by Schenectady County Department of Social Services (SCDSS).

  The CASAC program has one contract with Schenectady County.

Bethesda House ministers to a vulnerable, diverse, and challenging population. Therefore, it is important to recognize that the agency would not be successful without the incredible, selfless support from our volunteers.

Agency staff regularly attend meetings with:

Housing and Supportive Services Network
Single Point of Access Committee
Eviction Task Force
Dual Recovery Task Force
Coordinated Community Response to Domestic Violence
Schenectady County Re-entry Task Force
Schenectady Food Provider
The Food Pantries of the Capital District
Homeless Veterans
Homeless Services Planning Board
Schenectady Coalition for a Healthy Community
Coordinated Entry
Mental Health Sub-Committee
Adults at Risk – Schenectady County

Bethesda House has a variety of linkage agreements and Memorandums of Understanding (MOU) throughout the professional community.

Linkage Agreements:

The Alliance for Positive Health
The Center for Community Justice
Catholic Charities AIDS Services
Healthy Schenectady Families
Legal Aid Society of NENY
New Choices Recovery Center
Center Office of Fair Housing
SAFE Inc. of Schenectady
Schenectady County Department of Social Services
Schenectady Community Action Program (SCAP)
Schenectady Home Town Health Center
Schenectady Municipal Housing Authority (SMHA)
Sexual Assault Support Services of Planned Parenthood Mohawk Hudson (PPMH)
The YMCA of Schenectady

Memorandums of Understanding (MOU):

Ellis Medical Center Department of Psychiatry
The YWCA of Schenectady
Schenectady County Re-Entry Task Force
Cornell University Cooperative Extension
The City Mission

One moment can change a day, one day can change a life, and one life can change the world. Buddha

Bethesda House's Administration is fully invested in the freedom to be creative, to pioneer useful solutions and implement positive changes within the agency. Agency leadership is examining how effectively the agency works with area service providers, as it is essential that duplication of services is avoided and working collaboratively is in the best interest of the population we serve.

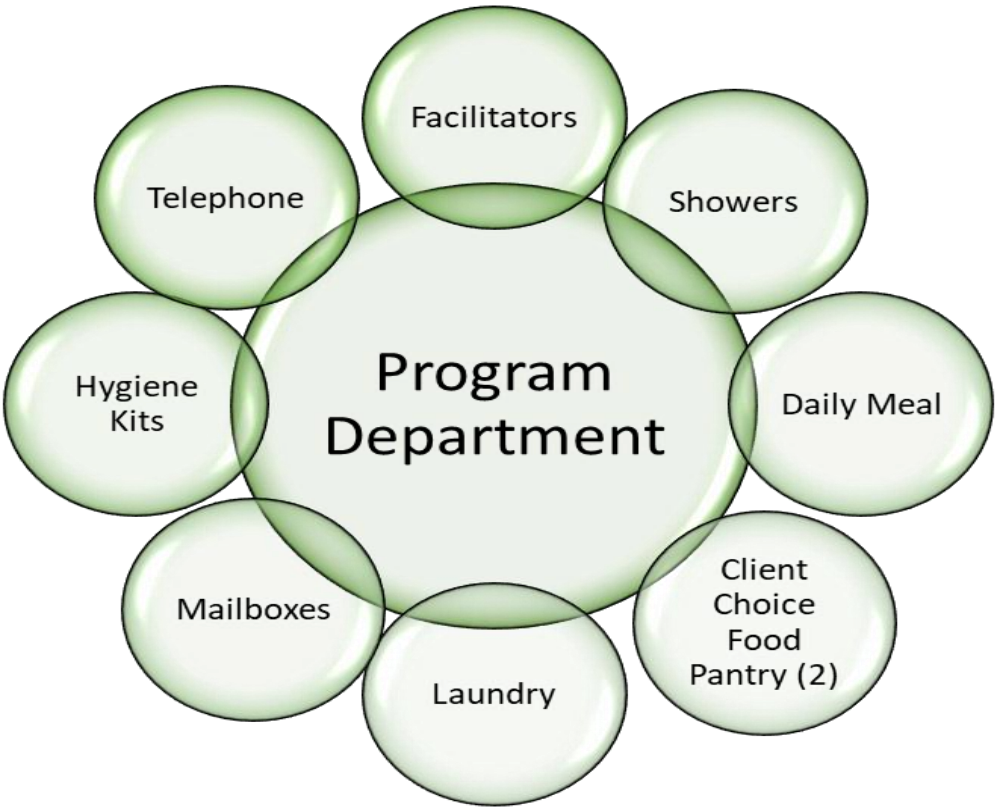
Worker safety is the common thread running through all of our departments and remains a priority.

The staff and administration of the agency wish to express our gratitude to the Board of Directors of Bethesda House. The Board's support and commitment to the agency are salient reminders to all of us, of the importance of our work. We are partners in ending homelessness and providing hope in the lives of Schenectady County's most vulnerable population. ***Thank you!***

Dr. Gary and Kathleen Dunkerley

Reverend Richard Parsons

Program Department



The Program Department's Day Program Drop-In Center is unique in that a wide variety of services are offered under one roof. It is well known on the streets as a safe place and is often the first and, many times, the only connection that homeless and at-risk of becoming homeless persons have to any system of care; it opens the door to forging trust and building relationships with the most challenging members in our community. The Day Program is the Agency's primary point of entry to Schenectady County's Coordinated Entry Program (CE). The CE program gives the community's homeless access not only to Bethesda House's permanent supportive housing program, but also to all the permanent supportive housing options in the county.

The Drop-in Center serves the most vulnerable and homeless population including individuals with challenging behaviors who have been barred from other agencies due to substance abuse, noncompliance to agency rules and behavioral management issues such as: unwillingness to enter or continue with treatment programs, issues with mental health, anger management, or other emotional and mental health concerns, which resulted in an unfavorable status within the community.

The Day Program services include: Drop-In for the homeless and working poor, a safe haven social setting for adults with a disabling condition, daily community meal (Soup Kitchen), referrals to other community agencies, mailboxes, laundry, shower, telephone, fax, hygiene kits, clothing room, and client choice food pantry. Several outside facilitators provide on-site expertise in a variety of programs. Bethesda House staff partner with area providers to offer: landlord/tenant training, women's/men's support groups, Safety Counts, HIV testing and education, Walgreens flu vaccine clinics, blood pressure clinics, substance abuse support, and nutrition education.

The Director of Program & Case Management Services is responsible for this department. The Day Program Coordinator manages the daily needs of the guests and maintains organization and calmness in the center. Collaboration with the Case Management, Social Work, Residential, and the Property and Facility Operations staff is essential to ensure efficiency of the daily operations. The team approach maximizes efficiency as staff members navigate their way through daily interactions with our clients.

The Agency's **Food Program** builds on partnerships and the nutritional platform implemented in 2012. The nutritional platform includes healthy, low-fat, low sodium meals offered in our soup kitchen. Food Program staff have revamped the Agency food program to be in line with the goals of reducing diabetes and obesity in the county. Cornell Cooperative Extension provides nutrition education and cooking classes, using items from our food pantry, they are informative, easy to follow and well received by program participants.

