The State of Housing in America in the 21st Century: A Disability Perspective

National Council on Disability
January 19, 2010

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National Council on Disability
1331 F Street, NW, Suite 850
Washington, DC 20004

The State of Housing in America in the 21st Century: A Disability Perspective

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Letter of Transmittal

January 19, 2010

The President
The White House
Washington, DC 20500

Dear Mr. President:

On behalf of the National Council on Disability (NCD), I am pleased to submit this report titled *The State of Housing in America in the 21st Century: A Disability Perspective.* This report looks at the state of housing for people with disabilities with the intent to provide recommendations that can improve housing opportunities. The research contained in this report provides a comprehensive overview of the state of housing in the 21st century and answers important questions about the current housing needs and options for people with disabilities living in the United States.

The Council is deeply appreciative of your efforts on behalf of people with disabilities. We hope that the recommendations contained herein will aid the Administration in addressing the challenges facing people with disabilities in attaining affordable, accessible, and appropriate housing for people with disabilities.

NCD undertook this study with three objectives in mind: (1) to evaluate public laws, policies, and program initiatives affecting the housing opportunities available to Americans with disabilities and others who have accessible housing needs for whatever reason, whether due to aging or a temporary disability; (2) to analyze what housing, supports, and other benefits are available through the public, nonprofit, and/or private sectors; and (3) to provide recommendations that can improve housing opportunities for people with disabilities in the United States.

Affordable, accessible, and appropriate housing is critical and integral to making a community more livable for people with disabilities. In this report, NCD finds that there are unmet housing needs based solely on standard measures of housing affordability. This analysis also reveals a gap between current policy goals and outcomes—even with laws in place requiring a portion of units to be accessible, some developers and property owners do not comply. Whether this noncompliance is due to ignorance or intent, the evidence suggests we have missed opportunities to increase the supply of accessible, affordable housing.

The findings and recommendations contained in this document are grounded in data and research gathered from federal agencies, either directly or via published reports, and from research completed by academics and disability advocates. This report also provides evidence of what can be effective in meeting the range of housing needs among a diverse group of consumers with disabilities. This includes best and promising practices drawn from real examples, and lessons learned from experts working on housing issues and policy. In reviewing best and promising practices, data were triangulated from different sources—interviews, published reports, and Internet research—to ensure a comprehensive assessment. To this end, the research has been reviewed and commented on by a diverse panel of experts and consumer groups that have all provided valuable insights and guidance.

NCD stands ready to work with you, members of your Administration, and the leadership in Congress as you work toward improving our nation's housing infrastructure.

Sincerely,

John R. Vaughn
Chairperson

(The same letter of transmittal was sent to the President Pro Tempore of the U.S. Senate and the Speaker of the House of Representatives.)

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Executive Summary

While great strides have been made by the National Council on Disability (NCD) and others to advance the notion of livable communities for all, there are still gaps in the knowledge about what exactly is needed to transform our communities. Affordable, accessible, and appropriate housing is a critical and integral part of making any community more livable for people with disabilities. This report looks at the state of housing for people with disabilities with the intent to provide recommendations that can improve housing opportunities. The research contained in this report provides a comprehensive overview of the state of housing in the 21st century and answers to seven important questions about the current housing needs and options for people with disabilities living in the United States.

1. What are the types and extent of housing needs of people with disabilities and what is currently available to meet those needs?

- **Total Households:** Currently, about 35.1 million households have one or more people with a disability—nearly one-third of all U.S. households in 2007. In addition, about 1.6 million people live in nursing homes and another half million in group homes.
- **Affordability:** The greatest need is the ability to afford housing. On average, the income level of people with disabilities is lower than that of people without disabilities. As a result, an estimated 14.4 million households with at least one person with a disability cannot afford their housing—this is 41 percent of all households with disabilities.
- **Worst-Case Need:** A recent report, *The Hidden Housing Crisis: Worst Case Housing Needs Among Adults with Disabilities,* estimates that about 2.4 million households with nonelderly people with disabilities, including 1 million families with children, have worst-case housing needs—nearly 40 percent of all worst-case housing needs in the United States. In addition, another 1.3 million "elderly households" (age 62 years or older) have worst-case housing needs, with many

likely also to have a disability. Most are very low income and paying more than half their monthly income for rent.

- **Homelessness:** A recent government report estimated that at least 43 percent of the homeless adults that stayed in a shelter—about 421,000 people—had a self-reported disability. This does not include homeless children with disabilities in shelters or the estimated 282,000 people homeless each night who are living on the streets, in abandoned buildings, or elsewhere not intended for human habitation. While estimates vary, a large portion of this total is likely to include veterans.
- **Physical Accessibility:** National housing survey data indicates that hundreds of thousands of people with disabilities need some form of modification to make their homes accessible. The majority need grab bars and ramps, which cost relatively little to greatly improve people's lives.
- **Environmental Sensitivities:** About 11 percent of the U.S. population has some level of chemical sensitivity (CS) that is likely to require housing that is free of disabling environmental triggers. Unless housing is universally designed to accommodate different sensitivities, it is better for some with CS to live in segregated housing that ensures control over potential exposures.
- **Mental Health Issues:** More than 300,000 people with psychiatric disabilities currently living in segregated housing could benefit from more integrated and least restrictive housing options.
- **Public Housing:** While Section 504 of the 1973 Rehabilitation Act requires a portion of public housing units to be accessible—5 percent for mobility impairments and 2 percent for hearing and visual disabilities—but we do not know if this is the case. If all public housing developments were compliant to this minimum, then about 68,000 could be accessible. There are potentially another 46,000 accessible units in rural multifamily developments if all were compliant. However, many of these units are likely to be in age-restricted developments (62 years and older), and therefore not available to all people with disabilities, even if accessible.

- **Private Sector Housing:** Similar patterns are found in federally subsidized housing operated by private sector nonprofit and for-profit groups. While about 156,000 units of the U.S. Department of Housing and Urban Development (HUD) multifamily housing portfolio (11% of total) are accessible, less than half (73,000 units) are designated for people with disabilities. While there are about 195,000 “year-round beds” in permanent supportive housing, which often targets people with disabilities, these can benefit only people who are homeless first. Furthermore, many of these programs link housing with services, which can restrict choice and independence.

2. What are the profiles of users for housing program supports and what is the quality of life of people relying on housing-related programs and supports?

Most people with disabilities in federally subsidized housing programs are without children and living alone. While there also may be children with disabilities, these families are not considered “disabled,” so they are not included in the numbers above.

A key concern is that need far exceeds the supply of accessible units. In 2008, about 211,000 nonelderly and 135,000 elderly (62 years and older) public housing households were identified as having disabilities. We know nothing about the type of disability or if the housing is appropriate for their needs. Similarly, we do not know how many of the households with disabilities using Housing Choice Vouchers—544,561 nonelderly families with disabilities and 374,265 elderly families—live in appropriate accessible units, or if they are integrated into the community.

Relatively little is known about the quality of life of people living in federal housing other than statistics that generally show public housing residents tend to have poorer health (mental and physical) than the general population and experience higher-than-average rates of crime and violence. Still, research shows that not all public or federally subsidized housing is dangerous, though it is likely to be poor quality due to poor

construction and deferred maintenance, which has led to the demolition of nearly 150,000 units in the past 10 years.

Finally, while the Section 811 program has produced about 27,000 housing units specifically for people with disabilities, most are segregated. Recent changes in the program, coupled with innovative strategies, such as buying condominiums in market-rate developments for people with disabilities, are encouraging. Still more is needed in terms of legislation, education, and capacity to scale up these ideas.

3. What is the geographic dispersion of housing and related programs and expenditures?

The federal resources needed for affordable accessible housing are not sufficient to meet the needs in most, if not all, communities. Most entitlement funding is based on formulas designed to reflect need on a per capita basis rather than relative need.

The States with the largest estimated number of noninstitutionalized people with disabilities are California (4,279,000 people), Texas (3,050,000), Florida (2,610,000), New York (2,533,000), and Pennsylvania (1,865,000). These same States have the largest number of renters with mobility impairments and housing problems in the United States, and also the largest share of HOME and Community Development Block Grant dollars annually. In comparison, Puerto Rico has the highest disability prevalence rate at 27 percent of its population (963,000 people), followed by West Virginia (24%), Kentucky (21%), Arkansas (21%), and Mississippi (21%).

Funding for subsidized housing units for people with disabilities—both public housing and multifamily housing—is not subject to formula but instead comes from direct grants and loans from the Federal Government. Looking across the States, we find the following:

- New York—and particularly New York City—has long had the largest share of public housing (205,000 units) in the United States, with four times the number

of units than in Pennsylvania (52,000), which is the next largest supplier. Furthermore, New York has the most public housing for people with disabilities, elderly people (ages 62 and older), and families, and the largest supply of federally funded multifamily housing (108,000 units), though only second and third, respectively, for units designated for people with disabilities and designated units for the elderly. The State ranks lower for Housing Choice Vouchers.

- California, while home to nearly twice as many people with disabilities as New York, has relatively little public housing (less than 40,000 units). Instead, the State has the largest number of Housing Choice Vouchers (290,000), with 78,000 being used by people with disabilities, 28,000 by elderly households, and 55,000 by households that are both elderly and with disabilities. California also has the largest number of federally subsidized multifamily housing units designated for elderly (39,000) and for people with disabilities (5,000).
- States that rank consistently in the top 10 across all categories of housing based on the number of units developed include Illinois, Ohio, Pennsylvania, and Texas.
- States ranking consistently in the bottom 10 across all categories of housing, based on the number of units, are Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming, along with the District of Columbia.

4. What barriers and gaps prevent people with disabilities from attaining accessible and affordable housing?

Creating and sustaining safe, accessible, affordable, and integrated housing continues to involve challenging and complex barriers that arise from the interaction of poverty, inaccessibility, funding rules related to acquiring supportive services, and a disability policy system rooted in the outmoded model of segregating people with disabilities from the community mainstream.

Affordability is a key challenge. For prospective buyers this includes securing financing, which is even more daunting with tighter rules guiding both conventional lending and affordable homebuyer programs. The single greatest barrier to rental housing in the private market may be the combination of too little subsidized housing and inadequate funding for Housing Choice Vouchers to close the gap between very low incomes and rental costs. Even if affordable, most market-rate housing lacks basic accessibility features. Some private building industry groups oppose additional mandatory accessibility requirements for new home construction, and bureaucratic complexities tied to funding supportive services add additional challenges and layers of difficulty.

A key challenge to putting housing and community services together is the difference between systems and funding mechanisms, their differing groundings and philosophies, and the complexity of housing and community living choice at the legislative and policy levels. States face several challenges when trying to create “real choice” in accessing affordable, accessible, and integrated housing. This includes differences in:

- Definitions related to housing and community living/integration, which make it hard to show need, coordinate services, and compare across States.
- Qualification and eligibility criteria, which are set by funding sources that often use different thresholds to determine initial and continuing eligibility (e.g., HUD uses median income in relation to national poverty and income thresholds, while Medicaid uses income/asset thresholds determined by individual State statute).
- System funding levels and disparities related to funding of housing and community living supports, as well as disparities between different disability and aging constituencies in accessing this funding.
- Information access, quality, and coordination, especially for people with disabilities who may be trying to access information during times of housing or health crises or emergencies, or from within settings where information access is difficult, unavailable, or withheld.

- Coordinated, consumer-directed system delivery, especially across housing and community services, but even within each.
- Monitoring and enforcement across systems.

5. What means are available to people with disabilities to enhance their capacity to choose and sustain accessible and affordable housing?

Potential best practices and models that respond to current barriers almost always involve public policy that supports (or can be interpreted to support) a particular solution, multiple public and private funding sources, local ingenuity and community commitment, and, in some situations, the courts. We do see "promising practices" that have been or are being implemented by and within States in the areas of systems change, information access, legislation, monitoring and enforcement, and research related to housing and community living. These include:

Systems Change and Coordination

One of the most promising trends has been the increasing cross-coordination of housing with community living and support systems, funding, and service delivery. Referred to as Single Access Points, One Stop Shop, No Wrong Door, and Comprehensive Entry Point, these systems enable consumers to enter through many different "doors" in order to receive coordinated housing and community living supports and services. Many of these initiatives, which often require new policies to enable coordinated service delivery, are based on a Money Follows the Person (MFP) framework to offer cross system, consumer-directed choice.

Cross-System Navigation

Several of these systems change initiatives have formally incorporated coordination with regional Aging and Disability Resource Centers, Area Agencies on Aging, and Centers for Independent Living (CILs) to provide information, case management, peer mentoring, legal assistance, and connection to related community living, transportation, social participation, and employment opportunities. Several States are using CILs and

peer mentors to support consumers in navigating complex housing and community living systems and programs. Coordination also involves continuous education of staff across systems and delivery programs.

Promoting Integrated and Least Restrictive Choice

Several States have targeted initiatives to create and expand integrated housing choices. For example, Washington is using federal demonstration grant funding to collaborate with local housing authorities throughout the State to develop more integrated and less restrictive (four or fewer beds/units) community living choice models. Oregon continues to expand community housing in small neighborhood homes, and is also developing individual apartment housing in which consumers can share support services with other consumers with developmental disabilities. Virginia is working to revise legislation and policies to enable people with developmental disabilities to share an apartment or single-family home with supports.

Increasing Information Access with Housing Locator Systems

A number of States have developed housing locator systems that allow online searches of affordable housing units. These systems range from minimal databases of State-financed developments to more sophisticated Web sites with multiple search options, detailed accessibility information, updated vacancy and occupancy status, and links to local service agencies and resources. Some States, such as Louisiana, have incorporated housing locators into housing developer contracts to make it easier for individuals to identify available housing options and to improve marketing of affordable and accessible units to consumers.

Legislative Promising Practices

As a result of disability advocacy, some States have enacted legislation to rebalance Medicaid monies toward community-based options. For example, Texas Rider 37 enables the Texas Department of Human Services to allow money to follow the person from a nursing facility to the community, enabling the transfer of funds from nursing home appropriations. As of 2007, an estimated 13,300 people transitioned from nursing

homes to the community via this initiative. Passed in 1996, Vermont Act 160 allows funds appropriated for nursing home care to be used for extensive home- and community-based services, and created a statewide system of Long-Term Care Community Coalitions to action plan methods to improve the infrastructure for Medicaid waiver and the long-term services and supports programs.

6. What practices exist that improve the housing status of people with disabilities?

In addition to the promising practices above, specific examples of effective housing solutions exist; however, they generally are not yet sufficiently scaled to meet the need. At a minimum, long-range solutions must include comprehensive changes in public policy. Such changes include substantially increasing funding for housing vouchers, creation of incentives for inclusion of housing units for very low income people with disabilities in all federal and State programs that support housing development and construction, and adoption of accessibility standards and universal design principles for all home construction by States, counties, and cities, as well as by the building and housing construction industry.

Although serious problems remain, some notable successes suggest that momentum is building for broader reforms. For example, the movement for housing to be constructed according either to universal design or visitability principles appears to be gaining currency. Designers, architects, and homebuyers are growing increasingly interested in these principles. Thirty-seven cities across the nation have adopted either mandatory or voluntary policies that are beginning to generate results: because of such policies, roughly 30,000 homes have been constructed with some level of accessibility. These advances are serving as models for other locales, demonstrating that accessibility and visitability can be achieved without undue cost or administrative burden.

For-profit and nonprofit developers are creating exemplary models of scattered, affordable, accessible mixed-income and mixed-use housing that set the bar for what can be accomplished. Other housing models are evolving that hold promise for people

with disabilities, including Naturally Occurring Retirement Communities (NORCs) and Limited-Equity Cooperatives (LECs). Supportive living programs ensure that people with disabilities receive the help they want and need to live as independently as possible in their own homes. The evolution of these programs nationwide has helped significantly reduce the number of people who are forced to live in restrictive institutions. Much remains to be done, but these and other areas of progress reveal that an important shift is taking place that eventually will lead to an increase in and improvement of housing and supportive services options for people with disabilities.

7. What lessons have been learned from national emergencies, such as Hurricane Katrina, regarding the provision of accessible and affordable housing in the wake of national disasters and emergencies?

1. **Hurricane Katrina revealed stark gaps in emergency housing for people with disabilities.** Progress toward closing these gaps has come from community and organizational initiatives and post-Katrina legislation that have led to the creation of guidance and planning materials. To this end, several promising and best practices are emerging that follow three principles:

2. **Forethought and planning for disabilities and special needs should serve as the main strategy.** This begins by taking a functional approach to special needs, which centers on communication, medical needs, independence, supervision, and transportation (C-MIST model). This approach is now supported through various guidance and planning materials, including the U.S. Department of Justice *Guidance for Emergency Shelters*: *ADA Best Practices Toolkit for State and Local Governments,* and the Federal Emergency Management Agency (FEMA) *Comprehensive Planning Guide*.

3. **Include and actively involve people with disabilities, disability organizations, and advocates to help planners and those involved in all aspects of emergency housing identify problems and address solutions.** In January 2009, FEMA approved a National Disaster Housing Strategy, which includes sections specifically on building partnerships to assist in the

evaluation and identification of special needs. At a formal level, FEMA's National Advisory Council has recommended the creation of Regional Disability Coordinator positions for each of the 10 FEMA regional offices to serve as liaisons between State and federal levels and to increase personnel available to coordinate and support outreach to victims with special needs.

4. **Ensure sufficient resources to support initiatives, including relocation and rebuilding.** Internet-based search tools provide a resource for both individuals and case managers to search for suitable emergency housing. Also, HUD has developed programs to help people relocate relatively easily to other communities while maintaining their housing assistance. For homeowners, the Mortgage and Rental Assistance Act of 2007 can help low- and moderate-income families keep their homes after a disaster. An example for rebuilding, Louisiana plans to create 3,000 new supportive housing units for people with disabilities using multiple sources of funding.

Introduction

> Communities in the United States are faced with increasingly difficult choices and decisions about how to grow, plan for change, and improve the quality of life for all citizens including children, youth, and adults with disabilities…we believe that for the promise of full integration into the community to become a reality, people with disabilities need: safe and affordable housing, access to transportation, access to the political process, and the right to enjoy whatever services, programs, and activities are offered to all members of the community by both public and private entities.[1]

This report looks at the state of housing for people with disabilities in America in the 21st century. It has three objectives: (1) to evaluate public laws, policies, and program initiatives affecting the housing opportunities available to Americans with disabilities and others who have accessible housing needs for whatever reason, whether due to aging or a temporary disability; (2) to analyze what housing, supports, and other benefits are available through the public, nonprofit, and/or private sectors; and (3) to provide recommendations that can improve housing opportunities for people with disabilities in the United States.

The first objective aims to produce information that can help stakeholders better understand the formal parameters—e.g., regulations, program guidelines, income restrictions, funding limits—that shape what housing exists now and is likely to be produced in the future for people with disabilities. This includes type, tenure, scale, design, features, and location, which are all important aspects for any person when searching for housing, but even more critical when considering the wide-ranging needs of people with disabilities. The second objective aims to take stock of what housing for people with disabilities is already being provided by the public and private sectors. The third objective provides evidence-based guidance for making improvement in existing systems, as well as considering new ideas for legislation, policy, and practice.

The research builds on previous NCD reports on livable communities, including *Livable Communities for Adults with Disabilities* (2006) and *Inclusive Livable Communities for People with Psychiatric Disabilities* (2008). A livable community is one that:

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

Affordable, accessible, and appropriate housing is critical and integral to making a community more livable for people with disabilities; without it or when it is insufficient relative to need, the benefits of the other five elements are diminished and made less accessible. To this end, the degree to which any community has an adequate supply of affordable, accessible, and appropriate housing depends on a complex mix of federal, State, and local policies and practices that bring the public and private sectors together to facilitate development by both nonprofit and for-profit housing producers, and to provide services that respond to and reflect needs relative to housing. To better understand how these different entities work—or do not work—together, five specific research briefs were completed:

- **NCD Topical Brief #1:** “Federal Evaluation.” A comprehensive evaluative study of public sector housing.
- **NCD Topical Brief #2:** “Private and Nonprofit Sector Housing.” Promising practices in the nonprofit and private sector.
- **NCD Topical Brief #3:** “Mental Health Issues—Housing for People with Psychiatric Disabilities.” An evaluation of housing issues related to people with psychiatric disabilities.
- **NCD Topical Brief #4:** “Homeland Security and Emergency Housing Evaluation.” An evaluation of housing and disaster relief, especially provisions for mortgage, rental, and temporary housing assistance.

- **NCD Topical Brief #5:** "State Evaluation." An examination of States' development of affordable, available, accessible, and integrated community housing options for people with disabilities.

The potential uses and benefits of all this research are many. At a minimum, assembling in one place the basic information about the current supply of housing for people with disabilities helps policymakers see what is and is not available across the entire scope of programs and sources. Unfortunately, this report also reveals how limited and uneven the data is that is currently available. In general, we know some things about public sector housing, such as the basic demographics of residents, including "disability status," but do not have any information about the accessibility of housing or if the unit is appropriate for the resident.[2] From the private sector, we have no information on the accessibility features of unsubsidized units or developments for the simple reason that there is no requirement to report it to a public agency. Although this is changing with the growth of Internet-based data clearinghouses and housing locator systems that include information for people with disabilities, this data has its own limits and challenges, as most is self-reported, unverified, and not subject to compliance verification.[3]

Still, with the data available now, we know that there is unmet housing need based solely on standard measures of housing affordability. For the most part, this reflects a real shortage of affordable, appropriate, and accessible housing. However, the analysis also reveals a gap between current policy goals and outcomes—even with laws in place requiring a portion of units to be accessible, some developers and property owners do not comply. Whether noncompliance is due to ignorance or intent, evidence suggests we have missed opportunities to increase the supply of accessible affordable housing.

Compounding matters is the lack of consistent compliance oversight and enforcement.

The gap between need and supply is further exacerbated because not all federally subsidized accessible units are available to all segments of the disability population. For example, a majority of the accessible housing developed through different federal

programs is age restricted (i.e., “seniors” or “elderly” only). As a result, thousands of affordable and accessible housing units built with public monies are not available to people with disabilities under the age of 62. Furthermore, most accessible housing that is built for people with disabilities is segregated by design and not integrated into communities.

Policymakers and others need to keep in mind that the ability to accurately assess current and future fit between housing supply and need requires accurate and complete information—an especially salient concern given the cost of housing production and the time it takes to develop. The findings and recommendations contained in this document are grounded in data and research gathered from federal agencies, either directly or via published reports, and from research completed by academics and disability advocates. This report also provides evidence of what can be effective in meeting the range of housing needs among a diverse group of consumers with disabilities. This includes best and promising practices drawn from real examples, and lessons learned from experts working on housing issues and policy.[4] In reviewing best and promising practices, data was triangulated from different sources—interviews, published reports, and Internet research—to assure a comprehensive assessment. To this end, the research has been reviewed and commented on by a diverse panel of experts and consumer groups that have all provided valuable insights and guidance.

Chapter 1 highlights housing needs among people with disabilities. Chapter 2 outlines what is currently available to people with disabilities through various federal housing programs and provides a profile of people using these programs. Chapter 3 provides an overview of the distribution of need across the States relative to the distribution of units produced by key federal housing programs. Chapter 4 discusses opportunities, gaps, and barriers created by existing policies and practices that limit the ability to produce integrated, affordable, and accessible housing, and it describes promising practices from different States that are currently surmounting these barriers. Chapter 5 provides promising practice examples from private and nonprofit efforts to improve choice and access to affordable, accessible, and integrated housing. Chapter 6 outlines lessons

learned about the provision of accessible and affordable housing in the wake of national disasters and emergencies. Chapter 7 provides recommendations aimed at improving federal and State efforts to provide integrated, accessible, and affordable housing for people with disabilities.

CHAPTER 1. **Housing Need**

This section summarizes key national data to illustrate housing needs among people with disabilities. We begin with a general profile of individuals with disabilities and a comparison of households with and without someone with a disability to illustrate common issues and differences among housing needs, followed by specific data on need for affordable, accessible, and appropriate housing.

Recent federal research estimates that 54.4 million people with disabilities live in the civilian population in the United States, representing approximately 19 percent of the noninstitutionalized population.[5] At all ages, women (24%) have a higher prevalence of disability when compared with men (19%). For all, the prevalence of disability increases with age, from 11 percent for people 18 to 44 years of age to 52 percent for people 65 years and older.[6]

An estimated 11 million people 6 years and older need personal assistance with activities of daily living (ADLs) such as bathing, eating, dressing, or getting around inside the home, or with instrumental activities of daily living (IADLs), which include household chores, doing necessary business, shopping, or getting around for other purposes.[7] Approximately 35 million people 15 years and older have a severe disability.[8] The number and percentage of people with a severe disability increases with age so that of those 65 and older with a disability, 37 percent had a severe disability. In addition to needing appropriate medical and public health services, this segment of people with disabilities is likely to need personal assistance as well as specific accessibility features within the home and in the community.

National housing survey estimates suggest that about 35.1 million households have one or more person with a disability, which is about 32 percent of the households in the United States in 2007.[9] These households are:[10]

- Small in size with about three-fourths of households in one- and two-person households.

- More likely to headed by someone age 65 or older (60% of households with a disability are in this age group; in comparison, only 2% of households without a disability are age 65 or older).
- More likely to be low income (65% compared to 36% of households without a disability).
- Nearly 2.5 times more likely to be extremely low income—earning less than 30 percent of the median, which is near the national poverty level (25% compared to 10% of households without a disability).
- More likely to be paying more than 30 percent of income for housing costs (40% compared to 32% of households without a disability).
- More likely to receive some form of government assistance with rent (9% compared to 2% for households without a disability).
- Less likely to live in a central city (26%) or suburb (30%) and more likely to live in a rural area outside a metropolitan area (20%) than a household without a disability.
- More likely to live in manufactured housing (8% compared to 5% of households without a disability).
- More likely to live in a building with a no-step entrance (45%) and in an apartment on the same floor as the building entrance (38% compared with 34% of households without a disability).
- More likely to live in a building/development that offers “impersonal” services (such as meals, transportation, housekeeping, financial management, telephone aid, and shopping) and personal services (assistance with bathing, eating, moving about, dressing, and toilet use).

Also important to note is that among people below the age of 65, people with disabilities are more likely than people without disabilities to rent their home (37% compared to 31%). However, nearly 15.1 million households with people with a disability between 65 and 85 years old own their own home. This means that among homeowners in this age

bracket, nearly 94 percent have a disability.[11] Such high levels of ownership among this age group are likely due to the fact that many purchased their homes before acquiring a disability as they aged. Many of these homeowners are likely to face challenges if they want to remain independent in a home that often is not accommodating and may be costly to maintain.

Finally, the data above does not include about 2.17 million people living in nursing homes or group homes.[12] About 1.6 million live in nursing homes, including an estimated 125,000 people ages 22 to 64 with severe mental illness—a 41 percent increase since 2002.[13] Estimates of people with a disability usually do not include this population because people in "group quarters" (i.e., nursing homes and group homes) are excluded from most federal reports on housing need. If current rates of growth continue without the development of new alternatives that allow people to remain in homes in their communities as they age, it is expected that there will be 3 million nursing home residents by 2030.[14]

Affordability

Poverty and low-income status of people with disabilities are key barriers to acquiring housing. The median monthly income earnings in 2005 for people with no disability ($2,539) were significantly higher than for people with severe disabilities ($1,458). While people with nonsevere disabilities did better, their monthly median income was still lower ($2,250). Poverty is much higher among people ages 25 to 64 with severe disabilities (27%) when compared to people in the same age group with nonsevere disabilities (12%) and no disability (9%). For many, this is due to being unemployed. In 2005, less than half (46%) of the population with a disability ages 21 to 64 was employed. In comparison, 84 percent of people in this age group who did not have a disability were employed.

Since the 1970s, policymakers and housing researchers have come to understand housing need based on assumptions about precisely how much consumers should pay for housing. Current federal guidelines fix the relationship between income and housing

cost at 30 percent. That is, housing is affordable if it costs a household no more than 30 percent of its income. For renters, this includes monthly contract rent plus utilities. For owners, cost includes monthly mortgage payments, insurance, utilities, and taxes. For both, and regardless of income level, housing is not affordable if a household uses more than 30 percent of its income for it. There is a need for affordable housing when there are fewer units than people can afford to pay according to this threshold.

Obvious evidence of need for affordable housing is homelessness. The most recent data from HUD suggests that at a minimum, 43 percent of homeless adults (about 421,246 people) who stayed in a shelter have a self-reported disability.[15] Missing from this account is the number of homeless children with disabilities and all people with disabilities not in a shelter that are literally homeless living on the streets, in abandoned buildings, or elsewhere not intended for human habitation.

Another indicator of need for affordable housing is people at risk of becoming homeless because they live in precarious housing situations. This can include low-income people who are "cost burdened" (i.e., paying more than 30% of income for housing) and whose need is considered "worst-case." HUD defines households with worst-case needs as "Unassisted renters with very low incomes who have one of two 'priority problems' either paying more than half of their income for housing ('severe rent burden') or living in severely substandard housing."[16]

A recent report determined that nearly 6 million households in the United States have worst-case housing needs. Of this total, between 1.3 million and 1.4 million are "nonelderly" (below 62 years of age) renter households with people with disabilities.[17] In addition, nearly 1 million worst-case need families with children include nonelderly adults with disabilities.[18] This means that as many as 2.4 million very low income households with disabilities may be worst-case—a rate of between 35 and 40 percent of the overall worst-case housing need in the United States. In addition, another million "elderly" households (ages 62 and above) were also found to be worst-case need, which is likely to include people with disabilities.[19]

The fastest-growing segment of need appears to be in rural areas.[20] Less is known about the need for accessible housing in these areas, though data from the 2007 American Housing Survey suggests that about 7 million households had at least one person with a disability in rural nonmetropolitan areas in the United States. Of this total, about 2.5 million are extremely low income but only about 10 percent are claiming any form of rental assistance from the government.[21]

A trend likely to be contributing to this problem is the continued increase in housing need among low-income people with disabilities living on Supplemental Security Income (SSI). According to *Priced Out in 2008*, a single person in the United States has an income that is five times greater than that of a person receiving SSI assistance, which on average is $668 a month.[22] With such a low income, a person on SSI has limited housing options. No State in the United States has an average-priced one-bedroom or studio apartment that would be affordable to someone on SSI. In fact, the average rental payment in the United States for a studio would require spending 100 percent of the monthly SSI payment and renting the average one-bedroom unit would require 112 percent of a monthly SSI payment. As a result, most of the 4.2 million people receiving SSI cannot afford housing in their community unless they receive some form of housing subsidy.

For people with disabilities who work, the challenge is finding work that pays a sufficient wage to afford housing. The National Low Income Housing Coalition (NLIHC) examines housing costs annually to estimate the "housing wage" needed to afford housing, assuming a household pays no more than 30 percent of its income for monthly rent. NLIHC uses HUD's Fair Market Rent, which is adjusted annually and by location to reflect regional variations. Nationally, a single person or household with one worker would need to earn at least $14.97 per hour (based on a 40-hour work week, working 50 weeks a year) to be able to afford the average rent for a one-bedroom rental unit.[23] This wage varies widely across the country, with a high of $24.15 per hour needed to afford to live in Hawaii and a low of $8.38 in North Dakota, which is still above the current national minimum wage of $7.25 an hour.[24]

Accessibility

Many people with disabilities are able to live independently, although current research suggests that a growing number are unable to find appropriate housing to meet their needs relative to their disability. Reasons include housing location, quality, physical accessibility, affordability, and an unmet need for supportive services that some individuals require in order to live independently in the community.

Based on the most recent national data available, thousands of people with disabilities need basic home modifications to make their homes accessible.[25] The greatest need was for grab bars or handrails (an estimated 788,000 households) that, relatively speaking, are not expensive to install. In addition, many people needed basic features that make units "visitable," including ramps to access the building or home (612,000 households), elevator or lifts to access the unit once in the building (309,000 households), widened doorways and halls in the unit (297,000 households), and accessible bathrooms (566,000). As might be expected, renters had proportionally greater unmet need for all features when compared to homeowners.

In addition to modifications to make the physical environment more accessible, there is a need to consider the overall built environment, given the growing number of people affected by environmental exposures—a physical condition that is triggered by the environment.[26] Symptoms include neurological, respiratory, muscular, cardiovascular, and/or gastrointestinal problems. Known triggers include the following:

- **Pesticides:** weed killers, bug sprays, treated wood products
- **Solvents:** paints, glues, gasoline, nail polish/remover
- **Indoor air Volatile Organic Compounds**: new carpet, formaldehyde, plasticizers, chlorine, fragrances and fragranced products
- **Cleaners:** bleach, ammonia, phenolic disinfectants, air fresheners
- **Combustion-related:** auto and diesel exhaust, tobacco smoke, natural gas, tar/asphalt

- **Drugs/medical devices:** anesthetics, antibiotics, implants, vaccines
- **Electrical devices:** microwaves, transformers, high-tension wires, fluorescent lighting, cell towers, cell phones

These triggers can be in the housing unit, elsewhere in the building if a multifamily unit, and/or outside it in the immediate community as well as in locations the person needs to or would like to visit in daily life. While some of these products are used in development of housing (and buildings in general), many are introduced by people through the care and maintenance of buildings as well as by people being in the building (e.g., someone wearing perfume). Current estimates suggest that 11 percent of the population has some sort of chemical sensitivity.[27] For people with environmental sensitivities, accessible housing must be free of these environmental triggers. However, unless the housing is universally designed to accommodate all the different sensitivities, for some it is better to live in segregated housing that assures control over potential exposures.

Assistance is another means to accommodate and/or remove environmental barriers in and around a home. Many people with disabilities need help with certain activities of daily living to make their housing accessible.[28] Using this "functional" definition of disability, current estimates of the population in need of accessible housing and communities who are under age 65 range from between 3.5 million to 10 million.[29] This population will grow as the population of aging baby boomers soon reaches an age where housing accessibility and livable communities will become one of their highest priorities. People with disabilities also are living longer and their housing and supportive requirements are changing; such trends directly affect these individuals' community living options. The population of people over age 65 is expected to double by 2030. Currently, 20 percent of people ages 65 and over require assistance with at least one activity of daily living. This number is expected to increase to 50 percent by age 85. Over the next 30 years, disability rates for people 85 years and older are expected to rise as this population triples.[30]

For people with psychiatric disabilities, accessible housing is a relatively recent public policy concern that focuses on promoting integrated rather than segregated community living. Before the 1960s people diagnosed with serious mental illness were considered incapable of living outside institutions. The development of psychotropic medications, a desire to save public funds, and growing concern about conditions in institutions led to a nationwide movement to deinstitutionalize hospital residents. As a result, the number of people diagnosed with mental illness living in public institutions dropped from 559,000 in 1956 to 154,000 people in 1980.[31] People released from mental institutions were supposed to receive treatment and support services in the community, but the promise of community-based treatment proved illusory, and the lack of support services coupled with the dearth of affordable housing swelled the ranks of people with mental illness living without shelter.

