Bethesda House of Schenectady, Inc.

ANNUAL REPORT

2017 2018

From Top to Bottom

Liz Davis, LMSW, with Day Program Guests

(L-R) Doug B., Volunteer, & Alvin Brown, Food & Nutrition Coordinator

Union College Students, 2017 Community Day

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

"Peace, to have meaning for many who have known only suffering in both peace and war, must be translated into bread or rice, shelter, health, and education, as well as freedom and human dignity - a steadily better life. If peace is to be secure, long-suffering and long-starved, forgotten peoples of the world, the underprivileged and the undernourished, must begin to realize without delay the promise of a new day and a new life."

-Ralph Bunche

Michael B., Volunteer, 2017 Holiday Meal

Amy W., Guest

Ron O., Guest

William O., A4TD
(Associates for Training & Development)

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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

Greetings!

I have been fortunate to serve on the Bethesda House Board of Directors the past seven years. During my time on the Board, I have been privileged to serve with a group is committed to our mission of reaching out and serving the homeless population of our community.

Working along with the outstanding staff and volunteers at Bethesda House, it's gratifying to know we have made a real difference in people's lives.

I've gotten to know many of our staff, and have learned more about what they do each day. It has encouraged and energized me to do all I can as a Board member, to provide support and communicate staff challenges to the rest of the Board. Over the past seven years, we have improved the coordination of our services with other agencies, to enhance services for the homeless; Bethesda House is recognized as a lead agency for many of these initiatives.

We all know that there is more work to be done to meet the needs of our homeless population and the needy in our community. From Code Blue to establishing a Food Pantry in Yates village; from our Soup Kitchen to Primary Care /Behavioral Health Integration services, as well as many other programs, we are striving to meet growing needs. The Bethesda House Budget has grown from $1,167,043 in 2011/12 to over $2,562,000 for 2018/19.

This growth in funding and programs doesn't just happen, it takes focus and commitment on the part of many.

Going forward we need *ADDITIONAL ENERGY* to seek out ways to build upon what has already been accomplished. Whether it is through additional contributions or lending your skills and talents, with more support and help, Bethesda House can continue the GREAT work we do, and continue to expand.

All the Best,

Rick Mausert
Board President, term end June 2018

Bethesda House at a Glance

"The first thing a kindness deserves is acceptance, the second, transmission."

-George MacDonald

Consumers Served

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

Guests Served	Total
Guests	54,180
Unduplicated Guests Receiving Services	6,064
First Time Guests	2,549
Homeless Guests	4,671

Program Department Services	Total
Consumer Choice Food Pantry — Meals Served	15,844
P.G. Wright Food Pantry – Meals Served	24,390
Clothing Room	1,008
Showers	1,726
Telephone	4,200
Hygiene Kits	5,710
*Mailboxes	43,390
Daily Meal	35,142
Laundry	1,477
Lockers	6,570

The numbers reflect cumulative totals of services provided.

Case Management Services	Total
Housing, Permanent, and Emergency	3,509
Representative Payee	2524
Case Management Services	1,291
Emergency Services	1261
Referred for Income	701
Secured Income	233
Social Work	1,714
DSRIP 2 ED Triage	249
DSRIP 3 Primary Care/Behavioral Health Integration	1,014
CASAC- DSS Assessments completed	1,600
Community Outreach Case Management	180
*Continuum of Care (COC) Coordinated Entry Referrals	480
*Continuum of Care (COC) Coordinated Entry Housed	271

The numbers reflect cumulative totals of scheduled appointments.

Residential Services	Total
Lighthouse total served including Veterans	23
Liberty Apartments total served	18

Code Blue Emergency Shelter – 11/20/17 – 4/22/18	Total
Un-Duplicated Guests Served	229
Beds Utilized	1,943

Home Connections	Total
Schenectady County DSS Referrals for Service	363
Individuals Stably Housed	114
Number of Males Referred for Housing	128
Number of Females Referred for Housing	235

Emergency Overnight Shelter – 4/23/18- 6/30/18	Total
Program Shelter Stay participants (unduplicated)	111
Total utilization of shelter stay beds	275
Total beds approved for shelter stay	429

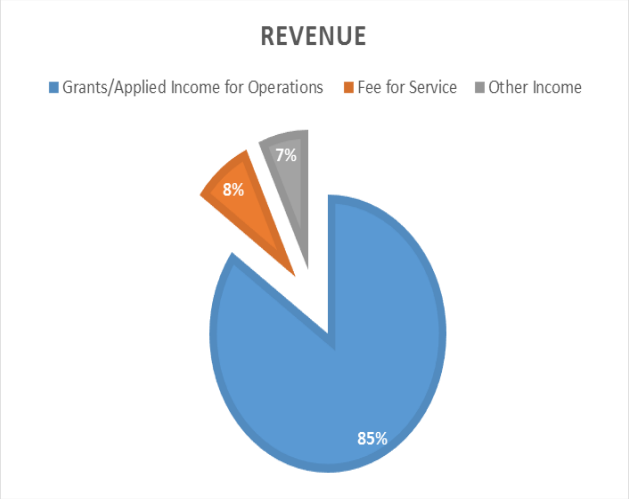
- *CoC is community-wide, includes 13 area providers.
- Consumers were referred to the agency from 16 area providers. Three thousand three hundred and ninety-eight (3,398) referrals were made for the following services: 312 Case Management, 363 Home Connections, 402 Emergency Services, 2,225 Social Work- Mental Health, and 80 Residential Services
- Case Management and Program staff referred 248 consumers to area providers to best meet the needs of the individuals.

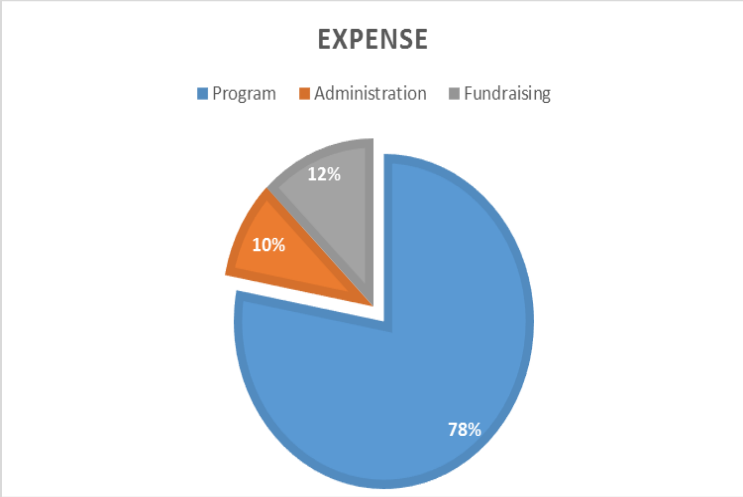
*** Mailbox calculation: 85 (3+82) mailboxes, 3 general, 95 individual; 95 individuals use the general mailboxes; 82 individuals have their own mailbox, available to users 249 days a year; 96% utilization rate**

Revenue & Expenses

Revenue	Amount
Grants/Applied Income for Operations	1,966,351
Fee for Service	189,937
Other Income	157,913
Total Revenues	2,314,201

Expense	Amount
Program	1,305,843
Administration	159,588
Fundraising	208,980
Total Expense	1,674,411





In-Kind & Volunteers 2017-2018

Volunteer Hours	11,235
Value of Volunteer Hours	$285,723
Value of Donated Items	$198,604

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, 2017 to June 30, 2018. 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 2017-2018. 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 2017-18 funding year, the total number of guests that were served increased 1.80% over the previous year (2016-17); and a 4.65% increase over the last two years. This steady increase is due to the new initiatives: Code Blue-Emergency Shelter, the Overnight Emergency Shelter, P.G. Wright Food Pantry (12308 zip code), Delivery System Reform Incentive Payment (DSRIP) programs (primary care & behavioral health services), Certified Alcohol Substance Abuse Counselor (CASAC), and the Coordinated Entry program. Due to the seasonal Code Blue Emergency Shelter and the Agency's Overnight Emergency Shelter, we have seen an influx of homeless singles. The number of homeless singles served during the 2017-18 funding year increased by 56% from our 2016-17 funding year.

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; people with unaddressed medical and mental health issues that have become exacerbated and need immediate attention. Fortunately, the new initiatives can address the complex and comprehensive issues that are encountered at Bethesda House.

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 City's and County's homeless and working poor population. Those services include the Day Drop-in Center/Essential & Emergency Services. The goal of these combined 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, 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), NYS OMH through Schenectady County, 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.

  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 and the College of St. Rose, 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. The Schenectady County Office of Community Services, Schenectady County (under the Home Connections program), and Delivery System Reform Incentive Payment (DSRIP) through the Alliance for Better Health Care.

- Since 2002, Bethesda House Residential Programs have operated using the "Housing First" model. 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.