Education includes how to stretch their SNAP Benefit (food stamps) and how to supplement with local food pantries and gain access to services offered through Schenectady County Healthy Neighborhoods Program, EFNP, and Food Stamp Assistance through our county's Nutrition Outreach and Education Program (NOEP), or Center for Independent Living. Case Managers offer one-on-one education to individuals that come in with emergency referrals for the pantry. Case Managers and Day Program staff meet with each individual and assess their food stamp allotment and buying habits that have led to the early depletion of their resources. In addition, our partnerships with CDPHP and Fidelis provides access to referral services to health insurance assistance.

Staff offer alternatives to corner store shopping and work with individuals on meal planning and stretching the food stamp dollars. The Agency's Registered Nurse meets with day program guests and residents and enforces the need for healthy choices. We have found that this approach, along with collaboration with Cornell Cooperative Extension, is met with enthusiasm. The Program Department continues to work in close collaboration with Concern for the Hungry and the Regional Food Bank to address the number of families and individuals suffering from food insecurity.

(L-R) Terry S, volunteer and Kim M., guest

Bethesda House partners with local justice officials to provide opportunities for individuals to complete community service hours and to receive on-the-job training. In addition to obtaining job skills, the participants are educated in social responsibility and offered assistance in career path planning. During the last three years, 404 people, total of 9,002 hours, have successfully completed this program.

Bethesda House works closely with the Schenectady County justice system. Agency staff continue to see a steady increase in the number of people released from incarceration, who are homeless and in need of physical and mental health intervention. Bethesda House provides social work and case management services with a goal of assisting in a smooth transition back into their community and to help reduce recidivism.

Monthly Program Department staff meetings are designed to address and review issues that impact all aspects of programming. A **House Meeting,** held once a month, includes guests, residents, and staff. During these meetings a variety of topics are covered: violence within the agency and in the community, guest issues, respect for others and the building, self-respect, community presentation, and the agency policies that directly impact those we serve. In addition, potential service or program changes are announced and discussed at House Meetings. Guests and residents are encouraged to engage with staff on the changes that they would like to see and, for those who prefer, we have a Suggestion Box for the guests located in the Hospitality Room for easy access.

The availability of **phones** has allowed numerous people the opportunity to arrange for job interviews and follow up on phone calls to the Social Security Administration and Schenectady County Department of Social Services for benefits and monthly cash assistance.

Administration and Program staff continue to increase our **volunteer pool** and promote community involvement. We actively reach out to local colleges and high schools, offering opportunities for internships and community service hours. We would not be able to offer the variety of services we do without the generosity of the community.

Schenectady Job Training Agency (SJTA) is active in referring high school students to the Agency for on- the-job training opportunities through the Federal Work Study Program. The design of the Summer Job Training Program, run by SJTA, is such that high school students are provided meaningful summer work opportunities and, through coaching and mentoring, gain an understanding of workplace etiquette and appropriate employment skills necessary to succeed.

Schenectady County Coordinated Entry

Schenectady County Continuum of Care Coordinated Entry process is designed to identify, engage, and assist homeless individuals and families, and to ensure that those who request assistance are connected to proper housing and services. Coordinated Entry uses a standardized assessment tool and incorporates a system-wide housing first, client choice approach and prioritizes housing for those with the most vulnerable service needs.

This HUD funded program is facilitated by Bethesda House and Legal Aid Society. The partnering agencies are, New Choices Recovery Center, SCAP, YMCA, YWCA, Mohawk Opportunities, Schenectady Municipal Housing, SAFE Inc., Soldier On, and Vet Help (SSVF), Alliance for Positive Health and The Re-Entry Task Force.

The four core elements of Coordinated Entry are: Access, Assessment, Prioritization, and Referral. It is these four principles that guide the team to effectively house the most vulnerable homeless individuals and families in Schenectady County using HUD funded beds. Through the "no wrong door" approach, a standardized, system-wide assessment tool aids in prioritizing vulnerability, which ensures a smooth interagency referral process. In 2018- 2019, the total number of homeless singles and families, who entered an area agency seeking services was 811, a 69% increase over 2017-18. This dramatic increase is due to increase in the number of evictions due to higher rents, lack of affordable housing, in addition to agencies streamlining their internal process and an increase in the number of staff meeting with homeless singles and families.

Overnight Emergency Shelter:

Bethesda House operates an on-going overnight emergency shelter that is staff with Shelter Aids, an Intensive Case Manager (ICM), and a Licensed Masters Social Worker (LMSW). The ICM meets with each shelter guest, processes an intake and needs assessment, and collaborates with the LMSW to address the needs of the whole person. A referral to the in-house Housing Case Manager is made along with connections to other area providers, as appropriate. Emergency Shelter staff have on-going communication with the Director of Program and Case Management Services who is in regular communication with Schenectady County DSS.

Services offered in our overnight shelter include the following: showers, a light meal, laundry, storage lockers, and a supervised, safe and warm environment. During bitterly cold winter or storms, Bethesda House remains open during the day on the weekends to ensure that homeless citizens had a safe, warm place to shelter.

Bobby, A4TD staff

(L-R) Kim M., staff, Flor, volunteer

Day Drop-in Center/Essential Services Stories

"Incredible change happens in your life when you decide to take control of what you do have power over instead of craving control over what you don't." — Steve Maraboli

Bethesda House provides many services that guests are able to take advantage of by just walking through our doors. The numerous wrap around services provided to our guests is what makes Bethesda House so unique. Some people need help with housing or food and health; some need help managing their finances and some people just need someone to talk with and a safe place to hang out.
At Bethesda House, there is a no wrong door policy and we will help anybody that walks through our doors. During the year, we work with so many different people and hear their stories. Each person offers a unique and special story, but there are a few that have stood out and we would like to be able to share these with you.

Each story that you read will have several things in common:

- The guest has reached a breaking point
- The guest is asking for help
- The guest is finally willing to receive help

These stories reflect the determination and dedication our guests have to change their lives.

SL is a male in his mid-50s with a mild learning disabilities and a neurological disorder. SL resided with his family for many years in a run-down rental unit in Hamilton Hill. His father died a few years ago and from this, SL spiraled into a severe depression. When we first met SL, staff discovered horrific living conditions. He was living with a bed bugs infestation, garbage piled up around the apartment, terrible hygiene and he had been wearing the same clothes for months. SL refused medical care and all help from several agencies. He aggressively rejected the idea of leaving his apartment however, with intense coaxing from our DSRIP SW team, SL agreed to leave his home. Due to his condition, immediate intervention was required. Bethesda House provided a shower, clothing, and shelter stay in our emergency bed program. Staff recognized that special consideration needed to be given to encourage him to engage and agree to be connected to medical care. Staff stayed with him each step towards stabilization. SL was brought to appointments, to the Salvation Army for breakfast, had his medications in a pill box and was continually being cared for by all staff. After weeks of staff intervention, SL began to adhere to staff recommendations and he was hospitalized for observation and medication management.