The need for community-based housing for people with psychiatric disabilities sparked the development of a new type of institution called the board and care home.[32] Board and care homes, which provide food and 24-hour supervision to residents, range in size from 2 to more than 200 residents. The majority house more than 50 people. Currently, approximately 330,000 people with psychiatric disabilities live in board and care homes. Board and care homes were not designed to lead to recovery—they simply filled the housing gap created by deinstitutionalization. Today, most board and care homes function as mini-institutions within the community. They provide very little privacy, a limited scope of services, and little opportunity to interact with people without disabilities in the community. In most homes residents have no opportunity to exercise choice in their day to day lives over roommates, meals, bedtimes, or other daily functions. Virtually all resident income goes directly to the home, making it impossible for residents to save sufficient funds to consider moving to private housing.[33] Also, there is little oversight and most homes are unlicensed, and as a result, there have been multiple press stories about abusive conditions in board and care homes.[34] Finally, few board and care homes help residents develop independent living skills or move on to independent housing.[35]

NCD's 2008 report, *Livable Communities for People with Psychiatric Disabilities*, underscores the need for new and more options beyond this form of congregate living.[36] While "different perspectives exist" on which is the best housing approach, consumers when given the choice are likely to choose independent, integrated living over some form of congregate arrangement. This also aligns with national surveys that consistently report that 80 to 95 percent of people with disabilities and seniors strongly prefer to remain in their own homes,[37] and report higher quality of life when they are able to remain in the community.[38] However, data also illustrate how community living is a constant fight to manage housing, finances, and transportation, all survival issues that directly affect people's choice, and potentially their health and participation.[39] Problems worsen when people do not have information to make informed decisions about least restrictive living.[40] People with disabilities need information they can use to become informed on their choices, as do policymakers and other stakeholders that can help expand choice. As the next section illustrates, information on housing options is currently quite limited in the United States.

CHAPTER 2. **Federally Subsidized Housing**

The three main sources of federal funding that either target or benefit people with disabilities are (1) U.S. Department of Housing and Urban Development (HUD), (2) U.S. Department of Agriculture (USDA) rural housing, and (3) the Low Income Housing Tax Credit (LIHTC) via the Internal Revenue Service. In addition, the Department of Veterans Affairs offers a number of housing programs that help veterans with mental and physical disabilities, some in conjunction with HUD and others with State agencies.

All housing built with federal funds and housing programs receiving federal funds are subject to the requirements of the 1973 Rehabilitation Act (Section 504), which provides for nondiscrimination in all programs, services, and activities receiving federal financial assistance; and in programs, services and activities conducted by executive agencies. Section 504 regulations require 5 percent but not less than one dwelling unit to be accessible to people with mobility disabilities, and at least 2 percent but not less than one dwelling unit to be accessible for people with visual and hearing disabilities. Section 504 regulations require compliance with the Uniform Federal Accessibility Standards (UFAS), published in 1984 by HUD and three other federal agencies to provide uniform standards for the design, construction, and alteration of buildings in accordance with the Architectural Barriers Act (ABA), 42 U.S.C. 4151–4157. The ABA applies to buildings and facilities designed, constructed, altered, or leased with federal construction monies.[41] While ABA covers only the facilities, Section 504 also covers programs, services, and activities, which must be accessible to people with disabilities.

Federal housing is also subject to American with Disabilities Act (ADA) Title II regarding public access and Title III regarding places of public accommodation in private multifamily property. Finally, all housing is subject to State and local regulations, including zoning and building codes.[42]

In addition, with few exceptions and regardless of funding source, all multifamily housing with four or more units in a single structure built after March 13, 1991, is subject to the design and construction requirements of the Fair Housing Act (1988). However,

the law does not ensure that the majority of rental units will be accessible to people with disabilities, since more than 85 percent of the rental housing in the United States was built before 1991.[43] For these units, there is the expectation that reasonable accommodations can be made to meet different accessibility needs of people with disabilities. This was recently reinforced through a jointly issued statement from HUD and the Department of Justice (DOJ) on June 17, 2004, which reminded that:

> One type of disability discrimination prohibited by the [Fair Housing] Act is the refusal to make reasonable accommodations in rules, policies, practices, or services when such accommodations may be necessary to afford a person with a disability the equal opportunity to use and enjoy a dwelling [42 U.S.C. § 3604(f)(3)(B)]. HUD and DOJ frequently respond to complaints alleging that housing providers have violated the Act by refusing reasonable accommodations to persons with disabilities.[44]

The statement aims to help housing providers better understand the rights of people with disabilities and the obligations of housing providers under the act. While determining what is a reasonable accommodation is dependent on the individual with the disability, the statement provides some examples that are likely common accommodation requests, including assigning a parking space close to an entrance for a person with a mobility limitation, allowing different means for paying rent (e.g., via mail instead of in person), and waiving "no pet" policies to allow assistance animals in the unit. Also, the statement reminds that housing providers cannot charge a fee for providing a reasonable accommodation.

Of course, people with disabilities need to first find housing in the market before they can seek accommodations. A recent study of the Chicago metropolitan area, *Discrimination Against Persons with Disabilities: Barriers at Every Step*, completed for HUD provides evidence that discrimination based on disability still occurs.[45] As part of a larger nationwide study, the Chicago area served as a pilot study, which focused on the treatment of people who are deaf using the TTY system—a device that allows individuals to make and receive text phone calls—to inquire about advertised rental housing and the treatment of people using wheelchairs visiting rental properties to inquire about available units. The findings indicate that "adverse treatment against

people with disabilities occurs even more often than adverse treatment of African Americans or Hispanic renters in the Chicago-area market."[46] This was evident in the lower rates of service, information provided, and units available, and in higher denial rates when requesting opportunity to inspect units for home seekers with a disability than for comparable home seekers without disabilities.[47]

Compounding the problem of discrimination, HUD continues to be behind in handling fair housing complaints, the majority of which are filed by people with disabilities.[48] Assuming someone knows if he or she has been discriminated against—which may not always be the case—a fair housing complaint can be filed up to 1 year after the alleged discrimination (180 days if filing under 504). Once filed, HUD is expected to take action. Currently, HUD outlines the process on its Web site.[49] Up front, HUD states it will "notify you if it cannot complete an investigation within 100 days of receiving your complaint" and then: "If, after investigating your complaint, HUD finds reasonable cause to believe that discrimination occurred, it will inform you. Your case will be heard in an administrative hearing within 120 days, unless you or the respondent wants the case to be heard in Federal district court."[50]

While the speed of the process is subject to many factors, including the cooperation of the person filing the complaint, there is concern that despite these commitments to timeliness, people with disabilities wait a very long time for resolution. A 2001 National Council on Disability report revealed that cases were open on average nearly 500 days in 2000. Based on a recent review by the National Fair Housing Alliance (NFHA), things do not appear to have changed all that much. NFHA found in its review of cases in which a charge was issued between January 2004 and October 21, 2008, that "the average age of cases in which a determination of reasonable cause was made and a charge issued was 502 days. The shortest time period between filing the complaint and the issuance of a charge was 143 days, while the longest was 1,254 days."[51]

U.S. Department of Housing and Urban Development

The U.S. Department of Housing and Urban Development (HUD) is the primary federal agency responsible for affordable housing programs. HUD administers all funding for public housing and Tenant-Based Rental Assistance programs, which are then implemented by the 3,300 Public Housing Agencies (PHAs) across the country. HUD also administers two competitive programs in which developers apply directly to HUD: Section 202 housing for "elderly" (ages 62 years and older) and Section 811 housing for people with disabilities. HUD also has oversight responsibility for a portfolio of developments created through now-inactive programs (project-based Section 8, Section 236 Interest Reduction program). Finally, HUD administers several formula-based grant programs under which funds are allocated to local agencies that are given fairly broad discretion on spending on housing. This includes the HOME program, Community Development Block Grant (CDBG), and the Continuum of Care (Homeless) program that produces permanent and transitional housing as well as emergency shelters for homeless people, including people with disabilities and with AIDS/HIV. HUD is also responsible for approving all Consolidated Plans (State and local) that establish specific priorities for allocating federal funds for housing and community development.[52]

Eligibility for HUD housing programs is determined by income limits using annual "family" Area Median Income (AMI), which is adjusted for family size.[53] HUD further distinguishes "extremely low income" households (income below 30% of AMI), "very low income" (income below 50% of AMI), and "low-income" (income below 80% of AMI). Table 1 below illustrates the variation in median income and the income limits associated with each HUD income category based on a family of four, which is the standard usually cited when public officials talk about median income. In this sample of 11 cities, the median income ranges from a high of $102,700 in Washington, D.C., to a low of $61,100 in Houston, Texas. Using HUD's calculations, an extremely low income family in Washington, D.C., has an annual income of no more than $30,800, while in Houston it would be $18,350. However, since many people with disabilities live alone, it is important to see how these income categories vary depending on family size. For example, in Washington, D.C., a one-person household would be extremely low income

Table 1. HUD Income Limits for a Four-Person Family in Selected Cities, FY 2009[55]

	Extremely low income 30% of median	Very low income 50% of median	Low-income 80% of median	Median
New York City	$23,050	$38,400	$61,450	$61,600
Los Angeles	23,800	39,650	63,450	62,100
Chicago	22,600	37,700	60,300	74,900
Houston	18,350	30,550	48,900	61,100
Philadelphia	23,350	38,900	62,250	77,800
Phoenix	19,750	32,950	52,700	65,900
Jacksonville	19,550	32,550	52,100	65,100
Washington, D.C.	30,800	51,350	64,000	102,700
Denver	22,800	38,000	60,800	76,000
Atlanta	21,500	35,850	57,350	71,700
Seattle	25,300	42,150	64,000	84,300

earning $21,550 annually, while an eight-person family would go up to $40,650. In Houston, the range would be from $13,400 to $25,300.[54]

Beyond income, HUD also identifies tenants as one of the following: elderly family, disabled family, or both elderly and disabled.

A **disabled family**, according to HUD, means a family whose head, spouse, or sole member is a person with a disability. It may include two or more people with disabilities living together, or one or more people with disabilities living with one or more live-in aides. By definition, a family with a child with a disability but no other adult with one is not a disabled family. HUD uses several means to determine disability status for purposes of qualifying for housing: Section 223 of the Social Security Act (42 U.S.C. 423), Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001[5]), or

> determined by HUD regulations to have a physical, mental or emotional impairment that: a) is expected to be of long, continued, and indefinite duration;

> b) substantially impedes his or her ability to live independently; and c) is of such a nature that such ability could be improved by more suitable housing conditions….The definition of a person with disabilities does not exclude persons who have the disease acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome (HIV). However, for the purpose of qualifying for low income housing, the definition does not include a person whose disability is based solely on any drug or alcohol dependence. (Note: The definition of a person with disabilities as defined in 24 CFR 8.3 must be used for purposes of reasonable accommodations and program accessibility for persons with disabilities.)[56]

Elderly family means a family whose head, spouse, or sole member is 62 years of age or older. The term *family* includes a single elderly person, two or more elderly people living together, and one or more elderly people living with one or more people who are determined to be essential to the care or well-being of the elderly person(s). An elderly family may include people with disabilities and other family members who are not elderly. To be classified as both elderly and disabled, the head, spouse, or sole member must be a person with a disability and 62 years of age or older.

HUD organizes its many housing programs into three broad categories: public housing, privately owned subsidized multifamily housing, and Housing Choice Vouchers (tenant-based housing assistance). We also include a fourth category: formula-based grant programs.

Public Housing

Most public housing was built between 1937 and the mid-1980s to provide low-income families affordable housing. Depending on the time period, public housing may be low-rise townhouses, mid-rise multifamily developments, or high-rise apartment buildings. Potential tenants have to be qualified based on their income, which cannot exceed the low-income limit for their area and family size; however, this does not guarantee that a household will be able to lease a unit, since this depends on availability. In many larger urban areas, applicants are on waiting lists for many years. Often PHAs open up waiting lists only periodically (e.g., every few years) and fill up after being open for only a short time. PHAs can set “local preferences” to move a household with greater housing needs

up on the waiting the list as long as these preferences are approved by HUD. This can include people with disabilities.

Once in a unit, tenants are required to pay either a minimum of $50 or 30 percent of income (as determined by HUD's eligibility criteria) for rent, depending on which is higher. The remaining rent—the actual cost of operating and maintaining the unit—is paid to the PHA through a contract with HUD. Rent usually includes some utility assistance or allowance. Each household is reviewed annually to verify income and adjust rent payments if income has changed.

Currently there are about 976,000 occupied public housing units in the United States.[57] This is less than 1 percent of all housing in the United States, and substantially lower than the 1.28 million public housing units that existed throughout the United States and Puerto Rico in 2000.[58] The 24 percent reduction in units is mainly due to the demolition of 150,000 public housing units under the HOPE IV program in order to develop new mixed-income housing developments, which, when completed, will have less than 50,000 replacement public housing units.[59] This lower number also reflects the loss of units that have been declared uninhabitable and other units permanently eliminated through demolition.

According to HUD's data, there were 210,760 "disabled families" (22%) and 307,782 "elderly families" (32%; of which 135,218 had a disability) living in public housing as of December 2008.[60] The remaining 457,182 were families (47%) in which the adult head of household was neither elderly nor with a disability.

There is no current information on how many public housing units are accessible. Section 504 requires PHAs to do a self-evaluation of all their programs, housing, and facilities to determine if they are in compliance and to develop transition plans to deal with conditions that are not in compliance. While these documents are considered public and should be available upon request from a PHA, there is no publicly available master list of all evaluation results that could help determine what proportion and number of units in public housing are up to UFAS standards. However, assuming the

minimum of 5 percent for mobility and 2 percent for vision/hearing impaired required by 504, we estimate there should be at least 68,300 units of accessible public housing in the United States based on current inventory.[61] Since this estimate is not based on actual data, the real number may be higher or lower.

Recent compliance reviews of several large PHAs suggest that the number is lower. Based on Voluntary Compliance Agreements with HUD, we know that at least nine PHAs were not meeting the minimum threshold (Atlanta, Boston, Chicago, Lafayette (LA), Las Vegas, Miami-Dade, Pittsburgh, Puerto Rico, and Seattle), and one State financing agency (Alaska).[62] With the exception of Chicago, all were given the mandate to make at least 5 percent of their units UFAS accessible. The Chicago Housing Authority was given a minimum of 5.3 percent for mobility impairments and 2.1 percent for sensory impairments.[63] Some PHAs were also required to complete a needs assessment to determine more precisely what is needed. Given the number of disabled families plus the number of elderly families that have someone with a disability, the minimum number of accessible units required under Section 504 appears to be significantly smaller than the need.

Finally, a further limitation to consider is that many accessible public housing units are in age-restricted “elderly only” developments (i.e., for people who are 62 years or older) and therefore are not available to all people with disabilities. Beginning in 1992, HUD allowed PHAs to designate public housing developments as elderly only. As of 2009, about 65,000 units had been added to this category, with the majority being one-bedroom units (40,900 units).[64] In addition, the designation of another 35,000 units had expired, while 60 requests from PHAs were denied designation status and another 50 requests had been withdrawn.[65]

Housing Choice Vouchers

Also known as tenant-based housing assistance, a Housing Choice Voucher (HCV) allows the household the same benefits as HUD’s public housing program, but in the private rental market. To qualify for an HCV, the household must be very low income (at

50% of the Area Median Income), which is a lower income threshold than required for public housing. A household with a voucher pays 30 percent of its income for rent (though it can choose to pay more if it wants). With a grant from HUD, the PHA pays the difference up to the Fair Market Rent, which is near the median rent for the area.[66] Housing units are required to meet HUD-specified quality standards verified through an inspection, and are subject to annual reviews to make sure they remain in compliance. As with public housing, there is likely to be a waiting list and PHAs can establish HUD-approved local preferences.

Currently, about 1.97 million households are using Housing Choice Vouchers in the United States. These figures include households that receive assistance through special voucher allocations that Congress has provided for the exclusive use of nonelderly disabled households. An estimated 64,000 vouchers are included in two programs: the Designated Voucher Program and the Mainstream Housing Opportunities for Persons with Disabilities program. The Designated Voucher Program began in 1997 as an effort by Congress to provide new vouchers for nonelderly people with disabilities who would have qualified for studio and one-bedroom units in federal public and assisted housing properties designated elderly only. An estimated 50,000 designated vouchers for nonelderly people with disabilities were appropriated between 1997 and 2001. Congress requires PHAs upon turnover of these vouchers to make them available only to people with disabilities. The Mainstream Housing Opportunities for Persons with Disabilities program is administered as the Housing Choice Voucher program, but is funded through the Section 811 Supportive Housing for Persons with Disabilities program. Congress has appropriated an estimated 14,000 Mainstream Vouchers, which must also continue to be used solely by people with disabilities if they turn over.

Of the total number of HCV holders, HUD data identifies 544,561 as disabled families (28%) and 374,265 as elderly families (19%), of which 150,499 also include someone with a disability. As with public housing, most voucher holders are nonelderly families with no person with a disability as head of household (1,052,906 households; 53% of total), and we do not know if there are children or other adults with disabilities in these

families, since HUD does not identify them. Based on the number of disabled families in the HCV program, it appears that the majority did not gain access to federal housing assistance through the Designated or Mainstream programs. As a result, the majority of vouchers currently benefiting people with disabilities are not guaranteed to continue to do so if returned, since there is no requirement for turnover to another disabled family.

Regardless of the type of voucher, there is no record of what, if any, accessibility features are in the units that tenants with disabilities occupy. While some public housing authorities and disability advocates keep a list of landlords with accessible rental units, there is no systematic recordkeeping for HUD on the number of voucher holders with disabilities renting accessible and/or adaptable units. Even if all vouchers in both of these programs were being used by people with disabilities, we cannot assume that all would be living in accessible units or units that fit the accessibility needs of the household.

A study commissioned by HUD found that people with disabilities using vouchers do not always search for housing solely to meet their accessibility needs.[67] When asked why a household selected a current unit, only 10 percent reported that they selected the unit because it offered more accessible features than other available units. The top reasons were because the unit was located in a “better” neighborhood (39%), was closer to friends (34%), and/or was located near shopping (33%).[68] About one-fourth did not even search for a new unit when they received their voucher, but instead stayed in the current rental unit.[69] And whether they moved or not, only 7 percent of the survey respondents indicated that they had asked for a modification to the unit.

Finally, using Housing Choice Vouchers continues to mean encountering and dealing with barriers including discrimination and lack of uniform protections across the country. Recent analysis of Housing Choice Voucher utilization rates indicates that usage was down among all households in the 1990s, going from 81 percent utilization (i.e., getting to use the voucher to rent a unit) in 1993 to 69 percent in 2001. At the time, many attributed this to tight rental housing markets in many cities coupled with a shrinking affordable housing supply to access. The 2001 data suggests that nonelderly people

with disabilities actually did better than average (74% success rate), while elderly people with disabilities did worse (54% success rate).[70] It is unclear why this was the case.

Multifamily Housing

There are 1.47 million rental units in privately owned buildings maintained by both for-profit and nonprofit entities that have been developed with various federal multifamily housing programs. This includes at least 396,000 units designated elderly only, with most built under Section 202 (270,000 units as of 2004). In contrast, there are only about 72,700 units in HUD's multifamily portfolio designated for people with disabilities only (which includes people ages 62 and older), with much of it built in the past 15 years under the Section 811 program. Other units were built under the Section 8 program and receive assistance to reduce rents in buildings so that low-income households pay only 30 percent of their income for rent. Most of these developments are designated as family, although some are combined elderly and disabled. The same is true for units built under various other rental subsidy programs from the 1960s that are no longer funded, including the Section 221(d)(3) below-market interest rate program and the Section 236 program. Both produced affordable housing, but for renters with incomes slightly above the public housing income limits. Over time, deep rental subsidies were attached to some of these units to keep them affordable, but there still are about 318,000 units that do not have these rental subsidies and therefore are not affordable to low-income households.[71]

Based on field inventories completed in 2008, there are approximately 156,000 accessible units (11%) in subsidized multifamily housing developments.[72] Not all are affordable to low-income households. Furthermore, as with public housing, the majority are likely to be in age-restricted developments, since 26 percent of the units in HUD's multifamily housing portfolio are designated for elderly people, while only 5 percent are designated for people with disabilities.[73] As with public housing, this means not all units in the accessible category can be accessed by younger people with disabilities. Finally, these figures in no way reflect the occupancy or bedroom size of accessible units and

whether a person with a disability, regardless of age, was occupying the unit when it was surveyed.

Section 811, which was authorized by the National Affordable Housing Act of 1990 and modified in 1992 by the Housing and Community Development Act, was specifically created to address the supportive housing need of people with disabilities. Section 811 has two program components: the capital advance/Project Rental Assistance Component (PRAC) and the Tenant-Based Rental Assistance component administered by HUD under the Section 8 Mainstream Housing Opportunities for Persons with Disabilities program. As noted above, there are approximately 14,000 vouchers in the Mainstream program.

As of 2007, about 27,000 units of housing had been produced through the 811 PRAC by nonprofit sponsors.[74] There are three categories of housing allowed: group homes, independent living facilities, and condominiums. A group home is defined by law as a single-family residence that is designed for up to eight individuals to occupy, in either single- or double-occupancy bedrooms, and with at least one bathroom per four people.[75] Also, the law says a group home developed with Section 811 funds is not to be located immediately next to or on the same lot as another group home. An independent living facility is like an apartment building, with separate dwelling units complete with their own kitchens, bathrooms, and bedroom(s); however, it also can include a unit for a staff person. These developments can be a single building on one site or multiple buildings scattered throughout the community.

Based on a nonrepresentative sample of 136 PRAC developments in 2003, the majority (81) of the projects surveyed were in facilities with 8 to 24 units, which means most are independent living facilities.[76] Furthermore, the majority of the surveyed developments targeted people with developmental disabilities (43 projects) and chronic mental illness (62 projects), rather than physical disabilities. While this data does not represent all 811 housing, the results are likely to reflect the need for housing specifically for these populations that is not being produced by the private sector.

The law limits to 24 the number of people with disabilities per 811 development; however, the annual Notice of Funding Availability limits this to 14 people with disabilities.

Condominium projects are similar to independent living, with separate units. However, assuming these are units purchased in a building that was not intended to solely house people with disabilities, the program tries to promote integration by limiting the number of units to whichever is greater: 14 units or 10 percent of the total units in the development, not to exceed 24 units. Still, HUD grants waivers to allow a larger percentage and therefore number of units both in existing buildings and in new developments.

While effective at creating housing, a concern is that the 811 program has also contributed to the segregation of people with disabilities from people without disabilities and also by different disabilities. Legislation states that 811 housing target people with physical disabilities, developmental disabilities, and chronic mental illness, or a combination of these three. However, through a waiver process, HUD can approve a project sponsor's request to not only target only one of these three but then also a subcategory of disability within it (e.g., autism). As long as HUD approves the waiver request (which it typically does), the project sponsor can deny housing to someone that fits the broader disability category (i.e., developmental disability) if that person is not part of the project's specific target population (i.e., autism). This is especially important to keep in mind given the relatively small number of Section 811 units when compared to the large number of people with disabilities.

HUD Formula-Based Housing Grant Programs

Community Development Block Grant

The Community Development Block Grant (CDBG) program, which began in 1974, provides funding to help metropolitan cities, urban counties, and States to "meet their housing and community development needs." The block grant is distributed through a formula based on need and size as well as housing conditions to entitlement

communities and States. Currently HUD provides annual CDBG grants to 1,180 units of local government. States distribute these funds to other smaller local jurisdictions (nonentitlement communities) based on need, while cities and counties distribute CDBG through different agencies delivering services and producing housing.[77]

In general, CDBG funds may be used for neighborhood revitalization, economic development, and improvement of community facilities and services. All activities must achieve one of the program's national objectives, such as benefitting low- and moderate-income people, aiding in the prevention or elimination of slums and blight, or meeting urgent community development needs. A minimum of 70 percent of funds are to be used to benefit low- and moderate-income people; however, this does not only mean housing assistance and production.

Currently, about 26 percent of CDBG on average goes to housing, which includes single-family and multifamily housing; however, the rate is much lower when looking at State allocation of CDBG funds, which is around 16–17 percent for housing.[78] Based on data for the past 8 years, about half of the housing funding has gone directly to single-family rehabilitation.[79] This may include retrofitting for accessibility, since this is an eligible use of funds; however, because the level of detail in reporting is not that specific, we cannot know if this is occurring.[80]

HOME Investment Partnerships Program

The HOME program is the largest federal block grant to State and local governments to exclusively create affordable housing for low-income households, allocating approximately $1.7 billion per year. HOME funds are exclusively for housing-related investments including Tenant-Based Rental Assistance (TBRA), housing rehabilitation, homebuyer assistance, and housing construction, as well as site acquisition and improvements. Funds may not be used for public housing or as a contribution to other programs. A portion of funds must target very low income people, and income levels and rental prices must meet HUD limits. All assisted housing must remain affordable in the long term (20 years for new construction of rental housing and 5–15 years for

homeownership housing). For rental housing and TBRA, at least 90 percent of families benefiting from HOME funding must have incomes that are no more than 60 percent of the HUD-adjusted family Area Median Income for the area. In rental projects with five or more assisted units, at least 20 percent of the units must be occupied by families with incomes that do not exceed 50 percent of the HUD-adjusted median.

To date, HOME funds have been used to produce more than 756,000 units of housing since the inception of the program (does not include Tenant-Based Rental Assistance [TBRA]).[81] While the allocation for HOME has generally increased over time, the annual completion rate is somewhat uneven. One constant is that HOME funds are strongly leveraged, generating nearly $4 for every $1 of federal funds provided, and commitment to Community Housing Development Organizations (CHDOs) has been above the 15 percent minimum at nearly 21 percent annually.

Unfortunately, like CDBG, the reporting system does not provide specific information to assess how people with disabilities benefit. A growing concern is that despite flexibility in how funds can be used, new homebuyers and existing owners consistently benefit the most from HOME. About 60 percent of HOME dollars have gone to homeowners receiving either rehabilitation or acquisition grants, while rental housing production under HOME is only 40 percent of the total unit count. Relatively speaking, rent assistance (TBRA) is more cost effective than production programs at about 10 times less per unit (compare an average of $3,151 per household for TBRA to an average of $35,495 per unit of new construction). The current TBRA commitment, which is less than 3 percent of the 2008 HOME budget, will assist about 200,000 households. Most families assisted are extremely low income (78%).[82] This income bracket could include people with disabilities relying on SSI, as well as most households with worst-case housing needs.

Homeless Shelter and Housing Programs

The McKinney-Vento Act passed in 1986 was the first legislation to directly deal with homelessness at the federal level. The act provides funds to develop and operate

emergency shelters, transitional housing, and permanent housing via a networked system of shelter and service providers known as the Continuum of Care (CoC).[83] In addition, P.L. 102–590 passed in 1992 enabling the Department of Veterans Affairs to develop transitional housing (the Grant and Per Diem program).

Today, HUD manages several homeless assistance programs that provide federal funding to local communities either through a formula (noncompetitive) or on a competitive basis. Competitive funding is awarded to applicants through the State's or local jurisdiction's Continuum of Care (CoC) plan, which is produced annually by a network of homeless-service providers and other stakeholders (including homeless people) working together either through or in conjunction with a government agency. The CoC plan is to guide the development and delivery of an integrated set of programs and services in the community that aim to help people once homeless eventually become permanently housed.

A significant shift in the last few years has been toward producing more supportive housing and less emergency shelter and transitional housing. As HUD defines it, supportive housing "provides long-term housing with supportive services for homeless persons with disabilities. This type of supportive housing enables special needs populations to live as independently as possible in a permanent setting."[84] Included in this are permanent supportive housing units developed specifically for people with disabilities and units developed via HUD's Shelter plus Care (S+C) program, which "assists hard to serve homeless individuals with disabilities and their families. These individuals primarily include those with serious mental illness, chronic problems with alcohol and/or drugs, and HIV/AIDS or related diseases."[85]

As of 2008, there were 195,724 "beds" in permanent supportive housing, of which 119,143 were for individual adults and the remaining 76,581 for families. While still not surpassing emergency and transitional housing overall (211,000 and 205,000 beds, respectively), permanent supportive housing increased the most in terms of the proportion of programs and number of beds added from 2007 to 2008. All permanent supportive housing built with these funds for the homeless requires the person entering

the program to be homeless prior to leasing the unit or being admitted. Such requirements, while useful at targeting people in need, nonetheless mean these "permanent" housing units can only play a limited role in meeting the needs of people with disabilities.

Low Income Housing Tax Credit Program

Since 1986, the Low Income Housing Tax Credit (LIHTC) program has been the primary source of funding for affordable housing in the United States. The LIHTC program is regulated by the Treasury Department through the Internal Revenue Service (IRS). The basic premise is that tax credits issued by the IRS get turned into equity, which is then used to reduce the cost of development and subsequently the rent the developer needs to charge to cover expenses for developing and operating the housing.[86] In exchange, the investor (equity partner) gets an annual tax credit for 10 years as long as the housing development and operator meets the compliance requirements. This includes keeping units occupied and restricting rents in a portion of units for 30 years or longer, depending on the agreement with the agency issuing the tax credits. Most housing produced through the LIHTC program is intended to be affordable to the "working poor"—households earning up to 40 and 60 percent of median income.

Unlike HUD funding, tax credits are not budget outlays but rather taxes that are not collected, which is fiscally and politically appealing to many. The allocation of the tax credit is based on a per capita rate for each State.[87] Beginning in 2003, the rate was set at $1.75 per person and is to be adjusted for inflation.[88] Guiding the allocation of the tax credits in each State is a Qualified Allocation Plan (QAP). States use these plans to evaluate development proposals from private and nonprofit developers building affordable housing and give points for different features or aspects of the proposed development. The QAP, which must be consistent with the State's Consolidated Plan, is also required by federal law to give priority to projects that (1) serve the lowest-income families, and (2) are structured to remain affordable for the longest period of time. Federal law also requires that 10 percent of each State's annual housing tax credit

allocation be set aside for projects owned by nonprofit organizations.[89] Beyond these requirements, criteria for awarding points vary greatly across the States.

Based on the latest data available, which is 2007, a little over $9 billion dollars in tax credits have been used to produce 1,669,300 units. This is an average of $5,400 tax credit dollars per unit developed. Since 1997, an average of between 1,300 and 1,400 new developments have been completed each year. Over time, the noticeable trend has been that the average development size increases from about just below 40 units in 1992 to around 80 in 2005.[90] Developments built 1995–2005 had mostly two-bedroom (42%) and one-bedroom units (31%).[91]

The units produced by the LIHTC program has exceeded the number of housing units built during the 60 years of public housing development and in one-third of the time.[92] Nearly 95 percent of the units are rent restricted to benefit low-income families.[93] Still, with many units for families earning close to 60 percent of the Area Median Income, many LIHTC units cannot be rented by households with worst-case needs because rent is fixed and not adjusted for income. For most very low income families to access these units would require substantial rental subsidy to make them affordable.[94] While no current data is available on how many units of LIHTC are also being subsidized by tenants using Housing Choice Vouchers, a Government Accountability Office (GAO) report in 1997 found that about 39 percent of the households living in LIHTC housing also directly received vouchers.[95]

While LIHTC is the most important affordable housing production tool in the United States today, we know very little about how it has benefited people with disabilities. For the most part, the reason is that there is limited reporting on who occupies these units other than by income bracket, since that is critical for meeting compliance requirements and assuring that investors continue to receive their tax credit. Still, we know that developers using tax credits sometimes target specific populations, including people with disabilities. Recent data now collected for inclusion in HUD's LIHTC database suggests that 27 percent of the developments put in service between 2003 and 2005 were to be for people with disabilities, and about 12 percent for the elderly (about

41,600 units).[96] However, most of these are likely to be permanent supportive housing for homeless people, and therefore only accessible to people with disabilities who are homeless.

A key distinction between HUD housing and LIHTC properties is that tax credit units are not covered by Section 504 regulations, though most are affected by the Fair Housing Act, since most units were built after 1991. However, since many developments use additional sources of funding, including federal dollars that are subject to 504, the assumption would be that if substantial, these dollars would trigger compliance. About 31 percent of developments that target either the elderly or people with disabilities used HOME funding, while fewer used other public sources.[97]

In general, we know that proportionately about half of all LIHTC projects are located in central cities, about 38 percent are in suburban communities, and the remaining 12 percent are in nonmetropolitan areas. The distribution of housing targeted for people with disabilities appears to be about the same for central city, suburban, and nonmetropolitan areas, representing 12 to 13 percent of developments placed in service between 2003 and 2005.[98] In contrast, housing targeting an older population is proportionally higher in suburban locations (35%) than nonmetro areas (28%) and central cities (21%).[99] Since this data does not include units placed in service before 2003, it is not known if this pattern applies to all LIHTC developed since 1987. We do know that about 22 percent of the units developed in this time period that target people with disabilities were in communities where more than 30 percent of the people were below the poverty line. In comparison, less than 16 percent of the LIHTC units that target the elderly were in high-poverty communities.

Rural Housing

The U.S. Department of Agriculture (USDA) housing program began with the 1949 Housing Act (Title V, P.L. 81–171), which authorized USDA to make loans to farmers for the construction of new housing and to refurbish existing homes and other farm buildings to ensure safe, decent housing for themselves and other tenants, lessees,

sharecroppers, and farm workers living on their land. Currently, through its Rural Development (RD) division, USDA makes housing loans and grants to rural residents and to developers of properties in rural areas. To date, about $116 million has been expended since 1949, assisting nearly 3.5 million households.[100]

The rural housing programs offered through USDA's RD division fall into two main categories: single-family and multifamily. While a few programs identify as eligible recipients people with disabilities and those who are aging, no RD program targets either group exclusively. This report focuses on RD programs most likely to benefit people with disabilities: 502 loans and grants, 504 loans and grants, 515 multifamily rental housing, 538 multifamily loans, and 521 rental assistance.

Single-Family Housing

About 80 percent of all development dollars available for rural housing has gone to assist in the production and rehabilitation of single-family homes. In general, rural homeownership (75%) continues to be higher than in urban areas (64%) and the U.S. rate (66%), which means that people with disabilities and/or who are aging living in rural areas are more likely to reside in single-family homes they own.[101] This has implications for accessibility requirements associated with federal housing funds as well as expectations for integration and affordability.