  The agency's Lighthouse Program's seven beds, Liberty Apartment's sixteen beds, and the Beacon Program's 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. All residences follow the *Housing First* model, 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. 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.

- Our Certified Alcohol and Substance Abuse Counseling 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
Evictions 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
Population Health Improvement Program Advisory
Coordinated Entry
Diabetes and Obesity Workshop
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
Peter Young: Housing, Industry & Treatment

"A choir is made up of many voices, including yours and mine. If one by one all go silent then all that will be left are the soloists."

Vera Nazarian

The Management Team is fully invested in the freedom to be creative, to pioneer useful solutions and implement positive changes within the agency. In addition, the team 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!***

L-R Cathy Terwilliger, Board VP, with COINS employees, Theresa Carriero & Al Diedrich

Rick Mausert, Board President

Former Board Presidents, L-R Richard Werner, Sharran Coppola, Genghis Khan

Program Department

The Program Department's Day Program Drop-In Center is well known on the streets as a safe place and is often the first and, many times, the only connection that chronically 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 provides much the same function as a street outreach team. The Day Program is the 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.

Bethesda House programs provide a unique entryway into the Continuum of Care where a wide range of services can be accessed. 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, storage lockers, mailboxes, laundry, shower, telephone, fax, hygiene kits, clothing room, and client choice food pantry. Several outside facilitators have been recruited to 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 and PPD testing, blood pressure clinics, substance abuse support, and nutrition education.

The Director of Program & Case Management Services oversees this department, which is managed by the Day Program Supervisor. 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 consumers.

The Agency's **Food Program** continues to grow and develop new partnerships. In May 2018, Bethesda House was approved to become an Associate Member of **The Food Pantries of the Capital District**. Our membership increases the level of services we provide, such as, formula and diapers, gift certificates for clients to purchase holiday meals, and education for volunteers and clients. Our continued partnership will provide additional services to Bethesda House in the future. Our Food Bank Orders will be delivered to our facilities, saving valuable staff and volunteer time and we will have increased access to funding sources that will enrich our food offerings.

The Agency's two food pantries continue their partnership with Cornell Cooperative Extension, who provide on-site nutrition education at our food pantry locations. 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. Food Program staff have revamped the Agency food program to be in line with the goals of reducing diabetes and obesity in the county. 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 members are finding that people continue to shop in corner stores, which are far more expensive than regular grocery stores, due to convenience and lack of transportation. BH staff offer alternatives to the corner stores and work with the individual on meal planning and stretching the food stamp dollars. We have found that this approach, along with collaboration with Cornell Cooperative Extension, who provides educational workshops and classes, 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 and scarcity. During the 2017-18 funding year, the Agency experienced a decrease in the number of requests for emergency food bags, this is a result of an increase in the number of food pantries available to consumers.

PG Wright Food Pantry located at Yates Village. Volunteers (L-R): Ellen, Sharran, Ellen, Nancy

Bethesda House **partners with local justice officials** to provide opportunities for convicted 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. Bethesda House increased its presence and expanded services within the Schenectady County justice system. During the last two operating years, Agency staff have seen an increase of people recently released from incarceration, who are homeless and in need of physical and mental health intervention. The justice system recognizes this underserved population and is working with Bethesda House to provide wrap around services that will ensure a smooth transition back into their community and to help reduce recidivism.

The Program Department holds staff meetings monthly to review issues that impact programming and staffing. 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. Potential changes for the Agency are 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.

Due to CDTA transportation service changes, Bethesda House presented an **on-site meeting, facilitated by CDTA** staff, to learn

how to obtain navigation cards, as well as enrolling eligible guests for the half-fare and Veteran's Bus Passes. CDTA bus schedules are distributed, as needed, to guests and are located in the Agency's Hospitality Center.

Bethesda House continues to improve our methods of data collection in order to create systems that capture accurate statistical information, which help to identify areas of need that are not being addressed, and to identify where there is a need to increase specific services.

Administration and Program staff continue to work with area congregations 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. When there is a need, the community responds.

Bethesda House **collaborated with Schenectady Municipal Housing Authority (SMHA)** in May 2018, to prepare for the opening of Schenectady County's Section 8 housing applications. It was the first time in four years that community members could apply for Section 8. The Section 8 program allows private landlords to rent apartments and homes at fair market rates to qualified low-income tenants with a rental subsidy administered by SMHA. On June19th, we opened our doors to assist over 135 Schenectady residents with their online application. Agency Case Managers worked with clients making the process simple and easy to access.

During the Agency's 2016-17 operating year, seven (7) new **Community Partnerships** were developed; those relationships were strengthened during 2017-18. Bethesda House continues to partner with Schenectady Job Training Agency (SJTA) in providing on-the-job training opportunities for high school students through the Federal Work Study Program. This program functions much like our Community Service program, where high school students are provided meaningful summer work opportunities and, through coaching and mentoring, youth gain an understanding about the workplace and appropriate employment skills necessary to succeed.

Schenectady County Coordinated Entry

Schenectady County Continuum of Care Coordinated Entry (COCCE) 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 is used to prioritize case's vulnerability, which ensures a smooth interagency referral process. In 2017- 2018, 271 singles and families were housed in either community based housing or in HUD funded beds.

Overnight Emergency Shelter:

Bethesda House has always been available as an emergency overnight shelter especially during inclement weather. During the winter months, NYS Governor's on-going mandate states that all homeless people in NY are required to be sheltered in temperatures 32 degrees and below. Schenectady County DSS acted in support of the Governor's mandate, and Bethesda House immediately responded to be an overnight shelter. Each night, our shelter was staffed and open to individuals referred to us through Schenectady County DSS. The Program /Case Management/Social Work team created a plan to interact with individuals in the overnight shelter to assist with emergency and/or permanent housing placement. In addition, staff met with each person in an effort to assist with other areas of need, such as mental and physical health, and/or substance use. With the overnight shelter, BH was open around the clock to the homeless of Schenectady and all staff were willing and able to come in at a moment's notice should the need arise.

Services offered in our overnight shelter include the following: showers, a light meal, laundry, and a supervised, safe and warm environment. During this particularly bitter cold winter, Bethesda House remained open during the day on the weekends to ensure that homeless citizens had a safe place to shelter. *Please see the Overnight Emergency Shelter Case Management / Social Work section of the Social Work Department which references additional, higher level services for singles in the Agency's shelter.* The winter felt as if it would never end and 2017-2018 was longer than most. Bethesda House's Code Blue emergency shelter ended; however, with contract approval from Schenectady County, the Agency transitioned to the Emergency Overnight Shelter that will be utilized all year long. The Emergency Overnight Shelter is staffed with an Intensive Case Manager, Shelter Aid that assists the guests overnight, and a full-time Licensed Social Worker that is on-site at 6:00 am to start the successful wrap around services that Bethesda House offers. The team works diligently providing information, updates and recommendations to meet the needs of every guest that stays at our shelter.

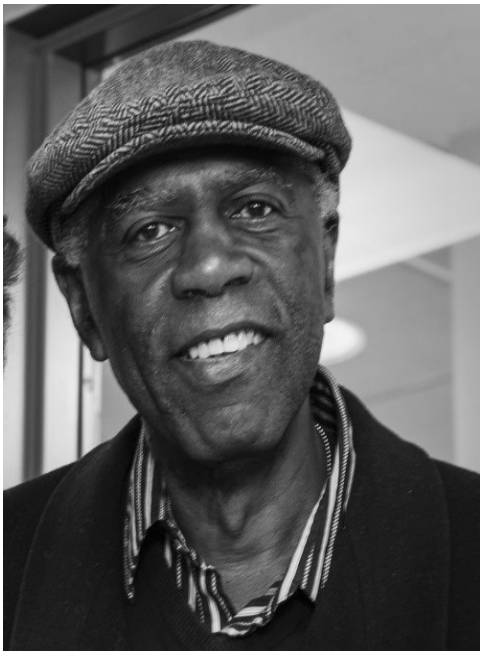
Day Drop-in Center/Essential Services Stories

"In this Home we do second chances. We do Grace. We do Real. We do Mistakes."

Bethesda House is about second chances and new beginnings. We are a home for the forgotten, the troubled, the disheartened, those who do not just need a place to stay, but a place to re-build. Second chances and new beginnings open up in our drop-in center, which serves as the living room of Bethesda House where warm hearts and hot coffee allow for relationships to form and trust to build. For the guest who needs a new beginning, their new life starts here.

J.B. entered our doors on the coldest of December days with nothing more than a book bag on her back, but a lifetime of baggage. She came to Schenectady without a plan, without money, without knowing anyone, but there she was on our door looking for help and guidance. She worked diligently with our case management team over the course of many weeks. Bethesda House's team was able to help her obtain her Social Security funds and documents she needed to support her Coordinated Entry Application. During these interactions, she formed healthy relationships with other guests and staff. She left our home for one of her own; our Program Department provided her household items, bedding, food, and clothing to help her settle into her new place. J.B never felt judged, she always felt supported and cared about, she was able to slowly re-build her life and start again.

