

FY20 COFU Year End Reporting

Stories of Impact

Grantees were asked to share a story of impact about a client participating in their program. Below are their stories sorted by prevalence of Priority Areas. Please note, out of 59 grantees, 41 grantees gave us permission to share their stories of impact.

Housing & Homelessness

Ann Arbor Meals on Wheels at Michigan Medicine

Supporting the homebound through home delivered meals for adults of all ages and network navigation for homebound seniors

One of our clients is currently aging in place with support from their friends and our program. The client's doctor recommended that they move to assisted living as their health is declining, but the client said that they are making their own decisions and do not want to move. They also shared that they would not be able to remain at home, which they want to do, without receiving our meals. They are so thankful that in the midst of COVID-19, they are able to stay in their own apartment. This is a common story among many of our clients and a great reminder of why we do the work that we do.

Ann Arbor YMCA

The Collaborative – Ypsilanti YMCA Early Childhood Development Center

The Ypsilanti YMCA Child Development Center (CDC) has impacted the lives of an international family by providing high-quality childcare for their four-year-old son. The mother of the child is a full-time student at Eastern Michigan University (EMU) and the father is self-employed. Being self-employed creates a financial situation that varies from month to month, and the mother's status as an international student limits options for employment. She is limited to on campus employment only, which also limits income for the family. The crisis for this family was the financial stress and finding high-quality childcare for their son close to their home. After being in another in-home childcare setting that was not well-equipped, the parents turned to the Ypsilanti YMCA CDC to support their son's development. The Ypsilanti YMCA CDC was able to provide financial assistance for the family to attend the high-quality child care center. Their son was able to grow in an environment that continued his development socially, emotionally and physically. Being able to continue at the Ypsilanti YMCA CDC has been a stress relief for the family and continued the development of the child. The child continues to grow strong friendships with his classmates and improve his emotional, physical and psychological well-being. The parents report that the highly qualified teachers work daily on their child's holistic development and are grateful for the high-quality care he receives, which reduces the stress for the parents so they can focus on their own success. Above is one of many impact stories from the Ypsilanti YMCA CDC families. At the Ypsilanti YMCA CDC, parents are extremely engaged and active in the success of the program. The Parent Advisory Committee has created true ownership of the program by developing special events (pre-COVID-19), giving feedback on how to improve, ideas on additional services, and engaging parents as consistent community advocates for the program throughout Ypsilanti and Washtenaw County.

Safety Net Health & Nutrition - SNH

Avalon Housing, Inc.

Avalon Youth Development Program

She was 5 when her family moved into an Avalon Housing community. At the time the family joined the community, they were dealing with a great amount of stress related to poverty, domestic violence, and housing instability.

While either in school or in the After School Program (ASP), she would often need to be removed from her peer group after reacting to stressful situations or conflict by yelling at or hitting others.

Her actions were understandable reactions to the incredible stress and strain placed on both her and those in her household. In response to her outbursts, YD staff provided her with calm and consistent interventions that, over time, gradually helped DG understand the expectations around her group behavior and also equipped her with some alternative coping strategies such as describing her feelings to staff, walking away from conflict, or simply asking for help. Additionally, as Avalon's staff members became more familiar with her and some of the typical triggers of her anger and frustration, they were able to intervene early. Her problem behaviors have not disappeared completely, but notable progress has been made, with a marked reduction in behavioral disruption.

Catholic Social Services of Washtenaw County

Catholic Social Services of Washtenaw County Senior Services (CSSW)-Resource Advocacy Program (RAP)

A 73-year-old white male veteran is living in an apartment in Ypsilanti, MI, with an annual income of less than \$17,000. He has been diagnosed with COPD, GERD, and is legally blind; he also disclosed a history of substance use. The client originally contacted the RA program to receive assistance with completing Medicaid and SNAP Food Assistance applications. A home visit was provided to assess the client for additional needs, during which RA staff noted that client's daughter and daughter's boyfriend were living with him in the small apartment. Staff noted that the client was sleeping on a recliner while his daughter and boyfriend slept in the bedroom. He disclosed that he believed his daughter was stealing medication from him and reported that his daughter's boyfriend would often become angry and violent, punching holes in the wall of the apartment. Client reported he no longer wished to have them living with him, but felt he could not ask them to leave. He also disclosed that he was at risk for eviction as he was over \$3000 in the arrears for rent, and had also been admitted to the hospital several times due to complications of COPD. Staff first provided him with assistance completing Medicaid and food assistance applications as well as enrollment in the Meals on Wheels delivery program. Trust and rapport was established with the client, allowing him to feel comfortable enough with staff to disclose information regarding his unsafe living environment. RA staff made two separate reports to APS, reporting his unsafe living environment and suspected medication stealing from the daughter. RA staff was also able to help the client receive services through the Housing Bureau for Seniors (HBS) and Legal Services of Southeast Michigan, who helped work with his landlord to get his daughter and her boyfriend evicted from the living space. RA

connection to HBS and Housing Access of Washtenaw County assisted in payment of rental arrears and prevented the client's eviction. RA staff have referred him to Jewish Family Services and have provided a warm hand off to the JFS long-term case management team to assist the client with future needs. He is no longer at risk for eviction, and his daughter and her boyfriend have moved out of the apartment. The client is receiving meal delivery from Meals on Wheels and is currently working with a long term case manager to ensure future needs are met. He had the ability to advocate for himself, he just needed a little extra support, connection, and encouragement from RA staff. The client reported that he often felt discouraged by complicated systems, which RA staff was able to help him navigate. Additionally, the client faced a difficult situation due to his daughter and her boyfriend living with him. Initially, he did not want to involve the landlord in fear that he may be evicted as they were not on the lease. He was also hesitant to report his daughter and her boyfriend to APS, so it took several months before they moved from his home.

Catholic Social Services of Washtenaw County

Nurturing Families Washtenaw

A mother of 3 children ages 1, 3, and 5, has several risk factors including: chronic homelessness, being a survivor of child abuse and neglect herself, and being a survivor of domestic violence. She began services with the program for her infant and began learning a lot about child development and protective information about all of her children. She took note of the signs and suspected that her 5-year-old daughter had been molested by the birth father. The mother called the Parent Coach and immediately took her daughter to the hospital as advised by the coach. The NF parent coach provided support and contacted CPS immediately to report the situation as well as the steps taken to protect her daughter. The mother notified the police and the hospital involved CPS as well. The father was removed from the home. The family then began receiving therapy and legal intervention services as well as regular supportive services from the NF Parent Coach.

She was then plunged into eviction: she could no longer pay for her apartment. She contacted the apartment manager who allowed her to terminate the lease early, keeping her record free from eviction. She had 10 days to find new housing. With poor credit and no income as she waited for approval to receive aid for her 2 disabled children who were being evaluated for SSDI. She needed housing quickly! She called the Housing Access in Washtenaw County and they told her there was nothing available and to call back. They couldn't help her.

In addition to all of the services and support provided to help the family heal from the trauma of the daughter's sexual abuse, the NF program provided her many services to help stabilize themselves in the midst of an eviction. The NF program assisted Ester with advocacy for housing access. We helped her explain that she would soon be living in her car, and that 2 of her children were disabled and there were risks of serious consequences with them being homeless. Her 3 and 5-year-olds had begun to make progress with their disabilities but needed regular routines, housing, and consistency for success. Being homeless and living in a car would have been a major deterrent to their health. We got an appointment with the lead Housing Access case manager who stated that she qualified for priority status. She was called to move into a homeless shelter a day before she had to leave her apartment. She moved into the homeless shelter, which is very strict. In order to remain in the shelter, families must be

employed and get their children in daycare, which NF helped her find. She went on a job interview and unknowingly shared some inappropriate information about herself, so she did not get the job. She was devastated and angry; no one had taught her the skills for interviewing. We did an hour-long mock interview session over and over until she laughed about it and became very comfortable. She made a list of her strengths and weaknesses and learned about the process and expectations. She became confident and prepared for the job interview. She was called for another interview and got the job. She has changed jobs since then and did not need any help from us. Meanwhile, a conflict arose at the childcare facility. She didn't know how to deal with it and wanted to just pull the children out of daycare and find a new one. We at Nurturing Families taught her how to effectively communicate her concerns and she was able to work through a small issue (where she previously would have simply ended the services rather than asking them to do things differently). We helped her learn healthy communication skills and boundaries, and she is doing great now. Today she now has her own apartment, she pays her own rent, and her children are safe, growing healthy, and doing well.