The two primary programs for rural single-family housing assistance are under Section 502: direct loans and guaranteed loans. Direct loans are made to the applicant via USDA's Housing and Community Facilities Program (HCFP). This is USDA's largest outlay for housing, helping more than 2 million low-income people purchase or construct homes in rural areas. Up to 100 percent financing may be obtained to buy, build, repair, or move a home, as well as to purchase and prepare home sites. Individuals or families may be eligible if they have an income up to 80 percent of the Area Median Income.[102] They also must be without adequate housing, be able to afford mortgage and other payments, be unable to obtain credit elsewhere, and have a reasonable credit history. Housing must be modest in size, design, and cost and meet all applicable building

codes. Loans are for up to 38 years, with the interest rate set by HCFP and modified by the payment subsidy.

In comparison, guaranteed loans are secured by the household through an approved lender and then guaranteed by USDA. These loans are generally used to help low-income people purchase homes in rural areas. Funds may also be used to build, repair, or move a home, as well as to purchase and prepare home sites. Low-income households may be eligible if they have an income up to 115 percent of the Area Median Income. Because these loans are provided by outside lenders and guaranteed by USDA, the applicant must able to afford the mortgage and other payments and have a reasonable credit history. Housing must be modest in size, design, and cost and meet all applicable building codes and loan limits (value) set by USDA.[103] Loans are guaranteed for 30 years, interest rates and repayment are set by the lender, and no down payment is required. Approved lenders include State Housing Agencies, Farm Credit System institutions with direct lending authority, and lenders participating in USDA Rural Development guaranteed loan programs. While the program began in 1977, it really did not take off until 1991. To date, more than 422,000 loans have been made through this program.

In addition, the Section 504 Housing Repair and Rehabilitation Loan program helps very low income homeowners with repairs and accessibility improvements. Loans of up to $20,000 are offered to help very low income individuals who own and occupy a home in need of repairs. Loans can be used to cover cost to repair, improve, modernize, or remove hazards in a home. Since its inception in 1950, about 161,000 loans have been made. Repair and Rehabilitation Grants are also provided specifically to help very low income senior individuals who own and occupy a home in need of repairs or accessibility improvements. Grants of up to $7,500 may be obtained for repairs and improvements in order to remove health and safety hazards in a home. The grant may be used in conjunction with a Rural Housing Repair and Rehabilitation Loan. Since 1950, about 157,000 loans have been made, and, as with the loan program, the number of grants has been steadily increasing since 1990.

Multifamily Housing

As with HUD's multifamily properties, USDA's multifamily housing program was designed to provide private sector—for-profit or nonprofit—developers with loans and grants to assist in the development of rental housing. USDA also makes these funds available to the public sector to produce housing, though not as "public housing" managed by a public housing authority. Someone looking to rent subsidized affordable housing in a rural area can use the RD online search engine to find housing via the location (State, county, town, or ZIP code) or property owner.[104] Property information includes total number of units, number of units assisted, and number of units by bedroom size and "complex type," which can be family, elderly, mixed, group home, or congregate.

Through all its multifamily programs, USDA has helped to produce or preserve about 668,000 units. Most are through the Section 515 loan program. Since its inception in 1963, the 515 program has produced 530,500 units of rental housing, which are widely distributed across the United States, Puerto Rico, Virgin Islands, and West Pacific territories. Based on a recent analysis by the Housing Assistance Council (HAC), nearly 89 percent of all U.S. counties (2,800) have at least one Section 515 development.[105] Half these counties have fewer than 5 projects, and 40 percent have between 5 and 10 properties at most. Despite the fact that most counties in the United States have at least one Section 515 property, most of the units are located in the Southeast (e.g., Florida, Georgia, Mississippi, Alabama, North Carolina, Arkansas) and Midwest (e.g., Missouri, Michigan, Illinois, Iowa, Indiana, Ohio).

The Section 538 Rural Rental Housing Guaranteed Loan program began in 1996 to target the same population as Section 515, but instead of providing the loan directly to a developer, USDA guarantees the loan secured through a lender. Eligible lenders include State Housing Finance Agencies and those approved by the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, Federal Home Loan Bank members, or the Department of Housing and Urban Development. USDA guarantees such loans, which are for up to 40 years and have fixed rates. As a result,

about 24,000 units have been developed through FY 2007, with an average of about 2,500 units per year.

In addition, USDA has provided rental assistance through the Section 521 program to nearly 981,000 households since 1978. As with HUD's voucher program, these subsidies are to be used to help low-income households with their rent. This includes people with disabilities and who are aging. However, unlike HUD's voucher program, which allows the tenant the "choice" to look anywhere in the housing market, this assistance is tied to properties funded by the HCFP through its Rural Rental Housing programs. HCFP establishes 5-year contracts with property owners in which they pay the difference between the tenant's affordable contribution and the monthly rental rate. Requests for funding are generally initiated by property owners; however, tenants may also petition such owners to obtain funding through this program. This competitive program is designed to give priority to housing with the highest percentage of tenants in need of rental assistance and areas with the greatest housing need in the State.

Recent estimates suggest that about 58 percent of Section 515 rental units are occupied by people with disabilities and/or people who are aging; however, this does not necessarily mean that these units are accessible.[106] Instead, this estimate is based on the designation of the property, which determines who can and cannot live in the development. As with HUD housing, a large portion—at least 40 percent—are age restricted (i.e., for elderly only).

A breakdown of USDA accessible housing is not available. Assuming that the multifamily housing met the 5 and 2 percent rule (Section 504 regulations require 5 percent but not less than one dwelling unit to be accessible to people with mobility disabilities, and at least 2 percent but not less than one dwelling unit to be accessible for people with visual and hearing disabilities), there could be about 33,000 units accessible in total for people with mobility limitations and 13,000 units for people with sensory impairments. However, a 2004 study by the National Fair Housing Alliance (NFHA) suggests this is likely not the case, as it found that several projects had less than 5 percent accessible units.[107] Moreover, even with sites that might have the

minimum number of accessible units, access for people with disabilities might be restricted. The 2004 NFHA study found that in extensive paired testing in 24 States where most rural rental housing is located, more than 20 percent of the sites were "illegally denied to potential renters based on their race, national origin, disability or familial status."[108] Based on paired disability tests, 36 percent "revealed some differential treatment on basis of disability."[109] This included inaccessible offices and entrances to apartment buildings; "blatant statements" about reasonable accommodations that would not be allowed and/or would not be accommodated if requested; and suggesting that fees might be charged for some accommodation requests that should not.[110] This data suggests then that even when USDA rental housing is accessible, it might not be available to people with disabilities and that it is likely to be segregated because of designation as either "elderly" or "disabled" or "group home" and/or discrimination.

Since its inception in 1978, the Section 515 program has assisted nearly 1 million households living in rural rental housing. However, over the years it has not necessarily ensured sufficient rent to cover the cost of maintaining the housing stock. A study done in 2004 for USDA concluded that a significant portion of the Section 515 Rural Rental Housing program portfolio was at risk of being lost due to insufficient reserves and inadequate cash flow.[111] As a result, the study concluded that the rate of decline was likely to accelerate in many properties, putting families at risk of losing their rental units and the overall supply of affordable rural rental housing reduced.

Complicating matters was the fact that many properties were eligible to "prepay" and become market-rate housing upon leaving the program, assuming RD determined that there should be no restrictions on keeping rents affordable. While technically this applied to about 60 percent of the Section 515 portfolio, the study determined that only about 10 percent would likely choose to prepay early in order to "opt out" of the program. Between 2001 and 2007, 880 properties representing nearly 15,000 units have prepaid. While this represents only about 5 percent of the Section 515 housing properties, this does not include a large portion of properties—another 7,300 properties

with 195,000 units—that are now eligible to prepay and potentially become unaffordable.[112]

In response to this problem, USDA developed the Rural Development Voucher demonstration program. This 1-year rental subsidy program was intended to "protect tenants of USDA Multi-Family Housing (Section 515) properties who have had their USDA loans foreclosed or prepaid between Oct. 1, 2005, and Sept. 30, 2006." These vouchers are in addition to the rental subsidy provided via Section 521, and can be used with the tenant's current housing to offset higher rents if the owner raises rents to market rate or can be used elsewhere in other rental property as with any tenant-based voucher. As of FY 2007, nearly $3 million had been committed for 1,100 vouchers. This suggests that many of the families in properties that opted out of the program did not seek voucher assistance, either because they did not need it or were not eligible for it.

Looking Ahead

The following highlights proposed legislation, new programs, and new directions that have only just been implemented or proposed and therefore cannot be evaluated, but nonetheless point to potentially promising practices.

Section 811 Legislation

H.R. 1675, the Frank Melville Supportive Housing Investment Act of 2009, is bipartisan legislation that will make significant reforms and essential improvements to the HUD Section 811 Supportive Housing for Persons with Disabilities program. An identical bill—H.R. 5772—unanimously passed the House of Representatives under Suspension of the Rules in September 2008. H.R. 1675 will help address the serious housing crisis facing millions of extremely low income people with disabilities by:

- Authorizing a new cost-effective Section 811 demonstration program that could triple the number of integrated units created through Section 811 without any increase in the program's appropriation. This demonstration program is designed to highly leverage capital funding provided through other federal

affordable housing programs, including the Low Income Housing Tax Credit and HOME programs.

- Enacting long-overdue reforms to the current Section 811 production program to reduce longstanding bureaucratic barriers and improve the program's efficiency and cost effectiveness.
- Authorizing a cost-neutral shift of fiscal responsibility for the Section 811–funded Mainstream Voucher program to the Housing Choice Voucher appropriation. Although funded and renewed from 811 appropriations, an estimated 14,000 Mainstream Vouchers created between 1996 and 2002 have been administered as Housing Choice Vouchers, have never been used for permanent supportive housing, and have never been targeted to people with the most serious and long-term disabilities.

For the past few years, because of Section 811's outdated structure, the program has produced only 800 to 900 new supportive housing units annually. H.R 1675 will reinvigorate the program by creating 3,000 or more new units annually through the demonstration program, and by authorizing more integrated housing approaches and models that are consistent with the housing needs and choices of people with disabilities.

New Funding for Affordable Housing via the National Affordable Housing Trust Fund[113]

On July 30, 2008, President George W. Bush signed the Housing and Economic Recovery Act, which included the establishment of a National Housing Trust Fund (NHTF)—an ongoing, permanent, and dedicated source of revenue to build, rehabilitate, and preserve 1.5 million units of housing for the lowest-income families over the next 10 years. This is the first housing program since 1974 directly dedicated to rental housing for very low income households, which can benefit people with disabilities, among others. At least 90 percent of NHTF resources must be spent on rental housing and 75 percent of all rental funds must benefit extremely low income households at or below 30 percent of Area Median Income. These funds are to be administered by States that

then make grants to developers with established capacity to build affordable housing, including nonprofit and for-profit organizations. Although no source of dedicated funding for the National Housing Trust Fund has been identified, HUD has requested $1 billion in new funding for this program in its FY 2010 budget request to Congress.

New Vouchers for Nonelderly People with Disabilities

In both the FY 2008 and FY 2009 HUD budgets, Congress provided $30 million each year to fund approximately 3,500 new vouchers for nonelderly people with disabilities. These appropriations signal the willingness of Congress to return to policies adopted between 1997and 2001 to provide new vouchers for nonelderly people with disabilities each year to offset the loss of subsidized public and HUD-assisted housing units from properties designated “elderly only.” PHAs must be willing to apply for these new vouchers, and could use them to create special initiatives, such as targeting them for people with disabilities who are leaving segregated institutional settings.

New Vouchers for Veterans[114]

In 1992, HUD and the Veterans Administration—now the Department of Veterans Affairs (VA)—collaborated to launch a Supportive Housing Program, known as HUD–VASH. Its objective was to serve homeless mentally ill veterans by providing affordable housing (through HUD’s Section 8 voucher program) and case management services (through the VA). Almost 1,800 vouchers were provided. The housing retention rates of HUD–VASH compare favorably to other supported housing programs. Furthermore, there were significant gains in employment, mental health, and reduction of drug and alcohol problems among participants.[115] In 2008, HUD–VASH was expanded to provide local PHAs with approximately 10,000 new rental assistance vouchers specifically targeted to assist homeless veterans and their families. An additional 10,000 vouchers have recently been added with the passage of the Omnibus Appropriation Act of 2009. A joint effort of the Veterans Administration and HUD will link VA medical centers to local PHAs to provide supportive services and case management to eligible homeless veterans.

Inclusive Home Design Act (H.R. 1408)[116]

This new legislation, introduced on March 10, 2009, by U.S. Representative Jan Schakowsky, aims to increase the number of affordable homes accessible to people with disabilities. The act would require that all newly built single-family homes and townhouses receiving federal funds meet four specific standards:

- Include at least one accessible ("zero-step") entrance into the home.
- Ensure all doorways on the main floor have a minimum of 32 inches of clear passage space.
- Include at least one wheelchair-accessible bathroom on the main floor.
- Place electrical and climate controls (such as light switches and thermostats) at heights reachable from a wheelchair.

Potential New HOPE VI Legislation[117]

On January 17, 2008, the House of Representatives approved H.R. 3524, the HOPE VI Improvement and Reauthorization Act of 2007, which would reauthorize the program for 7 years and make important improvements to the program. Specifically, improvements include requirements that all units demolished under future HOPE VI awards be replaced (i.e., one-for-one replacement), that the plans include offsite replacement housing in low-poverty areas, and that new HOPE VI projects offer more assistance for displaced families using housing vouchers. While this bill did not progress, advocates of public housing see promise in the groundwork laid. As described by the Center for Budget and Policy Priorities (CBPP), looking forward, the aim should be "to maximize the program's positive results and minimize any negative impacts it might have on people who are displaced when their homes are demolished."[118]

Section 202 Supportive Housing for the Elderly Act of 2009 (S. 18)

Currently in the Senate, a bill to amend Section 202 of the Housing Act of 1959 would significantly change the funding and operation of developments and how funds are allocated for developments regionally. It would give more discretion and autonomy to

owners of such properties.[119] It also would require the HUD Secretary to establish and operate a national senior housing clearinghouse.

HUD's Real Estate Management System (REMS)

At this time, we do not know the level of integration of units or tenants within buildings or developments. However, we may be able to learn in the near future the utilization rate in multifamily housing through HUD's integrated Real Estate Management System, which currently does or will collect data on the occupants of housing for people with disabilities and more detailed information about the bedroom size and specific accessibility features.[120] This will include, by bedroom size:

- Number of mobility impaired accessible units
- Number of vision and/or hearing impaired accessible units
- Number of people on waiting lists eligible for accessible units
- Number of accessible units occupied by elderly or family tenants
- Number of accessible units occupied by nonelderly tenants with disabilities that require the features of the unit
- Number of accessible units occupied by elderly tenants with disabilities that require features of the unit

This relatively new data collection system, which is used to independently monitor HUD's portfolio of multifamily housing, is an opportunity to look more closely at how people with disabilities and the elderly are integrated within housing developments and communities.

New Requirements for Low Income Housing Tax Credit Reporting

The Housing and Economic Recovery Act (HERA) of 2008 now requires HUD to collect and report for all LIHTC tenants race, ethnicity, family composition, age, income, use of Section 8 (or similar) rental assistance, disability status, and monthly rental payment. Not only will this data be of use for assessing how well the LIHTC program is serving

people with disabilities and the elderly, it will also provide a better understanding of how many LIHTC units are made affordable with the use of additional rental subsidies.

Green Efficient Public Housing

The Council of Large Public Housing Authorities released its *Future of Public Housing Framework* in October 2008, which included a commitment to "fully integrate green building standards to rebuild or retrofit all 1.2 million public housing units as part of the reinvestment strategy" and to raising $10 billion over the next 10 years to accomplish this goal.[121] The 2009 stimulus package includes funds to kick off this initiative.

Promoting Livable Communities

On June 16, 2009, a new partnership among HUD, the Department of Transportation (DOT), and the Environmental Protection Agency (EPA) was announced to support the creation of more sustainable development in urban, suburban, and rural areas. The agencies will focus on coordinating housing and transportation investment "while simultaneously protecting the environment, promoting equitable development, and helping to address the challenges of climate change."[122] This includes strategies that:

- Provide more transportation choices
- Promote equitable, affordable housing
- Enhance economic competitiveness
- Support existing communities
- Coordinate policies and leverage investment
- Value communities and neighborhoods

While these strategies are capable of producing livable communities for people with disabilities and the elderly, the initiative—at least in its fact sheet for the public—does not include specific language or discussion of either group.

CHAPTER 3. Geographic Dispersion of Housing Programs and Expenditures

Most federal funding for affordable housing is distributed and implemented through State and local government. This section reviews the distribution of federal funding for housing programs that can benefit people with disabilities distributed through State and local government via formula grants relative to the needs. First, however, we briefly review the State and local mechanisms that affect what type of housing is built and where it is located.

Since the early part of the 20th century, the development and location of any type housing in the United States has been primarily determined by building codes and zoning enacted through local and State government. Building codes aim to ensure housing meets health, safety, welfare, and property protection goals. However, as a 2001 HUD report points out, these "have been expanded in recent years to include other societal goals" including energy conservation, accessibility, disaster mitigation, historic preservation, and affordability.[123] While building codes are locally controlled, communities have long adopted standard building codes. Beginning in 2000, the International Building Code was developed by the International Code Council (ICC).[124] ICC provides guidance for accessibility from the American National Standard Institute and the U.S. Access Board. In addition to building codes, local ordinances and State legislation also provide specific instructions for making housing visitable. However, these are often voluntary, although frequently they come with incentives to encourage visitability.

Despite movement toward uniform building codes across the United States, regulatory barriers including zoning, local politics, and planning practices, among others, greatly affect where and if affordable, integrated, and accessible housing is built.[125] To a certain extent, federal policy and subsequent funding streams that flow into States and local jurisdictions to produce affordable housing acknowledge these variations by devolving to State and local government the ability to develop localized plans to expend federal funds. HUD requires each State to produce a Consolidated Plan, which outlines

how federal funding will be allocated to address housing and community development needs in each State. This plan must also include an analysis of barriers to fair housing and plans to remove or reduce them in line with the goals of the Fair Housing Act and its amendments.

The federally mandated Consolidated Plan identifies housing needs for different groups, including people with disabilities, and then outlines how funds will be used to meet those needs given the current and near future housing conditions. Developed for a 5-year window, the purpose of the Consolidated Plan is to guide the use of all federal housing dollars and other federal grants awarded either to or through the State. Each State and local jurisdiction receiving CDBG and HOME funds is required to develop its Consolidated Plan with citizen participation and public review prior to submission to HUD for approval. An annual plan report is used to monitor progress and also make adjustments, if needed, to the 5-year plan in order to respond to new conditions or opportunities. Unfortunately, there is no requirement that State and local governments coordinate or review plans to make sure they do not conflict.

The Consolidated Plan uses census data provided by HUD to assess needs among people with disabilities.[126] Appendix A, “Data Tables,” provides detailed data on the distribution of people with disabilities (defined on a limited basis by mobility limitations) that have “housing problems” by income, tenure, and age, for each State. A housing problem is identified as having one or more of substandard or poor-quality housing (lacking complete plumbing facilities or lacking complete kitchen facilities), living in overcrowded conditions (with 1.01 or more people per habitable room), or being cost burdened (paying more than 30 percent of income for housing).

Overall, HUD’s Consolidated Plan data shows that for all households with at least one person with a disability and some sort of housing problem, twice as many own their homes (12.8 million) than rent (6.3 million). Among renters, the largest number and proportion of renters of any income group with mobility impairments and housing problems in the United States is in California (13% of renters; 811,000 households), New York (10%; 645,000 households), Texas (6%; 391,000 households), Florida (5%;

330,000 households), and Pennsylvania (4%; 258,000 households). The majority of these renters are very low income, so it is likely that the housing problem is due to housing cost burden.

HUD Consolidated Plan data also reveals that nearly 13 million homeowners with mobility impairments have a housing problem. Unlike renters, the majority of these homeowners were in the higher-income bracket (6.9 million were above 80% of Area Median Income), which means they may not qualify for some or most public housing assistance (with exception of some local programs for owners).

A review of Consolidated Plans on HUD's Web site illustrates the variety of approaches States take to meet their affordable housing needs.[127] However, there is not always a clear connection made between need and the objectives/targets outlined in the plan when it comes to housing for people with disabilities, other than what is required at a minimum by law. In part, this may be due to the limited guidance HUD provides on using funds to meet the housing needs of people with disabilities and the aging population.[128] Still, some of these Consolidated Plans demonstrate promise, at least in terms of initiatives that respond specifically to people with disabilities.

Generally, the federal resources needed for affordable accessible housing are not sufficient to meet the needs in most if not all communities. In part, this is simply the result of historical funding patterns and allocation decisions. This makes it difficult to assess how well distributed federal housing funds are allocated relative to need, though most entitlement funding based on formulas designed to reflect need on a per capita basis are matched with population rather than relative need. For example, the State with the largest estimated number of noninstitutionalized people with disabilities is California (4,279,000 people), followed by Texas (3,050,000), Florida (2,610,000), New York (2,533,000), and Pennsylvania (1,865,000). These same States have the largest number of renters with mobility impairments and housing problems in the United States, and also the largest share of HOME and Community Development Block Grant dollars annually. In comparison, Puerto Rico has the highest disability prevalence rate at 27 percent of its population (963,000 people), followed by West Virginia (24%),

Kentucky (21%), Arkansas (21%), and Mississippi (21%). These are all higher rates than California, which has a 13 percent prevalence rate; however, because of population size, these States get significantly less HOME and CDBG funding.

Funding for subsidized housing units for people with disabilities—both public housing and multifamily housing—is not subject to formula but instead comes from direct grants and loans from the Federal Government. Much of this housing was built before the Consolidated Plan requirement. Looking across the States, we find:

- New York—and particularly New York City—has long had the largest share of public housing (205,000 units) in the United States, with four times the number of units than in Pennsylvania (52,000), the next largest supplier. Furthermore, New York has the most public housing for people with disabilities, elderly people (ages 62 and older), and families, and the largest supply of federally funded multifamily housing (108,000 units), though only second and third, respectively, for units designated for people with disabilities and elderly designated units. The State ranks lower for Housing Choice Vouchers.
- California, while home to nearly twice as many people with disabilities as New York, has relatively little public housing (fewer than 40,000 units). Instead, the State has the largest number of Housing Choice Vouchers (290,000), with 78,000 being used by people with disabilities, 28,000 by elderly households, and 55,000 by households that are both elderly and with disabilities. California also has the largest number of federally subsidized multifamily housing units designated for elderly (39,000) and for people with disabilities (5,000).
- States that rank consistently in the top 10 across all categories of housing based on units are Illinois, Ohio, Pennsylvania, and Texas.
- States ranking consistently in the bottom 10 across all categories of housing, based on the number of units, are Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming, along with the District of Columbia.

CHAPTER 4. Public Sector Initiatives to Increase the Housing Status of People with Disabilities

The Americans with Disabilities Act (ADA) expanded the fair housing rights of people with disabilities to include community integration and full citizen participation.[129] In 1999, the application of this right to "least restrictive" community living choice was put to fore within the U.S. Supreme Court case *Olmstead v. L.C.* (98-536) 527 U.S. 581,138 F.3d 893 (1999), referred to as the *Olmstead* decision.[130] At the crux of this case was the issue of integration, that is, whether people with disabilities have a right to live in least restrictive settings of choice, including community-based options, and whether States have responsibilities related to providing community living supports equitable to those given to people living in institutional and nursing home settings to realize this "real choice." The *Olmstead* decision enforced this right and States' responsibilities, mandating each State develop "comprehensive, effectively working plans," referred to as Olmstead plans. The purpose of these plans is to show what States would do to support community reintegration (e.g., from nursing home to community) and long-term community living (e.g., maintaining choice and preventing institutionalization). However, States vary as to whether Olmstead plans exist, are available to people with disabilities in accessible formats, the level of detail in relation to proposed actions to rebalance funding and address institutional bias within the State, inclusion of methods to monitor and enforce plan implementation, outcomes realized, and actions taken to address continuing needs and gaps.[131]

Movement to Coordinate Housing and Community Living Supports and Systems

In addition to planning, the *Olmstead* decision also sparked disability advocacy and systems changes within States to rebalance funding to address issues of institutional bias. Starting in 2000, the Centers for Medicare and Medicaid (CMS) was instrumental in coordinating Real Choice Systems Change Grants for Community Living to fund the needed infrastructure, systems change, and policy revisions to offer real choice related

to community living with supports. This systems change was further reinforced within the New Freedom Initiative and President George W. Bush's Executive Order 13217 titled Community-Based Alternatives for Individuals with Disabilities.[132]

A number of significant changes were made to Medicaid's coverage of long-term care services within the 2005 Deficit Reduction Act (DRA) to further support use of funds toward community living options. Through March 2008, CMS also awarded approximately $285 million in Real Choice Grants that were used to support States in providing community reintegration supports (e.g., transition from nursing home or institution to community), cross-system coordination and infrastructure, and resource rebalancing to address institutional bias. For many States, this involved the creation and expansion of Home- and Community-Based Waivers (HCBSs) and long-term community living programs. For some States, such as Texas with its Rider 37, this systems change was also legislated. However, many States remained challenged in implementing real choice, with great disparities between States on implementation and resource rebalancing.[133]

The concept of Money Follows the Person (MFP) then was proposed and advocated as a mechanism for monies to follow the person into the community at levels equitable to those allocated for institutional/nursing home care. The MFP movement also brought to the fore the coordination of information, supports, services, and funding across systems, and the need for consumer direction and control throughout the process. CMS funded over $1.75 billion in MFP demonstration grants in 31 States, with States estimating to transition more than 27,000 people out of nursing homes and other institutions to the community using these initiatives. Of note, States needed to also show a plan to maintain these MFP initiatives long term after the demonstration period.

At the same time, disability activists rallied for accompanying MFP-related legislation that has since been enacted or is now pending in several States. This advocacy continues nationally with the Community Choice Act and other related legislation. Additionally, many class action lawsuits were brought against States in relation to violation of ADA civil rights and the *Olmstead* decision, further influencing systems

change and funding rebalancing within specific States.[134] In some cases, these suits resulted in the creation of promising practices from which other States can learn.

This brief historical overview demonstrates how and why different systems and funding mechanisms exist, their differing groundings and philosophies, and the complexity of housing and community living choice at the legislative and policy levels.

Key Issues Influencing "Real Choice"

States, and citizens with disabilities living in them, are facing several key issues influencing "real choice" access to affordable, accessible, and integrated housing.[135] These include differences in (1) definitions related to housing and community living/integration, (2) eligibility criteria, (3) systems funding levels and disparities, (4) information access, (5) coordinated, consumer-directed system delivery, and (6) monitoring and enforcement across systems.

Differences in Definitions

One key issue facing States is the variation in definitions related to disability, housing features such as accessibility and affordability, and community integration.

1. Defining Disability

For States providing housing services through HUD and community living supports through CMS, how disability is defined determines who receives services. For CMS and State providers, a disability determination is criteria-based and complex. By law, disability is defined as "the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."[136] This definition centers on showing proof of long-term medical need and economic need related to productive employment/gainful activity. Additional criteria related to medical necessity, functional performance status, and age further influence specific CMS program eligibility. For HUD

housing programs and providers, disability is defined at both the individual and household levels.

In comparison to these systems definitions, the Americans with Disabilities Act and ensuing systems change initiatives are based upon the civil rights framing of disability, which is "The term 'disability' means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such impairment; or being regarded as having such an impairment."[137] This definition was used in the *Olmstead* decision to assert the right to least restrictive choice; however, the systems involved in implementing those rights continue to use existing medical and economic-based definitions that shift the onus to the individual to demonstrate need, versus to society and the systems within it to support the civil rights of citizens with disabilities.

2. Defining Accessibility

The other side of the coin relates to how we then define the environment, as in housing and environmental modifications, at the federal, State, and local levels. This brings to the fore definitions related to accessibility, most often defined by the Architectural Barriers Act, the Federal Fair Housing Act of 1988 accessibility guidelines,[138] and Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. 794). Additionally, many housing developers point to Uniform Building Code or the International Building Code standards of accessibility, as well as to State and local codes and regulations.[139]

Each of these offers differing versions of "accessibility," which are further complicated by terms such as *adaptable* and *visitable*. Adaptable housing does not implement full accessibility features and is built to allow for easier adaptation or addition of these features should the person need it in the future. For example, the housing may have a closet or storage space built in a way that could accommodate an elevator or lift addition if needed. "Visitability" focuses on building in a minimal set of access features so people with disabilities can visit others in the community and be able to move around and use the first-floor entrance and bathroom.[140] Neither "adaptable" nor "visitable"

corresponds to full accessibility, and many consumers are confused by the differences in these terms and the accessibility or lack thereof when they move in. Many also are not aware that it would be their responsibility to pay for such adaptations to make the housing accessible, even though it is their right to add it. Additionally, “accessible” primarily pertains to physical and sensory access, with far less coverage and consideration of diverse issues related to cognitive, social, psychological, and environmental sensitivity.

Another area of confusion—and contention—is that many people believe that townhouses and single-family detached homes are not covered by these accessibility regulations, therefore excluding a large section of housing supply from scrutiny and requirements. While these regulations may not directly require that some types of housing include accessibility features when developed or rehabilitated, all housing is subject to requirements of reasonable accommodation. Furthermore, all public housing programs are subject to 504 requirements, so if this type of housing is produced with federal funds, it must comply with these laws.

3. Defining Affordable

Among the different State plans, private and nonprofit housing is expected to be built and/or made affordable through use of a diverse collection of public and private funds. Since the 1960s, the Federal Government has gauged affordability relative to assumptions about precisely how much all consumers should pay for housing as a portion of their incomes, which currently is 30 percent of income. For renters, this cost includes monthly contract rent plus utilities. For owners, it includes monthly mortgage payments, insurance, utilities, and taxes. For both renters and owners, regardless of income level, housing is not affordable if a household has to use more than 30 percent of its income on it.

4. Defining Integration

States have not specifically defined “integration,” but instead rely on ADA and *Olmstead* decision terminology related to “least restrictive” choice to guide the provision of

integrated housing, programs, and services. This framing focuses on what integrated choice is not—placement in nursing homes or other institutional settings without choice about community-based options—rather than describing what it is. More recently, MFP legislation and policies have referred to specific numbers in which "community-based" options may not include more than four people with disabilities living together. Thus, a group home with 8 to 10 people in it would not be considered a community-based option under current legislation. However, these criteria and their enforcement differ by State. There is great variance within States, and particularly among housing developers and providers within them, in what "integrated" or "least restrictive" choice includes, often leading to class action lawsuits to put parameters around integration and enforcement related to it.

Why are definitions important? These different framings and multiple definitions make it very difficult not only to deliver coordinated housing and community living services, but also to show need versus supply disparities, to compare issues and outcomes across States, and to monitor enforcement and learn from promising practices.

Differences in Qualifying and Eligibility Criteria

For the most part, States defer to funding sources to set qualification and eligibility criteria, and different funding sources use different criteria.[141] As an example, both CMS and HUD use income/asset criteria; however, each uses different thresholds to determine initial and continuing eligibility (e.g., HUD uses median income in relation to national poverty and income thresholds, while Medicaid uses income/asset thresholds determined via individual State statute).

Qualifications are not just based on income. For those individuals who also need to obtain community living supports through Medicaid, States also use functional needs determination and risk management assessments to determine eligibility, criteria that may vary significantly among States. Additionally, type of disability (e.g., physical, psychiatric, developmental) or age may preclude people with disabilities from accessing specific State programs even if they have a need. For people who identify with multiple

disabilities or acquire them as they age, access to housing and community living supports becomes much more complicated. They may lose access or be offered very different services when transitioning between or among systems, again placing them at risk for premature or unwanted institutionalization or homelessness.

Differences in Funding and Parity of Supports and Services

States also face significant issues related to funding of housing and community living supports, as well as disparities among different disability and aging constituencies in accessing this funding.

1. Housing System Funding

As part of States' Consolidated Plans, allocation of housing resources is to be guided by need; however, need far exceeds what is available. This is true also for the LIHTC program; while it is based on a per capita formula, the actual dollars it can generate per State are quite small relative to the cost of building new housing. In addition, as noted previously, the complexity of using multiple layers of financing makes it quite difficult for many affordable housing developers to juggle the different eligibility requirements of different funding streams, which can deter or derail efforts to produce quality integrated housing. Finally, while State plans provide counts of units for people with disabilities and seniors, it is very difficult to ascertain the number of people with disabilities who actually receive housing units, housing subsidies, or monies for eligible housing retrofitting, rehabilitation, and supportive services. Also, the data does not examine differences by different disability type. All these issues significantly influence whether people have "real choice" in deciding where they live, whether they are able to support or maintain that living over time, and the quality of their living situation.

2. Community Living and Long-Term Services and Supports Funding

To live in community-based housing options, many people with disabilities also need accompanying community living supports that are often funded by Home- and Community-Based or related Medicaid waiver programs, and/or other State long-term services and supports programs that fall outside waiver designations. One indicator of

whether States have progressed in rebalancing funds to address institutional bias and provide community-based living choice is to compare funds spent on institutional long-term care (including nursing homes, State institutions, Intermediate Care Facilities [ICFs], etc.) to those spent on Medicaid waiver programs to support community living and trends over time. Based on federal data, a recent analysis by Thomson Reuters[142] shows that significant progress has been made nationally in this rebalancing, moving from institutional to community funding ratios of 85 percent institutional/15 percent community in 2000, to 58 percent institutional/42 percent community as of 2007, with an average growth of 10 percent a year in community-based funding from 2002 to 2007. However, this data is limiting and can be misleading. First, the data does not tell us about community-based housing funding needs and trends, as they only reflect long-term care system funding. The data also does not reflect the number of people who are on waiting lists for community-based services, or those who cannot find affordable and accessible housing and therefore remain in institutional settings.

Additionally, this data is complex to interpret. Although we have made gains in rebalancing on a national level, the funding ratios vary significantly by State. As of 2007, only 11 States had rebalanced their spending to support community-based options at levels of 50 percent or more of their total long-term care budget (New Mexico, Oregon, Arizona, Minnesota, Alaska, Washington, Wyoming, California, Kansas, Colorado, and Maine). In comparison, the rest of the States spent less than 50 percent on community-based services, with several reporting 30 percent or less (Mississippi, North Dakota, Pennsylvania, Alabama, New Jersey, Tennessee, Arkansas, Ohio, and Kentucky). Thus, the State in which you live influences real choice.