Robert L, Resident, with Day Program Guest



Jimmy W., Day Program Guest

Anne N., Day Program Guest

Program Department Stories:

Food & Nutrition ~

Soup Kitchen: JS is a young woman who comes almost daily to Bethesda House for our Soup Kitchen Meal. It is one of her main sources of nutrition for the day. She often chooses not to visit the other meal sites in Schenectady because she feels they are too far from her home. JS started gaining excess weight and having difficulty getting around like she used to, feeling uncomfortable in her own skin. JS said that between meals, she was eating a lot of food from a local pizza shop and convenience food from the corner stores. JS wanted to make a change. She started attending our weekly nutrition education classes offered by Cornell Cooperative Extension, every Tuesday, at Bethesda House. Instead of making excuses and taking the easy way out, JS started walking to other meal sites in Schenectady, getting exercise and better nutrition. Armed with the nutritional education she learned, she has been making better food choices and walking most places. She is starting to feel like her old self again and couldn't be happier.

P.G. Wright Food Panty: Adequate nutrition during infancy is essential for lifelong health and well-being. The World Health Organization and American Academy of Pediatrics both recommend that mothers exclusively breastfeed, when possible. What we have found at P.G. Wright is a cultural and socio-economic stigma with regards to breast-feeding. Understanding this, we offer a wide variety of infant formulas and baby necessities, as well as promoting breast feeding support groups in the area.

PL has been a client at P.G. Wright since she was seven months pregnant. She depended on the pantry to help her maintain proper maternal nutrition. Once her son was born, she relied on Bethesda House to fill a gap of time between her child's birth and her being able to go to the WIC office. We were able to meet her son's nutritional needs as well as supply her with enough diapers for several weeks. Diapers are not Food stamp or WIC eligible and for PL, she wouldn't have been able to manage the extra expense.

IJ is a single mother who works part-time and has a school-age child and an infant. When her youngest child was born, she struggled financially with being out of work and having a limited food stamp budget. She was having difficulty getting rides to DSS and to WIC and found herself without either benefit for a period of time. We were able to support her with enough food for her and her oldest child, as well as supply her with formula and diapers and a referral for Things of My Very Own, to secure children's clothing, bedding, more diapers, and other necessities for both of her children.

Coordinated Entry: PW had a long history of chronic homelessness and an almost lifelong substance abuse issue. PW's mental illness and involvement with CPS made independently securing housing impossible. PW was never where she needed to be, missing intakes and appointments with multiple providers regularly.

Coordinated Entry has a low barrier, systematic approach to house the most vulnerable in our community. When other programs won't work with no-call / no-shows, Coordinated Entry understands the challenges our clients have, that prevent them from being successful without our help. PW was on the Coordinated Entry Waitlist for several months. She had been approved for a voucher based program, but finding an apartment was difficult. Her provider worked tirelessly for her and eventually secured an apartment that would be large enough for her and her children when they came back into her custody.

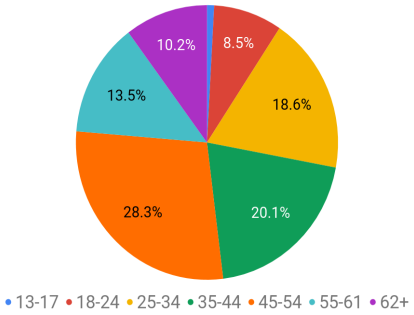
Jeanne P., CCE Educator

(L-R) Ellen M., Volunteer with Food Pantry Guest

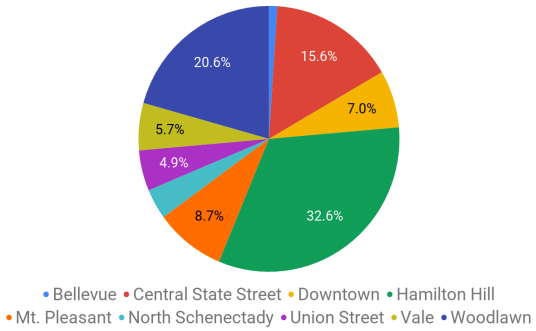
Colleen G., Day Program Guest

Program Department Clients

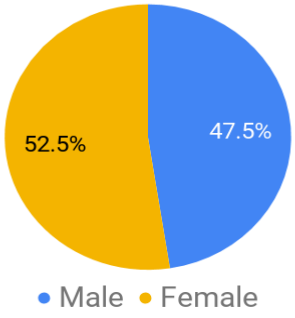
Age



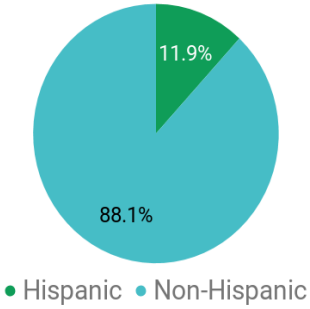
Neighborhood



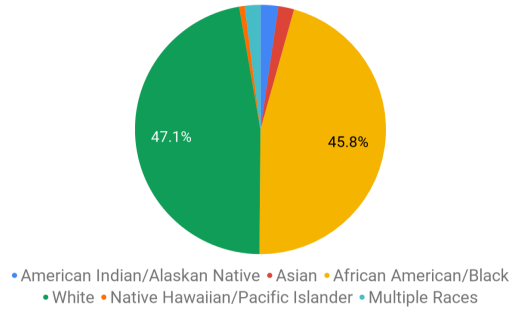
Gender



Ethnicity



Race



Development Disability	8%
Chronic Health	13%
Substance Use Disorder	15%
Mental Illness	40%
HIV/AIDS	1%
Physical Disability	23%

Case Management & Social Work Services

The Case Management Department is led by the Director of Program & Case Management Services who coordinates the team approach with the Day Program Supervisor and the Director of Social Work. The team focuses on the needs of our guests and, in collaboration with the Residential Department, addresses the needs of our residents.

Case Managers have been cross-trained to assist all people who are at risk of homelessness and/or in immediate need providing access to the Emergency/Essential Services that Bethesda House offers. The department meets with program and residential staff at the weekly Treatment Team meeting to review issues that impact clients, programming, and staffing.

In keeping with BH'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.

Case Management personnel cover the following needs:

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.

Case Managers meet these needs through the following programs:

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.

Bethesda House's Case Management staff works to increase landlord relationships and to facilitate the placement of homeless people in safe and secure housing. This position's primary responsibilities include homelessness prevention, helping individuals obtain housing and rapid re-housing, and assisting homeless individuals with finding permanent housing. Many strong, on-going, working relationships with landlords have been developed and have increased the outreach to house chronically homeless people. The Case Management staff have created an extensive landlord database, which aids in the success of securing affordable housing. In the 2018-2019 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.

Bethesda House Day Program is the gateway to all in-house and referral services. Staff meet with individuals to assess emergency service needs, and assist each in navigating the Agency's intake system in order to obtain the appropriate services. We are seeing a significant need for emergency services by individuals who are homeless or at risk of homelessness.

The number of individuals served by Bethesda House Case Management decreased during 2017/2018; this is directly related to the significant and demanding need of the homeless population. Due to each clients' lengthy list of complex needs, Case Managers spend more time providing one-on-one interactions with each person. Agency staff anticipate this level of interaction to continue, due to the opening of the Emergency Overnight Shelter and the demanding and intense needs of each homeless person that we serve.

Home Connections

Bethesda House received 363 referrals during the 2017-2018 fiscal year and, of those referrals, 114 were placed in permanent housing. Of the remaining 249 individuals that did not go into permanent housing, the reasons are broken down by percentage as follows: 1% were incarcerated, 10% found employment and no longer needed services, 37% never showed up at the shelter location, 3% left the State or moved to another county, and 40% 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.

Bethesda House's contract with the Schenectady Department of Social Services 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, 79% are disclosing a mental health disability.

The challenges we continue to face in this program are: locating affordable housing and the ability to obtain mental health services in a reasonable time frame. Home Connections is unique in that it acknowledges the critical component of aftercare when considering successful integration into one's community.

Once an individual is housed in the community, they become part of Case Management and receive wrap-around services. The program's Intensive Case Manager processes an in-depth assessment and develops a service plan with individualized goals and follow -up. Individuals are encouraged to enroll in the Representative Payee program for financial budgeting and management of their monthly income; this program is extremely successful in maintaining housing stability. The Agency's Licensed Social Workers assist with setting up appointments and attending mental health/substance abuse appointments/treatments with the client and provide on-going counseling and support as needed. Case Managers process referrals for services to area providers and are available for crisis and/or emergency support. 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.