All names and details were changed for confidentiality. This is a very typical success story. The high ACES, lack of skills, and repetition of childhood trauma are very common. Home visitors in our program help families gain the tools, support, resource referrals, and skills needed to move forward successfully.

Child Care Network

The Family Support Program (FSP)

Times have been quite hard, but parents of two children strive each day to build a better life for their family. The family connected with Child Care Network's Family Support Program. They were looking for assistance with childcare costs for their children whose school was closed due to COVID-19. Father is an independent contractor, and the sole provider for his two children and his wife, Tess. She suffered a life-changing injury and is permanently disabled.

The family recently moved into town for the mother's medical care. He shared that "it took incredible effort to find a job after 4 years of unemployment" while he was caring for his wife, and he was worried that he was now at risk of losing his employment all together if he could not find an affordable, reliable childcare option during the pandemic. "After [the children's school] closed, it became very difficult to keep working, even from home," the father shared. "My wife is completely disabled and cannot take care of the children. It proved increasingly difficult to try to work while taking care of (2 very young children), to the point where I had to take an emergency family leave."

While the father's employer allowed him to 'drop' to part-time hours, the father still had to pay his family's health insurance premiums in full, which already accounted for nearly 50% of his paycheck. "Now that I finally have a job, and caregivers for my wife, I am left with the impossible choice of working for essentially no income in the hopes of keeping my job, or going unemployed again. This scholarship would allow me to resume working full-time and still be able to pay the bills," the father stated.

Because of the Coordinated Funders of Washtenaw County, a child care scholarship has been provided to the family during the COVID-19 pandemic. As a result, the father has been able to work full-time. The family is able to afford the mother's medical needs, and the children are able

to attend a safe, stable, quality childcare program. The father is thankful for the “consideration and kindness in [his] family’s time of need,” and shares that scholarship support has been a “huge help” for him over the past few months.

Foundations Preschool of Washtenaw County

Building Foundations

One child (boy) came to us from a family with 5 children, one having severe developmental disabilities. Although a loving family, the boy was unkempt, withdrawn, and under a lot of stress. He was hesitant to participate and had difficulties communicating. His family was on the verge of homelessness. This was the mom's second marriage, and there were a lot of problems with nasty custody issues that the mom did not keep from discussing in front of the child. Getting the family to come on time was a challenge. This boy needed a regular schedule, to know that he was important, and the opportunity to start the day without feeling he had missed something important. We worked with the family to understand why it was important for the child to be here for the full day. Our social worker helped the family get connected with housing resources, and the teachers worked to help the child feel comfortable and worthy. The family found housing and was able to move into a section 8 home. The boy made friends with other children and found the confidence he lacked when he arrived. He began smiling and participating. The reports from home are that they are doing well. When we shut down due to COVID-19, we gave the family a small table that we had in storage so that they could homeschool their 5 children. Although this child has aged out of our program, the mother called recently to thank us for the table and said that they don't know what they would have done without it. I told her that we just put out extra child-sized chairs for free on the curb. She was so excited that she said she was turning around and picking them up!

Interfaith Hospitality Network of Washtenaw County

Emergency Shelter for Homeless Children and Families

A client came to Alpha House with her spouse after walking away from housing when they were assaulted in their home. For several months after leaving their home, they lived in a bus that was being renovated and inhabitable. She was 32 weeks pregnant when she arrived. The family was already connected to Community Mental Health and both participants were awaiting a decision from Social Security for Benefits. She was experiencing mental health issues along with past trauma due to difficulty dealing with events in her life. The income for this family was very low. Additionally, they lacked any support from any family members. Due to working with Alpha House, the family secured permanent housing. They were also connected to community resources to help them with the additional needs they had that might have prevented them from remaining housed. We were able to work with local resources, and CM and her family were able to move into Permanent Supported Housing through Avalon. They were connected with other local partners for furniture and housing supplies, as well as a case manager for any further ongoing assistance. The family had their challenges but we were able to work with them to help secure permanent supportive housing.

Shelter Association of Washtenaw County

Shelter Association of Washtenaw County Residential and Shelter Diversion Programs

A married couple presented for shelter at the Delonis Center after losing housing due to loss of income in April 2020. Both partners lost their income due to their place of employment reducing hours in the pandemic. Never experiencing homelessness, The partners were unfamiliar with the housing case management and shelter provisions that the Shelter Association of Washtenaw County has to offer. She presented with unique health needs and was scheduled for a medical procedure, making her high risk for COVID-19. Therefore, they were offered a hotel room for non-congregate shelter to better protect them from the virus. While staying at the hotel, Both received SAWC case management to overcome barriers to housing and also connection to benefits and resources to obtain housing. She was also connected to the Packard Health practitioner for routine health screenings at the hotel site, allowing her to get her primary care without having to leave the hotel. Packard Health also encouraged her to maintain her scheduled appointment for the medical procedure to help with her pain management. SAWC housing case management created a housing plan with the couple. He planned to find a new job to increase access to income, while she was connected with unemployment benefits and was able to save money for housing. After resume building and seeking out suitable jobs with SAWC case management, he secured a job after 5 weeks. With the combined income of unemployment and his new job, the couple was able to start a housing search with SAWC case management. By mid July, the couple located affordable housing! By having immediate shelter for the couple, SAWC was able to ensure that she was protected from exposure by staying in the hotel during her episode of homelessness. Along with providing the immediate shelter, SAWC was able to connect the clients with resources to increase income and locate affordable housing. If shelter was not provided for the couple, she could have been exposed to the virus, without any place to live, which would also further delay her medical procedure and potentially cause lifelong health complications. SAWC was proud to overcome barriers, connect to resources, and locate housing for the couple within 90 days of them experiencing homelessness. Due to many vulnerable persons with several barriers to housing, it usually takes 120 or more days on average to house a person. SAWC is proud that case management was able to beat this 120 day average for the couple and also find them housing in the midst of a pandemic.

SOS Community Services

SOS Family Shelter

A single mom with 5 children, no income, several evictions, and a large outstanding DTE bill was referred for services. Her family was experiencing homelessness due to eviction and was unable to stay with family or friends, so her family entered emergency shelter. A case manager worked with the mom to address her DTE bill as this was a barrier to securing future housing. SOS advocated for her to receive Rapid Rehousing. Once RRH was provided, the case manager began to work with her to locate safe, affordable housing. Her family was denied housing, but the case manager appealed the denial and the decision was reversed. Her family was able to exit the shelter into permanent housing.

SOS Community Services

Eviction Prevention Program for Housing Choice Voucher Residents

The person referred was a single male with mental health challenges, who for the past two years had experienced homelessness. He was referred to SOS as a first time voucher holder because he was having difficulty finding housing due to previous evictions. SOS HSC worked with the individual to locate housing and advocated with various management companies to accept the individual and his voucher. HSC assisted the individual with securing funds for the security deposit through HAWC and St Vincent DePaul. Referrals were also made for household items to Share House, and the individual also received PPEs and cleaning supplies from SOS. He secured a two bedroom townhouse so that his home care provider has a room.

Student Advocacy Center of Michigan

Check and Connect

At the time of referral, the student was 15 years old and attending Ypsilanti Community High School. The student was referred to the Check & Connect program due to low engagement in the classroom, poor academic success, and poor attendance. At the time of intake, the student was a general education student without additional school support in place. The student resided with his mother, who worked a full time job and had a little amount of time to engage in school with the student. The student had been a witness to a murder in the Ypsilanti area and had even been a victim in several shootings in the area. He had experienced an enormous amount of trauma, but was very reluctant to speak to anyone about the matter(s). The student was very quiet and was reluctant to interact with other students and staff in the building. At the time of intake, the student had 1.5 credits. He was initially referred to the Check & Connect program after being placed on probation for an assault with intent to rob while being armed. He also received a charge for possession of a pneumatic gun in furtherance of committing a felony. While on probation, the student was referred to Check and Connect due to his lack of engagement in school, poor academic success, and poor attendance. This student skipped most of his classes and used class time to wander the hallways or visit his girlfriend in her classes. The student would also skip class to leave the school building and smoke marijuana with his peers. When the student actually did attend class, he'd look at the assignment for a lengthy period of time and then start to play games on his phone or use social media to interact with his friends. The student would fail courses and then rely on summer school to obtain the credits that were missed during the school year.

