At-Risk Populations

The City of Sioux Falls is seeking to address the unique barriers to stability and well-being for populations at-risk of or experiencing homelessness. Funded initiatives must demonstrate measurable outcomes and employ prevention-based strategies that promote long-term resilience and community impact.

Organizations submitting an application are **encouraged to PARTNER** with each other to provide the full scope of service prescribed for each of the following initiatives.

At-Risk Populations—Initiative 1

Scope of Work: Temporary Housing Services

A. Program Description

Temporary housing is defined as **emergency or short-term shelter or accommodation intended for stays of less than 90 days**. This housing model is designed to meet the immediate needs of individuals and families in crisis, including but not limited to those experiencing:

- Homelessness
- Domestic violence
- Sudden eviction or unsafe living conditions

The program serves as a bridge to permanent housing and includes access to basic needs and supportive services such as case management, referrals, and housing navigation.

B. Program Guidelines

- **Length of Stay:** Guests are expected to stay no longer than **90 consecutive days**.
- **Extensions:** Exceptions to the 90-day limit must be based on active participation in programming (e.g., case management, housing navigation, behavioral health treatment) and documented in client records.
- **Program Focus:** Rapid stabilization, equitable access, and connection to long-term housing and support.

C. Monthly Metrics and Reporting Requirements

To monitor outcomes and ensure program compliance, the following **monthly data** must be collected, tracked, and reported by the 10th of the following month:

1. **Last Place of Residence**
    - Record the zip code from which each guest originates (last place of residence), to identify geographic areas with the highest housing instability.

2. **Total Single Adults Served** (unduplicated count)
    - Monthly count of individual adult guests served, with duplicates removed
    - How were they served (applications, referrals, description of services rendered) and outcome
    - Total housing placements
3. **Total Families Served** (unduplicated count)
    - Monthly count of distinct family units served, excluding repeat visits
    - Total housing placements
4. **Demographic Information**
    - Collect and report the following information:
        - Name—may use an identifier for reporting
        - Date of birth
        - Gender identity
        - Race, ethnicity, tribal affiliation
        - Veteran status
        - Disability status
5. **Guests with 90 Consecutive Days of Stay**
    - Track and report the number of guests who have reached or exceeded 90 consecutive days in the program.
6. **Guests with 90+ Total Days of Stay (Cumulative)**
    - Identify and report individuals who have returned to the shelter for 90 days or more in the last two years.
    - Develop and implement an action plan for the identified individuals

Respondents are encouraged to propose additional or alternative metrics for the City's consideration.

D. Program Deliverables

- Operate and maintain a temporary housing facility.
    - Provide number of beds/rooms in application
- Ensure that **100% of guests are assessed within seven days** of entry and offered referrals to long-term housing or wraparound services.
- Maintain an average guest length of stay under 90 days unless extension criteria are met.

- Submit required monthly reports, including quantitative metrics and a brief narrative summary highlighting progress, challenges, and success stories (as applicable).

At Risk Population—Initiative 2

Scope of Work: Transitional Housing Services

A. Program Description

Transitional housing is defined as a temporary living arrangement for 6 to 24 months that helps individuals and families who are experiencing homelessness or a crisis to stabilize their lives before moving into permanent housing.

- Homelessness
- Domestic violence
- Sudden eviction or unsafe living conditions
- Addiction recovery
- Re-entry from incarceration

The program serves as a bridge to permanent housing and includes access to basic needs and supportive services such as case management, referrals, and housing navigation.

B. Program Guidelines

- **Length of Stay:** Guests are expected to stay no longer than **6–24 months**.
- **Extensions:** Exceptions to the 24-month limit must be based on active participation in programming (e.g., case management, housing navigation, behavioral health treatment) and documented in client records.
- **Program Focus:** Long term stabilization, employment and education, and life skills development.