Case Management Stories:

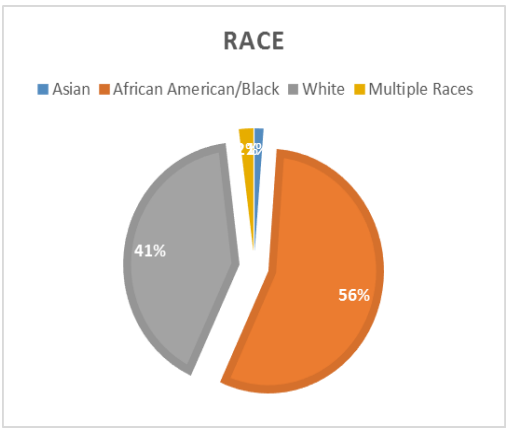
PL is a 58 year-old woman who was fleeing from domestic violence and was homeless. She lived with her partner for nearly ten years; the physical and emotional onslaught of abuse was daily. PL found her courage and fled, leaving behind not only her abusive partner but all her possessions and her home. She was briefly placed in a domestic violence shelter but was eventually moved to a larger shelter in the Hamilton Hill neighborhood. In an unfamiliar area, she struggled to navigate the region and ultimately did not make it to her scheduled appointments. While in the shelter, she made a few friends who referred her to Bethesda House. Initially she was leery of establishing new contacts; however, she contacted housing case management, made an appointment and requested directions from her shelter to the agency. When PL arrived at the agency she appeared at the end of her rope. A woman who had spent her life employed and never had experienced homelessness, she felt ill equipped to tackle the numerous steps on her list for stability. Case Management completed housing applications, referred her for employment counseling and mental health treatment. While working with Bethesda House, PL received her Personal Care Assistant (PCA) certificate and was approved for an affordable housing program. Today, PL is sustaining a full-time job at an area hospital and has a brand new, subsidized apartment she can call home.

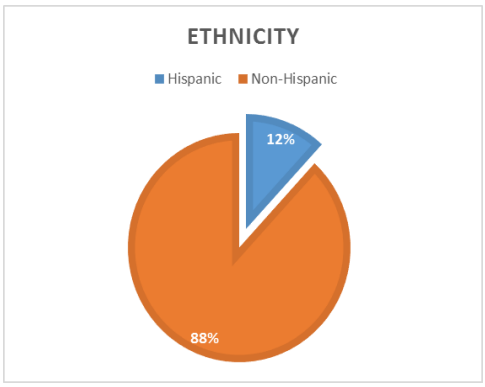
BB is a young woman with severe mental health issues and developmental disabilities. Her decision making is severely impacted by these disabilities and she is easily manipulated and taken advantage of. BB was raised by a mother, suffering from her own mental health challenges, who did the best she could to raise BB.

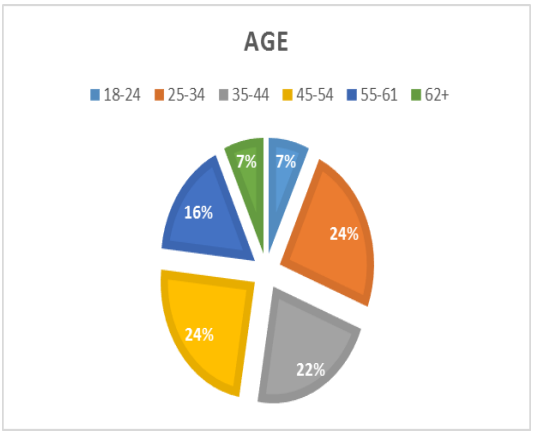
BB became pregnant and, within a short period of time, demonstrated that she was not capable of raising a child. BB's mother now has custody of the young boy who BB sees weekly. BB's intellectual challenges make it very difficult for her to understand what her responsibilities are, not only to meet her Individual Living Plan (ILP) but also manage her mental health needs. She is engaged with mental health services and has a service provider in the community. The programs Intensive Case Manager (ICM) developed a working relationship with her, which has resulted in BB's ability to reach out and ask for assistance without invoking her feelings of being judged. With the support of the ICM, BB has improved greatly which has allowed her to see her son more often each week. BB is making most of her mental health visits and is currently taking her medication as prescribed. BB has been able to obtain a very small apartment with a landlord, who not only understands the population we work with, but also accepted her unconditionally after meeting her. BB is successfully housed and continues to work with her ICM in the Home Connections CM program. BB knows she has a long road ahead of her, but with the supports from Home Connections, she is willing to work with the program and do what she needs to do. There is discussion that if BB remains compliant with her programs, she may someday have joint custody of her child with her mother; this is her goal, and having permanent housing is a box that she can check off to make this goal a reality.

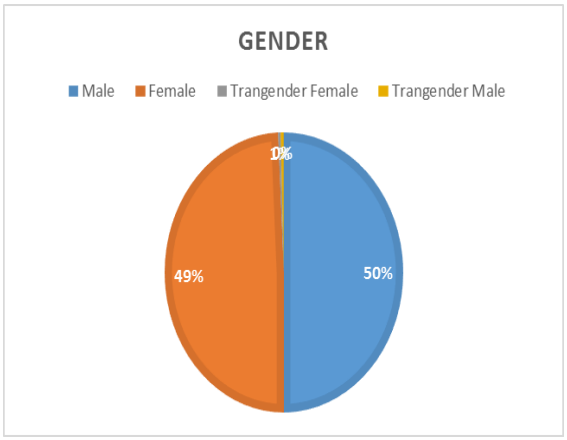
Emergency Shelter

FK is a 20 year-old man with mental health and substance abuse issues. He first presented at the shelter because he could not stay at his friends house anymore. When members of the youth population do not have anything else to offer the family, they are asked to leave; a common occurrence. At one time, FK had SSI; however, he lost this source of income due to his failure to submit required documentation. FK reported that he did not like school, dropped out, and was in and out of foster care. He had the desire to work with the staff at Bethesda House and, over time, he believed in what they were telling him, "You don't have to be homeless, we can help you!" FK began volunteering in our kitchen and demonstrated some skills that impressed our Chef so he asked FK to shadow him during the day. Program staff felt fortunate that FK worked in the kitchen, because staff had additional time to address the social determinants of health, that kept him in a homeless situation. Staff would take him to appointments, take him to SSA, assist him with paperwork, get him appropriate clothing and hygiene products from our donations, and saw to it that he showered and attended our daily meals; this went on for nearly two months. In February, SSA reinstated his SSI benefits and FK agreed to join the rep payee program. With income, housing options were available to him, and with assistance from Agency staff, he was accepted at the YMCA. He moved into his own studio in March 2018. At the time of this writing, he continues to be stably housed.









Disability	% of Population
Development Disability	6%
Chronic Health	25%
Substance Use Disorder	19%
Mental Illness	30%
HIV/AIDS	1%
Physical Disability	19%

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

Jasmine, Day Program Guest

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%

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 $675 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 maximal 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. During the 2017-2018 fiscal year, the number of participants in this program reached 109. Case Managers will continue to collaborate with the appropriate staff and local providers, particularly Schenectady County DSS Adult Protective Services, to ensure consumers secure housing placement and financial stability.

Representative Payee Stories:

NS is a 19 year-old African American man who was referred to Bethesda House through APS (Adult Protective Services) in May 2018. NS is a unique case, as he is a young homeless man who had been living in a motel room with his girlfriend and baby since December 2017. Their baby boy had been living in the motel room since his birth. NS was in need of a payee before Social Security would release his benefits, that were approved in December 2017. Bethesda House's typical client base is singles; however, due to the critical need, the agency made an exception to help this young couple and their baby.

Once NS and the payee went to Social Security together, the SSA worker was able to release his funds that same day, which was a relief to the family. Since his funds were held for several months, NS had enough to secure an apartment right away upon their release. NS found an apartment for his family and Bethesda House was able to work out an arrangement with the landlord in order to ensure that both NS and his girlfriend would pay each share of the rent on time. Bethesda House's Case Manager (BH CM) agreed to help NS's girlfriend obtain a money order every month for rent.

BH CM was able to assist the family with getting furniture and household needs in addition to items for their child. NS and family are doing very well in their new place and they are looking forward to a brighter future. NS reports that it is a huge burden off his chest knowing that his family is safe and that he has financial security with a payee.

Louie A.

David M.

Women's Group

Sisterhood is the bond that holds one of Bethesda Houses' longest running programs together. The dictionary states that Sisterhood is; "the close relationship among women based on shared experiences." 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 in Sisterhood to break bread and discuss addiction, abuse, homelessness, love and loss, in a covenant of confidentiality. The facilitators also offer the participants opportunities to grow, with the occasional outside speaker, arts and crafts, and self-care. Several times during the year, the women are treated to a luncheon in the community (that is paid by the volunteers), the women are honored and look forward to this special treat. Each woman is recognized and made to feel special. This past year, Woman's Group celebrated it's eighteenth year.