Another example of State differences is how funds are allocated between different programs (e.g., aging, and physical, psychiatric, or developmental disability). The national ratio of 58 percent institution to 42 percent community across all disability groups shifts to 69 percent institution to 31 percent community when looking specifically at aging and physical disability group funding, with 16 States reporting less than 20 percent allocated for community waivers for these groups. Thus, one's age or

disability designation as defined by each State also influences real choice. For example, in some States, older adults with disabilities may be able to access funding for either personal attendant or homemaker supports depending on their level of need, while in other States, their choice is limited to homemakers who may not be trained or authorized to help with heavy lifting or personal care tasks such as bathing. In many States, waiver programs are not available to people with psychiatric disabilities, significantly limiting their choices. For people with developmental disabilities, some States offer funding for a full range of living options, including innovative family and least restrictive shared living options of four or fewer, while other States continue to primarily fund more segregated living options such as Intermediate Care Facilities or shared living situations of more than four people, thus also limiting real choice. Additionally, some States impose service limits, or caps, on individual funding that may further restrict community-based services, while other States using a more flexible Money Follows the Person (MFP) approach in which funds that would have been spent on institutional services follow the person to the community to be used more flexibly, as needed and as directed by the individual. In summary, although States have progressed in addressing institutional bias issues, significant disparities continue to exist among States in regard to real choice and long-term control in housing and community living.

Differences in Information Access

The need for accurate, accessible, and transparent information also is critical for people with disabilities to have “real choice,” so they can make informed decisions about where and how they live. Information access, quality, and coordination are key issues within States, especially for people with disabilities who may be trying to access information during times of housing or health crises or emergencies, or from within settings where information access is difficult, unavailable, or withheld. Additionally, information needs to be accessible via alternative formats if consumers and significant others in their lives are to actually use that information to make a “real choice.” Accessibility may also involve modifications in policies or strategies, such as increased time to process information before making decisions, or use of peer supports or other accommodations during the process. Accessibility also relates to information technology use, such as cell

phones, computers, Internet, and email. In some States, emergency cell phones and basic Internet access have been integrated into housing and community living support services and funding.

Information about choices also needs to be accurate and consistent across different systems and providers, such as homeless shelters, emergency systems, information hotlines/centers, community organizations, medical and rehabilitation systems, nursing homes, and other long-term care settings. Disability advocates also point to problems providing this information in a way that is unbiased, highlighting the potential role of Centers for Independent Living, Senior Centers, and Disability and Aging Resource Centers to collaborate on offering access to information and to support consumers in navigating across different systems. Some States also have collaborated with these groups to implement housing locator systems that provide information on accessible and affordable housing; however, the availability, quality, accuracy, and level of accessibility detail vary widely among these systems.[143]

Differences in Coordination of Supports and Services Across Systems and Quality Control, Monitoring, and Enforcement

As referenced throughout this report, States have shifted toward coordination of housing and community living systems, particularly within Real Choice and MFP demonstration grants and related State initiatives. However, coordination of services and funding sources currently varies widely by State. In many States, housing systems have not been coordinated with community living and long-term services and supports systems, making it very difficult for people with disabilities to coordinate housing vouchers or subsidies with needed community living supports. As shown previously, many States continue to use silo systems, with services based on different disability or funding systems, such as those related to aging, physical disability, psychiatric disability, and developmental disability. In comparison, some States have used Real Choice and MFP grants to break down these silos and offer coordinated information and services, as well as equitable access to community living supports across systems. Coordination of services and funding is also an issue for people with disabilities who move to different

communities within States, as well as those who relocate to another State. The challenge is to provide “no wrong door,” that is, coordinated points of entry so that consumers can understand their rights and access housing and community living information and supports. This also means that States need to develop and fund infrastructure to coordinate policies and monitor access to and provision of coordinated services. This coordination is especially important to consistently and rigorously compare outcomes, impact, needs, and disparities across States and across the nation.

Housing and Community Living Promising Practices

Despite these challenges and limitations, we see “promising practices” that have been or are being implemented by and within States in the areas of systems change, information access, legislation, monitoring and enforcement, and research related to housing and community living.

Systems Change and Coordination

One of the most promising trends at the State level has been the increasing cross-coordination of housing with community living and support systems, funding, and service delivery. These have been referred to as Single Access Points, One Stop Shop, No Wrong Door, and Comprehensive Entry Point systems. These systems enable consumers to enter through many different “doors,” or systems/programs, yet still receive coordinated, consistent, and quality information, counseling, housing, and community living supports and services. The Rutgers Center for State Health Policy/NASHP (National Academy for State Health Policy) Community Living Exchange Collaborative reported 43 single entry points operating across Medicaid programs in 32 States.[144] Many of these initiatives were developed with systems change demonstration grants from CMS and related national initiatives (e.g., Robert Wood Johnson’s self-determination and cash and counseling projects).[145]

Although many States used these initiatives to streamline entry within specific Medicaid programs, some States have used them to break down silos created by categorizing people by disability type (e.g., developmental, physical) or age across all State

programs, so no matter how or where people enter, they receive information about their choices and coordinated access housing and community living supports.[146] Such commitment to long-term, cross-systems change has been especially useful to people who are transitioning between living situations (such as moving from a nursing home, institution, or ICF to community living) or people having to navigate multiple systems (such as people with disabilities as they age, people who identify with multiple disabilities, or families in which multiple people with disabilities are living and aging together and need supports across systems). They are also useful for maintaining community living choices over a lifetime (including coordination of young child, adult, and older adult systems), and preventing or responding to institutional placements that are not of choice at any time.

These initiatives offer valuable strategies to States to formally integrate consumer direction and control across systems.[147] They also offer infrastructure and strategies for States to document needs, service delivery, costs, and outcomes over time across systems,[148] contributing to research that documents their impacts and cost effectiveness.[149]

Even more promising, several States are expanding to coordinate community living with housing systems and delivery. Many of these initiatives are based upon a Money Follows the Person framework to offer cross-system, consumer-directed choice. These involve development of new policies to enable States to fund and deliver this coordinated package across systems. Current promising practices include:

- State initiatives to coordinate Home- and Community-Based Waivers with housing vouchers or subsidies via innovative funding collaborations, including use of HOME funds for rental assistance during transition to the community (e.g., Kentucky's Housing Finance Agency has allocated $50,000 in HOME funds to fund bridge subsidies, and Ohio's Dayton Metropolitan Housing Authority announced the use of HOME funds to fund tenant-based assistance and Section 8 funds for project-based vouchers for people with mental illness who are homeless).

- Development of Home Modification/Barrier Free Housing Trust Funds.
- Reuse of funds from institutional downsizing and closures for expanded housing vouchers, rental assistance, and community support packages.

As an example, Pennsylvania is implementing several of these practices in its Statewide systems change initiative, which coordinates between the Pennsylvania Department of Public Welfare and the Pennsylvania Housing Finance Agency (PHFA).

Two States, North Carolina and Louisiana, have been featured as examples for implementing Statewide, cross-systems change initiatives to coordinate mainstream affordable housing and community living systems for people with long-term disabilities, including people with disabilities who are homeless.[150] These include a targeted collaboration of health and human services systems and housing authorities across the State, including the use of bonus points within Qualified Allocation Plans (QAPs) with housing developers to target 10 percent set-asides for people with disabilities with extremely low incomes (below 30% of AMI), and the use of Targeting Plans and Local Lead Agencies to ensure coordination among community service providers and property managers with tenants with disabilities, and the provision of reasonable accommodations and supports. Louisiana replicated North Carolina's systems change to further target the needs of people with disabilities post-Katrina, adding the use of CDBG funds to support infrastructure and long-term support provision.

Cross-System Navigation

Several of these systems change coordination initiatives have formally incorporated coordination with regional Aging and Disability Resource Centers, Area Agencies on Aging, and Centers for Independent Living to provide information, case management, peer mentoring, legal assistance, and connections to related community living, transportation, social participation, and employment opportunities. Coordination also involves continuous education of staff across systems and delivery programs. Public Housing Agencies have used service coordinators to assist consumers with locating housing, employment, and social service information. Several States are using Centers

for Independent Living (CILs) and peer mentors to support consumers in navigating complex housing and community living systems and programs. For example, Pennsylvania is funding regional housing coordinators whose role is to provide coordinated information and assistance to individuals and organizations that help people with disabilities transition from institutions to community living, to educate property managers and housing developers on how to develop and market least restrictive housing options to people with disabilities, and to monitor that the housing needs of people with disabilities are being addressed.

Another example of such an initiative has been facilitated by Access Living, a Center for Independent Living in Chicago, Illinois.[151] Access Living has collaborated with the Chicago Housing Authority (CHA) to promote coordinated housing and community living information, increased access to and use of housing vouchers (Home Choice) by people with disabilities, and designated vouchers for people moving out of nursing homes and institutions to community-based options. This close collaboration has resulted in actions, such as the creation of an Office on Disability Policy within the CHA, a 504 self-evaluation, a 504 Voluntary Compliance Agreement, audits of accessibility of new housing by an architectural firm specializing in disability-related access, funding of a home modification fund for people receiving Home Choice Vouchers, time extensions and transportation support during the housing search, and creation of a targeted program and vouchers for people moving out of nursing homes to the community. Joint counseling sessions by Access Living and the CHA are conducted at Access Living to support people during this process and ensure the successful use of vouchers.

Promoting Integrated and Least Restrictive Choice

Several States have targeted initiatives to create and expand integrated housing choices. As an example, Washington is using federal demonstration grant funding to collaborate with local housing authorities throughout the State to develop more integrated and less restrictive (four or fewer) community living choice models and evaluate their impact. Oregon continues to expand community housing in small neighborhood homes, and is also developing individual apartment housing in which

consumers can share support services with other consumers with developmental disabilities. Virginia is working to revise legislation and policies to enable people with developmental disabilities to share an apartment or single-family home with supports.

Increasing Information Access with Housing Locator Systems

Access to consistent, quality, and current information about affordable, accessible, and integrated housing choices and features is critical. A number of States have developed housing locator systems that allow online searches of affordable housing units.[152] These systems range from minimal databases of State-financed developments to more sophisticated sites with multiple search options, detailed accessibility information, updated vacancy and occupancy status, and links to local service agencies and resources. Following are some examples of housing locator promising practices.

Socialserve.com

Socialserve.com is a nonprofit agency and the largest database provider of multistate housing registry services. Registries include listings of affordable rental properties in 27 States, and affordable housing for sale in 8 States and 1 county. Socialserve.com includes a toll-free call center with multilingual staff members who help landlords and tenants search the database. They can work with a particular State or community to customize a housing registry to meet specific needs. For example, registries can include a filter for searching for specific accessible features, such as bathrooms with grab bars and/or roll-in showers, kitchens with low counters, or entryways with flat or no-step entry.[153]

Mass Access: The Accessible Housing Registry

Maintained by the Citizen's Housing and Planning Association, Mass Access helps people with disabilities find barrier-free, accessible housing in Massachusetts. This housing locator includes information on the availability of affordable and accessible apartments, waiting list openings, information on homeownership opportunities, and links to housing locators in other States. Users can also search for specific accessible/adaptable features.[154]

Access Virginia: Virginia's Accessible Housing Registry

Access Virginia is sponsored by the Virginia Housing Development Authority and the Virginia Board for People with Disabilities. Access Virginia includes information on affordable and accessible apartments, as well as information about accessibility requirements and universal design. The site includes an Accessible Apartment Finder, an index of accessible housing resources, an interactive map to Centers for Independent Living (CILs) in Virginia, and links to related housing services and retailers of accessible appliances.[155]

National Accessible Apartment Clearinghouse

This clearinghouse is a national database of more than 80,000 accessible apartments across 50 States. The clearinghouse is a public service program of the National Apartment Association, the Virginia Housing Development Authority, and other organizations. Information is available from the clearinghouse via the Web, fax, or a toll-free hotline.[156]

Housing Connections

In Portland, Oregon, Housing Connections is an example of a city-sponsored site maintained by the city's Bureau of Housing and Community Development, with data provided by landlords on rental, for-sale, and shared housing.[157]

To link locators to long-term systems change, some States, such as Louisiana, have incorporated housing locators into housing developer contracts to make it easier for individuals to identify available housing options and to improve marketing of affordable and accessible units by developers to consumers.

Legislative Promising Practices

Many States have been hampered by current policies that restrict how monies can be used to provide services in a least restrictive, community-based setting. Given ongoing disability advocacy, some States have enacted legislation to rebalance Medicaid monies toward community-based options. Two examples are Texas and Vermont.

Texas Rider 37 of the General Appropriations Act of the 77th Legislature enables the Texas Department of Human Services to allow money to follow the person from a nursing facility to the community. Funds were transferred from nursing home appropriations to the HCBS waiver program to provide "real choice." Texas was one of the first States to enact such State legislation and policy, and estimates that as of 2007, 13,300 people will have transitioned from nursing homes to the community via this initiative.[158] Passed in 1996, Vermont Act 160 allows funds appropriated for nursing home care to be used for home- and community-based services, including for people who have the most significant support needs. In addition, the act created a Statewide system of Long-Term Care Community Coalitions to improve the infrastructure for Medicaid waivers and the long-term services and supports programs.[159]

CHAPTER 5. Best and Promising Practices in Accessible and Affordable Housing

While accessible, affordable, integrated housing remains elusive for many people with disabilities, various private and nonprofit organizations have tackled the problem by challenging federal and State policies that foster segregation and institutionalization; by capitalizing on federal State and local programs that offer various financial incentives and resources; and by building, operating, and managing housing that fosters the spirit and goals of independent living and self-determination for people with diverse disabilities. In some cases, multiple community partners working together have found ways to tap a variety of funding sources to ensure that residents have access to housing that is affordable, accessible, and integrated, and also provide voluntary supportive services as needed.

Most housing and supportive services that people with disabilities require to live as independently as possible exist in large measure because federal, State, and local housing policies dictate specific goals and allocate annual funding. Private and nonprofit organizations that develop and manage or operate housing or provide supportive services are dependent to a significant degree upon a combination of these public resources, as well as on certain private sources of funding that vary regionally. Consequently, any discussion of promising housing practices must acknowledge the extent to which public policy drives the development of projects as well as the influence of effective disability advocacy on both policies and final projects. Many of the following promising housing policies and practices illustrate the extent to which these factors are inseparable.

Examples of innovative policies, partnerships, and programs are described below that increase access to homeownership for low-income people with disabilities; facilitate, promote, or illustrate the principles of integration, affordability, accessibility, and scattered-site placement; and exemplify supportive housing. Examples of local and State policies calling for universal design or visitability are also presented. Several multiuse, low-income, integrated housing projects are described that embody principles

of universal design, and outcomes of several disability rights lawsuits illustrate how the promise of increasing integrated, accessible, affordable housing can be realized through litigation.

Intensive Homeownership and Housing Support

United Cerebral Palsy of Texas, Austin, Texas

Founded in 1954, the nonprofit United Cerebral Palsy of Texas (UCP Texas), Austin, Texas, is the State affiliate of United Cerebral Palsy, a national advocacy and support network for people with disabilities. The mission of UCP Texas is "to ensure that people with cerebral palsy and similar disabilities have the opportunity to participate fully and equally in every aspect of our society."[160] Serving all ages and people with all disabilities, UCP Texas provides technical assistance and support to families and individuals, advocates for people with disabilities, and organizes a variety of programs and services. A central component of UCP Texas's work focuses on assisting people with disabilities and their families to find housing. This work is driven by four goals: "to increase homeownership opportunities for people with disabilities; to increase the housing stock of accessible homes; to increase awareness of the need for more affordable, accessible, and integrated housing; and to educate people with disabilities on how to be successful homeowners."[161] These goals guide innovative housing programs that aim to provide affordable, accessible, and integrated residences for people with disabilities. Program descriptions follow.

The **Texas Home of Your Own (HOYO) program,** supported by HOME funds awarded through the Texas Department of Housing and Community Affairs, began in 1995 as part of the now-defunct National Home of Your Own Alliance and is now offered by UCP Texas. HOYO provides first-time homebuyers who are eligible with up to $15,000 in down payment assistance. These funds are awarded as a 10-year, deferred, no-interest, and forgivable loan that depreciates 10 percent each year; a second lien is placed on the home for 10 years. After that period of time, the loan is forgiven if the homeowner does not foreclose or sell the home, seek a home equity loan, or cease using the home as a primary residence. As of 2007, approximately 320 households or

individuals had become homeowners through the HOYO program. In order to be eligible for assistance, household income (typically SSI - Supplemental Security Income, and/or SSDI - Social Security Disability Insurance) cannot exceed 80 percent of Area Median Income (AMI), and most of the individuals UCP Texas has served through this program have had incomes at or near 50 percent of AMI.[162]

UCP Texas also provides for very low income people with disabilities to rent. Using affordable integrated, accessible apartments Section 811 funds from HUD, UCP Texas purchased two sets of condominium units, the first in March 2005 and the second in April 2008. Section 811 funds are frequently used to construct segregated group homes or apartment complexes for people with disabilities. However, UCP opted to use its Section 811 money to purchase 16 units integrated within two buildings populated primarily by professionals, students, and retired individuals.[163] It then found tenants by advertising through disability organizations and quickly filled the units.

UCP Texas also provides support, training, research, and advocacy to promote housing opportunities for people with disabilities. The organization's direct involvement with housing for people with disabilities has helped promote affordable, accessible, and integrated housing. UCP developed a comprehensive training package that the organization has used to train more than 100 public housing authority staff members. In addition, UCP trains nonprofit housing, social service, and disability advocacy professionals on how to promote consumer-directed barrier removal, and it provides technical assistance to the city of Austin as it undergoes an architectural barrier removal program.[164]

UCP Texas has successfully created integrated, affordable, and accessible housing for people with disabilities through HOYO and its use of Section 811 funds, "doing something that very few people thought was possible 10 years ago."[165] Furthermore, the program's support to homebuyers enabled them to weather the recent subprime mortgage crisis. None of the individuals who took advantage of HOYO financial assistance faced foreclosures, an unexpected benefit that came from stringent

requirements UCP Texas places on its homebuyers: loans that UCP supports must be than 1.25 percent above prime rate.[166]

Yet this work has not been without its share of challenges. Housing programs are expensive, and federal and State funding is limited. Home prices have increased from as little as $55,000, when HOYO began, to today, when "potential homebuyers have a hard time finding anything less than $100,000."[167] New State funding restrictions on HOME funds have forced UCP Texas to discontinue its home rehabilitation program, which supported accessibility modifications for new home purchasers. Furthermore, the organization not only has to plan and implement its programs, but it also has to challenge the perception that people with disabilities are dependent. UCP Texas found that they have to educate lenders about the disability community, many of whom rely on nontraditional income sources like SSD/SSI: "Early on, we had to do a lot of education, telling lenders [that SSI/SSD] income is steady income."[168] Moreover, UCP Texas had to sell the idea of scattered-site rentals to both HUD and the State of Texas because the norm is segregated disability communities.[169]

Housing Initiatives Program, Institute for Disability Studies, University of Southern Mississippi, Hattiesburg, Jackson, and Gulf Park, Mississippi

Based in Hattiesburg, with satellite offices in Jackson and Gulf Park, the Institute for Disability Studies (IDS) of the University of Southern Mississippi is the State's University Center for Excellence in Developmental Disabilities (UCEDD). A university-based nonprofit, IDS serves people with disabilities through a range of activities, including direct service, training, technical assistance, and research. Among these activities is IDS's Housing Initiatives program, which provides or facilitates homeownership assistance and loans, technical assistance, and training opportunities, as well as direct service to homeless people with disabilities. These efforts aim to serve people with diverse disabilities, including mental health issues and chronic illnesses. IDS's Housing Initiatives began in 1997 with a $25,000 HOME funds grant from the Mississippi Department of Economic and Community Development.[170] The program has expanded

through subsequent competitive grants and now has an annually allocated, noncompetitive budget.

The largest component of IDS's Housing Initiatives is its **Home of Your Own (HOYO)** program, which provides home purchasing assistance grants of $10,000 and $15,000 to low- to moderate-income people with disabilities and families with a member with a disability. Along with these grants, HOYO offers its participants person-centered planning through individualized support and guidance. This includes helping participants secure a loan for the remainder of the house's cost, pre- and post-purchase homebuyer counseling, referrals to services as needed, and advocacy with lenders. HOYO grants may be used for down payment, closing costs, principal reduction, and modifications necessary for accessibility. HOYO participants then choose from one of 15 partner lenders, many of whom use Fannie Mae's Community HomeChoice product for low- to moderate-income people with disabilities. The HOYO program has three primary components as determined by its funding sources. The first is HOME funds set aside by the Mississippi Development Authority ($500,000), Mississippi HOYO, which has assisted 256 individuals in obtaining homeownership in 44 of the State's 82 counties.[171] Second, drawing on HOME funds from the city of Jackson, Community Service Division ($264,000), HOYO has helped 52 individuals and their families to secure homes within Jackson's city limits. The third component, funded by the City of Hattiesburg, Community Development Division, provides counseling and $15,000 HOME grants to Hattiesburg residents.

The income for approximately 75 percent of HOYO participants comes primarily from Social Security benefits, while the income of the remaining 25 percent comes from conventional employment.[172] In spite of problems that confront current would-be homeowners, HOYO participants have less than a 2 percent default rate on mortgages.[173] IDS staff attribute this success to HOYO's "wraparound" support services, which involve counseling and advocacy.[174] These successes have been recognized with the HUD 100 Best of the Best Practices Award (2000) and the

Mississippi Governor's Communities of Excellence Award for the State's best homebuyer program (2002 and 2007).

The IDS administers several other programs supported by the Federal Home Loan Bank (FHLB) that provide funds and support to assist people with disabilities in becoming homeowners. First, the **FHLB Disability Initiative** has provided a $10,000 home purchase assistance grant for down payment, closing costs, and principal reduction to 10 very low income, 10 low-income, and 3 moderate-income families with a member with a disability.[175] Second, the **Special Needs Assistance Program (SNAP)** grant has provided $5,000 to 8 eligible families whose gross household income exceeds 80 percent of the median income level (adjusted by household size and county) to support home rehabilitation to make the homes accessible.[176] Finally, the **Mississippi Disability Initiative** has provided a $15,000 grant to each of 30 very low income to moderate-income families with a member with a disability in rural communities.

In addition to the financial assistance programs, IDS runs six other outreach, counseling, education, and direct support programs relating to housing for people with disabilities. First, the **Delta Housing Initiative,** funded by the F. B. Heron Foundation and started in January 2007, provides pre- and post-purchase counseling to 120 households and offers assistance to people with disabilities to find safe, affordable housing and community-based supports.[177] Second, IDS provides credit counseling, homebuyer education, and counseling services to Mississippi residents with funds from the Mississippi Home Corporation (MHC)/Freddie Mac Comprehensive Housing Counseling Grant. Third, IDS's HousingSmart program provides outreach to individuals with disabilities. To date, it has sponsored a total of 40 workshops that trained 657 people and disseminated printed and electronic fair housing information to an estimated 71,276 individuals.[178] Fourth, the Individual Development Account (IDA) initiative is designed to help low-income individuals and families who meet requirements set by the supporting foundation to become homeowners with a 3 to 1 match on funds to use for down payment or closing costs.[179]

The last two programs target homeless individuals with disabilities and their families. HUD-funded efforts, the **Shelter for All** and **Comprehensive Housing Counseling** programs, together provide one-on-one counseling, referrals, and specialized disability-related case management to eligible potential homebuyers. These services involve optional person-centered planning sessions that allow people with disabilities to gather relevant people (family, advocates, etc.) to collectively identify goals and challenges and plan how to secure permanent housing.[180] As of May 2008, these homelessness-related efforts have served more than 805 individuals.[181]

The Lease-to-Own Model: The Arc of the Central Chesapeake Region (formerly The Arc of Anne Arundel County), Maryland

The Arc of the Chesapeake Region in Annapolis, Maryland, a nonprofit service and support provider for people with developmental disabilities, started a project called **Opening Doors** in 1999, with a 2003 follow-up project called **More Doors to Open**. The Arc seeks to provide people with disabilities housing opportunities that are integrated, affordable, and emphasize self-determination. The Arc's housing efforts involve several components, including independent living counseling.[182] When Opening Doors began, the organization recruited four people with disabilities interested in living at a development through a lease-to-own model, and two others interested in renting other apartments. At the same time, the Arc helped people with disabilities attain Section 8 rental vouchers and State supports, published two guides related to housing for people with disabilities, and developed a "designated representative" role to allow a person with a disability to select someone to act on his or her behalf in housing matters.

The Arc's homeownership efforts culminated in a 56-unit complex named Homes at the Glen**,** the residents of which are restricted to 50 percent of Area Median Income.[183] Monthly rent payments include $15 payments to accounts that will be used to help buy the unit at the conclusion of the 15-year lease. Residents are responsible for home maintenance, volunteering, and taking part in self-governance activities. Service coordination and case management is provided by an agency funded by the Maryland Developmental Disabilities Administration. Anecdotal evidence suggests the Homes at

the Glen initiatives have been very successful.[184] Resident comments are positive and they report satisfaction with living independently in places they have chosen, they volunteer and participate in other community activities, and they appear to have improved their employment and health stability.[185] Currently, the Arc is working to expand its efforts with a new financial literacy program, a plan to replicate the program elsewhere, and by increasing the participation of communities of color.[186]

A combination of private, State, and local funds and support, together with innovative State policies, paved the way for the successes of the Opening Doors and More Doors to Open projects. Residents of the Homes at the Glen development benefited from Maryland's 1915(c) waiver, which allows States to offer Home- and Community-Based Services (HCBS) waivers that provide individuals with support (employment, direct personal care, home modifications, etc.) to remain in their own homes rather than in institutions. Direct grants came from private foundations, the Maryland Developmental Disabilities Council, and the Maryland Developmental Disabilities Administration.[187] The Maryland Department of Housing and Community Development (MDHCD) provided a second mortgage to the project and an annual allocation of $501,447 in equity-generating tax credit.[188] On the local level, the Anne Arundel County Housing Commission granted a $700,000 HOME loan, and the city of Annapolis and Anne Arundel County granted low payments in lieu of real estate taxes to make rent affordable. Another important State resource for this project was a 2002 MDHCD amendment to the State Qualified Allocation Plan.[189] The amendment provides bonus points in the competition for federal Low Income Housing Tax Credits (LIHTCs), as well as gap financing to applicants who build units for people with disabilities. LIHTC and gap-financing applicants who seek the points must reserve and market as much as 10 percent of the proposed project's units to people with disabilities for at least 30 days, beginning when the project is 80 percent complete. When completed, the project must be marketed exclusively to people with disabilities for 30 days.

Support for Independent Living

Neighbors, Inc., Franklin Park, New Jersey

Founded in 1995, nonprofit Neighbors, Inc., of Franklin Park, New Jersey, aims to support people with disabilities in living self-directed lives. Supporting more than 100 people in New Jersey and Pennsylvania, Neighbors emphasizes empowering individuals and their families rather than agencies, listening to people's aspirations and working to realize them, and helping them find friends, jobs, and homes.[190] Based on the founders' experiences with agencies with costly offices and overhead, they selected an alternative model of organization and support.[191] With no central office, the staff is small, with an executive director, an agency director, and five advisors who coordinate support for five to seven people.

Neighbors' employees view themselves as agents for the people they support.[192] To this end, Neighbors will work with anyone who chooses the agency to develop a support plan based on a budget determined by the individual. With support from Neighbors, many people who once lived in group homes or other institutions have been able to move on their own or with housemates into integrated housing that include apartments, condos, rentals, and homes they own.[193] Neighbors also provides daytime support for employment, volunteering, business ventures, and other community activities as alternatives to sheltered employment and day habilitation facilities. Meeting once a week or more, advisors assist each person with a variety of tasks, including hiring personal assistants (PAs), scheduling and managing PAs, and searching for employment or volunteer opportunities. By supporting people who may need assistance in managing PA services, Neighbors enables them to make use of another resource for increasing self-direction.[194] Finally, advisors also facilitate meetings between each person and his or her family, PAs, and case managers to further planning.

Neighbors has succeeded in supporting people with disabilities who want to live in integrated community settings. However, the organization faces challenges, such as limited funding, which mostly comes from State contracts through Medicaid waivers and private donations.[195] The Neighbors director explains that the flexibility and openness of

relevant State officials to the organization's alternative service model and a New Jersey Division of Developmental Disabilities program called Real Life Choices assists the organization's work. Real Life Choices promotes greater self-determination through individual budgets, which it arranges through allocations from Medicaid waivers guided by individually based reviews of support needs.[196]

Onondaga Community Living (OCL), Syracuse, New York

Based in Syracuse, New York, Onondaga Community Living (OCL) is a nonprofit that seeks to "empower and individually support people with developmental disabilities in their efforts to live full lives as integral, respected members of their community."[197] Started in 1987, OCL's current efforts grew out of lessons learned from operating group homes. OCL staff perceived that such homes were not meeting the needs or desires of their residents. In an effort to individualize and personalize services, the organization closed two of the homes and implemented a support model based on the needs, desires, and aspirations of the individual. The support enables the individual to live in integrated housing that is neither linked to services nor removed from participation in the wider community.

OCL's support takes several forms, including residential support, which is provided to approximately 50 people throughout Syracuse and the surrounding area in both urban and rural settings.[198] This support helps individuals remain in their own housing, which includes rentals and homes they own or that are held in trust. Support ranges from a few hours per week up to 24 hours a day through OCL-facilitated live-in housemates. General support may include personal care, housekeeping, cooking, nursing, or other services, but emphasis is always placed on the belief that everyone's home life is different and that everyone has unique desires and needs. Support outside the home includes service coordination, vocational assistance, and an academic initiative that enables people to attend college classes and activities (e.g., labs and social events) at Syracuse University.

OCL's support services are funded through Medicaid waivers.[199] Historically, federal and State policies have not encouraged or emphasized person-centered residential support services. In the absence of such policies, the OCL's executive director attributes its successes to its personalized model and philosophy of support, as well encouragement from and the flexibility of the New York State Office of Mental Retardation and Developmental Disabilities. In light of the predominance of relatively traditional group and congregate homes and related service systems for people with developmental disabilities, the State has nonetheless been open to alternative strategies for the use of funding. Further testifying to the promise of its support model, OCL is replicating its efforts elsewhere. To support greater numbers of people while remaining relatively small, the organization has developed a new organization called Connections of CNY, Inc., Syracuse, New York, which is currently in the process of raising start-up funds.

Options in Community Living, Madison, Wisconsin

Founded in 1981, the nonprofit Options in Community Living in Madison, Wisconsin, provides residential support to 102 people with developmental disabilities, ages 23 to 30. By using Section 8 rental subsidies, these individuals live in housing dispersed through the Madison metropolitan area, rather than remaining in congregate facilities. Approximately 45 of those participating in the program have roommates, 11 are homeowners, 2 live in homes held by family members on their behalf, and almost all the remaining individuals hold leases on rental units.[200] Options aims to support these individuals so they can participate as full community members. The organization does this by "approach[ing] support by building relationships with individuals," emphasizing each person's "hopes, dreams, and interests," and collaborating with family members when possible.[201] Intended to assist each person to "live life without life being about services," support is based on the model of self-direction.[202] The organization begins by carefully matching individuals seeking support with staff members who fit their personalities and can help address their needs. Service coordinators provide organizational oversight and help address challenges with other agencies, but the focus remains on the needs and desires of each individual being supported. Services, which

range from a few hours a week to 24 hours a day, might include personal care, household management, dealing with a landlord, assisting with financial management or energy assistance, and access to transportation systems, including paratransit.

Options has benefited from strong county support, including a commitment to self-directed services and the county's exceeding the required match on Medicaid waiver funds available for services that promote dispersed housing.[203] The organization also benefits from Wisconsin's relatively minimal requirements for service providers to qualify for funds from Medicaid waivers. The organization's director explains that this flexibility allows them to support people as active leaders in their own process, instead of having to follow conventional models focused on providing services to passive clients.

Recently, however, county budget cuts have undermined the organization's capacity. Consequently, in order to continue being supported, 11 individuals have moved to a 60-unit building with affordable units rather than remaining in housing dispersed throughout the community. Though this has allowed these individuals to continue with support, the organization views this "clustering" unfavorably, since it undercuts the commitment to dispersed, integrated housing and the principle of supporting individuals rather than groups.[204]

LifeLong Supportive Housing Program (Alameda County Health, Housing, and Integrated Services Network), Oakland and Berkeley, California

LifeLong Medical Care (LMC), which currently provides a broad range of health and social services to people of all ages, began as a storefront operation by the Gray Panthers, a senior citizens advocacy organization that merged with Berkeley Primary Care Access Clinic in the mid-1990s and rapidly expanded to become a community health center (CHC) with clinics located on five sites. LMC is a "safety net" provider of medical services to people who are uninsured and who experience complex health needs in Berkeley, Albany, Emeryville, and parts of Oakland, California.

LMC's Supportive Housing Program (SHP), also known as the Alameda County Health, Housing, and Integrated Services Network, is a collaboration of public and private

agencies that provide permanent housing and social and health services to formerly homeless people with disabilities. SHP provides onsite support services to approximately 600 tenants living in eight subsidized housing sites scattered throughout Berkeley and Oakland. Services provided by SHP are optional and available to all tenants living in this housing. LMC collaborates with nonprofit housing development corporations that create and operate affordable housing in Alameda and

Contra Costa counties. Supportive services include outreach, intensive case management, housing stabilization, eviction prevention, benefits advocacy, money management, medical care, mental health and substance abuse services, community building and social activities, and employment and vocational support.

Supportive Housing Programs for People with Psychiatric Disabilities

The following offers a closer look at three types of permanent housing programs for people with psychiatric disabilities. **Pathways to Housing** is the nation's oldest "housing first" program and has been heavily studied. It provides permanent, scattered-site supportive housing with voluntary, flexible, and individualized support services delivered by a staff that is heavily composed of peer providers. There are no requirements to use support services or abstain from substance abuse to either obtain or maintain housing, and tenants are accepted directly from the streets, homeless shelters, psychiatric wards, and correctional facilities.

The **Mental Health Association of New Jersey's Residential Intensive Support Team (RIST)** program is a modified housing first program because it requires agreement to continue psychiatric medications and participate in a treatment plan as a condition of obtaining housing, but not as a condition of maintaining it. Until 2009, all of its tenants came from a psychiatric hospital through a discharge planning program. It provides individualized onsite support services in scattered-site housing delivered primarily through psychiatric survivors.

Main Street Housing does not meet the definition of permanent supportive housing because it offers only housing. Rather than directly offering support services, it provides referrals to community-based support services upon request. It offers a mix of congregate and single-residency housing, and does not accept tenants with co-occurring substance abuse or who have committed violent crimes. Because it does not offer support services, it only accepts tenants who can demonstrate an acceptable degree of "wellness." However, it is included here because it appears to be the nation's only housing program for people with psychiatric disabilities that is entirely run by psychiatric survivors, and service provision by peers has been found to be an important predictor of housing success for people with psychiatric disabilities.

Pathways to Housing

In 1992, Pathways to Housing (Pathways) pioneered a new way of housing people with psychiatric disabilities that has come to be known as the "housing first" model.[205] Based in New York City, the program was founded by Dr. Sam Tsemberis, a clinical psychologist who had worked with homeless people with psychiatric disabilities. Tsemberis believes that housing is a basic human right, and should therefore be offered without any precondition, whether or not tenants agree to pursue treatment.[206]

Pathways provides housing to homeless people with mental illness and co-occurring substance abuse—the population that other homeless prevention programs have found most difficult to place. Tenants are offered independent private housing in the community when they enter the program. The only requirements to obtain housing are to agree to participate in biweekly visits by a service coordinator, attend a money management program, agree to pay 30 percent of income toward rent, and abide by a standard lease.