C. Monthly Metrics and Reporting Requirements

To monitor outcomes and ensure program compliance, the following **monthly data** must be collected, tracked, and reported by the 10th of the following month:

1. **Last Place of Residence**
    - Record the zip code from which each guest originates (last place of residence), to identify geographic areas with the highest housing instability.
2. **Total Single Adults Served** (unduplicated count)
    - Monthly count of individual adult guests served, with duplicates removed

- How were they served (applications, referrals, description of services rendered) and outcome
- Total housing placements

3. **Total Families Served** (unduplicated count)
   - Monthly count of distinct family units served, excluding repeat visits.
4. **Demographic Information**
   - Collect and report the following:
     - Name—may use an identifier for reporting
     - Date of birth
     - Gender identity
     - Race, ethnicity, tribal affiliation
     - Veteran status
     - Disability status

Respondents are encouraged to propose additional or alternative metrics for the City's consideration.

D. Program Deliverables

- Operate and maintain a transitional housing facility
- Provide the number of beds/rooms in the application
- Maintain an average guest length of stay for 6 to 24 months unless extension criteria are met
- Submit required monthly reports, including quantitative metrics and a brief narrative summary highlighting progress, challenges, and success stories (as applicable)

At Risk Population—Initiative 3

Scope of Work: Juvenile-Focused Services for Victims of Violence and Crime

A. Program Description

This project will provide **comprehensive direct services to victims of violence and crime**, with an intentional focus on **juvenile victims and youth intervention**. Services are designed to address immediate safety needs, provide trauma-informed support, and promote long-term recovery and resilience for youth impacted by domestic violence, community violence, exploitation, abuse, or other crimes.

Services include, but are not limited to:

- 24/7 crisis intervention and counseling
- Individualized safety planning
- Legal advocacy and support navigating the justice system
- Trauma-informed case management
- Referrals and access to emergency shelter, transitional housing, and medical care
- Linkages to behavioral health and mentoring programs

Special attention will be given to culturally competent service delivery and reducing barriers for youth who are system-involved, unhoused, or otherwise vulnerable.

B. Monthly Metrics and Reporting Requirements

To support evaluation and accountability, the following data must be collected and reported **monthly**:

1. **Total Youth/People Served** (unduplicated count)
    - Count of all individuals who received services during the reporting period, excluding duplicates.
2. **Demographic Information**
    - Capture and report:
        - Age (with a specific focus on youth under 18 and transition-age youth 18–24)
        - Gender identity
        - Race, ethnicity, tribal affiliation
        - Any other priority population indicators (e.g., system-involved youth, etc.)
3. **Source of Referral**
    - Track how clients accessed services (e.g., law enforcement, schools, hospitals, self-referral, community agency)
4. **Count of Services Provided**
    - Disaggregate by service type and volume:
        - Number of crisis counseling sessions
        - Number of safety plans created
        - Number of case management sessions
        - Number of housing placements or referrals
        - Number of mentor placements

- Legal or advocacy meetings

5. **Medical or Mental Health Referrals Made**
   - Number of referrals provided for physical or mental health services, including follow-up status if known

6. **Retention Rates**
   - Track and report outcomes such as:
     - Average length of engagement for youth clients
     - Percentage of youth who complete a counseling or mentoring program
     - Percentage of youth who complete a case plan

Respondents are encouraged to propose additional or alternative metrics for the City's consideration.

C. Program Deliverables

- Provide **trauma-informed, developmentally appropriate direct services** to people served
- Ensure all clients receive a safety assessment within 48 hours of intake
- Maintain strong partnerships with law enforcement, schools, and service providers for seamless referral and wraparound support
- Submit required monthly reports, including quantitative metrics and a brief narrative summary highlighting progress, challenges, and success stories (as applicable)

At Risk Population—Initiative 4

Scope of Work: At Risk of Homelessness Prevention and Stabilization Services

A. Program Description

This program targets individuals and families **at risk of homelessness**, offering timely interventions to prevent displacement and promote long-term housing stability. Clients may be:

- Facing imminent eviction
- Exiting institutional settings (e.g., hospitals, jails, foster care) without a permanent housing plan
- Staying temporarily with friends or relatives

- Severely rent-burdened or unable to secure stable housing due to income loss, domestic violence, or other crises

The program offers **direct services, housing navigation, legal support, and referrals** to wraparound resources that address root causes of housing instability.