The student initially stayed within the school district and would contact his mentor for transportation late in the school day. After a while, he had moved out of the district and became even less engaged in school, oftentimes skipping the school day altogether. The student would smoke marijuana prior to calling his mentor for transportation to school, and then sometimes sell marijuana to other students while at school. The student had admitted to the mentor that he had become dependent on marijuana, stating that it helped him prepare for school and make it through the school day. This student was also heavily involved in teen gangs and often carried a firearm with him. The student claimed that speaking on his experiences left him more exposed to people being able to "snitch" on him and his peers.

Check and Connect is a minimum of a two-year intervention. The student participated in Check and Connect for 2.5 years. During these 2.5 years, the Check and Connect mentor checked the student's school data at least weekly, if not more frequently. The mentor would then use this data in his weekly connects with the student. As the mentor continued to build a relationship with the student, it was clear that the student needed more academic support and services in place. The mentor supported the student and worked with his family to request an evaluation for special education services. At the end of the evaluation process, it was determined that the student was eligible for special education services. He received an IEP for a Specific Learning Disability (SLD) in math, writing, and reading comprehension.

Further, the mentor transported the student to and from school and used the transport time to discuss goals surrounding school and life post-graduation. The mentor had motivating conversations often with the student to help the student identify ways to accomplish his goals. The mentor explored career interests with the student and held mock interviews with the student along with completing job applications to hiring companies. The mentor also worked with the student one-on-one during class to help the student remain focused and get assignments and projects completed. The mentor spoke to the student about the value of education and shared data on the average salary based on education. The mentor connected with YCHS counselors and social workers to create educational plans for the student to earn high school credit and address the traumas that he had experienced. During this time, the mentor worked to help the student both accrue missing credits for failed classes and get on track for graduation.

The student began to improve his attendance and engage in the work that was assigned to him. The student also began to express interest in attending community college after seeing the value of education and how it correlates to his long-term career and life goals. He successfully completed probation. Throughout the 2.5 years that the student participated in Check and Connect, his mentor saw improvements in multiple areas of his life, particularly with regards to school. The student began to spend more time in the classroom, and began to skip classes less and less. As a result, his attendance improved. While in the classroom, he began to engage more with the teacher and the classwork. He began to complete more and more assignments with the mentor's support and encouragement. Additionally, the student significantly decreased instances of walking out of the classroom and behavioral instances. The student worked diligently with his mentor's support to make up courses he has previously failed. As a result, he was back on track for graduation, ultimately graduating this past summer. While in the program, the student accrued a total of 22 credits, graduating with a total of 23.5 credits. As the student neared graduation, he and his mentor engaged in a number of conversations over multiple months to explore possible interests and post-graduation options. The student expressed future interest in attending community college and obtaining employment. The mentor and student completed numerous applications for jobs, participated in mock interviews, and explored pathways and opportunities that align with his long-term career goals. Additionally, the student tried to refrain from carrying around a firearm and engaging in community gang activity. He also began to explore therapy and became more open to mental health supports and services.

At the time of intake, the student was not on track to graduate. The student was in the 10th grade by age, but had less credits than a 1st semester freshman student. On average, students accrue 3 credits per semester, 6 credits in a year. During the 2.5 years the student was in the Check and Connect program, he accrued a total of 22 credits! This is well above average. School staff noted they believe his progress and graduation are largely due to the support of his

Check and Connect mentor. Throughout the mentorship, the student became more motivated and developed a deep relationship filled with trust. Initially, he did not talk a lot in the beginning of the mentorship; however, as the formal mentorship came to an end, the student was actively engaged and reaching out to the mentor for support. Overall, he became more open to receiving help and support. Further, the student also developed a trusting relationship with his mother, as Check and Connect worked to bridge that relationship and support both parties in the relationship. The student also was much more excited about future plans and ended the formal mentorship relationship very excited about continuing in life.

Unified-HIV Health and Beyond

Mobile Health Project

Client is a 16-year-old who used Narcan 20+ times in the last 3 years on others and others have used Narcan on the client. The client asks, "Am I a hero?" The client shared that because they use drugs, folks don't care about them or others who use drugs unless they are sober and fit into others' ideas of how they should act. The youth feels that adults don't listen, respect, or value their opinions. As a result, youth keep dying. The client works with UHHB staff as a secondary distributor and has helped youth and adults obtain what they need to reduce the harm to themselves and others. This consumer feels that they are able to save themselves and others with the help of UHHB.

Washtenaw Area Council For Children

Cyber Safety and Bullying/Cyberbullying Prevention Program (CSP)

The Tappan Middle School students, staff, counselor, and Cyber Safety Peer Mentor group wanted to make their peers aware of the impact cyberbullying has and what each of them can do to prevent it or support their peers being bullied. Anti-bullying video:

Put together by Robert Oden, Tappan School Counselor, with assistance from Alyssa Newsome, the Cyber Safety Facilitator, they organized the students who wanted to be in the video. Alyssa put together a script, and the video was filmed in the school building. Mr. Oden did all of the video editing and was responsible for crediting everyone involved. The students involved were part of WACC's peer mentoring club at Tappan, the Anti-Bullying Club (The ABCs). The video was created so that the peer group could share their message of anti-bullying, promoting kindness, and increasing awareness of the impact of bullying as well as offering ways to handle being bullied. It was also a way to promote more student involvement in the peer group's bullying prevention campaign. All students were intricate in the development of this project. Some were actors in the video, while some were involved in the script discussion and vision. The video was shared with the entire school body and parents, and it received great reviews from the school administration and staff. It is also available for public viewing. Permission by the parents of students who appeared was approved. Mr. Oden worked diligently to get the parent permission and share that information with WACC.

The peer mentoring group is designed to promote student leadership. It recognizes and appreciates talent in all students and utilizes every member's strength. We recognize that when students are encouraged to be involved in a project of this nature, it increases self-esteem and promotes good emotional and social health. The video was a great success and is a great reflection of what this program is about and capable of accomplishing. The Tappan Middle School ABC students, Mr. Oden, and Alyssa should be proud of this project. It will always be a light point of the Cyber Safety program.

Washtenaw County Community Mental Health Project Outreach Team

The client is a caucasian gentleman in his mid-50's with co-occurring SUD and SMI. He had over two decades of literal homelessness, untreated SMI, untreated SUD, and frostbite resulting in loss of toes on one of his feet. We had years of engagement with him. The homeless individual eventually identified getting his ID so he can vote in this election as a goal. From this starting point and with assistance, we were able to begin first ever efforts at obtaining housing and social security funds. The individual has been picked for PSH through Avalon; we are working on an SSI application. We have assisted him in obtaining all forms of ID. For years we called him by a name he provided to us that we always believed to be a pseudonym, but through the efforts described above he provided us with his legal name. He had declined efforts to link with housing through PORT support for at least the last 5 years. He is now EXCITED to be housed!

Avalon Housing, Inc. PSH Family Services Team

A mother of three children, has been a part of Avalon Housing's community for the past two years. She has been the victim of tremendous and repeated instances of domestic violence in the past, but has neither had the resources nor the trust in others that is often necessary to ask for help. Since being housed with Avalon in 2018, she continued living with her assailant and had been fearful to take any action against him. She would call her Avalon Support Coordinator after each episode of domestic violence to discuss options for moving to safer housing, removing him from the lease, or taking legal action, but never was ready to take action. In this way, the cycle of abuse continued. This intervention was not a singular event, but a process of offering steady support over time. As this crisis continued, the support and consistency offered by her Support Coordinator slowly cultivated enough trust in others. She began discussing options for herself, such as moving to a new location and removing her assailant from her lease. Using motivational interviewing, her Support Coordinator worked with her to build internal motivation to seek out help. Before taking the next step out of this cycle of abuse, She needed to know that Avalon would be there for her when she was ready to make this move. Her Support Coordinator earned that trust. She worked with her Support Coordinator to access the services of SafeHouse while Avalon took steps to remove the assailant from her lease and secure housing for her and her children in a new, safer location where he would not know where she lived.

She is now living safely with her children in her new location. She was recently awarded Social Security, which has given her increased financial stability. Her children are also doing well and take part in the many opportunities for youth that Avalon offers through its Youth Development program.