Over time and with medical care, SL was able to be more independent. His favorite place to go was to the dollar stores. He was notorious for buying every single Valentine's Day, St. Patrick's, Easter and Mother's Day cards left on the shelves. He would give them to staff and thank everyone for helping him and especially to say to staff, "Have a great Day"! He would buy gag gifts and play pranks on the staff. His life turned around and he was finally ready to move on. After 5 months of shelter stay and stabilization services, SL moved into the YMCA. He continues to work with SW staff.

Women's Group ~ Nineteen Years of Sisterhood!

My friends are my estate. No matter what you acquire in life, nothing makes you feel more privileged than a strong friendship.
Emily Dickinson

One of the longest running programs at Bethesda House is bound by Sisterhood. This level of connection and commitment develops over time, and has been fostered by the compassionate and professional facilitators from Bethesda House, YWCA, and Planned Parenthood. Every Thursday, with the love and support of long-time volunteers, this group gathers to discuss addiction, abuse, homelessness, love and loss, in a covenant of confidentiality. The facilitators offer the participants opportunities to grow, with the occasional outside speaker, arts and crafts, and self-care. The Group has several luncheon outings each year which are supported by volunteers.

Story:

ML, who has been attending Women's Group for years, was suddenly experiencing a bed bug issue. She was absolutely horrified that this was happening in her home. ML was clean, didn't have many guests, and was always very careful about what she brought home; but still this was not enough. Her landlord found bed bugs during an inspection and she was informed that immediate action was required. ML put her furniture and bed on the sidewalk and thought, "people will know that they are mine and that I am disgusting for having bed bugs." Her thoughts about what people would think of her paralyzed her and she didn't leave her house for weeks. Concerned, a Women's Group volunteer reached out to her. ML broke down and explained what happened and why she was absent, essentially from life. The stigma attached to this very common issue is real and ML experienced shame. Our volunteer was able to get a few of the other women involved and provided her a new bed, new bedding, and a small used couch. The volunteers did this not only to help but to get ML back to group. At group there is no judging, only support; ML realizes this more than ever.

Men's Group ~ Four Years of Camaraderie

Reverend Richard Parsons facilitates group discussions on topics such as health, parenting, community, violence, being role models, and Spirituality. Guest speakers lead discussions on more sensitive topics such as terminal illness and trauma and loss. Men come together to share their thoughts and feelings and to work toward breaking down the barriers that confine them. The group meets at the State Street Presbyterian Church on Catherine Street every Thursday from 11:30 am – 1:00 pm.

Case Management

The Case Management Department is led by the Director of Program & Case Management Services who collaborates with the Director of Social Work and the Director and Assistant Director of Residential Services to best meet the needs of the guests and residents the Agency serves.

Case Managers have been cross-trained to assist people who are homeless, at risk of homelessness, and/or in immediate need of Emergency/Essential Services, that Bethesda House offers. All department staff meet weekly for the Treatment Team meeting to review issues that impact clients, programming, and staffing.

In keeping with Bethesda House's commitment to improve the lives of those we serve, all BH Case Managers and Directors were trained in SSI/SSDI Outreach, Access, and Recovery (SOAR); a program designed to increase access to SSI/SSD for eligible adults who are experiencing, or are at-risk of, homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder. The process for applying for SSI/SSD can be a laborious, cumbersome process, which can take many years of denials before being approved for the benefit. Many of those we serve find the process so daunting that they pursue legal assistance to obtain their benefits, which does not necessarily shorten the process.

Individuals that are awarded benefits after many years of attempt are given a retroactive payment from the time they applied, and that can add up to thousands of dollars that could be used for them to become financially stabilized and set them up to live more comfortably with their monthly allotment. However, for individuals that obtained legal services, they are required to pay the majority of their back benefits for the legal services rendered, resulting in the individual having a financial deficit. The SOAR program is a no charge service that gets results for the individual in 6-8 months. Case managers obtain releases so that all of the pertinent medical and psychiatric history can be obtained expediently.

Services:

Initial Intake and Assessment: triage and assessment of immediate needs, eligibility for entitlement programs, and the need for immediate referrals to other agencies.

Financial Case Management: managing the SSI/SSD benefits for disabled and identified guests. A budget is established with each person in our Rep Payee Program ensuring rent, utilities, food, medical care, and other essential needs are met and paid for before the guest receives a personal spending allowance.

Shelter/Housing

The Case Management team provides emergency services to assist homeless individuals with emergency shelter placement. Guests can continue to work with Case Management staff to obtain steady income and permanent housing (subsidized or programmatic housing) or to obtain placement in Drug/Alcohol rehabilitation.

Case Management staff have an extensive landlord database and continually work to increase and maintain relationships. Housing Case Managers primary responsibilities include homelessness prevention, emergency shelter referrals, rapid re-housing placement, and securing permanent housing. Many strong, on-going, working relationships with landlords have been developed and have increased the outreach to house chronically homeless people.

In the 2019-2020 operating year, the Sr. Case Manager will be conducting a monthly tenant education program, for clients to better understand what a successful working relationship with a landlord looks like and discuss tenant's legal rights. This training will also empower clients to better understand what it means to be a good tenant and how to work collaboratively with a landlord. We are excited to be able to offer this training and encourage and foster a positive working relationship between tenants and landlords.

The number of unique individuals served by Case Management staff in 2018-2019 increased over 2017-2018 by 45%. In addition, the number off meetings with each person increase over the previous year by 65%. This is directly related to the complex needs of individuals seeking housing and crisis management.

Home Connections

This program is designed to significantly reduce the length of time homeless individuals stay in emergency shelters. The Housing First model, which is employed by all departments within the agency, continues to be our guiding principle as we search to find permanent housing options for the most vulnerable. The majority of individuals that end up in shelters are chronically homeless and suffer from severe disabilities which include untreated and persistent mental health disorders. Of the total number of people served this past year in the Home Connections program, 85% are disclosing a mental health disability.

Bethesda House received 309 referrals during the 2018-2019 fiscal year and, of those referrals, 72 were placed in permanent housing. In Schenectady County, there is a critical concern of the lack of affordable housing for individuals who are receiving Department of Social Services temporary assistance support. In general, rents have significantly increased.

Of the remaining 237 individuals, 8 continue to be active; 229 did not go into permanent housing, the reasons are broken down by percentage as follows: 3% were incarcerated, 1% is deceased, 15% found employment and no longer needed services, 28% never showed up at the shelter location, 2% left the State or moved to another county, and 51% refused to comply with the goals of their Independent Living Plan (ILP), as dictated by the Schenectady Department of Social Services, thus making them ineligible for Temporary Assistance until such time as they are ready to comply.

Once an individual is housed in the community, they receive wrap-around services. An in-depth assessment is process and a service plan with individualized goals and follow up is developed. The services plan includes enrollment in the Representative Payee program for financial management, engagement with the in-house Social Work and Medical Care Program, and if appropriate enrollment in the Health Home program. This team wrap-around approach has proven to provide greater stability for the individual and increases their chance of successful integration into the community. BH's strong partnership with DSS has allowed for greater insight into the deficiencies of the service delivery system and has paved the way for improved relationships with other area agencies in the community. Barriers have been identified and plans are being implemented to address the growing needs of the homeless population of Schenectady.