Story:

After she had the courage to leave her abusive husband, TJ found herself at Bethesda House, following the suggestion of a friend who was already a member of Women's Group. She needed a place to feel comfortable to meet other women, who have experienced similar trauma, and listen to the stories of how they rebuilt their lives. TJ was a quiet addition to the group for many weeks; always attentive, always a smile, but hardly a word spoken. After weeks of silence, TJ finally shared a personal story. She felt safe and secure, and that her voice mattered. The woman surrounded her with love and support and TJ was never silent in group again. By attending the group, TJ was able to receive a referral for individual counseling. TJ attends Women's Group weekly and is a source of joy to the women around her.

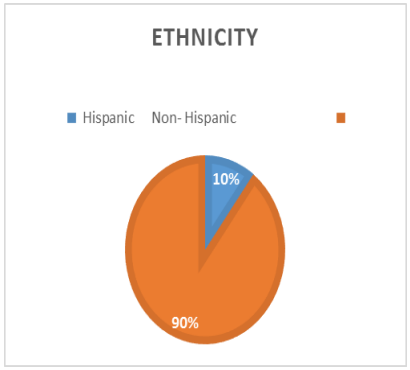
Men's Group

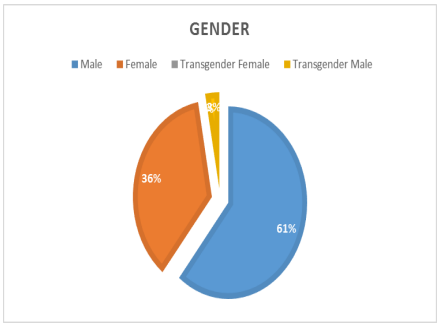
Men's Group celebrated their third year, and not only has the group maintained, it has flourished! Men are coming together to share their thoughts and feelings and to work toward breaking down the barriers that confine them. The group has been meeting at the State Street Presbyterian Church on Catherine Street every Thursday from 11:30 am – 1:00 pm. Reverend Richard Parsons facilitates group discussions on topics such as health, parenting, community, violence, being role models, and Spirituality. Outside facilitators are brought in as guest speakers who lead discussions on more sensitive topics such as terminal illness and trauma and loss.

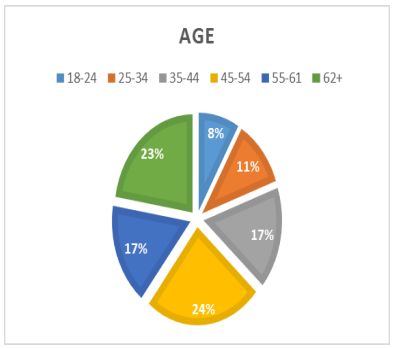
Consumer feedback, obtained at house meetings, has provided us with valuable information. In 2018-2019, we are implementing a consumer satisfaction survey to gain more insight on the effectiveness of the services we offer. Our goal is to ensure that consumers meet their milestones, and that staff are mindful of the services the individuals are seeking. We will carefully review the documentation we receive.

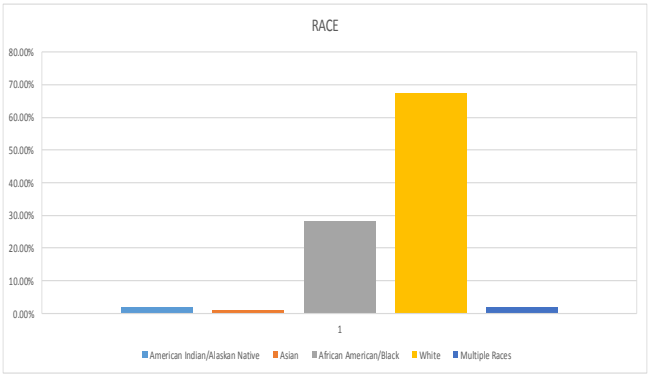
Nelda and Shari

Representative Payee Program

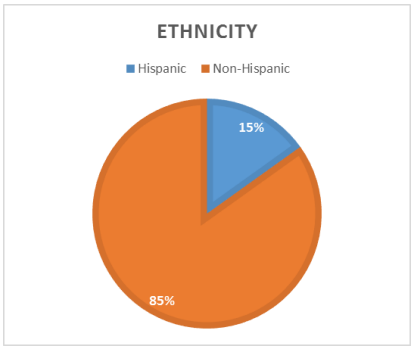


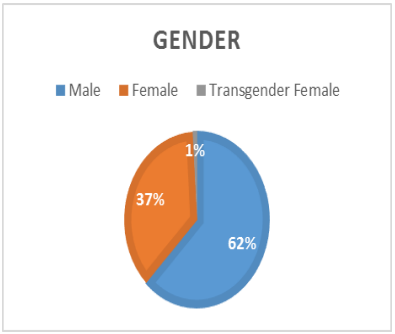


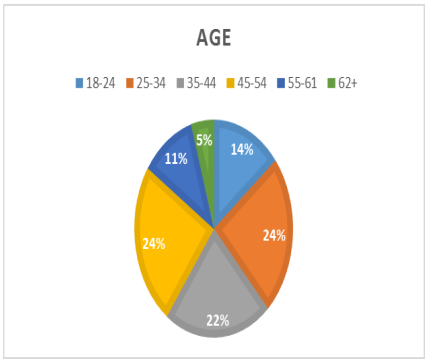


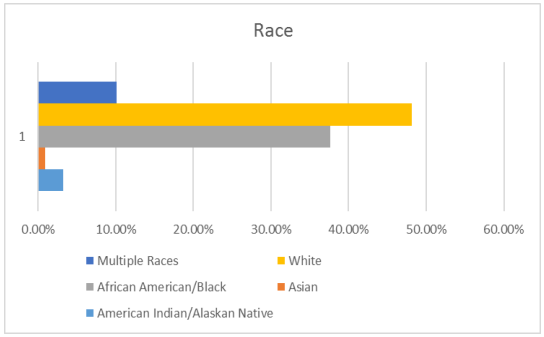


Overnight Emergency Shelter









Disability	% of Program Participants
Development Disability	23%
Chronic Health	41%
Substance Use Disorder	65%
Mental Illness	75%
HIV/AIDS	1%
Physical Disability	23%


(L-R) Roy Neville, Kevin McCormick

Social Work Program

The Social Work Program offers a unique approach to people who have severe, persistent, and untreated mental illness in Schenectady County. Bethesda House follows the Housing First model for our homeless consumers, and social work services are woven into all Bethesda House 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 Bethesda House 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, BH 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. Staff work diligently to connect consumers to appropriate psychiatric services, unfortunately the process can take time and a high level of coordination. Schenectady County continues to struggle with the demand for Mental Health Services, which far outweighs the availability of services in the community. Social Work staff work in collaboration with local Mental Health providers to navigate such circumstances, acting as an intermediary, an interim support, and outreach resource.

Our Licensed Social Worker continues to meet with the Medical Director at the local outpatient mental health clinic one afternoon a week, for consultation and supervision. Social Work staff attend monthly meetings with other community agencies to discuss the challenges in providing mental health services to the community and to explore creative solutions. The strong and mutually beneficial relationships that are established through Bethesda House Social Work Department with local providers, hospitals, treatment facilities, and community based organizations has evolved to address service gaps and social determinants of health. This approach to minimize service gaps encourages consumers to engage in services, to seek support proactively, and communicate their needs. A significant aspect of Social Work at Bethesda House is community outreach. Despite increased efforts for interagency cooperation, going into the community to ensure appointment follow-up, locate consumers who have lost contact, and provide wellness checks continues to be necessary.

Social Work Team Members: (L-R) Liz Davis, Leina Minakawa, Rachael Chabot, Tasha Davis

Delivery System Reform Incentive Payment Program

DSRIP Transportation Program

In addressing the medical and mental health needs of our population in Schenectady County, a significant determinant to our success is transportation. Weather, distance, scheduling - all can be deterrents for consumers reaching their appointments or obtaining medication at the pharmacy. Bethesda House Transportation program is designed to provide easy, accessible, friendly, door-to-door transportation to medical/mental health/substance abuse facilities, for community members. In addition, the BH Transportation Program works with Ellis Hospital to provide transports for those being discharged from the hospital who may require additional services such as emergency housing, clothing, food, medication pick-up, or case management support. This process has facilitated a smoother transition from an inpatient setting, back into community.

The Bethesda House Transportation Service provides an experienced Case Manager for the transport, in order to complete needs assessments, to determine if a referral for additional wrap around services is warranted, and to provide support during the ride as many of our consumers have complex needs. When indicated, the Case Manager will have basic living needs items available, such as food bags, hygiene products, blankets, and clothing. During the ride, a basic needs assessment is offered, in the case of Hospital discharge transports. If needed, the Case Manager secures medications and reviews discharge plans for follow up medical appointments. Assessment information and appropriate paperwork is given to the Social Work Department, so staff can follow-up, and attempt to make contact within 24-48 hours in order to address any additional needs that may have been identified during the transport, i.e. lack of food, need for case management support, and/or clothing. The follow-up care is conducted by a Licensed Social

Worker, to ensure long-term services are in place, to maintain stability for each patient returning to the community and that medical/ mental health treatment recommendations are understood and followed.