This situation highlighted how important it is to allow services to be client-led, to offer consistent support, and to build trust while employing motivational interviewing techniques. It also amplifies how long someone may endure the cycle of abuse before they are ready to leave the situation. The lack of safe, affordable housing makes this process even more difficult for survivors of abuse to leave dangerous and untenable situations.

Avalon Housing, Inc. PSH Miller Manor

A single female client in her 50s living at Miller Manor who has a history of trauma and has experienced mental health issues and housing instability in the past. Staff describe as somewhat reserved and reluctant to engage with others, but has a pleasant disposition and an incredible resiliency that has helped her continue to move forward toward achieving independence and housing stability over the past year. Prior to living at Miller Manor, she was living and working independently and was housed with a voucher that required her to make small but significant contributions to her monthly rent. After suddenly losing her job, housing stability was put into jeopardy as she was no longer able to meet her rental obligations. A promising opportunity through another city's housing commission was taken from her as she had an instance of eviction on her housing record over the past five years, putting her at imminent risk of returning to homelessness.

Avalon Housing and the Ann Arbor Housing Commission (AAHC) worked with her to secure housing for her at Miller Manor. Since entering the Miller Manor program, she has worked with Avalon and AAHC staff to achieve housing stability.

She has also participated in supportive employment through CMH and has accrued enough positive housing history that she is now able to begin exploring independent housing as a viable option. Throughout her participation in the program her mental health has improved significantly, and recently was able to move from having her medications delivered and monitored to being able to manage her medications independently.

She has not experienced continuous success. At multiple times throughout her participation in the Miller Manor program, she has been faced with stressful situations and setbacks caused by mental health issues and challenges in maintaining positive relationships with her family. She has, however, continued to meet these challenges with the support of staff and the Miller Manor community while maintaining housing stability and employment.

Catholic Social Services of Washtenaw County Washtenaw Child Advocacy Center

Our teenage client was sexually assaulted numerous times across several Washtenaw County law enforcement jurisdictions. We collaborated with the different police agencies to coordinate a single interview so that she would not have to re-tell (and re-live) her assault story multiple times. The WCAC is designed to simplify the investigation process for families and advocate for youth to feel safe. The caretakers met their multidisciplinary team (MDT) who were their consistent contacts throughout the investigation. Our location is child-friendly and our procedures are victim-focused. She did not have to go to a police station or have contact with officers, which can be intimidating for youth. Our forensic interviewer is specially trained to interview children about sexual abuse and sexual assault.

While we interviewed her, our crisis counselor met with the individual's caretakers. Our crisis counselor and C's caretakers discussed their feelings about the assault, how they can support her after the interview, and recommended community resources for further support.

She attended counseling at the WCAC to not only address the sexual assaults but also additional abuse that she experienced. After a thorough trauma assessment, our therapist determined that she experienced trauma during the first 8 years of her life. Our therapist is using TF-CBT with her as she becomes more comfortable with talking about her past trauma. At the beginning of each session, the therapist meets with the family to get an update on the child and address any concerns they may have. The family reported improvements in her behavior and communication between the individual and family. The family also developed their own self-care routine. As the case goes through criminal court, the WCAC will work closely with the prosecutor's office. Testifying in court can be intimidating, as her perpetrator will be present. To prepare her for this, the MDT will act as support people for her at the trial as well as the days leading up to it.

It highlights how the CAC model works successfully and our aim to be child-focused as well as collaborative with our MDT partners.

Community Action Network

Community Action Network (CAN)'s School Comes First! (SCF) @ Hikone, GBC & Bryant Community Centers

A funny, outgoing, creative, and compassionate 5th grade student Bryant Community Center's Fall Teen Block with her older brother and is always toting her four year old sister to make sure she is safe and supervised. Like so many students, particularly in the state of Michigan, the student faces challenges to access and equity associated with her education. Her literacy and math comprehension in particular were not at grade level when she first started attending CAN's After School Program two years ago in 2018. Remote school days brought on by the pandemic have also posed new challenges. Former VISTA, an English major and Global Studies minor, and current VISTA, a Secondary Education major, have tutored her on the 4 days per week she attends CAN's After School Program. Her time management, understanding of how to navigate tech and in particular Schoology, and her literacy and math skills have expanded because of the close work the VISTAs have done with her. The student and tutor are very close. The tutor lets the student sleep on her shoulder, and the student told her fifth grade teacher, "I have the best tutor!"

Community Action Network

Community Action Network (CAN)'s Read 2 Succeed and Summer Education Program (R2S & SEP) @ Brick Elementary School

A client is super social, ready to learn, and motivated to help. She regularly steps in to form relationships with other CAN participants who aren't connecting with their peers. She has often reflected that she appreciates CAN because she gets to do fun activities but also because she gets to meet new people, both the other kids and the adult staff and volunteers. COVID-19 and the need to adapt programming to remote connections, since Brick Community Center is in the school, we did not have an opportunity to run programs in person once the building was closed in March. As such, all programming was adjusted to a virtual setting, meaning students would not be seeing the SPFs or other participants off of a screen, and relationship building became a challenge. Daily virtual check-in utilizing Google Meet and the CAN A&D HOMEState was added to the curriculum. She very quickly became a helper to her leader, using her knowledge to help her other teammates learn how to share their screens and coming up with new games her group could play online to help everyone get to know each other better. She adapted to the circumstances that she was given and was able to continue to establish new relationships and deepen her love for CAN while staying safely at home. Her leader shared that one day after playing a particularly fun game of Pictionary with her team, She asked another team member to stay online and keep playing even after the leader got offline. This was particularly exciting because that other student was not someone who She had spent much time with prior to the summer.

Student Advocacy Center of Michigan Education Advocacy & Support

An eight-year-old male who came to SAC in second grade after we were contacted by his CMH therapist. He had experienced complex trauma in his household due to an abusive situation with his mother and her boyfriend. The child experienced a cyclical form of abuse, as the destructive behavior he exhibited at school, likely a result of trauma, would be met with more abuse at home.

He has since moved in with his grandmother, who has been able to provide love and nurturing. She has medical rights, and has tried to connect him with the social services he needs. His mother, who still has maternal rights, has threatened to take him back in the past, but doesn't have the financial resources to do so. His grandmother takes him on visits to see his sisters at his mother's house, as they are very important to him.

Last spring, prior to the onset of the pandemic, he experienced intense emotional outbursts in class, regularly forced to spend the majority of the school day in the hallway due to class disruptions. These issues created dangerous situations in the classroom including attacking his classmates. He is an extremely empathetic child, feeling bad about hurting his classmates after he was able to calm down.

Due to these outbursts, the child was regularly suspended. Despite exhibiting clear mental health problems, the school treated it as a disciplinary issue; no one from the mental health community regularly attended meetings for him. An outside CMH therapist attempted to

advocate with the school but was not getting anywhere. He had some support from the school social worker, but without access to Individualized Education Program (IEP) services, he was not able to receive the requisite level of support. Part of the problem was actually one of the child's strengths: his intelligence. Despite being mostly absent from the classroom for grades 1 and 2, the child was still above grade level relative to his peers, making the school less inclined to believe that he needed IEP services.

Once SAC was able to get involved, one of our advocates was able to make regular school visits, often with one or two interns. The child was able to maintain composure in his classroom much better with additional adult support.

Additionally, the advocate was able to shift the school's focus away from discipline and back towards special education supports. The advocate had to persistently push for a special education evaluation. Because one had been done in December of the prior year at a different school, his current school claimed they were not required to do two in one school year. The previous school had evaluated him for ADHD, not for an emotional impairment, because they believed that would be an easier way for him to get an IEP.

Once the child was given a new assessment, he received an individualized education plan in April. This is a legally binding plan that documents needs and services. Once the IEP was in place, his school became more responsive, getting services together and reviewing his care in a special education context rather than disciplinary. A Board Certified Behavior Analyst (BCBA) was added to his team, providing a process-oriented perspective that steered conversation away from shaming the child for his behavior.

Due to the pandemic, school life has not quite returned to normalcy for him. He is only in school eight hours per week due to the remote policy. However, he has been able to develop strong bonds with adults to a strong positive effect. He has been paired with a new mentor, engages with his teacher, and works well with a special education paraprofessional when he's brought to a breakout room.