The Representative Payee Program

The program provides benefit payment management for SSA beneficiaries for those who are incapable of managing their Social Security or Supplemental Security Income (SSI) payments. Individuals who want to secure permanent housing or are at-risk of homelessness, enroll in this program to ensure that their rent, utilities, and medical bills are paid before receiving a pre-determined personal needs allowance. This program is extremely successful in reaching the goals of continued housing and income stabilization. The self-determination that people gain from living independently is remarkable.

Many individuals who do not participate in this program find themselves being taken advantage of by others and run the risk of losing their minimal income to drugs/alcohol or other addictions due to their inability to handle and manage their monthly Social Security payment.

The current average income of a participant is $825 a month. Regardless of the amount, program participants are living on their own, not with family. In Schenectady, the current fair market value of a one bedroom apartment is approximately $904 a month. Without this valuable service of financial management, our client's would be unable to pay their rent and utilities, or have a few extra dollars in their pocket for personal needs. Our program allows for people to remain housed and be safe from the elements of the streets, while allowing for personal needs allowances based on their budget. Our Representative Payee Case Manager works with landlords to advocate for client's that need additional independent living skills, while working collaboratively with each client to prevent eviction.

Stories:

***Down but not out*: FF** is a 38 year-old woman who came to the emergency shelter because she had been evicted from her home. FF lived at the same address for 5-years but struggled each month when her rent was due. She presented as having no disabilities and she denied having mental illness. As a result of not having any identifiable disabilities, FF was not eligible for many of the services offered by area providers. Her employment history indicated that she would have 3-4 positions at one time and would be systemically let go from each one for a variety of reasons. The instability of employment resulted in her lack of ability to remain consistent with her rent payments. At the time of her eviction, she owed $1,000 in arrears. Nowhere to go, not eligible for DSS temporary assistance, she stayed in Bethesda House's emergency shelter. Eventually, FF agreed to work with Case Management staff. After many conversations, she agreed to return to Schenectady County DSS to obtain assistance.

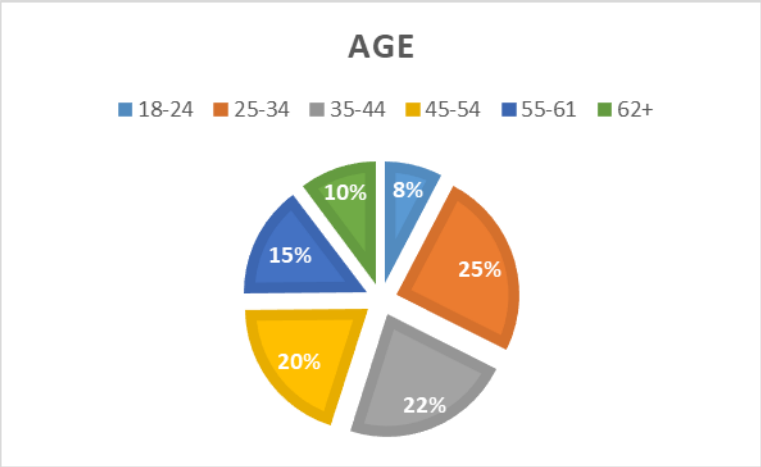
This time, because of her reduction in work and supporting her own emergency shelter placement, DSS approved her for several weeks of shelter assistance. Having shelter support prompted her to secure another job; this time for more hours per week. The Agency's Sr. Housing Case Manager was able to find a room that was affordable for FF. Today, she remains stably housed and has the supports she needs to maintain her housing. Occasionally, FF stops by to visit, have a meal and do her laundry. She updates the Sr. Housing Case Manager monthly and regularly thanks her stating that she should have asked for help.

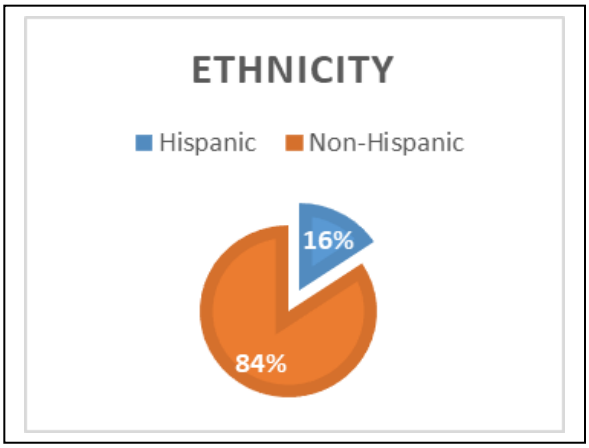
***Looks Like I've Made it!!:* EE** is a 25 year old male who has been referred to Home Connections several times; each time ending with him going to jail or moving out of state. This last time, after a release from Schenectady County Jail for a several month stint, he was referred to stay at the Overnight Emergency Shelter and work with staff to complete goals on his Independent Living Plan. EE has a significant MH diagnosis, used street drugs and refused to work with anybody. When he returned to the shelter on 1/1/19 he looked exhausted, tired and stated that he just wants to be housed and doesn't want to be homeless any longer. EE started working again with our LMSW, ICM and Case Management staff. Staff provided transportation to his medical appointments and ensured that he was compliant with medications. EE struggled for many years and refused to admit that he needed a supportive living environment.

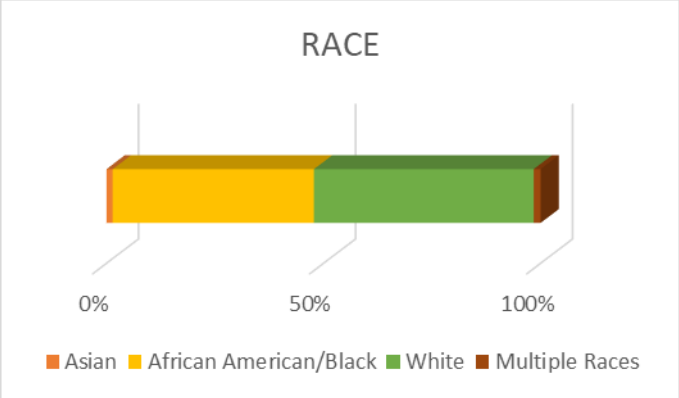
Since his return to the shelter and working so well with all staff, EE saw the benefits of how a team approach could benefit him. The Agency's LMSW assisted EE with the required paperwork to reside at a local MH supportive living housing program. EE met with staff, had dinner there several nights and eventually moved into the house. Since EE was compliant with medications and doing so well, his mother and brother started allowing him to visit home again and be part of the family. EE was the first to admit how his behaviors greatly affected his family and his relationships with family members. Recently, EE told staff that he has started a small engine repair business, he added that it helps him to stay busy and use his hands and his mind. EE is doing great and would like to return to BH to help volunteer with helping in the yard and fixing things around the property. He is accomplishing several of his dreams and we couldn't be happier for him!