DSRIP Primary Care / Behavioral Health Integration – Social Work

Traditionally, providing stable and consistent support services to homeless individuals, who are dually diagnosed and engage in maladaptive coping skills, has been challenging. The challenges only appear to grow as Health services become increasingly complex and tedious. Consumers' have limited ability to maintain contact with service providers, follow medical or mental health treatment recommendations, and establish a wellness-based lifestyle. For this reason, Bethesda House is uniquely qualified to engage this population in accessing health services because it already serves as a resource to address basic living needs and has a foundation of trust to work from. The Social Work and Intensive Case Management staff work closely with all departments within the agency in order to identify individuals needing medical or mental health services, and engage them in the program; this interagency communication creates a stream-lined, in-house referral process which has proven to be effective.


Program / Case Management / Social Work Team

Following the identification and referral of appropriate individuals to the program, BH staff assess the treatment needs of the consumer (i.e. PCP, MH, SA, med management) and work to connect them to service providers. An integral focus of this process is to determine the challenges and barriers for each consumer, that prevent them from engaging in treatment, and to minimize those barriers significantly. Maintaining consistent contact with consumers continues to be a challenge for a number of reasons, such as lack of a reliable phone, unavailability for home visits, or simply, an unpredictable lifestyle. Additionally, accurate reporting and information sharing is an issue due to mental health symptoms, substance abuse, and/or a lack of trust between worker and individual. Often times, the consumer will not agree with the suggested need for a particular service or consult; for example: refusing to attend an annual physical because they 'feel fine'. This speaks to the need for education and promotion of a deserved improved quality of life, and a transition to a healthier lifestyle and overall wellness. The mission of the program is to instill value to all aspects of the consumers' lives, while providing the appropriate support and education in an effort to connect individuals to the impactful treatment that will achieve said value. The ambitious goals of the program, in contrast to the limited medical and mental health resources in the community, requires staff and consumers to be diligent and persistent in addressing their treatment needs. Consistent contact and reinforcement of healthier habits and proactive interventions are incorporated to support consumer compliance with treatment recommendations, which ultimately improves their quality of life.

Certified Alcohol and Substance Abuse Counselor (CASAC)

Currently Bethesda House is providing Case Management services for the CASAC program, housed at SCDSS. Bethesda House has fostered and established a strong collaboration with Schenectady County Department of Social Services (SCDSS). Exemplifying the successful working relationship with SCDSS, this 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 BH CASAC. The BH 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, BH CASAC can refer individuals to BH 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 BH Case Management/Social Work Team will address treatment/service barriers and provide advocacy and outreach in order to meet ISP obligations.

BH Treatment Team

BH Treatment team is designed to ensure that all Agency service disciplines meet weekly to address specific client cases, review problematic areas, and address overall services for all clients. The many service points within the Agency, along with specific skills that staff bring to their positions, line the path for diverse relationships established with various staff. These diverse relationships add

substance and insight to discussions on how to best serve each individual. As such, the decision was made to expand the team to include all staff.

With limited options and many barriers to success, the team has the daunting task of finding alternatives for individuals that have few options. The team is able to use their collective expertise, and knowledge of resources, to creatively and efficiently meet the needs of these individuals within a small window of time. BH Treatment team is an added layer of behind the scenes support, which enhances our unique delivery system of services, providing our clients with stability and long-term successful outcomes.

Overnight Emergency Shelter: Case Management / Social Work Services

The Bethesda House Overnight Emergency Shelter provides emergency housing for homeless consumers who have shelter approval through Schenectady County Department of Social Service (please see the Overnight Emergency Shelter section under Program Department). The access and intake to the shelter is overseen by an Intensive Case Manager and Licensed Social Worker whose responsibility is to ensure a safe shelter experience, and provide access to treatment and the necessary services for community stabilization. Upon arrival, new shelter guests will have an intake and needs assessment completed by a Case Manager. The intake and assessment information is passed to day staff, particularly the program's Licensed Social Worker, who follows up with SCDSS, provides access to basic living needs, and to medical and behavioral health services. The involvement of the Intensive Case Manager and Licensed Social Worker is unique to the BH 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.

Community Outreach Case Manager

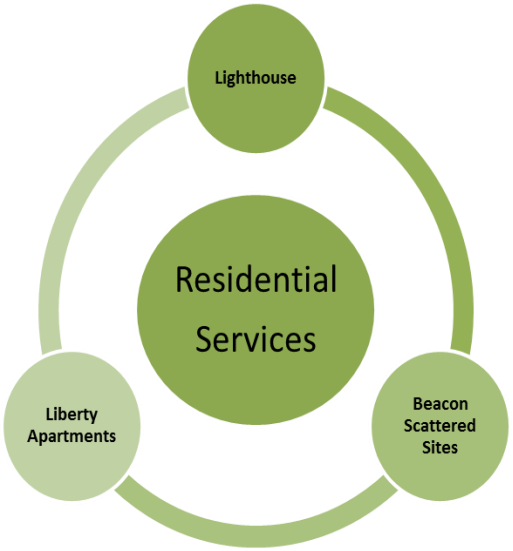
Effective coordination of services with the homeless and economically vulnerable population goes hand in hand with outreach services. In order to prevent loss of contact, Bethesda House created and developed an Outreach Case Management position, this spring, and it has proven to be a natural extension of all other services provided by Bethesda House. The role of the Outreach Case Manager (OCM) continues to evolve, but their core responsibility is to work within the community and reach the individuals who are in need of services, but do not visit the agency. The OCM provides basic living resources such as food, clothing, wellness checks, and transport to appointments, while acting as a bridge to services. Once an individual is engaged, the OCM continues to build trust and facilitate a connection to agency staff, so that the individual will receive the services and treatment needed to improve quality of life. The OCM also meets daily with in-house staff to identify individuals who have lost contact and require follow-up. The OCM will initiate outreach and provide extensive attempts to locate and reconnect individuals to services. This is not isolated to BH staff, as the OCM has contacted local providers and community based organizations to provide the very same service, in an attempt to locate and re-engage individuals in treatment.

Stories

EA is a young Hispanic man who first entered BH through our transportation program when he was discharged from the hospital. According to his hospital records, EA had four hospital admissions within the past two months because he was not connected to the appropriate treatment centers. An Intensive Case Manager (ICM) met with EA, processed an intake and assessment and immediately helped him access emergency services and housing assistance. EA presented as a timid, isolated young man, who had trouble making eye contact and finding his way around Schenectady. The ICM accompanied him to DSS and advocated for a shelter stay approval at Bethesda House. EA began working with the ICM and Licensed Social Worker (LSW) to address his housing, income, and treatment needs. Staff worked very closely with him and provided support and crisis intervention, while connecting him to medical and mental health treatment. EA initially expressed anxiety and mistrust with providers; staff recognized his concern and provided support for him, during appointments, to help him process information and encourage accurate reporting during appointments. Staff followed up with him after appointments, to ensure his comfortability and provide additional support. With his involvement in the program, EA has kept his appointments and maintained his treatment recommendations. He accessed BH wrap around services and successfully established housing and secured basic living needs. As this is an important transition, the ICM makes regular contacts via phone and home visits, to ensure the transition does not disrupt his health care.

FC is a Hispanic female who has been working with the BH SW department for the past year to access Social Services, such as SNAP benefits, SSI, and securing medical and mental health services. FC has responded positively to the fluid, daily support provided by our on-site social worker and has requested their involvement in her adult son's care. FC has a history of homelessness, domestic violence, and volatile behavior. Although she is currently stable in the community, social workers provide home visits, counseling and reinforce her medical and mental health treatment. As a result, FC has become a positive fixture in the BH Drop-in Center and volunteers regularly to assist others in the agency. FC continues to actively seek clinical support, insight, and guidance from the BH SW staff.

Residential Services Department



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, the Intensive Case Manager, 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. 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.

Many residents of the Lighthouse program 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.

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 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 addition, 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.

Each resident collaborates with the Director and/or Assistant Director of Residential Services, to design the most appropriate path in managing their respective mental health issues and addictions. Referrals are made to the agency's DSRIP programs for resident engagement with the licensed social work staff, as appropriate. Residential staff collaborate with the Social Work Department and DSRIP Primary Care / Behavioral Health Integration program to ensure each resident adheres to their service plans. Residential staff and/ or social work staff will often provide transportation to medical appointments, attend appointments with the residents, and assist with follow-up and treatment plans.

Residents are encouraged to participate in the Representative Payee program. One hundred percent (100%) of the residents receive Social Security benefits, and seventy five percent (75%) participate in the Representative Payee program. The remaining twenty five percent (25%) that do not participate in the payee program are responsible for addressing their monthly obligations with the assistance of the Director of Residential Services.