Unsurprisingly, the child is the most extraordinary part of this situation. While he has experienced incredibly complex trauma, he is a smart, empathetic kid. Despite the invalidation and spite he continues to receive from his mother, he has a capacity to trust and develop bonds with other adults in his life. With a dedicated, supportive team around him, he has the capacity to be successful in school and lead a happy, successful life.

School Aged Youth - Graduation

Michigan Ability Partners

Michigan Ability Partners Permanent Housing Supports

She immigrated to the United States from her birth country of India when she was in her twenties, and gained citizenship in the United States. She married and had a daughter, and held stable employment for most of her adult life. After the death of her husband, she started to present symptoms of schizophrenia, which caused her to lose relationships with family and other supports. The behaviors associated with her mental health struggles led to her experiencing chronic homelessness in Washtenaw County. She was referred to MAP for

permanent supportive housing in March of 2017. After she was housed with a PSH voucher, she continued to present with symptoms of schizophrenia, including persistent and severe hallucinations and delusions. However, she had no insight into her mental illness, and therefore did not realize that she needed help. This led to behavioral issues that ultimately got her evicted from her first apartment, despite MAP's attempts to advocate with the landlord. MAP moved her into another apartment complex that we hoped would help to alleviate some of her symptoms, but the behavioral issues continued and she was once again risking eviction.

MAP staff recognized that mental illness was impeding on her ability to live a full life - she was constantly living in fear because of her symptoms, and she was unable to form relationships, seek employment/volunteer opportunities, or maintain stable housing. Because of all these things, plus MAP's worry that she was potentially a danger to herself or others without intervention, MAP made the decision to petition the client for hospitalization/mental health treatment. After receiving treatment for her mental health, including court ordered medication and CMH services, her behaviors stabilized and she started to more enthusiastically engage with MAP's housing case management services.

About a year ago, she was awarded SSI and was enrolled into MAP's payee program to assist with budgeting, money management, and to ensure that housing and medical bills were being paid. Thanks to advocacy by MAP's supportive housing program she was able to maintain her housing and also received needed treatment for her mental health. MAP and CMH's partnership and collaboration led to positive mental health outcomes for her, which has led to re-establishing a relationship with her daughter and other family.

Because of payee services, her's rent and other bills are always paid on time. This has also helped save enough money to travel with her daughter, including a trip to India to visit family.

MAP's housing and payee services have helped to create positive changes in her life, and has helped her to gain a sense of safety and stability.

Ozone House Permanent Supportive Housing Services

This client has been in our SOLO program for 4 years and has struggled with mental health and behavioral issues throughout his time. Before coming to SOLO, this young man was sleeping in public bathrooms and struggling with his mental health. While he has been in programming for the past 4 years, he has received consistent and intensive case management to connect him to resources for his mental health and to work with him on his behavioral challenges, such as utilizing violent language. Through the consistency of case management, he was able to receive a diagnosis regarding his mental health that he feels accurately reflects what he is experiencing. Additionally, staff have worked with him to receive SSI and he is able to regularly pay his portion of rent. For the future, he is looking to be in a subsidized housing unit with a roommate so that he can live independently. This client has had multiple stays in an in-patient psychiatric facility throughout his time before Ozone House and while in programming. It has been over a year since he has had to be hospitalized.

Ozone House

Rapid Rehousing for Homeless Youth

A client who has been affiliated with Ozone House for over 10 years was able to gain a spot in Rapid Rehousing. The client has had a challenging relationship with her mom, and as a result took on many of the responsibilities for caring for her siblings. She became involved in case management with the intent to sign a lease when she turned 18. Once she turned 18, Ozone House was able to help her gain a Rapid Rehousing unit. She was in the program for one year, all the while working with case managers to gain and maintain employment. Despite COVID-19, she was able to find employment in July that allowed her to move into a non-Rapid Rehousing unit with a roommate and take over all rental payments. Ozone House has worked with this client in different capacities for over 10 years. She is now able to provide for herself to live independently.

Peace Neighborhood Center

Peace Neighborhood Center Alternatives for Youth Program

A current 7th grader, has attended Peace programs since 2nd grade. The Ann Arbor Public Schools have assigned an Individualized Education Program (IEP) for emotional impairment. Her reputation for aggression precedes her, making life tough to navigate as a pre-teen. She has written several inappropriate social media posts, leading to threats of violence and physical altercations between her and other youth. Prior to the transition to virtual schooling, the school district required a separate school bus to pick her up as the only passenger because of concerns about leaving her unsupervised with peers on the bus.

Her older sister, a current 8th grader, is outgoing and has a strong relationship with her father, while she has trouble making friends and does not have a relationship with her father, who lives out of state. It is understandable that these circumstances would generate insecurity in a young girl.

In addition to an older sister and a younger brother. Since the mom is an essential worker in food service, she had no choice but to take on some childcare responsibilities after school in the wake of the pandemic. Last year, Peace staff anticipated a difficult transition to middle school. Transitions are a challenge for all children, but with past behavioral and emotional challenges, she was more at risk than other students to struggle with this change. The shift from in-person to virtual learning as a result of the pandemic exacerbated this challenge. Peace staff have proactively identified and brainstormed intervention strategies to support the most significant areas for improvement: expressing and communicating her wants and needs, building positive peer relationships, and developing accountability for her behavior.

Even prior to the 2019-2020 school year, she was enrolled in Peace's Leadership Development Camp for the summer, which includes a variety of activities intended to support young people's academic success and development of leadership skills and social-emotional competencies.

At the beginning of the school year, Peace staff were in close contact with the mother and Ann Arbor Public Schools support staff to connect the dots between school, home, and Peace, providing a coordinated front to holistically support growth. A key part of the wrap-around strategy to support included sharing parenting strategies with her mother.

With the transition to virtual learning in March, the focus of both one-on-one and group tutoring through Zoom. These touch points provided academic support and guidance as she learned to navigate life during a pandemic. Throughout the last school year and into this period of virtual learning, she has demonstrated her ability to actively participate in groups with peers, and she has built relationships with female staff who serve as positive role models. Ultimately, Peace's work with her ensured that the transition to middle school and, from there, the transition to virtual learning, did not turn into a crisis. We are proud of the progress she has made, and we are hopeful that the behavioral improvements we have witnessed will translate into a successful high school experience for this promising young woman!

Shelter Association of Washtenaw County

Packard Health/SAWC Integrated Health Services at the Delonis Center

A 76-year-old hearing impaired individual seeking shelter with little to no supports for family. He presented to the Delonis Center in June 2020 and seemed distraught to be seeking shelter along with many other persons in the midst of the health crisis COVID-19 had been causing. The University of Michigan hospital contacted SAWC about him prior to his arrival. They alarmed us of his many health needs, his seemingly early onset of dementia, and his inability to recall how he became homeless. When he arrived at the shelter, he shared his concerns about contracting the virus while being among others at the shelter. Our staff assured him that there were safety and health protocols in place to protect everyone including health screenings three times a day, mask wearing, routine cleaning procedures, and also mandatory routine COVID-19 testing. He was assessed as needing a hotel during the pandemic according to his age and high vulnerability. He was connected to a housing case manager from SAWC and to Valerie, SAWC's Medical Case Manager. The Packard Health Clinic visited with him at least once a week to monitor his conditions. SAWC Medical Case Manager provided him with basic needs such as depends, a CPAP machine for his COPD condition, a renewal for Medicare insurance, a new pair of eyeglasses, and hearing aids. When working on his housing plan, it was decided that He would need a nursing home facility due to his incontinence and inability to meet his daily living activities on his own accord. With advocacy from Packard Health clinic, SAWC was able to refer him to a nursing home facility that will provide his basic need care and also provide permanent, sustainable housing. The Packard Health Clinic and SAWC are grateful that he received a hotel room to best protect him from the spread of COVID-19. SAWC Medical Case Management also provided many solutions/aids to his many health needs. At the end of his shelter stays, he seemed like a different person. He was cheerful, well rested, hopeful, and feeling more at ease about his housing and health outcomes.

SOS Community Services

SOS and IHN Rapid Re-Housing

We were connected to a family of 7, a two-parent family with 5 young children. The youngest has a disability, and the family became homeless due to a medical emergency. They were in a hotel and could longer afford to stay there. In March, SOS had a shelter vacancy and the family entered the shelter. SOS staff advocated for them to receive RRH. Once they were entered into the RRH Program, they started their housing search. They also were able to return to work.