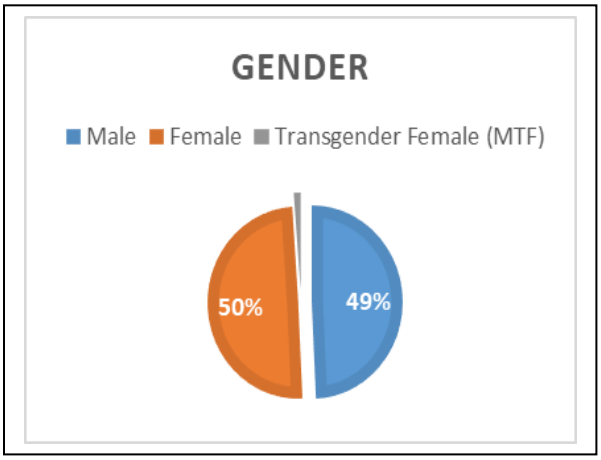
(L-R)
Louise O.,
Catherine C.,
Rachel B.

Tom B., guest









Disability	% of Population
Development Disability	28%
Chronic Health	67%
Substance Use Disorder	51%
Mental Illness	84%
HIV/AIDS	3%
Physical Disability	54%

Services

Stabilizing emergencies
Reducing obstacles
Access to community resources
Referrals to area providers
Emergency placement
Permanent housing
Rapid Re-housing
On-going support
Wrap around services

Neighborhood	
Central State Street	28.6%
Downtown	16.1%
Hamilton Hill	28.6%
Mt. Pleasant	16.1%
North Schenectady	1.8%
Union Street	8.9%

Social Work Department

The Social Work program offers a unique approach to people who have severe, persistent, and untreated mental illness. Social work services are woven into all the Agency's programs. While in the process of obtaining both emergency and permanent housing, our social work staff is available to the consumers for a comprehensive assessment and referral process to secure medical and/or mental health treatment, as well as other services needed for community stabilization. Social Work services are integrated into all internal Case Management services, and staff work closely to develop a multi-disciplinary, cohesive team. The Agency's approach uses this multi-disciplinary team to wrap services around the consumer in order to achieve residential and income stability, medical/mental health wellness, and improved quality of life. Our Social Work staff provides clinical support for walk-ins, community visits, wellness checks, and advocacy. In cases where a referral is made and appointments are scheduled, Social Work staff will assist in transport and will provide support during appointments and their follow-up.

Over the past several years, Bethesda House has seen a dramatic increase in the number of individuals with severe, persistent, and untreated mental illness. Licensed Social Workers provide support, counseling, health monitoring, and assistance with basic living needs; however, the treatment needs of these individuals far exceed the level of services offered on site. The strong and mutually beneficial relationships that are established through the Social Work Department with local providers, hospitals, treatment facilities, and community based organizations has evolved to address service gaps and social determinants of health.

Bethesda House implemented two Delivery System Reform Incentive Payment (DSRIP) programs in 2016.
Transportation Program is designed to incorporate safe transport for Schenectady Residents to Medical/Mental Health/Substance Use Disorder treatment appointments, as well as pharmacy pick-ups. It involves conducting a needs assessment for participants in order to provide beneficial case management or referrals to appropriate services when applicable. Case Management and Social Work staff works collaboratively with Ellis Hospital for discharges and post hospitalization case management. In most cases, those being discharged from the hospital are homeless and require support and assistance in securing housing, basic living needs, and facilitation of hospital discharge plan. Homeless individuals will meet with the Housing Case Management, Social Worker, and agency RN. If emergency shelter is needed, the individual will also meet with Shelter staff. BH works to support not only transition from hospital to community but to stabilize individuals once in the community.

This program is dedicated to providing free transportation to Schenectady County Residents regardless of insurance provider. The program was developed to assist in transition of inpatient and ED discharges from Ellis hospital, providing door to door transport, a basic needs assessment and offerings, and connection to medication pick up. Transported individuals are offered the comprehensive services available at Bethesda House. Staff contact emphasizes compassionate care so that the transition out of the hospital is fluid and supportive.

The Primary Care Behavioral Health Integration (PC/BH) (now referred to as Medical Case Management) this service provides Social Work and Intensive Case Management to individuals who are not engaged with a PCP/MH provider or inadequately connected to community medical/MH services. The goal of the program is to work closely with individuals to assess their comprehensive wellness needs (medical, MH, housing, nutrition, social supports, transportation, etc.), and address those things that negatively affect one's health and stability in the community. A key component is education of the client in the understanding of diagnosis and treatment. Comprehension of personal medical issues and care cannot be assumed with the population BH works with, as well as an inherent trust of medical providers that often exists. In addition, there is guidance and presetting done with clients so they are aware and informed of the procedures and nature of appointments. Staff provide support and advocacy during appointments, address medical compliance as much as possible and have on going check-ins to monitor progress or address and health decline. Frequently, staff meet with clients not only to provide medical case management, but also to support and encourage symptom management, de-escalate frustrations related to their health and well-being, and actively build rapport so they may be an in crisis management and interventions when needed.

Community Outreach Case Manager Program was in full operation during 2018-2019. This program is responsible for daily efforts to going into the community to seek and connect with homeless and disenfranchised individuals who are in need of basic living resources and community services. Staff establishes connections with community providers and businesses to network and further connect with those who are not connected but would benefit from community services, or perhaps are encountering barriers in accessing services.

The Outreach Case Manager (OCM) works closely with BH emergency shelter (ES) guests, particularly to connect them to basic living needs (food/clothing), DSS services, and medical/MH services. The OCM makes daily contact with ES guests and acts as a resource and a support source to encourage cooperation and engagement in wrap around services. Program staff visits local service providers and relevant locations such as library, bus stops, other shelters, and public places. As a result of the comprehensive services, the community and Schenectady residents actively reach out to the OCM for assistance in addressing those very needs. Services provided are: on-going needs assessments for those in the community with the intention of either bringing individuals to Bethesda House for shelter, clothing, food, or for social work, medical or case management services; individuals are referred to area providers as appropriate. There is also a strong emphasis in connecting individuals to clinical and medical services through BH wrap around services.

(L-R) Staff - John C., Leina M., Rachael C.

Savyon L., staff

Overnight Emergency Shelter: Case Management / Social Work Services is designed to provide safe emergency shelter services, and to embed critical case management and clinical services within the program. The shelter provides an Intensive Case Manager (ICM) in the evening to immediately assess the medical and mental health needs of individuals seeking emergency shelter due to homelessness. The ICM processes an intake and assessment, reviews client information such as hospital discharge paperwork and provides face-to-face interaction. Individuals that need immediate interaction with SW, Medical, or Case Management staff are asked to stay in the building. The involvement of the ICM and Licensed Social Worker is unique to our shelter, because they provide both direct care during their shelter stay and also case management services and support outside of shelter hours. This practice has allowed staff to establish trust with an individual more quickly to successfully engage individuals in appropriate day services so that they comply with SCDSS requirements and access permanent housing.