During 2017-18, residents continued to participate in the nutritional educational program led by agency staff and staff from the Cornell Cooperative Extension. Staff members work with residents to reinforce healthy menu planning and stretching food stamp dollars.

Our Residences:

The **Lighthouse Program** is a ten-bed facility located in the Mont Pleasant neighborhood of Schenectady. Seven beds are for single adults—formerly chronically homeless (as defined by HUD), 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 15 years, over thirty-seven percent (37%) of the residents have lived at the Lighthouse for four years or longer and thirty-seven percent (37%) have been in the program for over one year. Of the fifteen veterans admitted into the Veterans' Program, more than seventy five percent (75%) had their needs met and were discharged to permanent housing.

Our Life Skills Counselor and the Resident Assistants work with residents, helping them develop basic living skills so that they will be comfortable actively participating in their community. The residents participate in community activities weekly 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 as part of their weekly activities. 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.

The residents have taken an interest in keeping up the grounds at the Lighthouse facility by doing yard work and ensuring that the property is clean. There is a garden for residents to enjoy during the summer months and residents are encouraged to participate in its upkeep. Produce from the Lighthouse garden is used in daily meals or consumed by residents.

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. Seventy-five percent (75%) of the residents have been in their homes for over four years. Twenty-five percent (25%) of the residents have been in their homes for over one year.

Bethesda House'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.). Bethesda House provides outreach through services provided by the local business community; 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. The program's Intensive Case Manager (ICM) visits with each resident on a daily basis to further stabilize the program's participants. ICM visits are as frequent as necessary. Residential staff communicate with the participating landlords for this program, which ensures concerns and potential problems are addressed. Residential staff reference the Coordinated Entry waiting list to admit the most vulnerable of the population into the program. During 2017/2018, the Beacon staff have successfully admitted and developed individual service plans for sixteen (16) chronically homeless adults.

Residents of both the Lighthouse and Liberty Apartments, who require more intensive staff intervention, can work one-on-one with our Life Skills Counselor. The Life Skills Counselor works with all residents to provide graduated instruction and continues to meet with each resident until they can independently complete the more difficult tasks. For residents with physical disabilities, the Life Skills Counselor 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.

A year full of activities:
On July 4th, the residents collaborated and hosted a picnic at the Lighthouse. This was a warm experience; residents, who enjoy cooking, contributed their favorite dish and others provided side dishes. This was the opportune time for residents to socialize and teach each other new skills, like how to play lawn games or gin rummy. They enjoyed spending time outdoors in a quiet community setting; it was shown by their laughter and relaxed interactions. This was a day the residents let their indifferences go, which created a powerful sense of community and collaboration.

The summer months progressed, and residents kept the tradition of attending Jumpin' Jacks for a cool summer treat. August was a busy month! Residents collaborated during house meetings, and decided to organize a movie night and trip to Albany. With the assistance of the Assistant Director of Residential Services, the residents met as a group to choose what they wanted to watch and plan snacks . In late August, both new and old residents took a bus to the New York State Museum. The residents explored national and local history, while developing new friendships and connections among each other.


Resident , Tracy K.

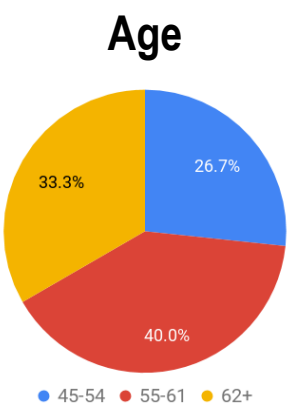
Fall is the time of year to plan ghost and goblin adventures. In October 2017, residents planned a small scary movie night and developed plans for next year's bigger, better haunted house trip.

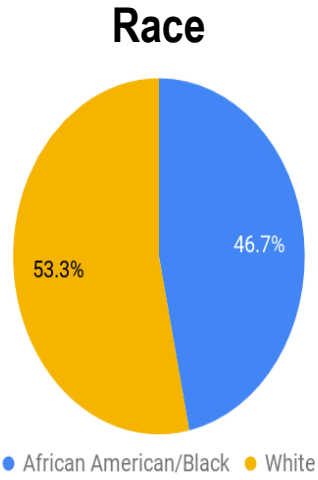
The chilly, and often frigid, winter kept residents in hibernation. They met monthly for a family style meal provided by our former Board President , who volunteers her time to do so. The meals are always yummy and the residents look forward to it. The days following the meals are always filled with conversation and remembrances of a great community meal.

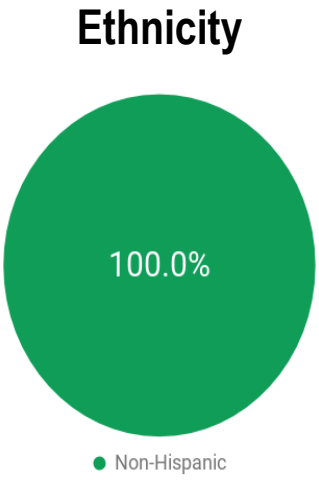
Finally Spring arrived! The residents were busy packing their calendar with activities, excited to get out of their 'cabin fever.' Schenectady's new VIA Aquarium was first on the agenda. VIA Aquarium has created affordable opportunities for local disabled individuals to explore what's under the sea. It was evident from the time residents first glided their hand through the stingray pool, it was going to be a day filled with excitement and exhilaration. Age was not a concern, with smiles, giggles, and wide eyes all around. Residents documented their day of familial affection with photos, then remained together for an impromptu lunch to plan new adventures and a return to the aquarium in the fall.

The residents continued to explore their local community by attending "First Friday of Albany" at the Albany Institute of History and Art. There was something for everyone: the history of dresses, local artist exhibitions, paintings of the Hudson, and original art and stories for an American Girl Doll. The most unique opportunity of all was exploration of the Institute's mummies. Chatter among the group was strong as they read each other information about the artifacts. The positivity of the trip led naturally to an outing to Bumpy's, another iconic Schenectady ice cream spot.

Lighthouse Veteran Housing





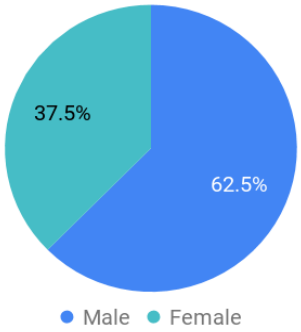


2018 Bowling Event: (L-R) Josh, Kevin, Paul (Resident), Dania, Crystal and Joe (Resident) in the front

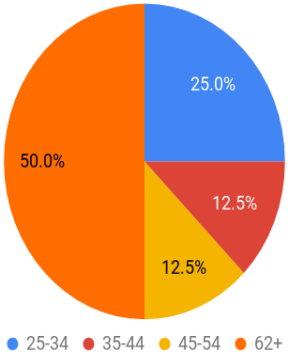
Disability	% of Residents, Based on 16 Residents
Development Disability	3%
Chronic Health	9%
Substance Use Disorder	21%
Mental Illness	42%
HIV/AIDS	0%
Physical Disability	24%

Lighthouse Permanent Supportive Housing

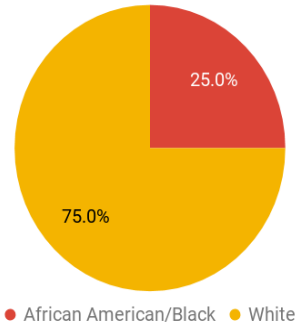
Gender



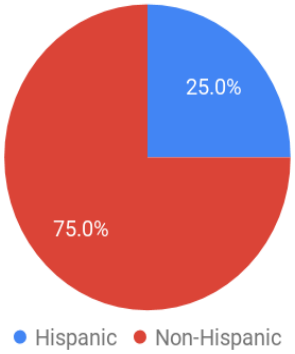
Age



Race

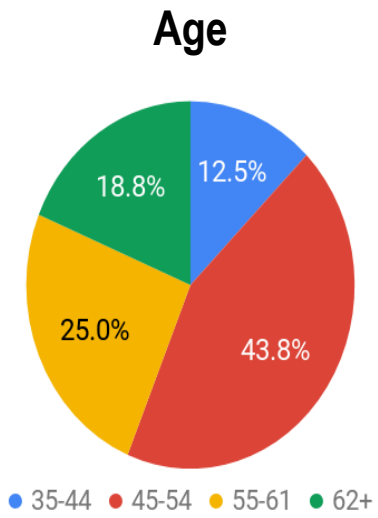


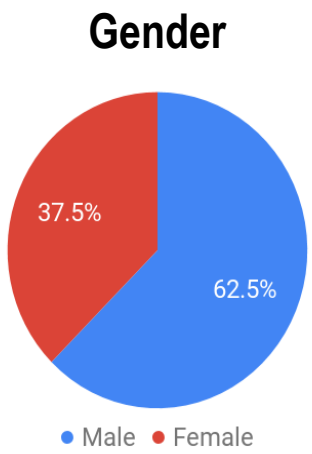
Ethnicity

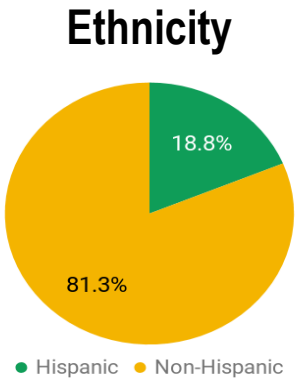


Disability	% of Residents, Based on 8 Residents
Development Disability	14%
Chronic Health	14%
Substance Use Disorder	18%
Mental Illness	32%
HIV/AIDS	5%
Physical Disability	18%