SOS HSC worked with the family on budgeting, and assisted with ensuring that they were able to get DTE in on their name. The family was able to secure housing. RRH assisted with move in cost. HSC will continue to work with the family to maintain their housing. The family continues to increase their income and each day their housing becomes more stable.

Early Childhood

Avalon Housing, Inc. **Rapid Re-Housing for Adults**

A single African American woman in her late 30s. Those who know her describe as incredibly resilient and able to weather tremendous challenges while continuing to move forward.

Before the COVID-19 pandemic began in early 2020, she was participant in Avalon's Rapid Rehousing program, had support and a stable life earned through the wages she made through working two part-time restaurant jobs. In mid-March, that changed when both restaurants were closed and forced to lay off their staff. A short time later, her mother passed away.

Losing both her jobs and a loved one in such rapid succession took a toll on her mental health, as such events would do to anyone. In response, she began to self-medicate, which only served to further worsen her mental state.

Rapid Rehousing staff working with her identified the need to intervene, and they did. Staff worked to connect her with Packard Health for mental and physical health support, and Packard Health staff, Dr. Ravi offered her the opportunity to receive counseling at her home. Out of necessity Dr. Ravi had to work creatively, which he did. Due to the no-contact protocols in place at the time, Dr. Ravi provided her with counseling in the front yard of her home where they could both sit and talk, six feet apart.

Over the course of the next few months, her mental health improved. Packard Health worked with her to continue receiving psychiatric treatment long term. She also has a new job. She is working full time and is on the cusp of being able to contribute toward her rent.

All of this is extraordinary, but the stability that we were able to assist her in achieving would not have happened if not for the support of our staff, program, and our partners.

Community Action Network **Community Action Network (CAN)'s School Comes First! (SCF) @ Mitchell Elementary**

A second grader at Mitchell Elementary School. She is a part of a low income family, and she was falling behind academically. Along with her academic struggles, she suffered from severe anxiety, specifically involving trees and using the restroom. Whenever the group went outside to play, she would become extremely nervous around trees and cry, and she cried whenever she used the restroom. Despite these challenges, she is very sweet and has a huge heart. As a part of their homework, second graders are expected to practice writing a couple of full sentences. However, struggled severely with spelling, and was unable to write a complete sentence. Her

anxiety also posed challenges, not only in the forms of panic attacks, but left her vulnerable to bullying from the other children. There were two key parts of the intervention in her case. First, she received daily homework help, and due to the small class size it was often one-on-one. She was consistently around adults who supported her, and her parents were very involved which allowed the momentum of her improvement to continue at home. During the After School Program, she participated in group play which helped to decrease the bullying she was experiencing and allowed her to bond with her classmates. By the end of the program, she was able to write full sentences on her own. She was enthusiastic about homework and frequently went above and beyond the assignments. Her anxiety also diminished, and she no longer cried when using the restroom. She also seemed more happy and talked to more people, greeting everyone when she came in the room, and showing off her drawings. Her case is a great example of not only academic but social growth that children experience through CAN's After School Programs. Through the After School Program at Mitchell, she was able to come into her own artistically. She was very enthusiastic about CAN's Art and Design program and got excited every time they came into the After School Program. Throughout attending the program, she was always drawing, and she even started getting creative with her homework assignments by writing even more than they required, and adding pictures to each one.

Growing Hope Home Vegetable Garden Program

A woman lives in the city of Ypsilanti, is in her mid-30s and has one child at home. She uses Medicaid, WIC and food pantries to meet her health care and food needs. She shops at Aldi and Fresh Thyme when they have good deals. She applied to the program because she loves to cook and wanted to teach her child how to cook with vegetables freshly harvested from a garden. As someone utilizing state and federal programs to meet her food needs, she is at the whim of political friction and tenuous policies to feed her family. As a result, changes in food policies and systems affect her family more than someone who has financial flexibility to always choose where and how to purchase their food. There remains a high need for someone like her to have greater control over her food choices in order to become self-sufficient. Growing Hope partnered with her in 2019 to set up a new home vegetable garden for her family. We asked what kind of seedlings she wanted to grow, and then worked with her to install raised beds in her yard. We checked in on her progress throughout the growing season and provided her with garden resources and a connection to a network of other area gardeners. We wanted her to become empowered to sustain her garden, without Growing Hope, for years to come. We ensured that we built in the education and networking that would help her succeed as a long-time vegetable gardener. Because of receiving a home vegetable garden, she reported some very positive outcomes. She said she spent more time outside in her yard, her child had greater access to fresh food, she cooked with her family more, she knew where to ask for gardening help, and importantly she said she feels proud of the food she grows and that gardening has become central to how she feels about herself. Her story is not extraordinary, but is in fact a story that hundreds of Ypsilanti residents could tell who have started home gardening because of Growing Hope. Unfortunately, there are many people living in poverty in our community who bear the burden of a broken food system. And while gardening by itself will not lift them out of poverty, gardening has the ability to create an alternative narrative that centers food sovereignty over dependence on systems that disproportionately burden low-income and people of color.

When people have choice, agency, and power to create the food system they envision for themselves and their neighbors, the community as a whole benefits. Gardening as a tool toward resiliency is extraordinary.

Ozone House

Transitional Housing for Homeless Youth- Miller House

A young man came to Miller House in December of 2019 in need of housing and employment. While in programming, he had some behavioral issues and mental health challenges associated with the COVID-19 quarantine and being in shelter with all female-identifying clients. He would have arguments often with other residents and was frustrated with the slow pace during the first months of quarantine. He built trusting relationships with staff, attended case management sessions every week, and participated in life skills groups. As a result of one of the life skills groups, he created a resume and cover letter that eventually assisted him with getting a job in food service. With the help of case management, he obtained his social security number and Washtenaw County identification which allowed him to gain employment. During the pandemic it has been especially frustrating and challenging to obtain employment, but this client persevered and has started saving his income.

Washtenaw Literacy

LIFT | Learning Is a Family Thing - Home-Based Literacy Intervention for Parents

A man and his family immigrated from Afghanistan 3 years ago. Here, he works as a custodian at a school but dreams of becoming a carpenter or an electrician. His wife completed 3rd grade in Afghanistan; she is illiterate in her first language and does not speak English. They have three children ages 8 years, 6 years, and 20 months old.

The older children are enrolled in Ypsilanti Community Schools and the baby is at home with her mother.

His wife (learner requested to not use her name) was isolated before the pandemic, and now is critically isolated. Without English language skills or the ability to read any language, she is dependent on her husband for nearly everything, including grocery shopping and communications outside of the home. His English was at a low beginning level when the family enrolled with LIFT. During the pandemic, he has been an essential worker and so concern for the family's health is a day-to-day consideration. The older children received Chromebooks and hotspots for school, but neither parent had used a computer before. After a comprehensive literacy assessment, Washtenaw Literacy staff placed one dedicated tutor to work with this family on at least a weekly basis. Beyond Washtenaw Literacy's Core Tutor Training (15 hours), LIFT tutors receive additional training in family literacy, cultural competency and sensitivity, and implicit bias. LIFT tutors work closely with Washtenaw Literacy staff to plan literacy programming. Initial LIFT programming focus for his wife was parenting support for the youngest child's development, and English language skills for him. But after the pandemic, programming expanded. In tutoring, he focuses on grammar, writing, and financial literacy (e.g., credit cards, credit scores, saving for a house). His wife focuses on vocabulary, ABCs, and everyday conversation. Washtenaw Literacy provided a Kindle Fire for tutoring and both parents

are expanding their digital literacy. During the initial stay-at-home period of the pandemic, tutoring focused on health literacy. Initial LIFT programming supported his wife and her interactions with the youngest child, a preschooler, and LIFT's original focus. Through the tutor's relationship and beginning to learn basic English, the mother's confidence quickly grew. She began to read, in English, books to the preschooler and teach the preschooler ABCs, something she had just learned herself. He is incredibly grateful that tutoring expanded after the pandemic to support educational activities with the older children and their at-home schooling, communications with the schools, and ensuring that both parents understand their children's devices and the required programs schools use (See Saw, Power School, etc.). The plain language health literacy programming was critical during the pandemic's early days when there was confusing information about COVID-19. Through Washtenaw Literacy's nationally-recognized, plain language COVID health literacy curriculum, Wash-Wipe-Cover, He and his wife quickly learned the vocabulary necessary to understand health information protocols they were expected to follow at home and as an essential worker. LIFT programming continues more frequently than once a week now that the learners and the tutor are connected online. A flyer that accompanies Wash-Wipe-Cover can be read here: washlit.link/wash-wipe-cover.