Pathways rents apartments via a network of landlords, and sublets the units to its tenants. By making timely rent payments and intervening quickly to solve tenancy problems, Pathways is able to maintain a stable number of units. Tenants are offered up to three units to choose from when they enter the program.

To ensure full community integration, the program does not rent more than 10 to 20 percent of the units in a building. Tenants are free to stay as long as they wish. There is no requirement to participate in mental health or substance abuse treatment. Tenants choose whatever support services, if any, they want.

Services are delivered onsite and are available 24 hours a day, 7 days a week, via an Assertive Community Treatment (ACT) team or at Pathways offices. ACT teams consist of a case manager—typically a peer counselor or former consumer—and a nurse, psychiatrist, social worker, vocational rehabilitation counselor, drug counselor, and administrative assistant. Approximately half of Pathways staff are in recovery from mental illness, substance abuse, or homelessness.

Staff help tenants develop independent living skills by accompanying them on trips to buy groceries, visit doctors, and perform other activities in the community. Depending on what a client wants, case managers can work directly with the client or, as tenants proceed toward recovery, can provide referrals to community services. The intensity of services is adjusted relative to a client's evolving abilities.

Pathways offices offer a range of support services and opportunities for socializing and recreation. There are writing groups, photography groups, computer classes, science groups, and people go to the movies together and socialize.

A person with a psychiatric disability's need for housing is no different from anyone else's. Housing is constant, while services vary as a function of disability. Unlike supportive housing programs that preceded Pathways, tenants who refuse mental health and/or substance abuse treatment and those who continue to abuse drugs or alcohol are not threatened with loss of housing, so long as they continue to comply with their lease.

Tsemberis believes that people with psychiatric disabilities have the capacity to immediately move into their own home in the community. He points out that homeless people have substantial survival skills that are masked by their disability. Homeless

people know where to go for meals, where to collect SSI checks, where to seek medical care, the location and eligibility rules for shelters, where to sleep when shelters are full, and what parts of the town are relatively safe to travel through. Tsemberis also believes that relief from the daily stress of life on the streets allows tenants to begin to focus on addressing other needs and developing the skills that can foster recovery.

> Pathways to Housing provides people with an apartment of their own first, so that they may find a reprieve from the war zone that is homelessness. Assistance is provided every step of the way so that tenants have all the support necessary to move and integrate into their community, and to begin the long journey through the recovery and rehabilitation process.[207]

Research substantiates the effectiveness of the housing first approach. One study demonstrated a direct relationship between participating in a housing first program and decreased homelessness and increased perceived choice.[208] This study also suggested that this approach may have a distal effect on decreased psychiatric symptoms. People in the housing first program obtained housing earlier, remained stably housed, and reported higher perceived choice.[209] Living in their own apartment through a housing first program and having choices also had a great impact on the psychological and social integration of people with mental illnesses.[210]

> Pathways to Housing separates housing from treatment. It treats homelessness by providing people with individual apartments, and then treats mental illness by intensive and individualized programs that seek out and actively work with tenants as long as they need, in order to address their emotional, psychiatric, medical and human needs, and on a twenty-four-hour, seven-day-a-week basis.[211]

Tsemberis believes the housing first approach is far superior to the status quo: “People with mental illness are in jail, or homeless, or in and out of psychiatric institutions. This is better, and far more cost-effective…. A housing first approach requires an agency to take the risk of putting people with mental illness and addiction into apartments and assume liability for that. Most programs want a containment/supervision model—that’s not based on data, but rather on prejudice about mental illness.”[212]

Finally, Pathways has an 80 percent tenant retention rate and is far more cost effective than emergency services used by homeless people with severe mental illness.[213]

Mental Health Association of New Jersey: Residential Intensive Support Team (RIST)

The Mental Health Association of Morris County, New Jersey, operates a permanent Supportive Housing Program for patients leaving Greystone Park Psychiatric Hospital.[214] It is known as the RIST program because it uses a Residential Intensive Support Team to provide support services. The program began housing 21 people in 2004 and has grown slowly since. By the end of 2008, the program served 36 people, and a total of 49 people had been housed directly from hospital discharge since the program's inception.

RIST staff meet with potential tenants before they are discharged from Greystone. They help patients locate private, single-residency, scattered-site housing in the neighborhood of their choice. The patients are then discharged directly into their new homes. The lease is in the tenant's name.

RIST is a modified housing first program, in that it seeks to serve "recovery-oriented" patients deemed ready for discharge. Patients must agree to continue to take their medication and participate in a treatment plan to win acceptance into the program. However, patients—referred to as "customers" by RIST staff—are not removed from their housing or from the program if they refuse to take medication or adhere to their treatment plan. The only criterion for maintaining housing is lease compliance.

Housing is permanent, with allowance for periods of absence from the unit of up to approximately 6 months, and sometimes longer on a case-by-case basis. If a customer cannot comply with the lease and is evicted, RIST staff will offer a new placement. Customers are allowed three housing placements before they are turned away from the program.

RIST customers are offered a rich array of support services in their units, in the community, and at a RIST drop-in center/social club. Most services consist of developing independent living skills, such as cooking, housekeeping, hiking, and accompaniment to spiritual services. Services are delivered by nine community life coaches, all of whom are consumer providers. RIST staff also help customers access vocational rehabilitation programs and educational programs. One customer obtained a massage therapy license, another completed a program in heating and air conditioning repair, and a third graduated from the RIST program and is pursuing a degree in pastoral counseling. Services are available 24 hours a day, 7 days a week.

In addition to community life coaches, RIST staff include one master's level residential coordinator, one full-time assistant coordinator, three full-time senior residence counselors (one of whom is a consumer provider), and a part-time nurse consultant. In addition, the program shares a bookkeeper, a housing development specialist, and a psychiatrist with other Mental Health Association of Morris County programs.

The RIST program defines successful community integration by several measures, including avoidance of hospital and jail stays, positive relationships with friends and family, and involvement in educational or vocational training. RIST has a goal that 80 percent or more of housed customers will participate in three or more different social/leisure activities each quarter. Social participation per quarter in 2008 ranged from 81 percent to 92 percent.

RIST has a goal that 75 percent or more of housed customers will be involved in one or more prevocational or vocational activities. Vocational and prevocational participation per quarter in 2008 ranged from 79 percent to 82 percent. This included 12 customers who were employed either part-time or full-time during the year.

RIST attributes much of its success to its use of consumer providers, who make up 71 percent of its staff. The key component of the program is the relationship between life coaches and customers, who are matched carefully to foster trust and teamwork. Having experienced psychiatric disabilities as well as recovery, life coaches can offer

more empathy, understanding, and tolerance, and can “meet their customers where they’re at,” while serving as role models.

Main Street Housing

Another emerging model of housing for people with psychiatric disabilities is Main Street Housing (MSH) in Maryland. A subsidiary of On Our Own of Maryland, an organization of psychiatric survivors, MSH was incorporated in 2001 as a nonprofit and began offering housing the following year. It was formed to provide an alternative to board and care homes and residential settings tied to service provision.[215]

MSH offers a consumer-run “housing only” model that differs from Pathways and RIST in several ways. It only offers housing, with no support services provided, although MSH staff are familiar with local services and will refer tenants to support services in their communities.

Today, MSH owns 15 buildings in nine Maryland counties that contain a total of 27 units and house 53 adults and families. Approximately half of the tenants live alone; the rest are families or adult roommates. Units include efficiencies, one- and two-bedroom units, and three-bedroom units for families.

Unlike Pathways, MSH owns its homes and leases them directly to its tenants. MSH’s Executive Director, Ken Wineman, says homeownership enables his organization to build equity it can use to leverage the purchase of new homes, and to offer the opportunity for tenants to sign leases and experience the responsibilities and privileges of tenancy.

MSH chooses its tenants carefully. Each applicant is screened by Ken Wineman, who is both a consumer and a social worker. Although treatment is not a prerequisite to obtain housing, applicants must demonstrate a “certain wellness level” to be accepted. Current substance abuse is not permitted, nor is a history of arrest for violent crimes.

Tenants must agree to monthly inspections for safety and cleanliness. If the home is not kept well, staff offer, but do not force, referrals for support services. When adults live together, each tenant must agree to be responsible for the upkeep of a specific common area. Housemates are expected to work out any problems that come up, and house meetings are the usual method used to do so. Staff are available to informally mediate disputes upon request. When a new tenant first moves in, staff will visit more frequently to help ensure a smooth transition. Staff will sometimes contact a tenant's case manager or other support staff if needed. Alcohol and tobacco use is discouraged but not prohibited—however, in shared living situations a tenant can request that his or her roommate not use either in the home.

Rent is kept low—typically it ranges from $200 to $275 per month. Section 8 vouchers are accepted, and MSH has adopted the housing authority rules of occupancy to ensure that Section 8 vouchers will be offered to its tenants. Wineman explained, "People in the mental health system see us as a model. We get referrals from State hospitals—and that enables workers there to see that it's possible to offer housing separate from support services."[216] Housing is permanent—tenants can stay as long as they wish. Wineman is particularly proud that MSH was able to help a mother regain custody of her child by offering stable housing for both.

MSH has successfully avoided "not in my backyard" (NIMBY) problems. When a home is purchased, no neighborhood notification occurs. If neighbors drop by while a home is being prepared for occupancy or when staff are doing repairs and maintenance, neighbors are welcomed and told that MSH is the landlord and will quickly respond to calls about any concerns neighbors may have. Wineman says that neighbors have responded well to this approach, which satisfies concerns without stigmatizing tenants by announcing the presence of mental health consumers.

Although MSH has not yet conducted studies, Wineman states that his experience at MSH has convinced him that stable housing leads to employment and more stability and grounding in nonpatient roles. To avoid segregation, MSH purchases buildings that range from single-family homes to buildings that contain no more than four units. No

more than six people reside per multiunit building. He explained, “I don’t buy anything I wouldn’t live in.”[217]

Finally, Wineman believes that the fact that MSH is completely consumer run provides significant advantages that contribute to the success of the program. Consumer staff provide role models and hope for tenants, and educate the broader mental health community that recovery is possible. Wineman also believes that a consumer-run program fosters a greater degree of tenant accountability, because staff have higher expectations of tenants to be self-sufficient. Tenants feel more comfortable interacting with staff who have faced similar mental health challenges. Tenants find the staff to be compassionate and nonjudgmental, and hence easier to approach for help. The presence of role models and the sense of acceptance help tenants develop their self-esteem. Research implies that peer support empowers people with psychiatric disabilities to make decisions relatively autonomous from professional staff.[218]

Affordable, Accessible, Integrated, Mixed-Use Housing Development

University Neighborhood Apartments, Berkeley, California

The nonprofit developer Affordable Housing Associates, Inc., built the University Neighborhood Apartments to increase affordable, accessible housing for individuals and families, including people with disabilities. All the apartments are designed using universal design principles and are fully accessible. Universal features include “one-story living; wide doorways and hallways; low countertops, cabinets, and keyholes; extra floor space to accommodate a wide turning radius; pull-out cutting boards; stoves with buttons on the front; push/pull lever faucets; and roll-in showers.”[219] All the units are available to households with 30 to 60 percent of Area Median Income, including 20 project-based Section 8 units and 9 units designated for households that include individuals with disabilities.

This building consists of 29 apartments, residential common areas that include a multipurpose room, management and service spaces, a large outdoor courtyard, ground-floor commercial areas, and a tenant parking garage. The building is located on

a main transportation corridor in the city of Berkeley and is approximately two blocks from the downtown area. The building is four stories, including three residential and one commercial story. A restaurant featuring ethnic African meals recently opened on the first floor of the commercial space. The 29 apartments are made up of 1 studio apartment, 3 one-bedroom, 14 two-bedroom, and 11 three-bedroom units.[220]

The building is designed so that all apartments are adjacent to a large interior central courtyard, which includes natural landscaping, seating, and a play area. A multipurpose/community room is located near the outdoor courtyard and offers a computer work area, service office, and kitchenette. The multipurpose room is used for educational classes, computer workstations, crafts, exercise classes, social gatherings, and meetings. The services office is used for counseling and for coordinating educational classes. A laundry room is located on the first floor and the manager's office is located adjacent to the courtyard.[221]

The development was funded by Bank of America, N.A., the Low Income Housing Tax Credit program, the State of California's Multifamily Housing Program, the Federal Home Loan Bank, Alameda County Housing Opportunities for People with AIDS, the city of Berkeley's Housing Trust Fund Program, and a HUD 108 loan. A California Housing Enabled by Local Partnerships Program loan was made by the city of Berkeley to assist with the initial acquisition of the property site.

Helios Corner, Berkeley, California

The nonprofit developer Satellite Housing, Inc., built Helios Corner, which provides affordable senior rental housing. All 80 units are affordable to seniors with incomes between 30 and 60 percent of Area Median Income. All units can be adapted for accessible features, 10 units are already accessible, and 40 units are project-based Section 8. Two of the accessible units also include features that enhance access for people with sight and/or hearing impairments, such as blinking doorbells and louder-than-average buzzers.

This four-story mixed-use building consists of three residential levels above 5,900 square feet of ground-floor commercial/office space and parking. The site is within short walking distance of community services and amenities, and is surrounded by a mixture of uses—single-family neighborhoods are to the north and west, and neighborhood commercial settings are to the south and east. A bus stop is located outside the front steps of the apartment complex and the North Berkeley BART station is just two blocks away.

The building consists of ground-floor office space for Satellite Housing and the Salvation Army. The main floor of the building houses the property manager's office, the service coordinator's office, a multipurpose room, and a large community room with a landscaped courtyard that is open to residents for daily recreational activities, family gatherings, community parties and meetings, movies, music, and classes. Satellite Housing focuses on tailored coordination, case management, and referral by its in-house service coordinators who work directly with service providers to ensure residents are able to access the services they need. Supportive services are also available onsite.

The development was financed by Low Income Housing Tax Credits, Silicon Valley Bank, the Federal Home Loan Bank, and city of Berkeley Housing Trust Fund. A California Housing Enabled by Local Partnerships Program loan was made by the city of Berkeley to assist with the initial acquisition of the property site.

Housing Cooperatives (Co-ops)

Housing Cooperatives allow residents to own and control their apartment through a corporation in which they own stock and are actively involved in management and programming. Maintaining affordability is difficult, but may be achieved by restricting resale prices, as in the case of Limited-Equity Cooperatives (LECs). Collectively owned and governed, LECs cap resale prices of shares by either regulating the resale price or the income levels of buyers.[222] A significant percentage of housing in Scandinavian countries, LECs are also growing in significance in the United States. A 2003 survey by the National Association of Housing Cooperatives reported 425,000 limited- and zero-

equity co-ops throughout the nation.[223] LECs enable stable affordable housing and the security this ensures, greater levels of tenant control and satisfaction, and neighborhood revitalization in economically depressed areas.[224]

LECs have promise for people with disabilities as a means to self-determination and affordable, accessible, integrated housing, with the possibility of support and services as needed. Services may or may not be offered onsite, can be informal or formal, and might involve either joint purchasing and/or scheduling of services or a coordinated and managed services program staffed by community agencies or the cooperative itself. Potential benefits for low-income people with disabilities include a relatively low financial investment and greater control over housing and the environment.[225] Moreover, research on Canadian LECs reveals that there they provide accessible, affordable, and integrated housing for people with disabilities.[226] Anecdotal evidence from the United States suggests these findings hold elsewhere. A resident of the integrated and accessible Connecticut LEC, A Common Thread Cooperative, in Manchester, Connecticut, observes that her co-op is cheaper than an apartment, enables her to influence the decisions of an active community, and allows her to participate in networks of mutual support among neighbors.[227] She adds, "If I get in a jam, I know people I can call. I know all my neighbors. I know they will be there for me."[228]

Penn South Cooperative, New York, New York

Penn South Cooperative, New York, New York, is a Limited-Equity Cooperative built in 1961 with 2,820 units, 6,200 residents, and 15 buildings spread over 20 acres. The co-op is geared toward individuals with low to moderate incomes; 55 percent of co-op residents have gross incomes under $40,000.[229] To preserve affordable rent, the co-op has also secured "shelter-rent" status from the city of New York, which bases property taxes on property income rather than value. With more than 50 percent of its residents over the age of 60, Penn South is also a Naturally Occurring Retirement Community (NORC) (see NORC, below).[230] As residents began to age, the co-op set up a collaborative program with community agencies to provide supportive services. Now a separate nonprofit agency offers cultural and educational programs, case management,

home care services, personal care, primary health care and wellness services, and a variety of other supportive services. All buildings are accessible, and people with disabilities make individualized access modifications to their units as needed.

Aging in Place

The “aging in place” movement is driven by the insight that most individuals prefer to remain in their homes rather than move to nursing homes or other facilities as they grow older. A 2005 AARP nationwide survey found that 89 percent of people ages 50 and over want to remain in their homes as long as possible.[231] Aging in place is made possible when individuals have access to appropriate support and services, including home modifications. Different models embody various aging in place ideals. All these models, however, recognize the preferences of people who wish to remain in their own homes in the context of an integrated community that mitigates social isolation and enables the accessibility and affordability of home care and personal assistance, house maintenance, shopping, and transportation.

Prominent examples of aging in place models include the “Village” and Naturally Occurring Retirement Communities (NORCs). A relatively new concept, Villages are community-initiated, -governed, and -operated organizations designed to meet the long-term support needs of older adults in the neighborhoods where they live. The Village model was initiated by Boston’s Beacon Hill Village, which is creating a technical assistance support center in conjunction with the nonprofit NCB Capital Impact to support Villages throughout the nation.

NORCs are typically defined as a geographic area, neighborhood, or building originally inhabited by people of all ages, which has evolved over time to contain a high proportion of older adults. In many NORCs, residents have collaborated with community service providers to develop supportive services that respond to the evolving requirements of aging residents. NORCs frequently provide supportive services to all residents regardless of income, disability, or health status.

Vladeck Cares/NORC Supportive Services Program, New York, New York

Vladeck Cares/NORC Supportive Services Program is operated by the Henry Street Settlement, which delivers a wide range of social services to New York residents. Henry Street Settlement's NORC program brings comprehensive supportive services to the Lower East Side community's older residents in response to their unique needs and cultural diversity. Vladeck Cares serves seniors living in Vladeck House, a public housing project with 27 buildings and 3,000 residents, 860 of who are elderly, many with disabilities.

The Vladeck Cares/NORC Supportive Services Program is a financial and cooperative partnership between the Henry Street Settlement and the New York City Housing Authority. This model brings social and health care services to Vladeck House, the first NORC located in public housing. Funded by the city, the State Department on Aging, and private sources, the program provides preventative health and social services, medical and health services, case management, mental health counseling, and educational and cultural opportunities.[232] The Vladeck NORC program helps develop, host, and link supportive services because they increase the autonomy and independence of seniors living in the community. In turn, the supportive services are able to provide more organized and comprehensive care to the populations they serve.

Increasing Very Low Income Housing Through the Low Income Housing Tax Credit (LIHTC) Program

The LIHTC program, which is based on Section 42 of the Internal Revenue Code, was enacted by Congress in 1986 to provide the private market with an incentive to invest in affordable rental housing. Federal housing tax credits are awarded to developers of qualified projects, who then sell these credits to investors to raise capital (or equity) for their projects, thereby reducing the debt that the developer would otherwise have to incur. Because the debt is lower, a tax credit property can, in turn, offer lower, more affordable rents.

Provided the property maintains compliance with the program requirements, investors receive a dollar-for-dollar credit against their federal tax liability each year over a period of 10 years. The amount of the annual credit is based on the amount invested in the affordable housing.[233] State Housing Agencies allocate LIHTCs through a competitive process. These agencies must develop an annual plan, called a Qualified Allocation Plan (QAP), for allocating the credits that is consistent with the State's Consolidated Plan. QAPs establish criteria for awarding points in the competition for tax credits, and they tend to vary greatly across the States because they are often written to meet State priorities. Federal law requires that a QAP give priority to projects that serve the lowest-income families, and are structured to remain affordable for the longest period of time. Federal law also requires that 10 percent of each State's annual housing tax credit allocation be set aside for projects owned by nonprofit organizations.[234]

Typically, LIHTCs have not been used to create housing for the lowest-income groups, including people at or below poverty level. In most States, only up to 10 percent of LIHTCs are targeted at people at or below 30 percent of AMI.[235] That is changing, however. To meet a demand that outpaces the supply, some States are increasing the number of units for individuals whose income is at the SSI level by awarding points for projects that target units for those individuals. LIHTCs hold a similar promise for people with disabilities, including very low income and low-income people with disabilities. Recent nationwide financial difficulties may have affected the demand for LIHTCs, but a revitalized housing market should reinvigorate this lag.

North Carolina LIHTC Development

Stemming from cooperation between the North Carolina Department of Health and Human Services and the North Carolina Housing Finance Agency, the State's QAP requires that all LIHTC developments must develop a Targeting Plan that reserves 10 percent of total units for people with disabilities or homeless populations, and at least five units must be reserved regardless of development size.[236] Furthermore, 5 percent of all units in new developments must be fully accessible beyond federal and State accessibility requirements. Also required is a memorandum of understanding among all

relevant parties (the developer, property manager, and local lead agencies) to ensure the availability of and access to supportive services and accommodations for residents. Further safeguards include marketing priorities and vacancy reservations for people with disabilities for 90 days after the units are finished. Importantly, tenancy cannot be conditioned on participation in these supportive services.

Targeting units for people with disabilities within LIHTC-financed properties is a promising strategy for ensuring housing accessibility, affordability, integration, and the delinking of housing from services.[237] Because North Carolina's housing initiatives for people with disabilities center on LIHTCs, they remain reasonably insulated from fluctuating State budgets. They have also supported the construction of substantial numbers of affordable housing. Between 2002 and 2006, approximately 900 units with voluntary services for people with disabilities were funded.[238] Other States have replicated these efforts. The Louisiana Housing Finance Agency, for example, is administering a tax-credit initiative for people with disabilities intended to create up to 3,000 units of housing with voluntary services.[239]

Disability Organizations Advocate for Very Low Income Housing with LIHTCs

Boston's Disability Law Center (DLC) and nine Independent Living Centers throughout Massachusetts filed comments with the Massachusetts Department of Housing and Community Development (DHCD). These organizations called for more housing resources under the LIHTC program to be set aside for very low income people with disabilities, even though the Massachusetts LIHTC program had exceeded the national average by requiring that 10 percent of all LIHTC target households whose incomes are at or below 30 percent of the Area Median Income (AMI). DLC and the ILCs recommended that an additional 10 percent of the units be targeted for people with disabilities with SSI-level incomes (well below 30% of AMI) through project-based vouchers. They also called for developers who are awarded LIHTC as a result of the competitive process to be required to submit a plan to ensure that the additional 10 percent of the units be made available to very low income individuals with disabilities. To ensure people with disabilities are integrated, the DLC and ILCs

recommended that Massachusetts establish a policy that calls for LIHTC projects to ensure integration by having no more than 15 percent of the total units in a project occupied by people with disabilities (absent a compelling programmatic reason to do otherwise). Finally, the groups called for visitability to be a threshold requirement for all new construction and renovation of existing housing units.

Increasing Accessible, Integrated, Supportive Housing Through Legal Advocacy

Laguna Honda Hospital Settlement, San Francisco, California

A class action settlement in the civil rights class action lawsuit *Chambers et al. v. City and County of San Francisco*, filed to prevent unnecessary institutionalization of people with disabilities at Laguna Honda Hospital, promises to greatly increase community-based housing and service options in San Francisco and improve coordination of care. The settlement creates an innovative program to coordinate services across city departments, enabling San Franciscans with disabilities who live at, or are referred to, Laguna Honda, one of the country's largest nursing homes, to instead receive community-based housing and services. Eligible individuals will be assessed for, referred to, and provided with subsidized housing, personal assistance, nursing care, case management, substance abuse treatment, mental health services, and assistance with meals.

Several hundred Medi-Cal Home- and Community-Based Waiver slots, which allow people to receive long-term health care in their homes instead of in institutions, will be made available to those who qualify. Another innovative aspect of the settlement agreement is the development of a rental subsidy program, through which San Francisco will, over the next 5 years, secure and subsidize scattered-site, accessible, independent housing for approximately 500 people with disabilities and seniors who are eligible for community-based services.

Fair Housing and Americans with Disabilities Act Housing Access Settlements

Based in Washington, D.C., the Equal Rights Center (ERC) conducted a survey of multifamily construction covered by the Fair Housing Amendments Act (FHAA) and ADA. The survey uncovered widespread violations by some of the largest American apartment and condominium developers. Several sets of surveys, reaching about 390 properties throughout the Washington, D.C., metro area and several States, uncovered some form of FHAA accessibility noncompliance in 100 percent of those properties.[240] Following up on this research, ERC initiated in-depth investigations into the practices of several prominent developers that led to a series of lawsuits and settlements.

By using litigation and related negotiations to ensure compliance with fair housing regulations, ERC has effected the retrofitting for federally mandated accessibility of more than 20,000 units in multifamily homes throughout the United States.[241] These legal successes have also yielded benefits beyond accessibility in a substantial number of homes. One of these settlements, with Trammell Crow Residential, led the developer to contribute $1.5 million to support ERC's Multifamily Housing Resource Program, which promotes compliance with housing laws through training and education, best practices, and compliance monitoring. Following another settlement that resulted in the retrofitting of more than 2,000 units, the developer, Bozzuto & Associates, adopted accessibility standards in townhomes and single-family homes that go beyond federal requirements.[242] These features draw on "aging in place" concepts and include no steps between areas in the same level, wide hallways and entries, accessible doorbells, handrails, and at least one wheelchair-maneuverable main level bathroom. Bozzuto committed to incorporating these features for at least 5 years in 75 percent of its upper-level garden-style condominium units and 50 percent of its single-family homes and townhomes.

Universal Design

6 North Apartments, St. Louis, Missouri

6 North Apartments is one of the nation's first examples of a multifamily residential building featuring 100 percent universal design (UD). All 80 of the project's one- and two-bedroom apartments—as well as its common spaces, coffeehouse, and live/work units—are fully usable by people with and without disabilities. The residential/mixed-use and mixed-income building is located at the corner of Laclede Avenue and Sarah Street in St. Louis's central-west end. UD features incorporated at 6 North include stepless entries, open floor plans, adjustable countertops and shelves, and high-contrast color and surface texture schemes. The three-story project contains 56 percent market-rate and 44 percent affordable units. As of 2006 it was fully leased, with eight apartments currently occupied by households that include at least one disabled member.

The project was spearheaded by Brinkmann Construction and real estate developer McCormack Baron Salazar. The project apartments and the concept for creating universal design were in the making for several years at McCormack and arose out of a need for affordable housing in the city and effective advocacy by Paraquad, the local Center for Independent Living. The $12.9 million development was funded in part by U.S. Bank, a $540,000 loan from the Missouri Housing Commission, and the St. Louis Affordable Housing Commission.[243] The project was awarded the John M. Clancy Award for Socially Responsible Housing.

University Neighborhood Apartments, Berkeley, California

The nonprofit developer Affordable Housing Associates, Inc., built the University Neighborhood Apartments to increase affordable, accessible housing for individuals and families, including people with disabilities. All the apartments are designed using universal design principles and are fully accessible. All the units are available to households having 30 to 60 percent of Area Median Income, including 20 project-based Section 8 units and 9 units designated for households that include individuals with

disabilities. Fourteen of the apartments are set aside for tenants with disabilities. (See above for additional information about this project.)

Universal Design and Visitability: Mandatory and Voluntary Policy Models

As of January 2008, the Rehabilitation Engineering Research Center (RERC) on universal design, School of Architecture and Planning, at the State University of New York at Buffalo, reports that 37 U.S. cities have adopted either voluntary or mandatory requirements for some level of universal design or visitability. These policies vary widely in terms of the type of homes to which the policies apply, building specifications, and whether the requirement is triggered only when federal, State, or local subsidies are involved. According to RERC, 15 cities have adopted voluntary policies and 22 have mandatory rules. Estimates by RERC and also by Concrete Change indicate that nearly 30,000 homes have been constructed that include visitability-related aspects of accessibility (e.g., zero-step entries, 32-inch-minimum interior doorways, levered handles, reinforced bathrooms for later grab bar installation, lowered electrical controls).[244] Several of these policies are highlighted below.

Concrete Change and Habitat for Humanity, Atlanta, Georgia

Beginning in 1987, the group Concrete Change developed a principle called "basic home access," later known as "visitability," and promoted it to housing developers and others. The basic features of visitability include a zero-step entrance, wide interior doors, and a half-bathroom on the main floor.[245] In 1989, Concrete Change persuaded the Atlanta chapter of Habitat for Humanity to include this basic access in new homes. By early 2006, Habitat Atlanta had built over 600 visitable houses.[246] In 1992, following outreach efforts by Concrete Change, the city of Atlanta passed the first U.S. visitability ordinance, requiring basic visitability in all private single-family homes and duplexes that receive tax incentives, city loans, land grants, fee waivers, and/or federal block grants.[247] Because of the ordinance, more than 600 homes have been constructed in Atlanta in compliance with the visitability standard as of 2002.[248] Moreover, similar requirements have been passed in cities throughout the United States, as well as at the

State level in Texas, Georgia, and Kansas. Visitability standards have been successfully replicated because of their affordability, especially when compared to the cost of retrofitting, among other reasons. While visitability dramatically expands the number of people who can visit or live in a house, the costs at the time of construction are relatively small. Concrete Change estimates that a zero-step entrance on a concrete slab should cost around $200, with an extra $50 for expanded doors.[249]

Minimum Universal Design Requirements for New Construction Using Affordable Housing Trust Funds from the City of St. Louis

In 2004, the city of St. Louis adopted policy to require that universal design principles be applied to new construction using Affordable Housing Trust Funds. All developers hire a registered project architect to produce detailed construction drawings prior to commencing construction and to oversee construction of the project. All new construction projects require written architectural certification at the time of application, at execution of the loan agreement, and at closeout by the project architect and the developer that the project is designed and built in compliance with universal design requirements. If construction begins prior to the review of the required documents, affordable housing funds may be revoked. The first certification requires that the project will be drawn and built in compliance with universal design requirements. Following the awarding of funds and prior to construction, the developer and architect must sign a second certification that includes a verification checklist.[250]

Design for Life Montgomery, Montgomery County, Maryland

Design for Life Montgomery is the first voluntary certification program in Maryland for visitability and “livability” in single-family attached and detached homes located in Montgomery County. Its guidelines apply to both new construction and renovation of existing homes. The program features two optional standards of accessibility and is voluntary, following the National Association of Home Builders’ guidelines that support voluntary programs. New construction and renovation of existing homes are targeted by the program, which represents a successful informal partnership involving county, building, and business interests and advocates. The program is administered by the

county as part of the regular permitting process and is not a special process. A checkbox for review and certification can be found on the standard application for permit, and there are no additional permitting costs beyond the standard fees.

The program started in March 2007. As of August 2008, 12 permits have been issued. Eight are for new construction, three for additions to existing buildings, and one for alteration of an existing structure. The program generally follows visitability principles and does not meet FHAA or ADA requirements or universal design guidelines.

California Model Universal Design Ordinance

Assembly Bill 2787, enacted in 2002, requires the California Department of Housing and Community Development to develop and certify one or more model universal design ordinances applicable to new construction and alterations for voluntary adoption by cities and counties. The department's model ordinance identifies rooms and denotes features that must be offered by a builder in residential units subject to the ordinance that are being newly constructed or substantially rehabilitated, but are only installed if requested by the buyer/owner and which would not cause an unreasonable delay or significant nonreimbursable costs to the developer or builder. In general, the model ordinance provides (1) definitions for critical terms, (2) local option as to types of units (owner-occupied and/or rental) and number of units, and (3) specific exemptions and enforcement mechanisms.

While voluntary models like A.B. 2787 and Design for Life Montgomery do not have the same impact as mandatory requirements, they are often important first steps, spurring the testing of a new concept that brings needed attention to the issue, while demonstrating it is both affordable and practical. They eventually contribute to the critical mass that is needed to generate stronger legislation or adoption of more comprehensive policies.

CHAPTER 6. Lessons Learned from National Emergencies Regarding the Provision of Accessible and Affordable Housing

A study by the U.S. Government Accountability Office indicated that "special needs populations are often overlooked in planning for disaster housing assistance."[251] In January 2009, the Federal Emergency Management Agency (FEMA) released a National Disaster Housing Strategy that included consideration of people with disabilities—the first significant statement by the lead disaster organization on this topic. Efforts to address the need through policy, practice, and research are emerging, although most of those efforts remain to be assessed. A careful look at the issues associated with emergency housing is thus required.

Key Issues

A number of reports published by the National Council on Disability, the National Organization on Disability, the U.S. Government Accountability Office, and independent researchers indicate that certain issues recur in disaster situations for people with disabilities. Problems start when officials notify the public of an impending emergency. Described as a "hole" in the warning system, notifications concerning rapid onset of weather events (e.g., a tornado) usually miss people who are deaf.[252] Closed captioning during emergencies is often not available despite Federal Communications Commission (FCC) policies requiring such dissemination of information. Further, notifications nearly always lack information for protective measures that are appropriate for people with disabilities.[253] However, even when people are notified, evacuation planning has been insufficient to accommodate people with disabilities who do learn of the warning and attempt to leave. Accessible public transportation is limited and typically dependent on self-identification in advance of an event.

Once people are in a shelter, their stay can be lengthy and traumatic. Problems stem from the lack of accessible and affordable temporary units, including public housing, rental units, and government-provided trailers. A key challenge is that rental units may

not have needed accessibility features. While FEMA recently established a Disaster Housing Portal that indicates if a unit offers basic accessibility and the U.S. Department of Housing and Urban Development (HUD) recently created a National Housing Locator System that helps people search for accessible units, these units are at times located at a considerable distance from one's original location. In some disasters, the Federal Government may authorize mobile homes or travel trailers, which are far from ideal and take time to transport and place, especially if an area requires the construction of roads and utilities.

Once people have been relocated into temporary units, other problems tend to arise. This can include proximity to accessible transportation as well as key health and social services during a temporary relocation, challenges faced by caseworkers in assisting people with disabilities into temporary or permanent housing, and the failure of most communities to conduct any type of pre-disaster recovery planning. Historically, few communities or organizations have made disabilities a key issue either before or after a disaster. In short, American communities are not ready to expeditiously and appropriately assist people with disabilities to secure emergency housing.