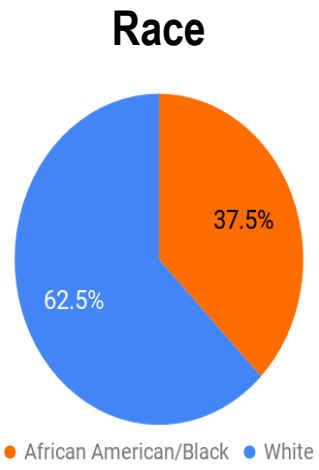
Liberty Apartments







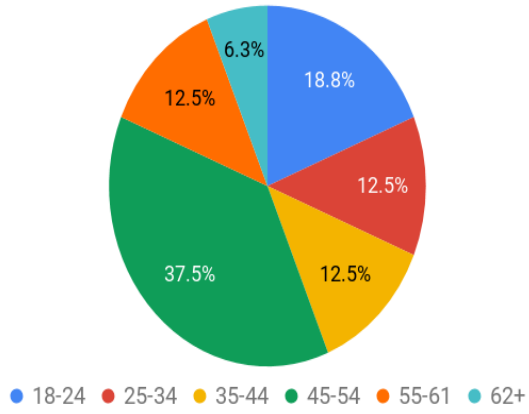
Residents: (L-R) Dave B., Melinda B., and Kathy O.



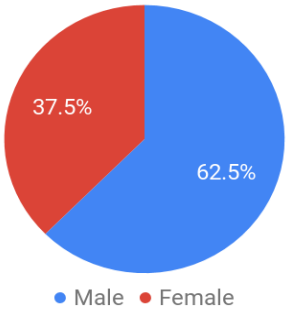
Disability	% of Residents, Based on 16 Residents
Development Disability	3%
Chronic Health	9%
Substance Use Disorder	21%
Mental Illness	42%
HIV/AIDS	0%
Physical Disability	24%

Beacon Housing

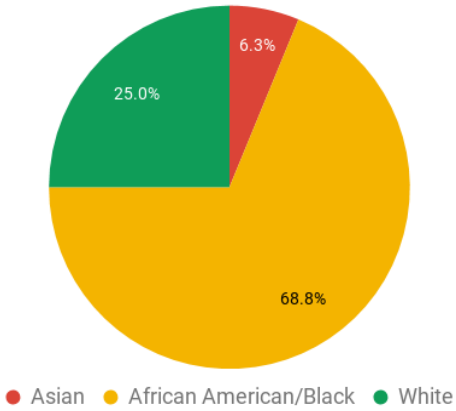
Age



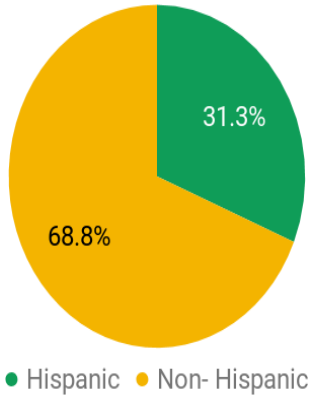
Gender



Race



Ethnicity



Disability	% of Residents, Based on 16 Residents
Development Disability	2%
Chronic Health	19%
Substance Use Disorder	26%
Mental Illness	35%
HIV/AIDS	2%
Physical Disability	16%

Looking Back

Thank you to our Volunteers and Community Supporters!

Bethesda House is deeply grateful for our wonderful volunteers. We feel their energy and love each day and would not be able to carry out our mission and vision without their gifts of time and compassion.

We are humbled by the generous gifts to our soup kitchen from—***St. Kateri Takawitha Parish Church, Our Redeemer Evangelical Lutheran Church, St. Josephs of Glenville, Immanuel Lutheran, Our Lady of Fatima, Grace Lutheran Church***—who provide delicious sandwiches for our daily meal, emergency shelter, and street outreach.

Each year we are graced by the **Congregation Gates of Heaven**'s congregation members on Mitzvah Day and for the Thanksgiving holiday! When the calendar year draws to an end, we find ourselves with high emotions of excitement for the holiday season tempered by the notion of the long, cold winter. November welcomes a renewed sense of brotherhood and we are warmed by the gift of community involvement and a special day for our residents.

The **Boy Scouts of America** have a tremendous food drive each year of which Bethesda House is a beneficiary. The 2017 food drive provided grocery assistance to hundreds of households. A huge thank you to everyone who supported the Boy Scouts and this critical need in our community.

It is with our deepest gratitude, that through our continued partnership with **Concern for The Hungry** and the Schenectady County Food Providers, we are able to receive thousands of pounds of non-perishable food from The United States Post Office Stamp out Hunger Food Drive. This annual food drive stocks our shelves to the brim and allows us to provide a variety of food 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. Students participate in sandwich making brigades and work in our Soup Kitchen. Due to the sensitive nature of Women's Group, select students take part in our Thursday Women's Group. 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. Bethesda House spoke to the students about the many opportunities we have to offer. As always, the turn out for this event was impressive; with students eager to listen to the many ways they can support and serve Schenectady.

The Agency's holiday meals are always filled with camaraderie and great food! Congressman Paul Tonko, wonderful volunteers, and carolers, who are 2012 Niskayuna High School graduates, help to make our community meals enjoyable and meaningful. Our holiday meals are a time for us to reflect on the blessings of the year while providing some warmth, love and support for those in need. Thank you to the staff at **Planned Parenthood of Schenectady Health Center** for donating turkeys to our meal allowing us to distribute to families in need.

A round of applause and a heartfelt thank you for the students at **Iroquois Middle School**. Your annual day of volunteerism was spent getting us ready for all our tabling events that we had in the fall of 2017.

We formed a new partner with the **Morning of Kindness**, created and managed by Ms. Kelly Mateja (*morningofkindness.org)*. On December 24th, people from all over our community perform random acts of kindness; Bethesda House was the recipient of many wonderful holiday gifts for our residents.

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.

Food Pantry Volunteers, (L-R),Karen S., Carole M., John S., Budd M., Terry S., *Karen, Carole, and Budd are also Board Members*

The best way to find yourself is to lose yourself in the service of others. Mahatma Gandhi

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 to Yates Elementary School.

Bethesda House hosted its Annual Community BBQ, in August 2017. This year, the weather was a bit chilly but was still well received by the community. Everyone enjoyed the food, and had a great time.

The Agency participated in **Rally Day for Good Sheppard Lutheran Church**. We provided congregation members and members of the community information on the services we provide, as well as opportunities for volunteerism and community service projects. It was a beautiful day and multiple community organizations participated. There was much fun for all with bounce houses, and delicious free food.

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 2017), 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.

SEFA Day is an annual event that allows Bethesda House the opportunity to discuss our services, recruit volunteers, and increase overall awareness about the Agency. It is a day full of dialog and building relationships, and we are happy to participate in each year.

Our Veteran population holds a special place in the heart of Bethesda House. Every year we look forward to the **Veterans Administration Veterans Stand Down**. This is an amazing day full of supports and services that is all offered in one location and are specific to 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.

Rachael C., ICM, and Luis S., Resident

(L-R) Rachel B., Housing Case Manager, Csiko S., ICM, Louise O., Director of Program & Case Management Services

Financial Summary

Bethesda House's 2017-2018 fiscal year ended with an operating surplus of $1,529 and an overall agency deficit of $180,234, which includes depreciation for capital items supported by foundation and government contracts.

The agency's most significant fiscal challenge this year was related to fundraising. In Human Service agencies such as Bethesda House, there is a direct correlation between the country's economic health and the number of people in need of services. During our 2017-18 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. Even with this commitment, our 2017-18 contributions were 2% below our 2016-17 contributions.

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. We have grown our partnership with Hannaford and have benefited from their useable grocery bag campaign, Hannaford Community Case powered by Clynk, and their most recent Hannaford BBQ.

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.

Danny P., Director of Residential Services

Kimarie S., Louise O., Rick M.

Bethesda House of Schenectady, Inc.

Management Team

Kimarie Sheppard, Executive Director

Danny Payne, Director of Residential Services

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

Leina Minakawa, Director of Social Work

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