LIFT is the only program of its kind in Washtenaw County providing programming for low-literate parents of preschool and, since the pandemic, school-aged children. The demand for this kind of intervention has expanded since the pandemic. The original purpose for LIFT -- supporting the academic readiness of preschoolers with low-literate parents -- exploded in the pandemic to include digital and health literacy and support for families with school-aged children. The agencies Washtenaw Literacy engages in LIFT programming has expanded from the original three home-visiting programs with Washtenaw Intermediate School District, SOS Community Services, and Catholic Community Services. Added partners include Ann Arbor and Ypsi Public Schools, Generations Preschool, and Perry and Beatty Early Learning HeadStart programs. The support Washtenaw Literacy has to address this critical gap is inadequate, and as of this program year, without reliable support, we have had to limit participation and turn away new partners. Since the start of the new program year, July 1, 2020, referrals to LIFT have increased by a factor of 2.5.

School Aged Youth - Safety

Aid In Milan

Aid in Milan Safety Net Services

The client is a disabled 57-year-old female who, along with her 60-year-old disabled husband, lives in HUD subsidized housing in Washtenaw County. The complex where the client lived did not have proper management, and paperwork was filed for tenant evictions. (Client was one of about 20 tenants to have this issue. Many of them were clients of Aid in Milan, as well.) The client also needed help managing other issues they were having with their housing complex. Their furnace was inoperable toward the end of winter and they had to use space heaters. They had contacted management multiple times to resolve the issue, without avail. The client's husband had fallen in the bathtub and they requested a handicap bar to be installed since he is disabled. Aid in Milan coordinated a meeting with these clients along with two representatives from Legal Services of South Central Michigan to talk about their rights and what steps needed to be made to take care of the legal issue. We assisted the client with writing a letter to the property management at the complex regarding the furnace repair. It was recommended they contact the Fair Housing Center of Southeastern Michigan to help with the modifications to their bathtub. The legal issue outcome was a success; no residents were evicted and all cases were dismissed. The client's personal issue with the furnace was resolved after some time and the handicap bar on the bathtub issue is still pending -- we are providing additional support to help resolve this issue. Aid in Milan has helped the client with their 2020 DHHS renewal and also provides this client with nutritious food when needed. The client's renewal was a success, as they were able to keep their SNAP benefits. The number of people being evicted at once was a red flag and we were relieved the client felt comfortable coming to Aid in Milan for assistance. We were able to help many people who were experiencing fear of eviction, especially as the issue continued into the pandemic. The rich connections we have made in Washtenaw County allowed us to be able to resolve this situation by collaborating with Legal Services of South Central Michigan. This is also an example of what true Resource Advocacy looks like in terms of assisting a client with a multitude of resources to live a healthy and safe life.

Avalon Housing, Inc.

PSH FUSE

A middle-aged male who staff describe as friendly and willing to engage with staff in supportive services. Although he has faced multiple setbacks and hardships stemming from his mental health issues and substance abuse problems, he is persistent and remains determined to work toward his housing stability and wellbeing. Immediately upon entering into the FUSE program, He was at risk of losing housing and was accessing the ER for his healthcare needs on a weekly basis in response to mental health issues stemming from substance abuse. At this time he was also unable to maintain his apartment and was at risk of losing housing after being issued a 30-day eviction notice. Avalon Support Coordinators working with he recognized the need for increased levels of care and worked with him to get him admitted into inpatient substance abuse treatment. While in treatment, he worked with Avalon and his landlord to successfully relinquish his unit in order to avoid eviction. Avalon staff then worked with the Ann Arbor Housing Commission to secure new housing where he would be supported with a higher level of care.

He was able to successfully avoid returning to homelessness as he was able to sign his lease and take possession of his new unit on the same day he left substance abuse treatment.

It is easy to imagine that were this client not being supported by our FUSE team, he would have returned to homelessness and suffered pretty severely given his addiction and chronic health challenges. Our partnership with the AAHC was especially critical in moving this client, avoiding a physical eviction from his previous housing, and avoiding any return to unsheltered homelessness. The client is now in a more appropriate care setting, and this would not have happened without the advocacy of his Support Coordinator and the willingness of the AAHC to house him.

Catholic Social Services of Washtenaw County

Catholic Social Services of Washtenaw County Senior Services (CSSW)-Home Services Program (HSP)

Client is a 92-year-old female living in the Dexter area. Client is widowed and living alone with few close family members nearby. Client is below 200% of the federal poverty level. She has been diagnosed with COPD and arthritis. She called the home services department to inquire about the types of services that are offered in the program. Client was interested in snow removal, however through assessment and conversation, staff learned that she did not have carbon monoxide detectors in her home. Furthermore, she was unsure when her fire detectors had been checked last. Client also reported that she uses a kerosene heater to increase heat in areas of her home. Home Service technicians were able to complete a home visit to her home and provided her with carbon monoxide detectors and smoke alarms. Home Service technicians also advised her on safety measures to take while using a kerosene heater in the home as well as alternative ways to preserve heat. A follow-up with the client was completed to ensure that her needs were met and assist with further weatherization. During the follow-up, the client indicated that her carbon monoxide detector had gone off during the night while she was using her kerosene heater and she had sought medical attention in case of carbon monoxide poisoning. The client indicated that she was fine, but would no longer be using the heater. She stated she was working with her son to find a better way to heat her home.

It is possible that without the carbon monoxide detector provided by the home services program, the client could have become very sick.

SafeHouse Center

SafeHouse Center Shelter Program

Client is a mother of 5 who is also pregnant. She was forced by her assailant to stay home with the children and not allowed to work outside of the home because he did not want her making friends and communicating with people he did not approve of. The client fled her home with her children after the assailant pulled a gun on her and continuously showed up at her home unexpectedly. She became afraid for her and her children's lives and came to shelter for safety. Once in shelter, she struggled with housing as her family was no longer a support system for

her due to the relationship breakdown that took place because of the assailant's isolation techniques. She had no friends and was unable to get a job because she had little ones who were not school age. She was also 5 months pregnant and had not yet seen a doctor. During her shelter stay, she began to see the nurse practitioner and was able to get a referral to a labor and delivery department. She worked with the children's program in shelter to get her school-aged children in school and was diligent in looking for housing. Unfortunately, housing options were limited due to both financial hardship and the lack of affordable housing. After four months in shelter, she was pulled for Rapid Rehousing and was able to move into her own apartment 3 weeks later. Without the RRH program, the family would have more than likely stayed in the shelter much longer than 4 months. She was able to keep her children in the same school with assistance from EPHY and received support and resources through the RRH program.

Ypsilanti Meals on Wheels

Home-delivered meals for persons under 60

Precautions cause a peak in demand for help. Access to food was difficult for the client even before COVID-19. But with the added risks caused by the virus, his occasional trek to the corner store wasn't just cumbersome and expensive, it became dangerous. When he called Ypsilanti Meals on Wheels for help, he was told he would have to wait for a space to open up before he could begin receiving meals. He was one of a few dozen people on the waiting list – the first that YMOW had seen in several years.

But thanks to the donation of a van by Toyota Motors North America and grant assistance from Meals on Wheels America, his wait, and the wait of others, was shorter than expected. He now has meals delivered to his door – meals that do much more than fill his stomach. he said that knock on his door each Monday, Wednesday and Friday lifts his spirits. "I actually feel a little vibrant. Like I don't have to worry too much," he said.

As he continued to shelter in place, Ypsilanti Meals on Wheels provided him with toilet paper, deodorant, a face mask, and a toothbrush and toothpaste. Those things would have taken a chunk out of his limited budget if purchased at the corner store – his only accessible shopping option. Meals and support from YMOW have allowed him to save some money for other necessities, and the food is better and healthier than anything he could prepare himself.

He describes himself as a social person, so sheltering in place has been hard. He enjoys his walks to the corner to pick up a few necessities. But until it's safe to venture out, he's grateful to have food and other items delivered to his door by the friendly staff and volunteers of YMOW.

He also looks forward to his weekly chats with a YMOW volunteer. "I was in a very bad rut when the pandemic first hit," he said. The weekly calls he receives from YMOW's Only a Ring Away program have helped to replace the human contact that he's missing. "It gives me a lift," he said. And reminds him that while he continues to self-isolate for his own safety, YMOW is there to make it all a little easier.