The Emergency Housing Process

Overall, the emergency housing process begins with dislocation from one's home into either emergency or temporary shelter followed by moving into either temporary housing or (eventually) some form of permanent housing.[254]

Emergency Shelter

This phase is typically ad hoc and short lived. People may seek out locations such as cars, tents, or lawns to stay for a short duration before moving to a more amenable location. For Hurricane Katrina, those emergency shelter locations included overpasses, rooftops, and places like the New Orleans convention center. Such locations typically vary in their access to food, water, medical assistance, or personal security. Such circumstances can range from being places of simple discomfort to acute and life-threatening locales for anyone, and especially so for those who are medically fragile.

Temporary Shelter

The second phase provides basic amenities that include, at a minimum, food, water, and a place to sleep free from exposure to the elements. Two kinds of temporary shelters may be available: general population and special or medical needs shelter. Usually, emergency managers identify and announce predesignated general population shelter locations most commonly established by the American Red Cross. General population shelters usually offer shower facilities, first aid, psychological support, case management, and more. These locations must accept and accommodate people with disabilities and service animals, though reports from Hurricane Katrina suggest that this was problematic.[255] Some areas may choose an alternative system where the Red Cross provides support. In Texas, for example, a shelter hub system is used under the State's emergency response plan. This mass care system is managed by a designated liaison between voluntary organizations and the State, with support from a variety of health, medical, and voluntary organizations. In addition there are often ad hoc shelters that can vary from a local worship location that sets up cots and has congregants provide food to the mega-shelters established by Texas officials in large facilities to host massive numbers of Katrina evacuees. The abilities of ad hoc shelters to accommodate people with disabilities can vary widely, relying on local resources and personal networks. In all, staff and/or volunteer understanding of disability issues can also vary.

Typically, less than 20 percent of the population goes to a public shelter, preferring instead to stay with family, friends, or in a motel, or try and remain in their own homes.[256] People who do go to a public shelter tend to be lower income. Because people with disabilities tend to have lower-than-average incomes, it seems more likely they would go to public shelters. However, some research suggests that if people with disabilities do not believe shelters are ready for them, they will not evacuate when they should.[257]

The second kind of shelter, special or medical needs, is usually opened and staffed by county or State agencies, coordinated and planned in advance of a disaster, and supported (or even operated alone) by federal agencies. Transportation to medical

needs shelters is provided by State or federal resources in many instances, including contracts with private ambulance services and even the military. For Hurricane Ike in 2008, Gulf Coast officials worked in concert with the Federal Government and military to convey patients from congregate facilities and private homes to reception centers away from areas of risk.

A triage system based on specific criteria is usually used to determine if the individual should go to a general population or medical needs shelter or on to an advanced care facility such as a Federal Medical Station, a nursing home, or hospital. At all shelters, there is an intake or registration process, which can also vary from minimal to extensive. Ideally, registration processes should identify the specific needs that an individual may have, including disabilities and related support issues. In a preplanned and well-managed shelter, those issues are accommodated in an appropriate manner. In reality, considerable gaps exist in shelters across the nation generally due to a lack of knowledge among shelter providers, adequate resources, and connections to disability organizations.[258] Medical needs shelters, particularly those in areas of repetitive risks, have improved since Hurricane Katrina, but planning and implementation for such facilities ranges from nonexistent to extensive across the nation at present.

Transitioning into Temporary or Permanent Housing

Temporary housing is defined as housing that allows for reestablishing normal household routines that may include cooking, laundry, and sleeping in a safe, secure location.[259] For people with disabilities, temporary housing may also require particular accommodations, such as ramps, communication devices, or kitchen counters at an appropriate height. Permanent housing means that no more moves are necessary. It is not unusual for people to move many times before finding or rebuilding a permanent home. To help people with the transition from shelters into temporary or permanent housing, a discharge process is usually recommended to identify issues that can impede relocation and to link the evacuee with appropriate support services. In some communities, a case management process may develop, although the organization and

delivery of such services is never guaranteed and the credentials of the case workers may vary considerably.

Moving people through the sheltering stages into temporary or permanent housing is a time-consuming process that depends on several conditions. First, units must be available in the community, and must be accessible and in an environment well suited to the individual's particular type of disability. It also means that resources must be secured to offset expenses ranging from moving to storage to the cost of a rental unit. While insurance companies must provide settlements to those holding policies, the process can take time depending on the type of disaster. To obtain government assistance, a Presidential Disaster Declaration must be issued. When that occurs, FEMA makes Individual Assistance payments to those affected. Individuals must first apply to the U.S. Small Business Administration for a loan. If rejected (usually because of income, credit history, or inability to repay), then applicants can seek a federal grant. In 2009, the maximum grant amount was $33,300, an amount that changes with the fiscal year every October 1. Grants are provided to those who meet income requirements; FEMA must inspect the property in question to verify the claim, often with little to no recourse or appeal process for the homeowner if denied.

Federal Programs for Temporary and Permanent Housing

Several federal agencies provide direct assistance to disaster survivors to help them after disasters, including FEMA, the U.S. Small Business Administration (SBA), and HUD.

Federal Emergency Management Agency (FEMA)

FEMA programs cover temporary housing (money to rent a place to live for a limited period of time); repair (money for homeowners to repair damage from the disaster to their primary residence that is not covered by insurance); replacement (money so homeowners can replace their home destroyed in the disaster that is not covered by insurance); and permanent housing construction (direct assistance or money for the

construction of a home but in locations specified by FEMA, where no other type of housing assistance is possible).

FEMA also provides additional funds to cover costs such as medical, dental, funeral, and burial needs; clothing, household items, tools related to employment and some educational resources; fuel for heating a home; resources to clean a damaged home; vehicle damage due to the disaster; moving and storage; and other "necessary expenses or serious needs as determined by FEMA" and "authorized by law." FEMA also operates a special needs desk that responds to questions regarding disabilities. The FEMA Office of Equal Rights exists to promote equal access to programs and benefits and provides both technical assistance and complaint resolution through its civil rights program.[260]

In most disasters, FEMA is reluctant to provide trailers because they are not an ideal temporary solution, particularly for an individual with a disability. Still, this may be needed when rental property is not available. A number of issues exist with establishing trailers. A location with appropriate utilities and roads must exist or be created. Months can pass before such locations become available in even a small-scale disaster. Either mobile homes or smaller travel trailers may be made available. The latter are particularly unpleasant, as such units provide cramped conditions not conducive to quality of life let alone the ability to maintain independence with a disability. Along these lines, a serious challenge is finding sufficient accessible trailers. Five months after Katrina, less than 1 percent of trailers complied with accessibility guidelines. As a result of the settlement of *Brou v. FEMA*—and nearly 2 years after the disaster—1,260 households received accessible trailers and 256 were awarded modifications.[261] Furthermore, trailers have been found to contain or produce health hazards that while dangerous for all people, can be especially so for people with chemical sensitivities.

Small Business Administration (SBA)

SBA makes disaster loans available to homeowners or renters for repairs or replacement of "damaged real estate or personal property owned by the victim." SBA

loans require that applicants have an acceptable credit history and demonstrate an ability to repay loans. They require collateral for loans over $14,000, and interest rates vary from 2.187 percent to 4.375 percent as of January 30, 2009. Home loans are limited to $200,000 for real estate repairs and $40,000 for personal property damage. Loan recipients are also required to carry insurance.

U.S. Department of Housing and Urban Development (HUD)

After the 2008 Gulf hurricanes and flooding across Iowa, Indiana, and Wisconsin, HUD granted a 90-day moratorium on foreclosures of mortgages that the Federal Housing Administration (FHA) had insured and encouraged that "loan services take such actions as special forbearance, loan modification, refinancing, and waiver of late charges."[262] Under a Presidential Disaster Declaration, HUD may allow States to use their Community Development Block Grant (CDBG) and HOME programs for housing victims. HUD also has the capacity to provide mortgage insurance under its Section 203(h) program for disaster victims and can give local and State governments Section 108 loan guarantees for "housing rehabilitation, economic development and repair of public infrastructure."

U.S. Department of Justice (DOJ)

The DOJ offers support to communities damaged by disasters through its Project Civil Access,[263] which provides technical assistance to communities to increase compliance with ADA and is not based on any complaints. Ultimately, the technical assistance can result in new codes and construction that is more accessible. Case examples after Hurricane Katrina (Mississippi and Louisiana) and a toolkit can be found at the Project Civil Access Web site.

Rebuilding Permanent Housing

Even more challenges exist for those seeking to rebuild their homes. Depending on the extent of the disaster, it may be extremely difficult to secure the key resources needed to rebuild. From permission to rebuild through securing funding, contractors,

subcontractors, labor, and supplies, the rebuilding process is cumbersome and exhausting for anyone. For a person with a disability, particularly a senior citizen, the rebuilding process may be too daunting. The loss of community, social networks, and home associated with a disaster and having to face the rebuilding may mean that a person cannot return home.

When a community experiences a disaster, local officials typically act to improve the quality and disaster resistance of local housing. Doing so takes planning and time to implement, which can delay the reconstruction process. In a large-scale disaster, the delays can be considerable as local, State, and federal officials conduct assessments to determine recommendations. Contractors, subcontractors, voluntary organizations providing labor, and building inspectors all must become familiar with new codes and ordinances, and the local offices responsible for implementing and monitoring the new procedures must take on additional work. People must come to understand how this system works, which is often a new, confusing experience for those now facing reconstruction. Although the anticipated outcome is desirable, the time and personal cost to someone with a disability living in a temporary situation can be burdensome.

Renters remain dependent on building owners to reconstruct their properties. Building a multistory unit takes considerably more time than a typical single-family unit. People living in public housing may have several options. If availability exists, they can relocate to a new unit or another location can be approved by the local housing authority.

For homeowners, insurance is the key to recovery. However, insurance remains expensive and in some areas, such as earthquake and hurricane zones, coverage may be prohibitively expensive, especially for those at low incomes. In either case, policyholders' coverage may be insufficient to cover the current cost of rebuilding. If a Presidential Disaster Declaration is issued, the homeowner may qualify for either an SBA loan or a grant from FEMA. However, few programs specifically target the kinds of rebuilding needs associated with disabilities. Some additional funds may be available for disability concerns, but disaster survivors report they must aggressively pursue those funds. Regardless, the FEMA Individual Assistance amount is assumed to be

supplemented by personal insurance and personal funds. These assumptions, coupled with the realities of living at lower incomes, mean that many people with disabilities face considerable trouble in rebuilding.

To assist, a long-term recovery committee often forms in disaster-stricken communities. Such a committee can take the place of a formal planning unit with elected or appointed officials and/or representatives, or it may evolve from an interfaith group of faith-based organizations. Most such entities tend to bring in voluntary organizations and labor teams to rebuild homes. These voluntary organizations usually work within the case management system described earlier to target the homes of those with low incomes, senior citizens, single parents, and people with disabilities. Faith-based voluntary organizations are often the key to helping people return home, as they provide labor, expertise, and resources to rebuild cost effectively. Such organizations, though, may require some guidance and advice as they rebuild, so that they incorporate accessibility into the projects. Contractors and subcontractors may also need guidance. Some communities offer housing fairs to encourage various kinds of rebuilding, including green rebuilding and energy-efficient designs. However, such events typically fail to offer insight into universal design, ADA compliance, or accessibility features. Project Civil Access mentioned earlier, which links federal technical assistance to State and local government on access issues, can provide a means to do so.

Further, local commitment to the permanent housing process can vary in regard to accessibility and affordability. Although affordable housing remains a concern across the nation, few communities specifically plan for post-disaster housing, let alone taking into consideration issues of affordability or accessibility. However, the city of Watsonville, California, did so in 1989 after the Loma Prieta earthquake, by passing an ordinance that requires 25 percent of all new housing to meet standards for affordability.[264] Communities facing disaster could do the same by adding elements to their recovery plans that emphasize accessibility and affordability. ADA standards beyond basic levels could be mandated, and universal design elements could be

required as part of building codes. Disaster represents not only an unfortunate circumstance; it is also an opportunity for change.

Congregate Care and Group Locations

Little is known about the reconstruction process for larger facilities, which tend to be privately owned and are usually covered by sufficient insurance. It is fairly clear that facilities owned by larger chains are more likely to be able to relocate their residents. Smaller, independent facilities face considerable challenges from evacuation to relocation. While many plan for evacuation, just as many fail to drill or to think through the consequences of long-term or permanent relocation.[265] In one creative response for temporary housing, an effort in Santa Cruz, California, relocated residents who were low income, elderly, and/or with disabilities from a downtown, earthquake-damaged hotel into a vacant nursing home facility for nearly 2 years.[266] A local day care provider for adults with dementia served as the facility administrator with support and funding from local social services and FEMA. Some permanent housing solutions for the population included moving back in with family or to an assisted living or nursing home facility. After Katrina, Louisiana and Mississippi social workers also reported a similar pattern. Individuals who could not return to their facilities or their homes moved into congregate care locations either by choice or not.

Risk Mitigation

Ideally, reconstruction allows for mitigation of the risk that prompted relocation. Mitigation may include either structural or nonstructural measures. Structural measures might allow for elevations, (re)building levees, hurricane lamps, shutters, or safe rooms. Nonstructural measures include building codes, insurance programs, and public education. Structural mitigation measures have not been assessed for their impact, positive or negative, on people with disabilities. Presumably, mitigation would reduce risk for them, too. However, some mitigation efforts, such as creating new standards for building elevations, have been critiqued as displacing people with disabilities permanently from their homes, if the new standards make it difficult to make housing

accessible. Existing codes and plans for large-scale safe rooms usually fail to address accessibility issues.[267] In Mississippi after Katrina, some social workers reported that some residents felt compelled to move into congregate care facilities, thus losing their independence. A few elevations along the Louisiana coast after Hurricane Andrew (1992) included elevators so that people could return to their home communities. Ramps may also provide access, but organizations involved in rebuilding may require education and resources to provide these features. At present, federal programs do not provide funds specifically for disability mitigation needs. Some funds may be added to an SBA loan for mitigation purposes, although this information is not widely advertised.

A nonstructural mitigation measure that has been attempted, particularly in areas of repetitive flooding, is relocation. In a relocation, also called a federal buyout, the Federal Government can offer fair market value for a home. Yet, relocation buyouts can still be difficult for the individual, because moves undermine established relationships, resources, and services that may be critical to independence. Relocation efforts must be worked out in the context of potential impacts such programs can have on people with disabilities. Successful relocation efforts integrate the needs of an individual with a disability in the relocation planning process. The individuals, their advocates or representatives, and those providing the relocation must negotiate a new environment thoughtfully. Ideally, relocation will afford greater safety and allow the resident to remain in a set of social, economic, and health care relationships that allow that individual to retain or return to his or her original quality of life.

Promising Practices

Several principles should undergird efforts to strengthen emergency housing. First, forethought and planning for disabilities and special needs should serve as the main strategy for emergency housing. Second, to help planners and those involved in all aspects of emergency housing identify problems and address solutions, people with disabilities, disability organizations, and advocates should be actively involved. Third, resources must be made to support these recommendations.

Much of the progress made in the promising practices below derives from two sources: post-Katrina legislation drove changes in awareness and prompted the creation of guidance and planning materials, while community and organizational initiatives have proved to be important agents of change.

A Functional Model

Historically, disabilities have been viewed as a limitation and have been "treated" with some type of remediation that is often medical in nature, such as referring people with disabilities to special needs or medical shelters rather than providing accommodations in general population shelters. A functional approach to special needs looks at specific assistance that is required centering on communication, medical needs, independence, supervision, and transportation, also called the C-MIST model.[268] Special needs groups may include people with disabilities but also individuals with morbid obesity, higher-risk pregnancies, in need of kidney dialysis or other critical support, or those lacking transportation. The diversity that exists across disabilities means that while some may require C-MIST assistance, many others will not. The implications for emergency housing are significant: planning for a variety of communication needs; screening for functional independence needs; training staff and volunteers to supervise people with dementia, disorientation, and other conditions in either general population or special needs shelters as deemed appropriate; and providing accessible transportation. The functional model serves as a means to identify and address issues associated with those at highest risk but also provides a lens to think through what is truly needed in all types of emergency housing.

U.S. Department of Justice Guidance for Emergency Shelters

DOJ has created a useful set of materials in the *ADA Best Practices Toolkit for State and Local Governments* that provide guidance for shelters and rely implicitly on the functional model. The documents include why people with disabilities should be accommodated in general population shelters, descriptions of ways to provide such accommodations, and checklists for planning purposes. While these documents can be used at the local, State, regional, and national levels by any entity involved in sheltering,

it is not known how influential and extensively these materials are either known or utilized.

Search Tools

Internet-based search tools provide a resource for both individuals and case managers to search for suitable emergency housing. The U.S. Department of Housing and Urban Development initiated a National Housing Locator System as a result of Hurricane Katrina and implemented it after the 2007 California wildfires.[269] To help evacuees after Hurricane Ike, HUD's National Housing Locator System (NHLS) was supplemented with government and local databases. The NHLS required those listing rentals to comply with the Fair Housing Act and to make reasonable accommodations for people with disabilities.[270] Similarly, the U.S. Access Board initiatives include links and information for accessible housing after a disaster. A key link is to the National Network of ADA Centers that was used after Hurricane Katrina.[271] In a related vein, FEMA has created a National Housing Portal to assist people with finding suitable post-disaster homes.[272] The portal allows for basic and advanced searches by State, county, city, ZIP code, number of bedrooms, and cost. The advanced search allows a user to look for accessible units, although detailed information on the nature of that accommodation may not be provided.

U.S. Department of Housing and Urban Development

HUD's participation in disasters has varied over the past 30 years, focusing on both temporary and permanent housing. Specifically, the Department:

- Administers two mortgage insurance programs, which assist disaster survivors in purchasing, renovating, or rebuilding housing.
- Administers an insured housing rehabilitation loan program.
- Makes its foreclosed housing portfolio available for purchase by disaster survivors at a discount in areas affected by a declared disaster.

- Provides annual grants (grants through supplemental appropriations may also be available) that may be reprogrammed post-disaster (Community Development Block Grant and HOME Investment Partnerships Program) to local, county, and State governments that would directly assist eligible recipients to purchase, rehabilitate, or construct housing.
- Provides a 90-day moratorium on the repayment of FHA-insured mortgages for homes damaged in a declared disaster area.
- Encourages private mortgage lenders to take special forbearance, loan modification, refinancing, and waivers of late charges on loans they hold.

HUD's efforts in New Orleans post-Katrina included the Road Home small landlord rental program, which used Community Development Block Grants (CDBGs) to provide landlord incentives. Those who rebuild using the funds must maintain units at affordable prices for up to 5 years, which qualifies the landlord for loan forgiveness. HUD also offers the Disaster Housing Assistance Program (DHAP), which provides for the public housing authority to pay landlords a Fair Market Rent (FMR) for 6 months. Thereafter, the tenant pays $50 of the rent, an amount that increases $50 monthly until the full rent is being paid or the renter leaves the program. The Disaster Voucher Program transfers those in Section 8 or the Housing Choice Voucher program to other housing authorities where housing is available.

Mortgage and Rental Relief

The Mortgage and Rental Assistance Act of 2007 served to help people keep their homes under the duress of a disaster event. The intent of the legislation was to reinstate the funds after a revision of the Stafford Act dropped the program. Eligibility is income based, although exceptions can be made in areas with high costs of living.[273] In addition, FHA under Section 203(h) offers insurance that protects lenders of qualified disaster victims. The intent of the program is to support those with low and moderate incomes and is limited by HUD by amount, home type, and location.[274]

FEMA Comprehensive Planning Guide

FEMA is creating a series of Comprehensive Planning Guides (CPGs) that includes CPG-301 (*Emergency Management Planning Guide for Special Needs Populations*) and CPG-302 (*State, Territorial, Tribal, and Local Government Household Pets and Service Animals Plan*). The current sheltering and mass care section describes basic guidelines for shelters and refers users to DOJ and FEMA Office of Equal Rights guidance materials. A shorter section indicates that jurisdictions should provide communication services to assist people with special needs through the disaster assistance application process and that "accessibility of both temporary and permanent housing is crucial. Timely allocation of adequate stock of accessible housing safeguards against individuals with disabilities (e.g., physical impairments) having to remain in a shelter environment longer than others or being inappropriately relocated to a congregate setting."[275] The document indicates that housing provided through government sources must comply with the Fair Housing Act and "meet physical accessibility requirements."[276] CPG-301 also recommends that recovery planners involve special needs populations and use the recovery as an opportunity to meet accessibility requirements.

CPG-302 resulted from Katrina experiences, particularly the unwillingness of people to evacuate without their pets. This observation prompted Congress to pass the Pets Evacuation and Transportation Standards (PETS) Act in 2006. The intent of CPG-302 is to aid jurisdictions to plan for and evacuate both pets and service animals. A FEMA fact sheet indicates that content will discuss integration with the National Incident Management System as well as planning principles and strategies for household pet and service animals.

National Disaster Housing Strategy

In January 2009, FEMA approved a National Disaster Housing Strategy.[277] Sections specifically address disability issues, including building partnerships to assist in the evaluation and identification of special needs; compliance with Section 504 and ADA for shelters and Fair Housing Act regarding housing; and working with local groups and

organizations to find accessible interim housing. A National Disaster Housing Joint Task Force is to be convened to enhance existing outreach programs by involving disability organizations, and State-led Disaster Housing Task Forces should also be convened to do the same. While this represents an important step forward in a national commitment to people with disabilities affected by disaster, it also makes equally clear that although existing disaster assistance programs apply to everyone, there are no standalone disaster housing programs specifically for people with disabilities.

Concerns About Federal Guidance

At the January 2008 National Council on Disability Quarterly Meeting, participants raised public comments about the guidance materials and new criteria for special needs planning. The main concerns centered on a lack of funds or resources available to implement the planning recommendations and that "the worry is that local jurisdictions are being set up to fail and not meet new criteria." A related critique of the National Response Framework, which includes ESF#6 Mass Care (shelter) and ESF#14 (recovery), did not "provide clear direction to the States and local jurisdictions about how to operationalize the concepts."[278]

FEMA Disability Coordinator(s)

The 2006 Post-Katrina Emergency Reform Act (PKEMRA) allowed for the appointment of a Disability Coordinator to assist with and support issues related to disabilities in disasters. The FEMA position was posted and filled in 2007. The Disability Coordinator position is situated in the FEMA Office of Equal Rights. Since then the Disability Coordinator has been onsite for multiple disasters and continues to provide guidance on disability issues before, during, and following a disaster. In December 2008, the FEMA National Advisory Council (NAC) recommended the creation of Regional Disability Coordinator positions for each of the 10 FEMA regional offices, to serve as useful liaisons between State and federal levels and increase personnel available to coordinate and support outreach to victims with special needs. This proposal has been supported in March 2009 testimony before the U.S. House Subcommittee on

Emergency Communications, Preparedness and Response, and the National Council on Disability report issued in August 2009.

Voluntary and Community Organizations and Advocates

As noted at the January 2008 NCD Quarterly Meeting in New Orleans, a number of local, State, regional, and national organizations and advocates were critical in dealing with emergency housing after Hurricanes Katrina and Rita. This includes sharing information, case management, even helping to expedite rebuilding accessible housing since so little existed before the disaster. Local organizations have also stepped in to advocate for and empower disaster survivors with disabilities to find housing themselves. And since housing resources are so scarce, voluntary and community organizations and advocates that already focus on low-cost affordable housing development, including faith-based groups, have proven critically important. Without their free labor, construction expertise, and commitment, many people with disabilities would never be able to return home again.

CHAPTER 7. **Recommendations**

The following recommendations derive from the findings presented in this report and the five detailed briefs that were produced on specific topics (see NCD Topical Briefs 1–5). Many are cross-cutting and have been organized thematically. Others are narrowly focused on specific issues, including changes in how States implement and respond to federal policy; how local providers of housing for people with psychiatric disabilities operate programs; and how people with disabilities are accommodated in disasters and emergency housing. A crosswalk follows that links specific recommendations by theme back to the topical brief(s) for more in-depth analysis.

Recommendations by Theme

1. **Increase affordable, accessible, and integrated housing for people with disabilities to meet needs and demand.**

   The most pressing need for people with disabilities is affordable housing. This need, which is evident in the number of people with disabilities who are homeless, have worst-case housing needs, or just cannot afford their housing, can be met with new housing construction, rehabilitation of existing units, and by increasing Housing Choice Vouchers. While each requires additional funding, there are several sources being considered in Congress that can be tapped immediately once legislation is enacted. This includes H.R. 1675, which will increase production in the Section 811 program from 800 to 900 units a year to 3,000 units annually. Another source is to pass legislation that fully funds the National Housing Trust Fund. Funding can also come from shifting resources expended on board and care homes, nursing facilities, and psychiatric hospitals to housing programs that maximize client choice and community integration.

   More units can also result from requiring more accessible units in new developments. This includes significantly increasing the minimum percentage that Section 504 of the Rehabilitation Act currently requires in all federal housing and encouraging all new federally funded development to be visitable, including

for people with environmental sensitivities. Congress should modify the Internal Revenue Code so that Low Income Housing Tax Credit properties are considered recipients of federal funding and hence are obliged to comply with Section 504. Along these lines, States should adopt policies that award points under the Low Income Housing Tax Credit program for projects that (1) target housing units for people with disabilities whose incomes are either at the SSI level or at less than 30 percent of average monthly income for the area; (2) include visitability features in all projects; (3) include universal design principles in all designs; and (4) ensure integration by limiting the total units in a project occupied by people with disabilities to 15 percent, unless there exists a compelling reason to do otherwise.

2. **Increase access to existing units.**

   In addition to developing new units, another means to meeting housing needs is by opening up and making available existing federal housing currently not accessible to people with disabilities. Many people with disabilities are denied accessible housing simply because of program definitions and targeting. HUD and UDSA can change this by reforming their existing programs to be universally designed to accommodate all people with disabilities regardless of age or type of disability. This would require reframing programs so that people with disabilities are no longer narrowly defined as “special needs” and instead, all programs, services, and activities are made accessible and available to people with different types of disabilities, including people with environmental sensitivities. At the same time, HUD should incentivize PHAs to set local preferences to give people with disabilities “preference” on all waiting lists for housing, including people in institutions, and verify that PHAs are meeting the minimum 504 requirements in all its housing.

3. **Prevent further loss of affordable, accessible housing.**

   This should be a goal for all communities and States in general; however, specific changes in national policy could help further this goal. Congress should review current public housing redevelopment plans to make sure sufficient accessible replacement units are planned for and provided, and, if not, place a

moratorium on plans requiring demolition and/or redevelopment until plans are revised. Congress should also pass new HOPE VI legislation that requires more replacement units than under the previous program.

Housing Choice Vouchers provide the most flexible form of housing assistance for renters and even homebuyers. While not a substitute for permanent affordable universally designed and integrated housing, vouchers present the most potential for helping people with disabilities find accessible housing in a livable community. Congress must increase Housing Choice Voucher funding targeted at people with disabilities. Furthermore, Congress and the President should develop a permanent “Barrier Elimination Trust Fund” (BETF) for accessibility modifications for people transitioning out of institutions, including nursing homes and group homes, and those at risk of institutionalization. Funding for the BETF could come from fines for failure to comply with Section 504 and Fair Housing Amendments Act requirements. HUD should provide incentives to increase use of HOME funds for rental assistance for people with disabilities, and especially those who are leaving institutions.

Before appropriating annual funds for all Mainstream and Designated Vouchers for people with disabilities, Congress should make sure that all vouchers funded through these programs in the past that had been converted to regular Housing Choice Vouchers (i.e., not specifically for people with disabilities) are recommitted to people with disabilities. Also, Public Housing Agencies should participate in HUD-approved programs to assist low-income people with disabilities to pursue homeownership using Housing Choice Vouchers as one source of funding.

5. **Improve fair housing enforcement of disability rights.**
   Changes are needed within HUD to expand and improve local fair housing work to prevent and mitigate discrimination and to reduce the time cases filed by people with disabilities remain open. This includes providing regular mandatory training to educate all HUD and Fair Housing Act enforcement offices to be

consistent in interpretation of the laws guiding accessibility of new development and rehabilitation, including Section 504, FAIR HOUSING ACT, and ADA.[279] HUD should work with the U.S. Access Board to adapt a single design standard for new construction that harmonizes 504 and the Fair Housing Act with the ADA/ABA Accessibility Guidelines and model building codes to minimize differences with State and local accessibility codes.

HUD should also require enforcement offices to coordinate with disability rights organizations/groups and to partner with the disability community to develop testing, education, and enforcement strategies focused on disability rights and housing. Congress also must increase funding to ensure enforcement of the Fair Housing Act's accessibility requirements, including more resources for staff in field offices, for contracted fair housing organizations, and for litigation work. Along these lines, HUD should produce a follow-up study to its 2005 *Disability Discrimination Study*. A report on activities since the 2005 study can encourage additional, comprehensive disability-based testing and support future disability-related enforcement and education.

6. **Review HUD and PHAs for compliance with Section 504 and the Fair Housing Act.**

   If federal agencies want private sector developers to comply with fair housing requirements, then the federal housing stock should be in compliance. HUD, over the next 5 years, should evaluate all PHAs for compliance with Section 504 and, as appropriate, enter into Voluntary Compliance Agreements with them, and take enforcement action for noncompliance. The same should be done in HUD field offices. HUD should also provide regular comprehensive training for staff in PHAs and field offices, as well as fair housing contractors, on fair housing for people with disabilities, including providing accommodations.

7. **Support and enact new legislation.**

   Besides H.R. 1675 (see above, recommendation 1), there currently are several bills in need of immediate support from Congress that can directly impact housing for people with disabilities as highlighted in this report. This includes the

Inclusive Home Design Act (H.R. 1408) that will ensure a basic level of accessibility (i.e., visitability) in all housing built with federal funds that are not covered by the Fair Housing Act, and the Community Choice Act to ensure least restrictive housing choice and control and equitable provision of supports and services to enable real choice. In addition, Congress should also amend the Assets for Independence Act (P.L. 105–285) to specifically include people with disabilities among the target populations. Finally, in broad terms, any new legislation dealing with housing and economic recovery should include, to the extent possible, specific requirements and guidance for maximizing benefits to people with disabilities.

8. **Adapt and implement new federal guidance on helping people with disabilities in an emergency**.

   So much has been learned from the catastrophic disasters in the last few years. A key to moving forward is adapting and implementing new guidance from the Federal Government found in the 2009 National Disaster Housing Strategy, which has sections that specifically speak to disability issues. Moving this forward, the Federal Emergency Management Agency should publish as soon as possible the *Emergency Management Planning Guide for Special Needs Populations* (CPG-301) and *State, Territorial, Tribal, and Local Government Household Pets and Service Animals Plan* (CPG-302), and provide resources to publicize, train, and implement plan elements at the State and local levels. In addition, State and local disaster planning entities should review its various reports and seek input from people with disabilities in all phases of planning.

9. **Develop cross-system coordination and collaboration.**

   This recommendation is multifaceted and needs attention at all levels to ensure continued progress on providing more effective housing and community support for people with disabilities and our aging population. The key is bringing together public and private entities such as HUD, State and local housing agencies, private foundations, and housing referral and advocacy organizations to form a partnership to establish and fund a new disability and housing technical assistance initiative. Concurrently, CMS and HUD should build on current work

together through its HUD–HHS partnership. This includes examining current policies, regulation, and funding requirements to improve cross-system coordination with the intent to ensure timely, quality access to accessible, affordable, and integrated housing and community living supports by people with diverse disabilities across their lifespan, including people who are homeless or choose to move out of institutional settings to the community. This should include expanding cross-agency funding of Money Follows the Person and Community Choice systems change demonstration projects to focus on cross-system, coordinated delivery, and funding of housing and community living supports in States, and especially in those that have not shown significant progress in rebalancing funding to address institutional bias. This should also include implementation of No Wrong Door quality, consistent information access regardless of type of disability, age, or system entered.

10. **Change systems at the State level.**

    Much of the coordination and collaboration needed to change systems and increase affordable, accessible housing for people with disabilities needs to happen at the State level. A key here is to identify and eliminate barriers to coordination and systems change. This should begin by the National Conference of State Legislatures collaborating with national disability and aging advocacy organizations to convene a task force to examine federal policies to support cross-system delivery of housing and community living supports within States, and make it easier for States to provide these in a timely fashion. This can include requiring nursing homes and institutional settings to provide periodic reevaluation and meaningful transitional planning to support people with disabilities' right to choice and to support transition to community living in a timely manner. Also, jails and prisons should be required to provide meaningful discharge planning that helps prisoners with psychiatric disabilities identify and apply for quality supportive housing prior to release, to minimize recidivism and maximize successful transition to independent living in the community. Similarly, probation services should help people with psychiatric disabilities obtain stable

supportive housing and support services that foster independence and meaningful participation in community life.

State and local disability organizations should actively participate in HUD's Consolidated Planning process in order to help expand homeownership and affordable rental housing for people with disabilities. These organizations should also share best practices—many documented in this report—to demonstrate how others can develop integrated least restrictive housing options.

11. **Provide guidance for housing programs for people with psychiatric disabilities.** While specific policy change to affect housing for this population is needed, more discussion, debate, and research are also needed. In the interim, the following strategies may make housing less restrictive and more integrated for people with psychiatric disabilities:

    - Prospective tenants should participate in choosing their housing, and such choice should be preceded by a meaningful opportunity to observe and understand what is being offered and resolve any concerns they may have. People who prefer not to live in such housing should not be forced to do so.
    - Housing must be offered without being tied to treatment or use of supports as a condition of obtaining or maintaining housing. Lease compliance should be the only criterion for maintaining housing.
    - Housing providers must self-assess to determine that people with psychiatric disabilities are entitled to the legal protections offered all tenants.
    - Brief absences should be tolerated without loss of housing, and program staff should stay in close touch with tenants and landlords to maximize the chances that tenants will return to their homes.
    - Tenants should be offered individualized, flexible support services that are available 24 hours a day, 7 days a week.
    - Whenever possible, housing and support services should be staffed by people who have themselves recovered from mental illness. For programs that serve tenants with both psychiatric disabilities and substance abuse

problems, staff should include people who have recovered from drug and/or alcohol abuse.

- Program staff should be responsive to concerns from property managers, landlords, and neighbors, and intervene promptly to resolve tenancy problems to help tenants avoid eviction.
- Program staff, tenants, and landlords should be educated about fair housing rights and responsibilities, with emphasis on the right to reasonable accommodation. Housing staff should have formal backup support from fair housing attorneys for training, advice, and help in resolving disputes.