The Medical Care Program is dedicated to providing medical intervention and oversight to those who are disconnected from community providers and/or experiencing a medical event. The RN is available on site Monday through Friday, and is able to make home visits when needed. The RN is available to consult and provide nursing evaluations for clients and is often is called to review discharge paperwork from hospital discharges, assist with medications and compliance, wound care, symptom management, and will offer education and advocacy to an underserved population. The RN collaborates with the Ellis Residency Program in order to provide Medical evaluations and prescriptions by volunteer residents to the population served at Bethesda House. Frequently, the Medical Program assists clients with unmanaged chronic conditions are requesting medication refills, addressing chronic and acute pain, and wound care. The RN and Ellis Residents, supported by ICM/SW support team, establish follow up care.

The funding for the above programs allowed for the recruitment and hiring of professional staff whose expertise and innovative thinking enhanced each program. Programs evolved to become individually unique yet interdependent on other agency programs that provide high quality services to the community's homeless and impoverished citizens. Each program has specific staff and responsibilities with the overarching need for licensed social workers that bridge the services. Individuals that enter services through any single DSRIP/Alliance funded program are referred and have a warm handoff to, quite possibly, all DSRIP/Alliance programs especially if the individual is homeless. The result is an intensely collaborative team effort that uniquely addressed the need of each individual served.

Certified Alcohol and Substance Abuse Counselor (CASAC)

The Agency's CASAC program is located at Schenectady County Department of Social Services (SCDSS). The program exemplifies the successful working relationship with SCDSS, and further strengthens the continuum of care in Schenectady County. The program works closely with the Department of Temporary Assistance (TA) to provide evaluation and treatment recommendations for those seeking TA. Licensed CASAC staff screen individuals for substance use disorder, provide diagnosis and treatment referrals, as well as on-going communication and follow-up with treatment providers. The initial referral for CASAC evaluation originates from the TA caseworker that screens applicants. Frequently, a history of drug or alcohol use or evidence of current use will result in a referral to CASAC. The CASAC staff act as a liaison between treatment providers and SCDSS, while ensuring that applicants have several options for treatment and services, customized to meet the needs of each individual. An added benefit to this partnership is that during the assessment process, CASAC can refer individuals to Bethesda House for appropriate wrap around services to address any identified unmet need. For those who access this added layer of support, it helps to minimize the likelihood of an individual becoming sanctioned for noncompliance, as the Case Management/Social Work Team will address treatment/service barriers and provide advocacy and outreach in order to meet ISP obligations.

Health Home Program, St. Peter's Health Partner is the lead agency; Bethesda House is a Care Management Agency as of January 2019, employing three Care Coordinators providing medical care coordination to individuals who are Medicaid eligible and meet eligibility criteria. Since its start, Care Coordinators have opened 273 cases with an active caseload of 101 individuals with chronic medical and mental health conditions. Health Home Services assist those coping with chronic conditions and frequently, mental health issues. The services include coordinating medical/mental health appointments, assisting in securing medications, addressing Social Determinants of Health, and referring/collaborating with other Community Based Organizations for support services.

Care Coordinators are responsible for monthly documentation of contacts and case management activities, billing submissions, and development of a Plan of Care. There is a process of on-going education with clients to promote wellness, medical compliance, and comprehension of medical diagnosis/treatment. The Care Coordinators work with clients to develop a plan of care to work on areas of personal value and achievement. The program staff incorporates wrap around services offered within the agency such as Transportation, RN services, PNP services, and Outreach Coordination, to provide comprehensive, effective care. Care Coordinators manage various programs within the Health Home umbrella, such as Health Home Plus and Harp services. In each case, clients are offered a higher level of service and support, encompassing interventions in areas such as Mental Health, Substance Abuse, Housing, Income, Food Security, and Vocational needs. Despite the basic requirement of Care Coordinators meeting with clients once a month with case management support, our Care Coordinators experience a high utilization of services and frequency of contact due to the nature of the population served. Managing issues of limited social support, lack of resources, poverty, housing instability, involvement in institutions such as LDSS, APS, CPS, and Criminal Justice often require a high level of support, resulting in weekly contact rather than monthly.

Residential Services

Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness. This model is at the core of all services Bethesda House provides and was directly implemented in 2002 when the Agency's first residential program began operations.

Many residents have never known a home of their own. They have lived in areas that are not fit for human habitation such as wooded areas, under bridges, in attics or abandoned buildings, and, in some cases, sleeping on strangers' front porches. All of our residents come in with survival skills that are engrained in their thinking. They have survived by living on the defense, living in filth, eating out of dumpsters, and resting whenever and wherever they can. The skills that are necessary for a life on the street differ greatly from those necessary for keeping a house. The average person, that experiences chronic homeless, does not think about sanitation; they think only of survival.

Bethesda House's Residential Services Department meets the daily challenges of encouraging and assisting each resident as they work toward the goals of their Individual Service Plans. Staff and volunteers are an essential part of the success of each resident. The Director and Assistant Director of Residential Services, and the Life Skills Counselor are key staff members on the Residential Team. The Team works closely with the Program, Case Management and Social Work departments as well as the Property and Facility Operations staff, to maintain efficiency while staff members navigate the needs of the residents. The Residential Services Department meets bi-monthly to review issues that affect programming and staffing. With the assistance of the Residential Services Team, each resident is able to work one-on-one with staff to develop the skills necessary to keep their environment neat and orderly and to tend to their personal hygiene. In addition, staff will encourage residents to be more active and to regularly participate in BH's volunteer program.

The Director and Assistant Director regularly attend the Single Point of Access (SPOA) meetings which provide a setting to:

- Identify residents' needs
- Seek community services
- Build accountability to the treatment plan among service providers
- Develop treatment recommendations and review medications
- Develop social / vocational / employment goals
- Address representative payee issues
- Create personal goals and objectives
- Seek input and evaluation on employment and / or vocational options
- Review all mainstream benefits
- Review and discuss options to assist residents in obtaining independence and self-sufficiency.

The Agency has three (3) Permanent Supportive Housing (PSH) programs. In two (2) of the programs, the Director and/or Assistant Director of Residential Services meets with each resident bi-weekly, establishing a standard of consistency and demonstrating the importance of each resident.

During scheduled meetings, the discussions between staff and residents focus on progress towards goals, immediate concerns, and any modifications to their existing service plan. In-house referrals are made to the Social Work and Medical Care programs to ensure each resident has the necessary tools, engagement, and connection to medical and mental health stabilization services. The Director and/or Assistant Director of Residential Services informally interact with each resident on a daily basis. Due to the scattered-site design of the Agency's third PSH program, client interaction is daily.

Residents are encouraged to participate in the Representative Payee program. Ninety-five percent (95%) of the residents receive Social Security benefits, and fifty percent (50%) participate in the Representative Payee program. The remaining residents that do not participate in the payee program are responsible for addressing their monthly obligations with the assistance of the Director of Residential Services.