Corner Health Center

Here for Youth

An uninsured young adult male did not qualify for Medicaid, but insurance was not offered by his workplace and he couldn't afford the premiums on any Marketplace plan. He was diagnosed with diabetes in the emergency department earlier this year, and he was admitted to the hospital for a period of time due to high blood sugars from not being able to afford his insulin. Despite this inpatient hospital stay, he was discharged home with no insurance assistance. Since then, he has been forced to halt his insulin usage due to cost. The care management team worked after hours to identify patient assistance plans offered by certain pharmaceutical companies, and with assistance from the medical staff, helped the patient to apply. After much anticipation (and legwork!), the patient was approved and a 3-month supply of insulin and supplies was sent to the clinic at no cost.

When he came to pick it up, the patient was able to sit down with clinical staff experienced in diabetes management and undergo over an hour of one-on-one diabetes education, including injection training, monitoring and recording blood sugar levels, and securing adequate follow-up.

The 3-month supply of insulin provided is enough to get the patient through the end of the year, when he will be eligible for insurance after the 90-day probationary period for insurance through their job.

Corner Health Center

Family Shelter Health Assessment and Referral Program (FSHARP)

A client came to the FSHARP program in late 2017 as a 34-year-old woman, staying in one of the local shelters with her 2 teenage sons. They came from out of state and ended up living in their car before they came to the shelter. She had a history of asthma, chronic back pain, and mental health issues. Both teens were healthy apart from seasonal allergies.

No one in the family had adequate preventative care or access to needed medications.

At the time of the assessment, she was restarted on her medications and a prescription for the allergy medication was sent to a local pharmacy. She was seen at Packard Health for a long-overdue pap smear, started therapy at Packard, and her medications were monitored for mood stability.

Her 2 children were referred to Corner Health, and they both received complete physical exams, were caught up on medications, and were cleared for sports participation. This year, three years after the initial assessment, She and her children have both continued regular care. They are in permanent housing, and she is working full-time. Both teens receive annual sports physicals with appropriate adolescent risk assessments, and they are up to date on immunizations.

The nurse practitioner recently connected with their housing case manager to provide a letter of support for her continued stable housing.

The initial contact and assessment in the family shelter, the “warm hand off” to care with primary care providers who are FSHARP partners, and the continued ongoing regular and preventative care for families is what FSHARP was designed to provide.

Food Gatherers

Food Gatherers' Food Security Network

Before COVID-19 hit, there were limited ways a client could get a grocery delivery to their home. Jewish Family Services, part of our Food Security Network, had a program with limited spots, and we worked with a few churches that would deliver groceries in dire situations.

With the onset of the COVID-19 pandemic, we had many people who instantly needed grocery delivery because it was not safe for them to leave the home. These are individuals who are older, or have underlying health conditions that makes them at risk for severe illness if they get COVID-19.

Food Gatherers worked with our Food Security Network and helped provide the food they needed so they could respond to the increased need they were seeing. Our partners were seeing many new clients and many people were calling us needing grocery delivery. Food Gatherers referred most homebound people to Jewish Family Services and Hope Clinic who established grocery delivery programs. Both Jewish Family Services and Hope Clinic saw dramatic increases in the numbers served. Prior to the pandemic, Jewish Family Services was serving 200 households a month, in March that was 430, and by June 2020 they were serving 946 per month. Prior to the pandemic, Hope Clinic was serving 500 households a month, and in March 2020 they were serving 900. Northfield Human Services and Bryant Community Center also launched a delivery option for those who needed it. Our other rural partners, Active Faith, Faith in Action, Manchester Community Resource Center, Saline Area Social Service and Aid in Milan also were doing deliveries for clients who needed it. SOS and Catholic Social Services had limited capacity but were able to do grocery delivery for some of their clients participating in other programs.

Because of our partners' grocery delivery programs, with food provided by Food Gatherers, we were able to reach many vulnerable neighbors who were able to stay safe at home. Many times these neighbors do not have someone that can go get food for them, and when they call us needing food, they are in a desperate situation, and experience great relief when our Community Food Programs team helps them sign up for grocery delivery.

Because we already had an established partnership with key community organizations, who already had well-run food programs, we were able to work quickly with them to rapidly scale our support to meet their needs to serve the community. Our partners already had on-site storage, but may have needed an extra delivery each week. We also bought additional units if a site needed more refrigeration or freezer capacity. With the help of the National Guard, Food Gatherers has been pre-boxing assorted non-perishables for our partners, so it makes it easier for them to serve more clients when they have limited volunteers.

Washtenaw Community College Foundation

The Parkridge Youth Program (PYP)

This year the WCC Parkridge team offered a 6-week virtual experience for 34 campers. The camp combined virtual and in-person academic and enrichment programming for youth 6-12 years old. Camp programming consisted of 90 minutes of outside activities, and up to 90 minutes of virtual enrichment sessions, 4 days per week (Monday-Thursday). Part of our goal included making observations about the impact of virtual/online learning on our kids and families. In mid-March, a worldwide pandemic began. Changes in everyday living were made by all. Stay at home orders were enacted, masks were required, social distancing was introduced, and many lives were lost. As the government slowly and safely made changes in how people could interact safely, we began to plan what our role would be in this new normal. Parkridge staff felt it was necessary to engage our children socially and safely. We also felt that our best program, summer camp, must continue. In following both local and state guidelines, we adhered to social distance requirements, while providing an outlet for campers to be safe outside of their homes. Many of our campers had been isolated at home since the pandemic began in Mid-March. Our Personal Protection Equipment (PPE) plan included daily temperature checks, required wearing of masks by staff and campers, availability of hand sanitizer and soap/water, and outside access to a portable bathroom equipped with a hand washing station.

The WCC/Parkridge planning team felt that it was important to consider certain factors in recruitment. Transportation, accessibility and delivery of supplies played a key role in our decision to recruit in a very small radius from the Parkridge Community Center. No camper lived more than a mile away, in fact 32 of the 34 registered campers lived less than a 5-minute walk from the outside pavilion at Parkridge Park which was the “hub” of our programming.

Virtual U, as we titled our 2020 version of summer camp, ran from July 6, 2020- August 13, 2020. Our Virtual U team of staff, teachers, student workers and contracted partners engaged each camper in a variety of academic skill-building and fun-enrichment activities. The additional goal of providing a safe delivery of Virtual U due to the effects COVID-19 enhanced the learning opportunities for our campers and community. Our goal was to embrace the current effects of the pandemic while keeping some of our most treasured citizens engaged in learning. Virtual U Summer Camp was an essential opportunity to offer to community members in Ypsilanti. On the Virtual U Celebration Zoom meeting, parents were in tears thanking Washtenaw Community College for making Parkridge Community Center open for their kids to attend summer camp. Virtual U Summer Camp not only provided academic support and enrichment activities for their children, but it also provided child care for working parents who cannot afford to send their children anywhere. The virtual component made staff aware of the technology limitations in households and how crucial it is to have support for these families as they navigate through education being virtual. Virtual U staff were able to assist families on acquiring electronic devices and how to navigate the internet and connect to virtual platforms. Of the active registered students, 61% of the students signed on to virtual sessions. Students enjoyed coming to the in-person sessions and interacting with their peers. They made a point of connecting with one another and participating in activities and discussions. It was obvious that the students and staff had missed socially interacting with others. Camilla is a 6-year-old girl who just finished her kindergarten year. She is quiet, loves being “pretty” and is shy. Camilla enjoyed playing outside with the “bigger” girls during summer camp and made some new friends. When asked what she liked most about summer camp her response was, “My friends!” This speaks to how important it was for kids to interact with other kids as they adjusted to the social distancing and stay at home orders. What Camilla did not share is that once a week for 6 weeks she learned how to code. On her virtual home days, she engaged virtually with a program call from Accelerated Kids, part

of our “Connected Cars and Autonomous Vehicles (CCAT) program. Camilla was actively engaged using an app called Scratch Junior for an hour weekly. She was able to use a laptop and a tablet simultaneously for this program. She listened to instruction and entered code to create her bot, create scenery and program it to move in various directions. She said she likes coding and wants to do it again. But being with her friends is her favorite.

*Please note, no stories of impact were collected from the priority area of Aging.