12. **Improve the data on people with disabilities and housing needs.** Understanding needs and monitoring progress toward meeting those needs requires reliable and credible data. Congress and the Administration should develop initiatives to produce effective data on housing needs of people with disabilities, including people with environmental sensitivities (chemical and/or electromagnetic), psychiatric disabilities, and other disabilities that are currently not accounted for in housing need. HUD and USDA should produce an annual report on occupancy of their accessible units to determine if these units are actually occupied by people who need accessible features. HUD should improve its Worst-Case Housing Needs estimates by using data from the American Community Survey and Survey of Income and Program Participation (SIPP) to address the dearth of disability data available in the Annual Housing Survey. Congress and HUD should require inclusion of people in group quarters (i.e., correctional facilities, nursing homes, mental hospitals, college dormitories, military barracks, group homes, and shelters) in estimating worst-case needs and other assessments, including people with disabilities.

Crosswalk for Specific Recommendations

The following table identifies the topical brief(s) to refer to for more background information on each recommendation. Reports are identified by number:

1. Federal Evaluation
2. Private and Nonprofit Sector Housing
3. Mental Health Issues—Housing for People with Psychiatric Disabilities
4. Homeland Security and Emergency Housing Evaluation
5. State Evaluation

Table 2. Recommendations and Corresponding Topical Briefs

1. Increase affordable, accessible, and integrated housing for people with disabilities to meet needs and demand.	**Brief**
HUD and USDA should require that a higher percentage of affordable housing constructed with federal funding be accessible for people with disabilities as allowed at 24 C.F.R. 8.22 of Section 504 of the Rehabilitation Act.	1
Congress and the President should substantially increase funding for construction of accessible, affordable, integrated housing. This should include fully funding the National Housing Trust Fund to ensure very low income renters are assisted.	1
Congress and the President should enact and immediately implement H.R. 1675.	1, 2, 5
HUD and USDA should award incentives in all new Notices of Funding Availability (NOFAs) to encourage visitability features, including for people with environmental sensitivities, in all housing funded.	1
Congress should redirect federal housing and treatment funds from board and care homes, nursing facilities, and psychiatric hospitals to housing first programs that maximize client choice and community integration.	3, 5

Table 2. Recommendations and Corresponding Topical Briefs (cont'd)

2. Increase access to existing units.	Brief
Reform existing HUD programs to end the definition of people with disabilities as a "special needs" category and make all programs, services, and activities accessible to people with different types of disabilities, including people with environmental sensitivities.	1, 2, 3, 5
HUD should incentivize Public Housing Agencies (PHAs) to set local preferences to give people with disabilities "preference" on all waiting lists for housing, including people with disabilities in nursing homes.	1
HUD should make sure all PHA housing meets the minimum Section 504 thresholds, including all new HOPE VI developments and redeveloped public housing.	1
HUD and USDA must make sure publicly subsidized housing for people with disabilities is offered without being tied to treatment or use of supports as a condition of obtaining or maintaining housing. Lease compliance should be the only criterion for maintaining housing.	1, 2, 3
HUD should establish a well-funded national modification fund to pay for reasonable modifications that are necessary to make private units accessible (or at least usable by people with disabilities). This can include strongly recommending that entitlement communities direct a portion of their CDBG funding to modification activities as a means of complying with affirmatively furthering fair housing opportunities for people with disabilities.	1, 5
States should adopt policies that award points under the Low Income Housing Tax Credit program for projects that (1) target housing units for people with disabilities whose incomes are either at the SSI level or at less than 30 percent of average monthly income for the area, (2) include visitability features in all projects, (3) include universal design principles in all designs, and (4) ensure integration by limiting the total units in a project occupied by people with disabilities to 15 percent, unless there exists a compelling reason to do otherwise.	1, 5
Congress should modify the Internal Revenue Code so that LIHTC properties are considered recipients of federal funding and hence are obliged to comply with Section 504 of the Rehabilitation Act.	1

Table 2. Recommendations and Corresponding Topical Briefs (cont'd)

3. Prevent further loss of affordable, accessible housing.	Brief
Congress should review current public housing redevelopment plans to make sure sufficient replacement units are planned for and provided; if not, then a moratorium on demolition and/or redevelopment should be issued until plans are revised.	1
Congress should pass new HOPE VI legislation.	1
4. Expand and focus usage of vouchers.	**Brief**
Congress must substantially increase Housing Choice Voucher funding targeted to people with disabilities.	1, 2, 3, 5
Congress, before appropriating annual funds for all Mainstream and Designated Vouchers for people with disabilities, should make sure that all vouchers under both programs are committed to people with disabilities. This includes any vouchers that may have been turned into regular Housing Choice Vouchers.	1, 2, 3, 5
HUD should recommend and provide incentives to increase the use of HOME funds designated as Tenant-Based Rental Assistance for use by people with disabilities, and especially for people who are leaving institutions.	1, 2, 3, 5
Congress and the President should create new "reintegration" housing vouchers for people transitioning out of institutions, including nursing facilities and group homes, annually for a fixed period. This requires HUD and the Centers for Medicaid and Medicare Services (CMS) to work together to make sure that these vouchers go to people, regardless of type of disability or age, living in nursing facilities and other institutions. This cooperation has begun with implementation of the Money Follows the Person demonstration program but needs to be vastly expanded.	1, 2, 3, 5
Congress and the President should develop a permanent "Barrier Elimination Trust Fund" (BETF) for accessibility modifications for people transitioning out of institutions, including nursing homes and group homes, and those at risk of institutionalization. This fund should be increased annually using the Consumer Price Index. Funding for the BETF could come from fines for failure to comply with Section 504 and Fair Housing Amendments Act requirements.	1, 2
HUD should strongly encourage Public Housing Agencies to develop programs that use Housing Choice Vouchers to assist low-income people with disabilities to purchase homes.	2

Table 2. Recommendations and Corresponding Topical Briefs (cont'd)

5. Improve fair housing enforcement of disability rights.	Brief
Congress must increase funding for HUD's Fair Housing Initiatives Program (FHIP) to expand enforcement of the provisions of the Fair Housing Act as amended, including accessibility requirements, and to extend FHIP grant periods to 2 or more years.	1, 5
HUD should provide mandatory training to educate all HUD and Fair Housing Act enforcement offices and contractors so they can be consistent in the interpretation of the laws guiding federal accessibility requirements.	1, 5
HUD should convene a small working group, including design and construction professionals and people with disabilities, to explore the feasibility of developing a single design standard for new construction under the Fair Housing Act that would be harmonized with all other federal accessibility guidelines (ADAAG), ABA, 504) and model building codes, to help eliminate conflicts with other federal standards and minimize differences with State and local accessibility codes.	1, 5
HUD should encourage consumer-directed organizations (e.g., Centers for Independent Living) to apply for FHIP funding under the education and outreach category.	1, 5
HUD should dramatically ramp up its enforcement of Section 504 of the Rehabilitation Act by providing more resources (funding and staff) to field offices, and by requiring enforcement offices and fair housing contractors to coordinate with disability rights organizations/groups and to partner with the disability community to develop testing, education, and enforcement strategies.	1, 5
HUD should proactively disseminate information to all field offices and fair housing contractors about "best practices" with regard to disability-related enforcement activities, testing campaigns, compliance, and educational activities.	1
HUD should regularly follow up on its 2005 *Disability Discrimination Study* (see *Barriers at Every Step*) as a means to encourage additional, comprehensive disability-based testing and as a lever to support future disability-related enforcement and education.	1
HUD should effectively coordinate with the Department of Justice to issue public written binding guidance that interprets the statute of limitations period for fair housing complaints in new development broadly and states that a failure to design and construct accessible housing is a violation of the Fair Housing Act that continues until the violations are corrected.	1

Table 2. Recommendations and Corresponding Topical Briefs (cont'd)

6. Review HUD and PHAs for compliance with Section 504 and the Fair Housing Act.	**Brief**
HUD should ensure that compliance with Section 504 is built into its ongoing monitoring activities for PHAs and enter into Voluntary Compliance Agreements (VCAs) with noncompliant PHAs, and, if necessary, take enforcement action for noncompliance with those requirements. HUD should include disability rights advocates in the development of VCAs.	1
HUD should conduct a 504 self-evaluation of the programs, services, and activities of its field offices and, as needed, develop a VCA and transition plan for each office not in compliance.	1
HUD should develop a comprehensive 504 and fair housing training program for all PHAs with mandatory certification every 5 years.	1
7. Support and enact new legislation.	**Brief**
Congress should support the Community Choice Act to ensure least restrictive housing choice and control and equitable provision of supports and services to enable real choice.	3, 5
Congress should support the Inclusive Home Design Act (H.R. 1408) that will ensure a basic level of accessibility (i.e., visitability) in all housing built with federal funds but not covered by the Fair Housing Act.	1
In any new legislation dealing with housing and economic recovery, include, to the extent possible, specific requirements and guidance for maximizing benefits for people with disabilities.	1
Congress should amend the Assets for Independence Act (P.L. 105–285) to specifically include individuals with disabilities among the target populations, require related reporting from Assets for Independence (AFI) projects to include information on participants with disabilities, and encourage funders who match AFI dollars to eliminate categorical restrictions that serve as additional barriers to participation by people with disabilities.	2

Table 2. Recommendations and Corresponding Topical Briefs (cont'd)

8. Adapt and implement new federal guidance for helping people with disabilities in an emergency.	Brief
FEMA should publish CPG-301 and CPG-302 as soon as possible and provide resources to publicize, train, and implement plan elements at the State and local levels.	4
FEMA should create and fill the Regional Disability Coordinator positions in FEMA and add Regional Advisory Committees to support the positions as soon as possible.	4
Temporary locations such as trailer parks for temporary disaster housing must include accessible transportation, so that people can travel to work, grocery stores, senior centers, Centers for Independent Living, medical facilities, and other locations.	4
Congregate facilities should be required by law to locate appropriate temporary locations in advance of disaster as part of their annual disaster planning. Facilities should plan to transfer residents and their caregivers, family, and medical records to reduce transfer trauma.	4
The Federal Emergency Management Agency should continue post-disaster reports under the National Response Framework's Emergency Support Function #14 on special needs and disability issues.	4
Additional federal funding beyond the Federal Emergency Management Agency Individual Assistance maximum for disaster recovery is needed to replace disability-specific items like durable medical equipment, assistive technologies, service animal needs, and ramps, and to fund accessible features in post-disaster reconstruction.	4
HUD must continue to expedite the certification of new Section 8 units after disaster and supplement these units with funds for increased utilities. HUD's Disaster Housing Assistance Program should be continued and ensure that a portion of funds are set aside for accessibility issues.	4
Local and State governments should revise building codes after disaster to increase accessibility, including universal design.	4
Mitigation funding and programs that increase rather than displace people with disabilities need to be developed and provided.	4

Table 2. Recommendations and Corresponding Topical Briefs (cont'd)

9. Develop cross-system coordination and collaboration.	Brief
CMS and HUD should examine current policies, regulation, and funding requirements to improve cross-system coordination and timely, quality access to accessible, affordable, and integrated housing and community living supports by people with diverse disabilities across their lifespan, including people who are homeless or choose to move out of institutional settings into the community.	5
Disability organizations should actively participate in HUD's Consolidated Planning process in order to help expand affordable for-sale and rental housing for people with disabilities.	1, 5
Public and private entities such as HUD, State and local housing agencies, private foundations, and housing referral and advocacy organizations should form a partnership to fund a new disability and housing technical assistance initiative, and support an active affordable, accessible housing registry.	5
Public and private partners should draw on the experience of the Arc of the Central Chesapeake Region, Maryland, to create lease-to-own projects for very low income people with disabilities.	2, 5
10. Change systems at the State level.	**Brief**
Nursing homes and institutional settings should be required by State systems to provide periodic reevaluation and meaningful transitional planning to support people with disabilities to become informed of their right to choice, to identify and apply for affordable, accessible, and integrated housing and supports, and to support transition to community living in a timely manner. These evaluations and informed choice counseling and supports should be provided in collaboration with community and disability/aging organizations and peer mentors.	5
In collaboration with the National Conference of State Legislatures and national disability and aging advocacy organizations, convene a task force to examine federal policies to support cross-system delivery of housing and community living supports within States, and make it easier for States to provide these in a timely fashion.	5
Expand cross-agency funding of Money Follows the Person and Community Choice systems change demonstration projects (across CMS and HUD) to focus on cross-system, coordinated delivery, and funding of housing and community living supports in States, especially in States that have not shown significant progress in rebalancing funding to address institutional bias. This should include implementation of No Wrong Door quality, consistent information access, regardless of type of disability, age, or system entered.	5

Table 2. Recommendations and Corresponding Topical Briefs (cont'd)

10. Change systems at the State level. (cont'd)	Brief
Sponsor and share innovative models of financing least restrictive, community-based options, such as use of combined waiver and voucher funding, use of HOME funds toward rental assistance, bridge subsidies during transitions, development of integrated least restrictive housing options, and home modification trust funds and programs.	5
Fund the development of a network of housing registry systems and infrastructure to report, share information, and monitor housing accessibility, affordability, and integration within and across States. Fund mechanisms for community-based organizations, such as Centers for Independent Living, Area Agencies on Aging, and Aging and Disability Resource Centers to coordinate and maintain these resources and serve as Housing and Community Living Navigators.	5
11. Provide guidance for housing programs for people with psychiatric disabilities.	**Brief**
Prospective tenants should participate in choosing their housing, and such choice should be preceded by a meaningful opportunity to observe and understand what is being offered and resolve any concerns they may have. People should not be forced into housing they do not choose.	3
Housing must be offered without being tied to treatment or use of supports as a condition of obtaining or maintaining housing. Lease compliance should be the only criterion for maintaining housing.	3
Housing providers must self-assess to determine that people with psychiatric disabilities are entitled to the legal protections offered all tenants.	3
Brief absences should be tolerated without loss of housing, and program staff should stay in close touch with tenants and landlords to maximize the chances that tenants will return to their homes.	3
Tenants should be offered individualized, flexible support services that are available 24 hours a day, 7 days a week.	3
Whenever possible, housing and support services should be staffed by people who have recovered from mental illness. For programs that serve tenants with both psychiatric disabilities and substance abuse problems, staff should include people who have recovered from drug and/or alcohol abuse.	3
Program staff should be responsive to concerns from property managers, landlords, and neighbors, and intervene promptly to resolve tenancy problems to help tenants avoid eviction.	3

Table 2. Recommendations and Corresponding Topical Briefs (cont'd)

11. Provide guidance for housing programs for people with psychiatric disabilities. (cont'd)	**Brief**
Program staff, tenants, and landlords should be educated about fair housing rights and responsibilities, with emphasis on the right to reasonable accommodation. Housing staff should have formal backup support from fair housing attorneys for training, advice, and help in resolving disputes.	3
Jails and prisons should be required to provide meaningful discharge planning that helps prisoners with psychiatric disabilities identify and apply for quality supportive housing prior to release, to minimize recidivism and maximize successful transition to independent living in the community. Similarly, probation services should help people with psychiatric disabilities obtain stable supportive housing and support services that foster independence and meaningful participation in community life.	3
12. Improve the data on people with disabilities and housing needs.	**Brief**
Congress and the Administration should develop initiatives to create effective data collection on the housing needs of people with disabilities, including people with environmental sensitivities.	1, 5
HUD and USDA should collect data annually on the accessibility features and occupancy of its accessible units, and report how many units are actually occupied by people who need accessible features.	1
HUD should improve its Worst-Case Housing Needs estimates by using data from the American Community Survey and Survey of Income and Program Participation to supplement Annual Housing Survey data already used.	1
Congress and HUD should include people in group quarters (i.e., institutional: correctional facilities, nursing homes, and mental hospitals, and noninstitutional: college dormitories, military barracks, group homes, missions, and shelters) in further analysis for the worst-case needs and other assessments that include people with disabilities.	1
The U.S. Census Bureau should develop SIPP reports that analyze relevant housing data for households of people with disabilities (i.e., not just individuals).	1

NCD Topical Brief #1

Federal Evaluation

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Introduction

This report examines the range of publicly assisted housing options available to people with disabilities in the United States through different federal programs. There are three main sources of funding offered by the Federal Government that either target or can benefit people with disabilities: U.S. Department of Housing and Urban Development (HUD), U.S. Department of Agriculture rural housing, and Low Income Housing Tax Credits (LIHTC). In addition, the Department of Veterans Affairs offers a number of housing programs that help veterans who have mental and physical disabilities, some in conjunction with HUD and others with State agencies.

This report begins by reviewing the need for housing and continues with a summary of housing programs, including estimates of accessible units and, when known, people with disabilities and the aging population benefiting from these programs. This inventory is critical, as the United States has had significant and noticeable changes in its portfolio of public sector housing in the past decade. These changes include:

- Reducing the overall number of public housing and project-based assisted units that have traditionally served very low income individuals and families, both with and without disabilities, through various changes in policy. These changes include granting property owners the ability to “opt out” of the Section 8 project-based housing program and giving local public housing authorities the ability to designate public housing developments as “senior only.”
- Transforming public housing sites into mixed-income/mixed-tenure developments through the HOPE VI program.
- Expanding the use of housing vouchers to subsidize relocated public housing residents and other low-income renters in private sector housing.
- Relying heavily on the Low Income Housing Tax Credit to produce most new affordable housing in the United States, which generally serves a higher-income group of renters than currently in public housing.

This report then provides an overview of recent trends and makes recommendations to improve housing options for people with disabilities.

Need for Housing

Recent federal research estimates that there are 54.4 million people with disabilities in the civilian population living in the United States, representing approximately 18.7 percent of the noninstitutionalized population.[280] At all ages, women (24%) have a higher prevalence of disability when compared to men (19%). For all, the prevalence of disability increases with age, from 11 percent for people 18 to 44 years of age to 52 percent for people 65 years and older.[281]

An estimated 11 million people 6 years and older need personal assistance with the activities of daily living (ADLs), such as bathing, eating, dressing, and getting around inside the home, or with instrumental activities of daily living (IADLs), which includes household chores, doing necessary business, shopping, and getting around for other purposes.[282] Approximately 35 million people have a severe disability.[283] The number and percentage of people with a severe disability increase with age, so that of those 65 and older with a disability, more than one-third (37%) have a severe disability. In addition to needing appropriate medical and public health services, this segment of people with disabilities is likely to need personal assistance and specific accessibility features within the home and in the community.

National housing survey estimates suggest that there are about 35.1 million households with one or more person with a disability, which is about 32 percent of the households in the United States in 2007.[284] These households are:[285]

- More likely to headed by someone age 65 or older (60% of households with a disability are in this age group; in comparison, only 2% of households without a disability are age 65 or older).
- Small in size, with about three-fourths of households in one- and two-person households.
- More likely to be low-income (65% compared to 36% of households without a disability).

- Nearly 2.5 times more likely to be extremely low income, earning less than 30 percent of the median, which is near the national poverty level (25% compared to 10% of households without a disability).
- More likely to be paying more than 30 percent of income for housing costs (40% compared to 32% of households without a disability).
- More likely to receive some form of government assistance with rent (9% compared to 2% for households without a disability).
- Less likely to live in a central city (26%) or suburb (30%) and more likely to live in a rural area outside of a metropolitan area (20%) than a household without a disability.
- More likely to live in manufactured housing (8% compared to 5% of households without a disability).
- More likely to live in a building with a no-step entrance (45%) and in an apartment on the same floor as the building entrance (38% compared with 34% of households without a disability).
- More likely to live in a building/development that offers "impersonal" services (such as meals, transportation, housekeeping, financial management, telephone aid, and shopping) and personal services (assistance with bathing, eating, moving about, dressing, and toilet use).

Also important to note is that among people under the age of 65, people with disabilities are more likely than people without disabilities to rent their home (37% compared to 31%). However, nearly 15.1 million households with a person with a disability between 65 and 85 years old own their own home. This means that among homeowners in this age bracket, nearly 94 percent have a disability.[286] Such high levels of ownership among this age group are likely due to the fact that many purchased their homes before acquiring a disability as they aged. Many of these homeowners are likely to face challenges if they want to remain independent in a home that often is not accommodating and may be costly to maintain.

Finally, the data above does not include about 2.17 million people who live in nursing homes or group homes (1.6 million of these live in nursing homes).[287] This includes 125,000 people ages 22 to 64 with severe mental illness in nursing homes, which is a 41 percent increase since 2002.[288] Federal estimates of housing need among people with disabilities usually do not include people in "group quarters" (i.e., nursing homes and group homes). If current rates of growth continue without the development of new alternatives that allow people to remain in homes in their communities as they age, it is expected that there will be 3 million nursing home residents by 2030.[289]

Affordability

Poverty and low-income status of people with disabilities are key barriers to acquiring housing. The median monthly income earnings in 2005 for people with no disability ($2,539) were significantly higher than for people with severe disabilities ($1,458). While people with nonsevere disabilities did better, their monthly median income was still lower ($2,250). Poverty is much higher among people ages 25 to 64 with severe disabilities (27%), when compared to people in the same age group with nonsevere disabilities (12%) and no disability (9%). For many, the reason is that they are unemployed. In 2005, less than half (46%) of the population ages 21 to 64 with a disability was employed. In comparison, 84 percent of people in this age group who did not have a disability were employed.[290]

Since the 1970s, policymakers and housing researchers have come to understand housing need based on assumptions about precisely how much consumers *should* pay for housing. Current federal guidelines fix the relationship between income and housing cost at 30 percent. That is, housing is affordable if it costs a household no more than 30 percent of its income. For renters, this includes monthly contract rent plus utilities. For owners, cost includes monthly mortgage payments, insurance, utilities, and taxes. For both, and regardless of income level, housing is not affordable if a household uses more than 30 percent of its income for it. There is a need for affordable housing when there are fewer units than people can afford to pay according to this threshold.

Congress requires the U.S. Department of Housing and Urban Development (HUD) to report periodically on the need for affordable housing among low-income households to determine how many have "worst-case needs." Households considered to have worst-case needs are "unassisted renters with very low-incomes who have one of two 'priority problems,' either paying more than half of their income for housing (severe rent burden) or living in severely substandard housing."[291] HUD's most recent report determined that nearly 6 million households in the United States have worst-case housing needs, with most being severely rent burdened. Further research suggests that of this total, between 1.3 million and 1.4 million are "nonelderly" (below 62 years of age) renter households with people with disabilities.[292] In addition, nearly 1 million worst-case need families with children include nonelderly adults with disabilities.[293] This means that there may be as many as 2.4 million very low income households with disabilities that are worst-case—a rate of between 35 and 40 percent of the overall worst-case housing needs in the United States. In addition, another million "elderly" households (ages 62 and above) were also found to be worst-case need, which is likely to include people with disabilities.[294]

The fastest growing segment of worst-case need appears to be in rural areas.[295] Less is known about the need for accessible housing in these areas, though data from the 2007 American Housing Survey suggests there were about 7 million households with at least one person with a disability in rural nonmetropolitan areas in the United States. Of this total, about 2.5 million are extremely low income, but only about 10 percent are claiming any form of rental assistance from the government.[296]

A trend likely to be contributing to this problem is the continued increase in housing need among low-income people with disabilities living on Supplemental Security Income (SSI). According to *Priced Out in 2008*, a single person in the United States has an income that is five times greater than that of a person receiving SSI assistance, which on average is $668 a month. With such a low income, a person on SSI has limited housing options. No State in the United States has an average-priced one-bedroom or studio apartment that would be affordable to someone on SSI. In fact, the average

rental payment in the United States for a studio would require spending 100 percent of the monthly SSI payment and 112 percent of a monthly SSI payment to renting the average-priced one-bedroom unit. As a result, most of the 4.2 million people receiving SSI cannot afford housing in their community unless they receive some form of housing subsidy.

For people with disabilities who work, the challenge is finding work that pays a sufficient wage to afford housing. The National Low Income Housing Coalition (NLIHC) examines housing costs annually to estimate the "housing wage" needed to afford housing, assuming a household pays no more than 30 percent of its income for monthly rent. NLIHC uses HUD's Fair Market Rent, which is adjusted annually and by location to reflect regional variations. Nationally, a single person or household with one worker would need to earn at least $14.97 per hour (based on a 40-hour work week, working 50 weeks a year) to be able to afford the average rent for a one-bedroom rental unit.[297] This wage varies widely across the country, with a high of $24.15 per hour needed to afford to live in Hawaii and a low of $8.38 in North Dakota, which is still above the current national minimum wage of $7.25 an hour.[298]

Accessibility

Many people with disabilities are able to live independently, although current research suggests that a growing number are unable to find appropriate housing to meet their needs relative to their disability, whether physical, cognitive, developmental, or environmental. Reasons include housing location, quality, physical accessibility, affordability, and an unmet need for supportive services that some individuals require in order to live independently in the community.

Based on the most recent national data available, thousands of people with disabilities need basic home modifications to make their homes accessible.[299] The greatest need is for grab bars or handrails (an estimated 788,000 households) that, relatively speaking, are not expensive to install. In addition, many people need basic features that make units "visitable," including ramps to access the building or home (612,000 households),

elevator or lifts to access the unit once in the building (309,000 households), widened doorways and halls in the unit (297,000 households), and accessible bathrooms (566,000). As might be expected, renters have a proportionally greater unmet need for all features when compared to homeowners.

In addition to modifications to make the physical environment more accessible, there is a need to consider the overall built environment, given the growing number of people affected by environmental exposures—a physical condition that is triggered by the environment.[300] Symptoms include neurological, respiratory, muscular, cardiovascular, and/or gastrointestinal problems. Known triggers include:

- Pesticides: weed killers, bug sprays, treated wood products
- Solvents: paints, glues, gasoline, nail polish/remover
- Indoor air Volatile Organic Compounds: new carpet, formaldehyde, plasticizers, chlorine, fragrances, and fragranced products
- Cleaners: bleach, ammonia, phenolic disinfectants, air fresheners
- Combustion-related: auto and diesel exhaust, tobacco smoke, natural gas, tar/asphalt
- Drugs/medical devices: anesthetics, antibiotics, implants, vaccines
- Electrical devices: microwaves, transformers, high-tension wires, fluorescent lighting, cell towers, cell phones

These triggers can be in the housing unit, elsewhere in the building if a multifamily structure, and/or outside in the immediate community or locations the person needs to or would like to visit in daily life. While some of these products are used in development of housing (and buildings in general), many are introduced by people through the care and maintenance of buildings and by people in the building (e.g., someone wearing perfume). Current estimates suggest that 11 percent of the population has some sort of chemical sensitivity.[301] For people with environmental sensitivities, accessible housing must be free of these environmental triggers. However, unless the housing is universally

designed to accommodate different sensitivities, for some it is better to live in segregated housing that ensures control over potential exposures.

Assistance is another means to accommodate and/or remove environmental barriers in and around a home. Many people with disabilities need help with certain activities of daily living to make their housing accessible.[302] Using this "functional" definition of disability, current estimates of the population in need of accessible housing and communities who are under age 65 range from between 3.5 million to 10 million.[303] This population will grow as the population of baby boomers soon reaches an age where housing accessibility and livable communities will become one of their highest priorities. People with disabilities also are living longer and their housing and supportive requirements are changing; such trends directly affect these individuals' community living options. The population of people over age 65 is expected to double by 2030. Currently, 20 percent of people ages 65 and over require assistance with at least one activity of daily living. This number is expected to increase to 50 percent by age 85. Over the next 30 years, disability rates for people 85 years and older are expected to rise as this population triples.[304]

For people with psychiatric disabilities, accessible housing is a relatively recent public policy concern that focuses on promoting integrated, rather than segregated, community living. Before the 1960s, people diagnosed with serious mental illness were considered incapable of living outside institutions. The development of psychotropic medications, a desire to save public funds, and growing concern about conditions in institutions led to a nationwide movement to deinstitutionalize hospital residents. In 1956, 559,000 people diagnosed with mental illness lived in public institutions.[305] By 1980, only 154,000 people diagnosed with mental illness lived in public institutions.[306] People released from mental institutions were supposed to receive treatment and support services in the community, but the promise of community-based treatment proved illusory, and the lack of support services coupled with the dearth of affordable housing swelled the ranks of people with mental illness living without shelter.

The need for community-based housing for people with psychiatric disabilities sparked the development of a new type of institution called the board and care home.[307] Board and care homes, which provide 24-hour supervision and food to residents, range in size from 2 to more than 200 residents. The majority house more than 50 people. Currently, approximately 330,000 people with psychiatric disabilities live in board and care homes. Board and care homes are not designed to lead to recovery—they simply fill the housing gap created by deinstitutionalization. Today, most board and care homes function as mini-institutions within the community. They provide very little privacy, a limited scope of services, and little opportunity to interact with people without disabilities in the community. In most homes, residents have no opportunity to exercise choice in their day-to-day lives over roommates, meals, bedtimes, or other daily functions. Virtually all resident income goes directly to the home, making it impossible for residents to save sufficient funds to consider moving to private housing.[308] Also, most homes are unlicensed with little oversight, and as a result there have been multiple press stories about abusive conditions in board and care homes.[309] Finally, few board and care homes help residents develop independent living skills or move on to independent housing.[310]

NCD's report, *Livable Communities for People with Psychiatric Disabilities*, underscores the need for new and more options beyond this form of congregate living.[311] While "different perspectives exist" on which is the best housing approach, when given the choice, consumers are likely to choose independent, integrated living over some form of congregate arrangement.[312] This also aligns with national surveys that consistently report that 80 to 95 percent of people with disabilities and seniors strongly prefer to remain in their own homes,[313] and experience higher quality of life when they are able to remain in the community.[314] However, data also illustrates how community living is a constant fight to manage housing, finances, and transportation—all survival issues that directly affect people's choice, and potentially their health and participation.[315] Problems worsen when people do not have information to make informed decisions about least restrictive living.[316] People with disabilities need information they can use to become informed on their choices, as do policymakers and other stakeholders who can help expand choice.

Accessibility Requirements in Federal Programs

All housing produced and operated with federal funds is subject to the requirements of the 1973 Rehabilitation Act (Section 504), which provides for nondiscrimination in all programs, services, and activities receiving federal financial assistance, and in programs, services, and activities conducted by executive agencies. Section 504 regulations require 5 percent (but not fewer than one unit) of dwelling units to be accessible to people with mobility disabilities and at least 2 percent (but not fewer than one unit) of dwelling units to be accessible for people with visual and hearing disabilities. Section 504 regulations require compliance with the Uniform Federal Accessibility Standards (UFAS), which was published in 1984 by HUD and three other federal agencies to provide uniform standards for the design, construction, and alteration of buildings in accordance with the Architectural Barriers Act (ABA), 42 U.S.C. 4151–4157. ABA applies to buildings and facilities designed, constructed, altered, or leased with federal construction funds. HUD is in the process of updating its ABA standards, which apply to federally funded residential facilities. While the ABA only covers the facilities, Section 504 also covers programs, services, and activities, which must be accessible to people with disabilities.

Section 504 also aims to produce integrated housing by providing guidance for distributing accessible units within buildings and developments, and on how to "maximize the utilization of such units by eligible individuals."[317] Section 8.26 within the Section 504 legislation states that:

> Accessible dwelling units required by Sec. 8.22, 8.23, 8.24 or 8.25 shall, to the maximum extent feasible and subject to reasonable health and safety requirements, be distributed throughout projects and sites and shall be available in a sufficient range of sizes and amenities so that a qualified individual with handicaps' choice of living arrangements is, as a whole, comparable to that of other persons eligible for housing assistance under the same program."[318]

Furthermore, Section 8.27 states that:

> (a) Owners and managers of multifamily housing projects having accessible units shall adopt suitable means to assure that information regarding the availability of accessible units reaches eligible individuals with handicaps, and shall take reasonable nondiscriminatory steps to maximize the utilization of such units by eligible individuals whose disability requires the accessibility features of the particular unit. To this end, when an accessible unit becomes vacant, the owner or manager before offering such units to a non-handicapped applicant shall offer such unit:
>
> > (1) First, to a current occupant of another unit of the same project, or comparable projects under common control, having handicaps requiring the accessibility features of the vacant unit and occupying a unit not having such features, or, if no such occupant exists, then
> >
> > (2) Second, to an eligible qualified applicant on the waiting list having a handicap requiring the accessibility features of the vacant unit.
>
> (b) When offering an accessible unit to an applicant not having handicaps requiring the accessibility features of the unit, the owner or manager may require the applicant to agree (and may incorporate this agreement in the lease) to move to a non-accessible unit when available.[319]

Federal housing is also subject to the American with Disabilities Act (ADA) Title II regarding public access and Title III regarding places of public accommodation in private multifamily properties. Finally, all housing is subject to State and local regulations, including zoning and building codes.[320]

In addition, with few exceptions and regardless of funding source, all multifamily housing with four or more units in a single structure built after March 13, 1991, is subject to the design and construction requirements of the Fair Housing Act (1988). However, the law does not ensure the majority of rental units will be accessible to people with disabilities, since more than 85 percent of the rental housing in the United States was built before 1991.[321] For these units, there is the expectation that reasonable accommodations can be made to meet different accessibility needs of people with disabilities. This was recently reinforced through a jointly issued statement from HUD and the Department of Justice (DOJ) on June 17, 2004, which reminded that:

> One type of disability discrimination prohibited by the [Fair Housing] Act is the refusal to make reasonable accommodations in rules, policies, practices, or services when such accommodations may be necessary to afford a person with a disability the equal opportunity to use and enjoy a dwelling [42 U.S.C. § 3604(f)(3)(B)]. HUD and DOJ frequently respond to complaints alleging that housing providers have violated the Act by refusing reasonable accommodations to persons with disabilities.[322]

The statement aims to help housing providers better understand the rights of people with disabilities and the obligations of housing providers under the act. While determining what is a reasonable accommodation is dependent on the individual with the disability, the statement provides some examples that are likely common accommodation requests, including assigning a parking space close to an entrance for a person with a mobility limitation, allowing different means for paying rent (e.g., via mail instead of in person), and waiving “no pet” policies to allow assistance animals in the unit. Also, the statement reminds that housing providers cannot charge a fee for providing a reasonable accommodation.