Bobby (Ghost) L., resident

Our Residences:

The **Lighthouse Program** is a ten-bed facility, for single adults, located in the Mont Pleasant neighborhood of Schenectady. Seven beds are dedicated to chronically homeless adults and three beds serve as transitional housing for veterans. All Lighthouse residents strive for greater independence. The Lighthouse staff work with each individual to take on more responsibility in all areas of daily living.

One resident has lived at the Lighthouse for over 16 years, over forty percent (40%) of the residents have lived at the Lighthouse for four years, and twenty percent (20%) have been in the program for over two year. Of the eleven veterans admitted into the Veterans' Program, eighty percent (80%) had their needs met and were discharged to permanent housing.

Our Life Skills and Resident Assistant staff help residents develop basic living skills so that they will be comfortable actively participating in their community. The residents participate in community activities and some volunteer at our main facility's Day Program Drop-in Center. Residents take trips to area grocery stores, movie theaters, parks, shopping malls, and restaurants. Two of our residents attend church regularly. Most residents have established significant relationships with members of the community and look to them to provide support during difficult times.

At the Lighthouse, there are opportunities to help with yard work as well as maintenance of the garden; residents enjoy home responsibilities during the summer months. Produce from the garden is used in daily meals and snacks.

The **Liberty Apartments** is a fifteen-unit, sixteen-bed facility located on State Street in Schenectady. Residents live privately and independently while having access to supportive staff 24/7. Fourteen units are single room occupancies and one unit has double occupancy; all units have their own bathroom and fully functional kitchenette. Each resident is encouraged to make their home their own and, if necessary, to stay permanently. Eighty percent (80%) of the residents have been in their homes for over five years. Twenty (20%) of the residents have been in their homes for over two years.

The Agency's Day Program Drop-in Center is a primary point of contact / entry into the system of care. Residents make use of the Hospitality Center, the clothing room, food pantry, and the medical management services offered (blood pressure clinic, aids counseling, etc.). Residents have access to insurance services through Fidelis and CDPHP. In addition, a representative from the Veterans Administration visits weekly. Residents are encouraged to participate in monthly house meetings where they can express concerns. The Property and Facility Operations Manager attends all house meetings in order to answer questions and address concerns. The residents plan social and recreational activities during these meetings as well; Bethesda House has a van and a bus available to transport residents to these community activities.

The design of the program allows for greater autonomy, but most residents seek interaction with their resident neighbors, our Day Program population, and general staff members. In addition, ninety-five percent (95%) of the residents have developed their goals for their service plans with minimal assistance from staff.

The **Beacon scattered-sites residential program** opened in July 2017. Residents live privately and independently and are responsible for the upkeep of their homes and for developing positive relationships with their neighborhoods. Residential staff interact regularly with landlords to address concerns. Program participants are referred through the Coordinated Entry program. During 2018/2019, the Beacon staff have successfully admitted and developed individual service plans for fifteen (15) chronically homeless adults.

Residents of both the Lighthouse and Liberty Apartments, who require more intensive staff intervention, work one-on-one with our ***Life Skills Counselor***. The Life Skills Counselor works with all residents to provide graduated instruction and encourages as much independence as possible, while assisting with tasks that are beyond their physical capabilities. The Life Skills Counselor also assists residents with nutritional counseling, menu planning, food and personal needs shopping, and planning recreational activities. Obtaining secure and stable housing is the first step in alleviating the lifestyle affects and trauma associated with living on the streets. It takes a great deal of time for a homeless person to let go of street life and to trust that they are worthy of their new life. With each step forward, there can be several steps back, but with patience and persistence, no goal is out of reach.

Residents actively participate in social activities and most thoroughly enjoy each others company. It is refreshing to see over seventy percent of the residents engage in various activities such as Women's and Men's Group, movie theater trips, nutrition classes, grocery shopping, community events at local congregations, and on-site events.

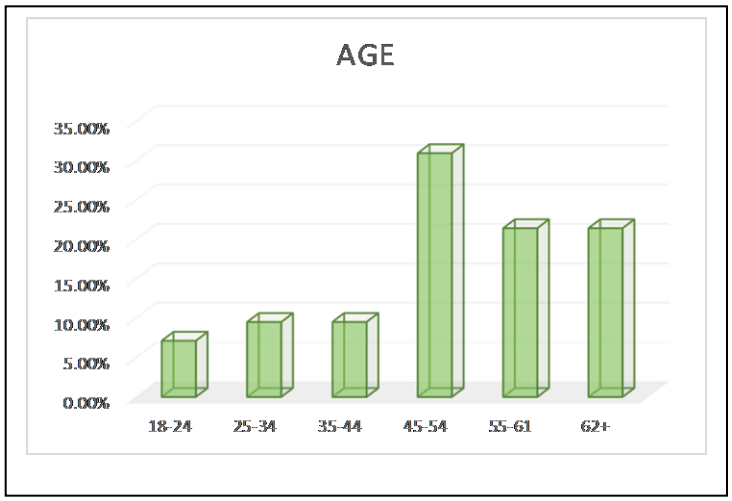
Paul B., resident

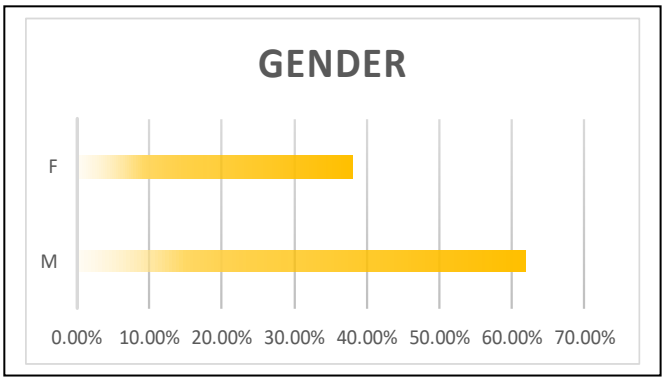
(L-R) Tracy K., resident; Melissa R., staff

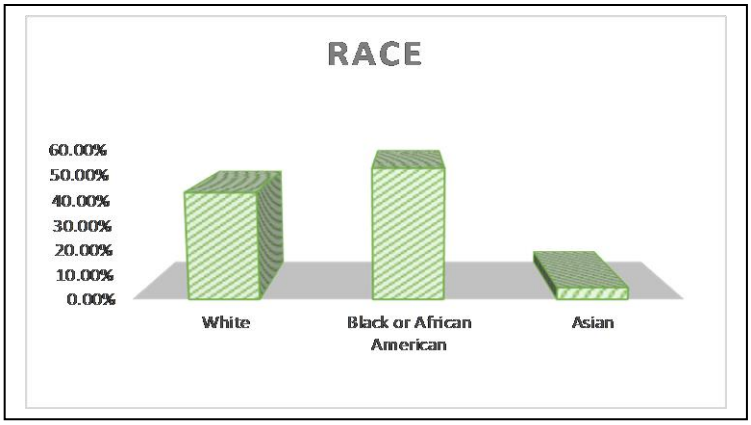
Disability	% of Residents, Based on 31 Residents
Development Disability	11.90%
Chronic Health	35.71%
Substance Use Disorder	52.38%
Mental Illness	78.57%
HIV/AIDS	2.38%
Physical Disability	45.24%