B. Program Goals

- Prevent homelessness through early identification and targeted support
- Reduce shelter entries by stabilizing housing situations before displacement occurs
- Promote access to income, health, and social services that support long-term stability

C. Monthly Metrics and Reporting Requirements

To track service reach and impact, the following **monthly data** must be collected and reported:

1. **Total Individuals Served** (unduplicated count)
    - Number of single adults or individuals receiving services during the month
2. **Total Families Served** (unduplicated count)
    - Number of family units (including at least one adult and one minor) receiving services
3. **Demographics**
    - Collect and report for all clients:
        - Name—May use an identifier for reporting
        - Date of birth
        - Race and ethnicity
        - Gender identity
        - Household type (e.g., single adult, single parent, multigenerational, etc.)
4. **Risk Factors Identified**
    - Document each client's primary risk factor(s), such as:
        - Eviction notice
        - Job loss or reduction in income
        - Domestic violence
        - Discharge from an institution without housing
        - Uninhabitable or unsafe housing conditions

        - Lack of affordable housing options

5. **Number of Eviction Prevention Services Provided**
    - Count and categorize services delivered:
        - Legal advocacy
        - Court representation or accompaniment
        - Landlord mediation
        - Rental arrears assistance or short-term rental support

6. **Referrals Made**
    - Track outbound connections to:
        - Employment and job readiness programs
        - Behavioral or mental health services
        - Public benefits or financial assistance
        - Health care providers
        - Child care or transportation services

Respondents are encouraged to propose additional or alternative metrics for the City's consideration.

D. Program Deliverables

- Serve a minimum of 100 individuals and 20 families monthly who are at risk of homelessness
- Conduct risk assessments and housing stabilization plans within five business days of intake
- Refer 90% of clients to at least one support service appropriate to their stabilization plan
- Submit required monthly reports, including quantitative metrics and a brief narrative summary highlighting progress, challenges, and success stories (as applicable)

At Risk Population—Initiative 5

Scope of Work: Mental and Physical Health and Addiction Services

A. Program Description

This program provides **direct, person-centered services** to individuals experiencing or at risk of homelessness who are in need of mental health care, physical health treatment, and/or substance use disorder (SUD) services. The approach integrates

outreach, case management, and referrals to ensure that participants receive appropriate, timely, and trauma-informed support that addresses both immediate and long-term health and wellness needs.

Services may include:

- Medical screenings and primary care
- Mental health counseling and psychiatric care
- Detox services and outpatient or residential substance use treatment
- Case management and care coordination
- Street outreach and engagement for individuals disconnected from traditional systems
- Navigation support for access to insurance, treatment programs, and specialized providers

The program prioritizes individuals with co-occurring conditions and those facing barriers to accessing health care through conventional means.

B. Program Goals

- Improve access to integrated behavioral and physical health care for underserved individuals
- Reduce emergency room use, overdose incidents, and psychiatric crises
- Promote recovery, stability, and long-term well-being through sustained support and referrals
- Build trust and continuity of care among clients who are unsheltered or unstably housed

C. Monthly Metrics and Reporting Requirements

To assess effectiveness and service reach, the following data must be collected and submitted **monthly**:

1. **Total Individuals Served** (unduplicated count)
    - Number of unique individuals receiving any form of direct service during the month.
2. **Demographic Information**
    - Collect and report:
        - Age
        - Gender identity
        - Race, ethnicity, tribal affiliation
        - Housing status (sheltered, unsheltered, transitional, stably housed)

        - Veteran status (if applicable)

3. **Referrals to Medical Treatment**
    - Number of clients referred to:
        - Primary care physicians
        - Clinics or hospital systems

4. **Referrals to Mental Health Counseling or Psychiatric Care**
    - Track referrals made to:
        - Licensed counselors or therapists
        - Psychiatrists or community mental health centers
        - Crisis response teams

5. **Referrals to Substance Use Disorder (SUD) Services**
    - Track and report:
        - Detox or withdrawal management
        - Residential or outpatient treatment
        - Peer recovery support or harm reduction services

Respondents are encouraged to propose additional or alternative metrics for the City's consideration.

D. Program Deliverables

- Provide direct health-related services and outreach to a minimum of 1,200 unduplicated individuals annually
- Make appropriate referrals for at least 75% of clients served each month
- Maintain partnerships with local health providers, recovery centers, and mental health agencies to streamline access
- Submit required monthly reports, including quantitative metrics and a brief narrative summary highlighting progress, challenges, and success stories (as applicable)