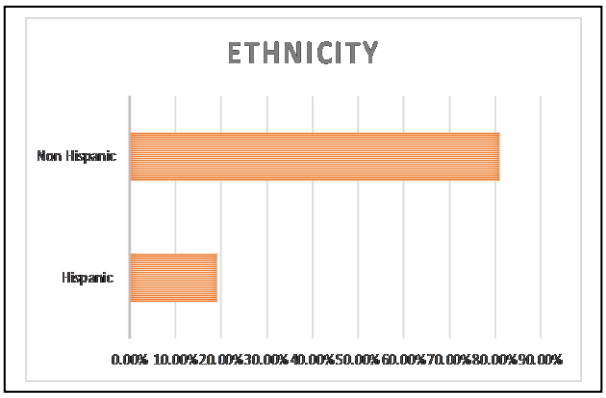
Number of Conditions	
1 Condition	9.52%
2 Conditions	19.05%
3+ Conditions	71.43%

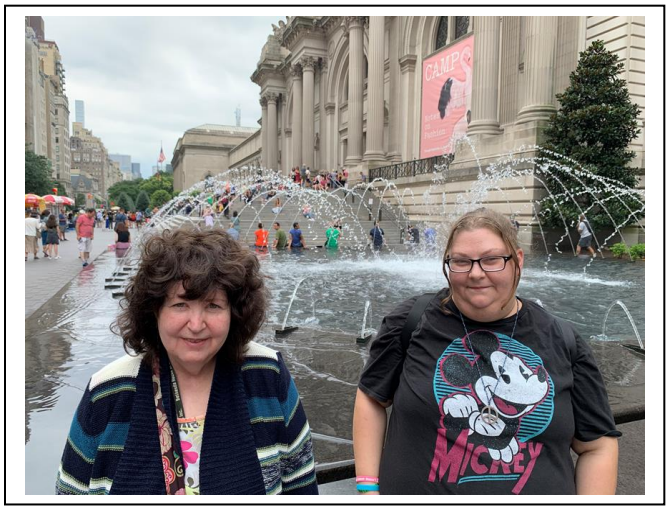
Lighthouse, Liberty, Beacon Programs











(L-R) Melinda B. & Rebecca S. ~ residents ~ Day trip to NYC

Looking Back

Thank you to our Volunteers and Community Supporters! Volunteering is not just about giving; it is a way of* living*!

We are deeply grateful to ***St. Kateri Takawitha Parish Church, Our Redeemer Evangelical Lutheran Church, St. Josephs of Glenville, and Immanuel Lutheran*** — who provide delicious sandwiches for our daily meal, emergency shelter, and street outreach.

We are humbled by the support from ***Eastern Parkway United Methodist Church, Congregation Gates of Heaven, Friendship Baptist Church, Ladies of Charity Schenectady Vicarate, St. George Episcopal Church, St. Stephen's Episcopal Church, St. George's of Clifton Park, St. George Greek Orthodox Church, Unitarian Universalist Society, Harvest Church Clifton Park, and Burnt Hills United Methodists Church.***

The **Boy Scouts of America** have a tremendous food drive each year of which Bethesda House is a beneficiary. The 2018 food drive provided grocery assistance to hundreds of households.

Union College students have supported Bethesda House in many ways. Each year during orientation, students sign up for their annual day of service. Students come to the Agency and help with seasonal work or building projects. ***Empty Bowls*** is a fundraising initiative created by the students; Bethesda House is one of three beneficiaries of this fun event. Union College adds to the culture of Bethesda House, supporting our staff and enriching the lives of our clients. These students also volunteer weekly in our Soup Kitchen.

Congressman Paul Tonko and wonderful volunteers help to make our community holiday meals enjoyable and meaningful. We come together to share in the importance of caring for our neighbors and reflect on the blessing we have. Thank you to our Board members and staff at **Planned Parenthood of Schenectady Health Center** for donating turkeys for our meal and families in need.

Thank you, **Burnt Hills-Ballston Lake Women's Club** for your ongoing support. Your continuous donations of hygiene products, household goods, and clothing are deeply appreciated by our guests.

Community Programs & Partnerships

Bethesda House's *Back to School Backpack Program* is designed to prepare as many children, for school, by providing a back-pack filled with all the required school supplies. This year, funds allowed the Agency to present 200 backpacks.

Bethesda House hosted its Annual Community BBQ, in August 2018. Our BBQ was met with great success, scrumptious food, laughter, and togetherness.

Alliance for Positive Health offers a multitude of services to benefit the community. Bethesda House and the Alliance continue to work together to provide educational resources on HIV and STIs, as well as support services and health management services for clients diagnosed or at-risk for HIV/STI's, as well as clients with Substance Abuse issues.

On "national HIV testing day" (in July 2018), we transformed our Day Program into a testing site. Staff from Alliance for Positive Health performed all the testing on-site in a secure, confidential, and compassionate manner. This strong relationship is one we will continue to build upon, which will only enhance the lives of our clients.

Every year we look forward to the **Veterans Administration Veterans Stand Down**. This amazing day full of supports and services, which are offered in one location for our Veterans. From medical testing, haircuts, hot breakfast, lunch, activities, live music, free clothing and more. This day is such a wonderful day for the staff of Bethesda House to be a part of and we are grateful for the opportunity to make an impact in the life of a Veteran.

Plush Salon staff were on site to help beautify men and women who wanted to partake in this fun and energizing offer. There were smiles all afternoon both days staff were here.

Financial Summary

Bethesda House's 2018-2019 fiscal year ended strong with an operating surplus and overall increase in our contributed support.

During our 2018-19 fiscal year, Bethesda House Administration and Board of Directors took an active approach to fundraising initiatives, securing funds from private foundations, and continuing to cultivate a more extensive donor base.

Contribution dollars allow our agency to enhance and increase the services we provide to the homeless and impoverished citizens of Schenectady County. We are deeply grateful to have received generous donations from long-term donors, The COINS Foundation, The Edward D. Cammarota Foundation, Inc., SEFCU Foundation, Ladies of Charity Schenectady Vicariate, Golub Family Foundation, Inc., First Reformed Church of Schenectady, Eastern Parkway United Methodist Church, St. Kateri Takawitha Parish Church, Stewarts Holiday Match, and The Community Foundation.

Bethesda House will continue to explore initiatives to increase our contribution dollars, in order to strengthen our programs and build upon our current success of housing the homeless, feeding the hungry, providing social work services directly related to mental health, and providing crisis and emergency services to those in need.

Bethesda House of Schenectady, Inc.

Kimarie Sheppard, Executive Director

Leina Minakawa, Director of Social Work

Louise O'Leary, Director of Program & Case Management Services

Danny Payne, Director of Residential Services

Staff volunteered to sell pies at Proctors showing of *Waitress*

(L-R) Dania L., Crystal T., Kim M., Louise O., Annette G., and Christopher H.

Past and Present Board Members

(L-R) Cathy T., Rick M., Sharran C., John S., Karen S.

Carrot Festival

Rachel, B., staff

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