U.S. Department of Housing and Urban Development Programs

The U.S. Department of Housing and Urban Development (HUD) administers all funding for public housing and the Housing Choice Voucher (HCV) program implemented by Public Housing Agencies (PHAs) and private developers. HUD also administers two competitive multifamily housing programs in which developers apply directly to HUD: Section 202 housing for "elderly" (ages 62 years and older) and Section 811 housing for people with disabilities. HUD also has oversight responsibility for a portfolio of multifamily developments created through production programs that are now inactive (e.g., project-based Section 8, Section 236 Interest Reduction program). Finally, HUD administers several formula-based grant programs that allocate funds to State and local agencies, which are given fairly broad discretion on spending on housing. This includes the HOME program, Community Development Block Grant (CDBG), and the Continuum of Care (Homeless) program, which produces permanent and transitional housing and emergency shelters for homeless people, including people with disabilities and with HIV/AIDS. HUD is responsible for approving all Consolidated Plans (State and local), which establish specific priorities for allocating federal funds for housing and community development.[323]

The ability for anyone to access HUD housing programs is determined by income limits using annual family Area Median Income (AMI), which is adjusted for family size.[324] HUD further distinguishes "extremely low income" households (income below 30% of AMI), "very low income" (income below 50% of AMI), and "low-income" (income below 80% of AMI). Table 1 below illustrates the variation in median income and the income limits associated with each HUD income category based on a family of four, which is the standard usually cited when public officials talk about median income. In this sample of 11 cities, the median income ranges from a high of $102,700 in Washington, D.C., to a low of $61,100 in Houston, Texas. Using HUD's calculations, an extremely low income family in Washington, D.C., has an annual income of no more than $30,800, while in Houston it would be $18,350. However, since many people with disabilities live alone, it

Table 1. HUD Income Limits for a Four-Person Family in Selected Cities, 2009[326]

	Extremely low income 30% of median	Very low income 50% of median	Low-income 80% of median	Median
New York City	$23,050	$38,400	$61,450	$61,600
Los Angeles	23,800	39,650	63,450	62,100
Chicago	22,600	37,700	60,300	74,900
Houston	18,350	30,550	48,900	61,100
Philadelphia	23,350	38,900	62,250	77,800
Phoenix	19,750	32,950	52,700	65,900
Jacksonville	19,550	32,550	52,100	65,100
Washington, D.C.	30,800	51,350	64,000	102,700
Denver	22,800	38,000	60,800	76,000
Atlanta	21,500	35,850	57,350	71,700
Seattle	25,300	42,150	64,000	84,300

is important to see how these income categories vary depending on family size. For example, in Washington, D.C., a one-person household would be extremely low income earning $21,550 annually, while an eight-person family would go up to $40,650. In Houston, the range would be from $13,400 to $25,300.[325]

Beyond income, HUD also identifies tenants as one of the following: elderly family, disabled family, or both elderly and disabled. A *disabled family*, according to HUD, means a family whose head, spouse, or sole member is a person with a disability. It may include two or more people with a disability living together, or one or more people with a disability living with one or more live-in aides. By definition, a family with a child with a disability, but no other adult with one, is not a disabled family. HUD uses several means to determine disability status for purposes of qualifying for housing: Section 223 of the Social Security Act (42 U.S.C. 423), Section 102 of the Developmental Disabilities Assistance, the Bill of Rights Act (42 U.S.C. 6001[5]), or:

> determined by HUD regulations to have a physical, mental, or emotional impairment that: a) is expected to be of long, continued, and indefinite duration; b) substantially impedes his or her ability to live independently; and c) is of

> such a nature that such ability could be improved by more suitable housing conditions…. The definition of a person with disabilities does not exclude persons who have the disease acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome (HIV). However, for the purpose of qualifying for low-income housing, the definition does not include a person whose disability is based solely on any drug or alcohol dependence. (Note: The definition of a person with disabilities as defined in 24 CFR 8.3 must be used for purposes of reasonable accommodations and program accessibility for persons with disabilities.)[327]

Elderly family means a family whose head, spouse, or sole member is 62 years of age or older. The term *family* includes a single elderly person, two or more elderly people living together, and one or more elderly people living with one or more people who are determined to be essential to the care or well-being of the elderly person(s). An elderly family may include people with disabilities and other family members who are not elderly. To be classified as both *elderly and disabled*, the head, spouse, or sole member must be a person with a disability and 62 years of age or older.

Public Housing Agencies (also referred to as PHAs) are responsible for local implementation and management of federal public housing and usually Tenant-Based Rental Assistance through the Housing Choice Voucher program within their jurisdictional area. Some PHAs also administer other HUD programs, but many do not. Public housing administration includes collecting monthly rents; assuring tenant compliance with leases; setting other charges (e.g., security deposit, excess utility consumption, and damages to unit); annual reexamination of tenant household income; transferring families from one unit to another to correct over/under crowding, repair or renovate a dwelling, or because of a resident's request to be transferred; terminating leases; and maintaining the development in a decent, safe, and sanitary condition.[328] Currently, there are approximately 3,300 PHAs in the United States. Most are quasi-governmental; however, some PHAs are part of local government. Housing authorities serving predominantly rural areas or low-density areas often operate at the county level and in some States the State Housing Agency may administer the Housing Choice Voucher program for the entire State (e.g., Michigan and Massachusetts).

Public Housing

Most public housing was built between 1937 and the mid-1980s to provide low-income families affordable housing. Depending on the time period, public housing may be low-rise townhouses, mid-rise multifamily developments, or high-rise apartment buildings. Potential tenants have to be qualified based on their income, which cannot exceed the low-income limit for their area and family size; however, this does not guarantee that a household will be able to lease a unit, since this depends on availability. In many larger urban areas, applicants are on waiting lists for many years. Often PHAs only open waiting lists periodically (e.g., every few years) and fill up after being open for only a short time. PHAs can set “local preferences” to move a household with greater housing needs up on the waiting the list, as long as these preferences are approved by HUD. This can include people with people with disabilities.

Once in a unit, tenants are required to pay either a minimum of $50 or 30 percent of income (as determined by HUD’s eligibility criteria) for rent, depending on which is higher. The remaining rent—the actual cost of operating and maintaining the unit—is paid to the PHA through a contract with HUD. Rent usually includes some utility assistance or allowance. Each household is reviewed annually to verify income and adjust rent payments if income has changed.

Currently there are about 976,000 occupied public housing units in the United States.[329] This is less than 1 percent of all housing in the United States, and substantially lower than the 1.28 million public housing units that existed throughout the United States and Puerto Rico in 2000.[330] The 24 percent reduction in units is mainly due to the demolition of 150,000 public housing units under the HOPE VI program in order to develop new mixed-income housing developments, which, when completed, will have fewer than 50,000 replacement public housing units.[331] This lower number also reflects the loss of units that have been declared uninhabitable and other units permanently eliminated through demolition.

According to HUD data on public housing tenants, there were 210,760 “disabled families” (22%) and 307,782 “elderly families” (32%), of which 135,218 (11%) have a disability, living in public housing as of December 2008. The remaining 457,182 are families (47%) in which the adult head of household is neither elderly nor with a disability.[332]

There is no current information on how many public housing units are accessible. Section 504 requires PHAs to do a self-evaluation of all their programs, housing, and facilities to determine if they are in compliance and to develop transition plans to deal with conditions that are not in compliance. While these documents are considered public and should be available upon request from a PHA, there is no publicly available master list of all evaluation results that could help determine what proportion and number of public housing units are up to UFAS standards. However, assuming the minimum of 5 percent for mobility and 2 percent for vision/hearing impaired required by 504, we estimate there should be at least 68,300 units of accessible public housing in the United States based on current inventory.[333] Since this estimate is not based on actual data, the real number may be higher or lower.

Recent compliance reviews of several large PHAs suggest that the number is lower. Based on Voluntary Compliance Agreements with HUD, we know that at least nine PHAs (Atlanta, Boston, Chicago, Lafayette (LA), Las Vegas, Miami-Dade, Pittsburgh, Puerto Rico, and Seattle) and one State financing agency (Alaska) were not meeting the minimum threshold.[334] With the exception of Chicago, all were given the mandate to make at least 5 percent of their units UFAS accessible. The Chicago Housing Authority was given a minimum of 5.3 percent for mobility impairments and 2.1 percent for sensory impairments.[335] Some PHAs were also required to complete a needs assessment to determine more precisely what is needed. Given the number of disabled families plus the number of elderly families that have someone with a disability, the minimum number of accessible units required under Section 504 appears to be significantly smaller than the need.

Finally, a further limitation to consider is that many accessible public housing units are in age-restricted “elderly only” developments (i.e., for people who are 62 years or older) and therefore not available to all people with disabilities. Beginning in 1992, HUD allowed PHAs to designate public housing developments as elderly only. As of 2009, about 65,000 units had been added to this category, with the majority being one-bedroom units (40,900 units).[336] In addition, the elderly only designation of another 35,000 units had expired, while 60 requests from PHAs were denied elderly only designation status and another 50 requests had been withdrawn.[337]

Housing Choice Vouchers (HCVs)

This program allows the household the same benefits as HUD’s public housing program, but in the private rental market. To qualify for an HCV, the household must be very low income (at 50% of the Area Median Income), which is a lower income threshold than that required for public housing. A household with a voucher pays 30 percent of its income for rent (though it can choose to pay more if it wants). With a grant from HUD, the PHA pays the difference up to the Fair Market Rent, which is near the median rent for the area.[338] Housing units are required to meet HUD-specified quality standards verified through an inspection, and are subject to annual reviews to make sure they remain in compliance. As with public housing, there is likely to be a waiting list and PHAs can establish HUD-approved local preferences.

Currently, about 1.97 million households are using HCVs in the United States. These figures include households that receive assistance through special voucher allocations that Congress has provided for the exclusive use of nonelderly disabled households. An estimated 64,000 vouchers are included in two programs: the Designated Voucher Program and the Mainstream Housing Opportunities for Persons with Disabilities program. The Designated Voucher Program began in 1997 as an effort by Congress to provide new vouchers for nonelderly people with disabilities who would have qualified for studio and one-bedroom units in federal public and assisted housing properties that were designated elderly only. An estimated 50,000 Designated Vouchers for nonelderly people with disabilities were appropriated between 1997 and 2001. Congress requires

PHAs to make these vouchers available only to people with disabilities upon turnover. The Mainstream Housing Opportunities for Persons with Disabilities program is administered as the HCV program, but is funded through the Section 811 Supportive Housing for Persons with Disabilities program. Congress has appropriated an estimated 14,000 Mainstream Vouchers, which must also continue to be used solely by people with disabilities if they turn over.

Of the total number of HCV holders, HUD data identifies 544,561 as “disabled families” (28%) and 374,265 as “elderly families” (19%), of which 150,499 also include someone with a disability (11%). As with public housing, most voucher holders are nonelderly families with no person with a disability as head of household (1,052,906 households; 53% of total), and we do not know if there are children or other adults with disabilities in these families, since HUD does not identify them. Based on the number of disabled families in the HCV program, it appears that the majority did not gain access to federal housing assistance through the Designated or Mainstream programs. As a result, the majority of vouchers currently benefiting people with disabilities are not guaranteed to continue to do so if returned, since there is no requirement for turnover to another disabled family.

Regardless of the type of voucher, there is no record of what, if any, accessibility features are in the units that tenants with disabilities occupy. While some public housing authorities and disability advocates keep a list of landlords with accessible rental units, there is no systematic recordkeeping for HUD on the number of voucher holders with disabilities renting accessible and/or adaptable units. Even if all vouchers in both of these programs were being used by people with disabilities, we cannot assume that all would be living in accessible units or units that fit the accessibility needs of the household.

A study commissioned by HUD found that people with disabilities using vouchers do not always search for housing solely to meet their accessibility needs.[339] When asked why a household selected a current unit, only 10 percent reported that they selected the unit because it offered more accessible features than other available units. The top reasons

were because the unit was located in a “better” neighborhood (39%), was closer to friends (34%), and/or was located near shopping (33%).[340] About one-fourth did not even search for a new unit when they received their voucher, but instead stayed in the current rental unit.[341] And whether they moved or not, only 7 percent of the survey respondents indicated that they had asked for a modification to the unit.

Multifamily Housing Programs

There are 1.47 million rental units in privately owned buildings maintained by both for-profit and nonprofit entities that have been developed with various federal multifamily housing programs. This includes at least 396,000 units designated elderly only, with most built under Section 202 (270,000 units as of 2004). In contrast, there are only about 72,700 units in HUD’s multifamily portfolio designated for people with disabilities only (which includes people ages 62 and older), with much of it built in the past 15 years under the Section 811 program. Other units were built under the Section 8 program and receive assistance to reduce rents in buildings so that low-income households pay only 30 percent of their income for rent. Most of these developments are designated as family, although some are combined elderly and disabled.

The same is true for units built under various other rental subsidy programs from the 1960s that are no longer funded, including the Section 221(d)(3) below-market interest rate program and the Section 236 program. Both produced affordable housing, but for renters with incomes slightly above the public housing income limits. Over time, deep rental subsidies were attached to some of these units to keep them affordable, but there still are about 318,000 units that do not have these rental subsidies and therefore are not affordable to low-income households.[342]

Based on field inventories completed in 2008, there are approximately 156,000 accessible units (11%) in subsidized multifamily housing developments.[343] Not all are affordable to low-income households. Furthermore, as with public housing, the majority are likely to be in age-restricted developments, since 26 percent of the units in HUD’s multifamily housing portfolio are designated for elderly people, while only 5 percent are

designated for people with disabilities.[344] As with public housing, this means not all units in the accessible category can be accessed by younger people with disabilities. Finally, these figures in no way reflect the occupancy or bedroom size of accessible units and whether or not a person with a disability, regardless of age, was occupying the unit when it was surveyed.

Integration of HUD Housing Programs

The degree to which federal housing is integrated can be examined at different levels: regionally, relative to need and conditions; within each program, relative to population served; and within a development /building, relative to distribution of units and people.

We currently do not have data on the distribution of people with disabilities in public housing relative to the communities in which developments are located. For the most part, data is lacking on the integration of people with disabilities in HUD housing at all of these levels.

Within HUD programs, targeted housing assistance aims to assist specific populations: families with children, nonelderly people with disabilities, and people who are aging (generally 62 years and older), whether or not they have a disability. Only one program, Section 811, targets people with disabilities, while many target or provide special assistance for people who are aging. This includes HUD housing units that can benefit people with disabilities but, due to changes in policy in 1992, are now designated as elderly only.[345] The following reviews what we do know about how each population "category" is integrated in HUD housing programs.

People with Disabilities

Section 811, which was authorized by the National Affordable Housing Act of 1990 and modified in 1992 by the Housing and Community Development Act, was specifically created to address the supportive housing needs of people with disabilities. Section 811 has two program components: the capital advance/Project Rental Assistance Component (PRAC) and the Tenant-Based Rental Assistance component administered

by HUD under the Section 8 Mainstream Housing Opportunities for Persons with Disabilities program. As noted above, there are approximately 14,000 vouchers in the Mainstream program.

As of 2007, about 27,000 units of housing had been produced through the 811 PRAC by nonprofit sponsors.[346] There are three categories of housing allowed: group homes, independent living facilities, and condominiums. A group home is defined by law as a single-family residence that is designed for up to eight individuals to occupy, in either single- or double-occupancy bedrooms, and with at least one bathroom per four people.[347] Also, the law says a group home developed with Section 811 funds is not to be located immediately next to or on the same lot as another group home. An independent living facility is like an apartment building, with separate dwelling units complete with their own kitchens, bathrooms, and bedroom(s); however, it also can include a unit for a staff person. These developments can be a single building on one site or multiple buildings scattered throughout the community.

Based on a nonrepresentative sample of 136 PRAC developments in 2003, the majority (81) of the projects surveyed were in facilities with 8 to 24 units, which means most are independent living facilities.[348] Furthermore, the majority of the surveyed developments targeted people with developmental disabilities (43 projects) and chronic mental illness (62 projects), rather than physical disabilities. While this data does not represent all 811 housing, the results are likely to reflect the need for housing specifically for these populations that is not being produced by the private sector.

The law limits to 24 the number of people with disabilities per 811 development; however, the annual Notice of Funding Availability limits this to 14 people with disabilities.

Condominium projects are similar to independent living, with separate units. However, assuming these are units purchased in a building that was not intended to solely house people with disabilities, the program tries to promote integration by limiting the number of units to whichever is greater: 14 units or 10 percent of the total units in the

development, not to exceed 24 units. Still, HUD grants waivers to allow a larger percentage and therefore number of units both in existing buildings and in new developments.

While Section 811 is effective at creating housing, one concern is that the program has also contributed to the segregation of people with disabilities, not only from people without disabilities, but also by different disabilities. Legislation states that 811 housing target people with physical disabilities, developmental disabilities, and chronic mental illness, or a combination of these three. However, through a waiver process, HUD can approve a project sponsor's request to not only target only one of these three, but then also a subcategory of disability within it (e.g., autism). As long as HUD approves the waiver request (which it typically does), the project sponsor can deny housing to someone that fits the broader disability category (e.g., developmental disability) but not the project's specific target population (e.g., autism). This means that fit is determined based on how well the housing and households in *each* disability category line up. This is especially important given the relatively small number of 811 units relative to need.

People Who Are Aging

The U.S. GAO recently issued a report that examines the different federal programs that target the elderly (this includes USDA rural housing) to determine what proportion of the units were occupied (or in the case of vouchers, what proportion were being used) by this population.[349] This data, which is drawn from 13 federal programs, illustrates the degree to which the aging population is using public housing assistance.[350] Whether or not the subsidy targets them, the U.S. GAO estimates that about 30 percent of the housing was being used by someone age 62 or older (about 1.36 million households). However, this is based on a large number of elderly people living in Section 202 rental housing, which is now exclusively for the elderly.[351] When compared to the usage rates within public housing and the different multifamily rental programs, relatively few seniors use Housing Choice Vouchers (16%). This suggests that older renters receiving federal housing subsidies are more likely to be segregated—living with other elderly

households—than integrated, since vouchers provide the most opportunity for anyone to rent in nonelderly and nondisability-only or -majority buildings.

In the past, segregated housing has been justified on the basis that makes it easy to efficiently provide specific services to assist people with disabilities and/or an aging population. This can include meals, personal care, transportation, housekeeping, and social and recreational activities that may be offered onsite or offsite. However, the U.S. GAO report found that relatively few housing assistance programs that either target or are significantly used by the elderly can also use federally funded supportive services programs. This means that many housing programs do not directly offer federally funded supportive services, and instead must rely on external resources and services for tenants.[352] So, while people are grouped according to disability in federal housing, this does not ensure services are offered.

HUD did offer for 1 year the HOPE for Elderly Independence (HOPE IV) demonstration program, which combined rental assistance with case management and supportive services to "help very low-income, frail, elderly persons remain in an independent living environment and to prevent their premature placement in nursing homes."[353] HUD awarded grants to 16 agencies for a 5-year demonstration period. Eligible participants had to be elderly (householder 62 years or older). Participants were to pay 10 percent of the supportive service cost (HUD paid 40% and the Public Housing Agency provided 50%).

Service coordinators were to assess residents' needs, identify and link residents to appropriate services, and monitor the delivery of nonmedical services. Eligible social services included housekeeping, transportation, home-delivered meals, in-home health care, personal care, meals at a senior center, recreation, and counseling. A service coordinator could also educate residents about what services are available and how to use them, or help residents build informal support networks with other residents, family, and friends. The resident was not required to accept the supportive services, and a Professional Assessment Committee (PAC), in conjunction with a service coordinator, was to determine each participant's condition and needs.

Evaluation of the demonstration program recommended some type of formal program that would include connecting frail Section 8 households to supportive services that could help them to maintain their independence. This was based on two complementary findings:

> First, the study showed that the HOPE IV demonstrations were successful in improving the quality of life and care for low-income, frail elderly tenants by providing a unique combination of housing assistance, case management, and supportive services that was often unavailable elsewhere in the community. A second finding, however, was that even with the benefit of separate funding and a PHA commitment for the program, these demonstrations had to first overcome substantial structural and functional barriers to implementation within their own host agencies and among other community partners, in addition to the extensive effort required to serve a population with considerable needs.[354]

On the latter finding, the evaluation team stressed the importance of having the service coordinator not only work with tenants but also to help change the culture in the public housing agency, to be more responsive and proactive in dealing with and placing frail elderly in the community with vouchers. They also noted, however, that the long waiting lists for vouchers makes it difficult to use as a means to prevent institutionalization, unless more vouchers are added and/or existing ones are targeted so that upon turnover some proportion go to frail elderly people in public housing.[355]

HUD Formula-Based Programs

The following sources of funding do not exclusively produce affordable housing, but can be used to develop, rehabilitate, and subsidize affordable housing, offer housing-related services, and/or produce shelter. Like the HUD programs above, all are subject to the same federal accessibility requirements. For all, the use of funds is to be driven by a comprehensive plan, known as the Consolidated Plan, which identifies needs, includes a housing market analysis, and outlines how funds will be used to meet those needs given current and near future housing conditions.[356] Developed for a 5-year window, the Consolidated Plan is to guide the use of all federal housing and community development dollars. It is to be developed with “citizen participation” and reviewed by the public prior to local government approval and submission to HUD for approval.

Community Development Block Grants (CDBGs)

Begun in 1974, the CDBG program is managed through HUD's Community Planning and Development office and is one of the older continuous sources of federal funds still being used to produce affordable housing.[357] CDBG provides funding to help metropolitan cities, urban counties, and States to "meet their housing and community development needs." The block grant concept was offered as a means to consolidate a seemingly large collection of federal funding programs for housing and community development work into one pot of funding, which was then distributed to State and local governments through a formula based on need, size, and housing conditions. The logic behind the block grant was that it would be more efficient to manage at the federal level and be used more effectively at the local level. Both points appealed to lawmakers. And while block grants also appealed to local government, the shift to a block grant meant that some communities would have direct access to federal housing and community development funds, because the formula determined which communities were "entitled" to the funds and which were not.

Communities that receive CDBG funds are known as entitlement communities, which include metropolitan cities—principal cities of metropolitan areas or other cities within such areas with populations of at least 50,000, and urban counties with a population of 200,000 or more not within metropolitan cities. In addition, all States get an allocation of CDBG funding. Both State and county government then can distribute these funds to other smaller local nonentitlement jurisdictions based on need, while cities distribute these funds through discretionary funds and reviewed applications for support from different agencies that deliver services and produce housing. Currently, the CDBG program provides annual grants on a formula basis to about 1,200 general units of local government and States.[358]

In general, CDBG funds may be used for neighborhood revitalization, economic development, and improvement of community facilities and services. All activities must achieve one of the program's national objectives, such as benefit low- and moderate-income people, aid in the prevention or elimination of slums and blight, or meet urgent

community development needs. The amount of annual grants is determined by community need based on poverty rate, population size, housing overcrowding, age of housing, and growth lag.

While the CDBG program contributes to the production of affordable housing in the United States, this is not the sole activity supported by CDBG. It can also be used for economic development and to improve infrastructure, as long as a minimum of 70 percent of funds are used to benefit low- and moderate-income people. About 26 percent of CDBG on average currently goes to housing ($1.16 billion in FY 2008), which includes both single-family and multifamily housing. The rate is much lower when looking at State allocation of CDBG funds, which is around 16 to 17 percent for housing.[359] Based on data for the past 8 years, about half the funding has gone directly to single-family rehabilitation ($582 million), followed by rehabilitation administration ($138 million), and code enforcement ($137 million).[360] Rehabilitation may include retrofitting a home to make it accessible, since this is an eligible use of funds; however, it is hard to know if this is occurring because the level of detail in reporting is not that specific. More generally, we cannot know if or how many people with disabilities benefit from CDBG, since the outcomes reported in HUD's Integrated Disbursement and Information System (IDIS) do not include this detail.[361]

HOME Investment Partnerships Program

The HOME program is the largest federal block grant to State and local governments to exclusively create affordable housing for low-income households, allocating approximately $1.7 billion per year the past few years. The HOME program is authorized under Title II of the Cranston-Gonzalez National Affordable Housing Act (NAHA), which was passed in 1990. NAHA was the result of a bipartisan group of senators and housing experts, which created the National Housing Task Force in 1988. The task force's report, *A Decent Place to Live*, condoned the diminished role of the Federal Government in directing local housing activities, but also recognized the need to increase federal housing funding. It also acknowledged: "A new generation of community based nonprofit development corporations, propelled by persistence and

inventiveness, is an important part of the new delivery system."[362] The task force's centerpiece was a proposed $3 billion housing block grant to States and local governments to be provided "with maximum flexibility and minimum (Federal Government) interference." Out of this recommendation came the HOME program. Its initial allocation was just $1.5 billion—half of what the task force recommended.

Today the program enjoys widespread support in Congress and among the housing community. HOME funds are exclusively for housing-related investments, including Tenant-Based Rental Assistance, housing rehabilitation, homebuyer assistance, housing construction, and site acquisition and improvements. Funds may not be used for public housing or as a contribution to other programs. A portion of housing and assistance must be for very low income people, and incomes and rental prices must meet HUD limits. For rental housing and rental assistance, at least 90 percent of families benefiting from HOME funding must have incomes that are no more than 60 percent of the HUD-adjusted family Area Median Income. In rental projects with five or more assisted units, at least 20 percent of the units must be occupied by families with incomes that do not exceed 50 percent of the HUD-adjusted median. All assisted housing must remain affordable in the long term, which is 20 years for new construction of rental housing and 5 to 15 years for construction of homeownership housing and housing rehabilitation, depending on the amount of HOME subsidy.

Creation of the HOME program guidelines was influenced by a nationwide movement of low-income housing advocates, which resulted in the specific program rule that requires States and local jurisdictions to set aside 15 percent of funds for use by community-based housing groups known as Community Housing Development Organizations (CHDOs). CHDOs are certified nonprofit organizations that must:

> (1) Maintain at least one-third of its governing board's membership for residents of low-income neighborhoods, other low-income community residents, or elected representatives of low-income neighborhood organizations; and (2) Provide a formal process for low-income program beneficiaries to advise the organization in all of its decisions regarding the design, siting, development, and management of affordable housing projects.[363]

The HOME program is implemented through government entities called Participating Jurisdictions (PJs). A PJ may be a State or unit of local government, including urban counties and cities. To be an eligible PJ, cities and counties must qualify for at least $500,000 in direct funding under the formula described below. Localities that are in proximity to each other can join together to form “consortia” in order to qualify for the minimum amount. PJs must match every dollar of HOME funds used (except for administrative costs) with 25 cents from nonfederal sources, which may include donated materials or labor, the value of donated property, proceeds from bond financing, and other resources. This requirement can be waived for PJs following a Presidential Disaster Declaration.

Nationally, HOME funds are allocated according to a formula designed to make sure funds are not allocated excessively to any one community or State based on the following criteria:

- Relative inadequacy of housing supply
- Supply of substandard rental housing (worst-case housing needs)
- Number of low-income families in rental housing units likely needing repair
- Cost of producing housing
- Number of families in poverty
- Fiscal incapacity to carry out housing activities without federal assistance

As with CDBG, HOME funds are to be guided by the Consolidated Plan to make sure the affordable housing needs of each community are addressed relative to local supply and demand. The most current HOME National Production Report provides a good overview of the program in terms of production (new construction, rehab, acquisition), commitment to CHDO activity, and income and tenure targeting.

To date, HOME funds have been used to produce more than 756,000 units of housing since the inception of the program (does not include Tenant-Based Rental Assistance

[TBRA]).[364] While the allocation for HOME has generally increased over time, the annual completion rate is somewhat uneven. One constant is that HOME funds are strongly leveraged, generating nearly $4 for every $1 of federal funds provided, and commitment to CHDOs has been above the 15 percent minimum at nearly 21 percent annually.

Unfortunately, like CDBG, the reporting system does not provide specific information to assess how people with disabilities benefit. A growing concern is that despite flexibility in how funds can be used, new homebuyers and existing owners consistently benefit the most from HOME. About 60 percent of HOME dollars have gone to homeowners receiving either rehabilitation or acquisition grants, while rental housing production under HOME is only 40 percent of the total unit count. Relatively speaking, rent assistance (TBRA) is more cost effective than production programs, at about 10 times less per unit (compare an average of $3,151 per household for TBRA to an average of $35,495 per unit of new construction). The current TBRA commitment, which is less than 3 percent of the 2008 HOME budget, will assist about 200,000 households. Most families assisted are extremely low income (78%).[365] This income bracket could include people with disabilities relying on SSI, as well as most households with worst-case housing needs.

Homeless Shelter and Housing Programs

In 1986, the Federal Government passed the McKinney-Vento Act, which was the first legislation to directly address homelessness at the federal level. Prior to this, most programs—shelters and services—were developed and operated through local nonprofit and religious organizations with funding from foundations and other charitable giving. The McKinney-Vento Act provides funds to develop and operate emergency shelters, transitional housing, and permanent housing through a networked system of shelters and service providers.[366]

Today, HUD manages several homeless assistance programs that provide federal funding to local communities either through a formula (noncompetitive) or on a

competitive basis. Formula funding goes primarily to local entitlement jurisdictions and States to provide resources to develop (renovate or convert) buildings for use as emergency shelters or transitional housing; to provide related social services (case management, physical and mental health treatment, substance abuse counseling, and childcare); operating costs (rent, maintenance, security, insurance, utilities, and furnishings); and homeless prevention (e.g., short-term and first-month's rent, eviction or foreclosure assistance, utility payments, security deposits, landlord-tenant mediation, and tenant legal services). The receipt and use of these funds is tied the State's or local jurisdiction's Consolidated Plan.

Competitive funding is awarded to applicants through the State's or local jurisdiction's Continuum of Care (CoC) plan, which is produced annually by a network of homeless-service providers and other stakeholders (including homeless people) working together either through or in conjunction with a government agency. The CoC plan is to guide the development and delivery of an integrated set of programs and services in the community that aim to help people who are homeless eventually become permanently housed. The Continuum of Care planning process is completed annually, and includes periodically collecting a point-in-time count of homeless people in the community.[367] HUD defines the term *homeless* as "a person sleeping in a place not meant for human habitation (e.g., living on the streets) or living in a homeless emergency shelter." This excludes people who are "doubled up" or staying temporarily at the home of a friend or family member, and it does not include people at risk of losing their housing due to being extremely cost burdened and usually low income.

Based on the latest aggregated annual CoC data, which is from October 2007 through September 2008, at a minimum, 43 percent of homeless adults (about 421,200 people) who stayed in a shelter have a self-reported disability.[368] Most are adult individuals not in families, and most (about 73%) stayed in emergency shelters during this period, while the remaining stayed in transitional housing or both. While the majority of homeless people with disabilities are found in shelters in cities, 42 percent were in suburbs and rural areas where there generally are fewer shelter and transportation options. HUD's

data also includes veterans who may or may not be disabled. Relatively speaking, during this time period there were fewer homeless veterans (135,600) in shelters than people with disabilities overall.

Missing from this account is the number of homeless children with disabilities and all people with disabilities not in a shelter who are literally homeless, living on the streets, in abandoned buildings, or elsewhere not intended for human habitation. Furthermore, this does not include anyone at risk of being homeless because they live in precarious housing situations. HUD's report also does not include estimates of people who are unsheltered. These estimates come from local Continuum of Care groups, which conduct annual (or biannual) "point-in-time" counts of people who are to include sheltered and unsheltered people. This means going out on the streets, into parks, abandoned buildings, and other places likely to be "hot spots" for homeless people. To limit double counting people who stay in shelters overnight, this count is usually completed late at night into early morning, after shelters stop taking people in, and is usually conducted in the winter, when the weather is coldest, and near the end of the month when people are likely to be low on cash while waiting for the next month's assistance check.[369]

The Point-in-Time (PIT) count data for a single night in January 2007 estimated 671,888 sheltered and unsheltered homeless people nationwide. About 58 percent of them were sleeping in an emergency shelter or transitional housing facility. This means 42 percent (about 282,200 people) were sleeping on the streets or in other places not meant for human habitation. Because data is often collected by observation only (i.e., individuals are not surveyed), disability, veteran status, age, etc., are not known. However, the National Alliance to End Homelessness (NAEH) provides some insight into these populations.

NAEH estimates that up to one-fourth of unsheltered homeless people are veterans, with 150,000 to 200,000 homeless veterans on the street "on any given night." It also cites the 2008 U.S. Department of Veterans Affairs (VA) PIT estimate that 154,000 veterans are homeless.[370] This suggests that NAEH estimates a larger number of

unsheltered homeless people overall. NAEH also makes the distinction between veterans of different conflicts when looking at veteran homelessness:

> Research indicates that those serving in late Vietnam and post-Vietnam era are at greatest risk of homelessness. Veterans returning from the current conflicts in Afghanistan and Iraq often have severe disabilities that are known to be correlated with homelessness. Among these new veterans, women are more common than in the past.[371]

Regarding people with disabilities who are homeless, NAEH uses a broader definition that includes people with mental health and physical health problems to consider preventative, acute, and long-term health care needs, as well as their housing/shelter needs. NAEH states that "approximately half of people experiencing homelessness suffers from mental health issues. At a given point in time, 45 percent of homeless report indicators of mental health problems during the past year, and 57 percent report having had a mental health problem during their lifetime. About 25 percent of the homeless population has serious mental illness, including such diagnoses as chronic depression, bipolar disorder, schizophrenia, schizoaffective disorders, and severe personality disorders."[372] In addition, there are known high rates of alcohol and drug use, and, in some cases, these problems exacerbate health problems. In 2007, the VA's Health Care for Homeless Veterans treated 65,802 homeless veterans, of whom 39,086 completed a formal intake and assessment. According to this, 51 percent had a serious psychiatric condition, 66 percent were dependent on drugs and/or alcohol, and 57 percent had a serious medical problem.[373]

Based on this data and accumulated experience over the past 20 years, HUD and the Continuum of Care have changed the way we look at homelessness in the United States, defining different categories of homeless people for planning and service delivery purposes. In current practice, this includes seven groups: chronically homeless, severely mentally ill, chronic substance abusers, veterans, people with HIV/AIDS, victims of domestic violence, and unaccompanied youth (under 18 years of age). This list does not specifically distinguish people with disabilities, but instead focuses on people who are severely mentally ill. In part, this reflects the fact that so many homeless

people are severely mentally ill and in need of both housing and health care. It also reflects past research that demonstrated that, when looking at the expenditure of public resources for homeless services, this population has generally required a great deal of assistance, because people with mental illness cycle through shelters and programs without necessarily getting into permanent housing.[374] This concern is reflected in the latest category added: chronically homeless. While not apparent, many people with disabilities are counted in the "chronically homeless" category.

By federal definition, a chronically homeless person is either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, or (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past 3 years.[375] According to HUD, a disabling condition is "a diagnosable substance abuse disorder, a serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions." In addition, "a disabling condition limits an individual's ability to work or perform one or more activities of daily living."[376]

Based on CoC PIT counts, there were 123,833 chronically homeless people on a single night in January 2007, which was about 18 percent of the combined sheltered and unsheltered homeless population. More important, two-thirds of chronically homeless people were sleeping on the streets or in places not meant for human habitation.

While the McKinney-Vento Act has provided much-needed assistance for millions of homeless families and individuals over the past 20 years, it has also raised concerns that we are institutionalizing homelessness rather than reducing it. In part, this can be attributed to the McKinney-Vento Act, which primarily targets people who are already homeless rather than focuses on prevention. However, many advocates also point to the lack of sufficient permanent affordable housing for very low income people—including people with disabilities—as a problem that concurrently needs to be addressed if we ever are to end or even reduce homelessness. To this end, the National Alliance to End Homelessness announced in 2000 *A Plan, Not A Dream: How to End Homelessness in Ten Years*. The plan focuses on "closing the front door to

homelessness through prevention programs, and opening the back door out of homeless by rapidly re-housing individuals and families," and "calls for building an infrastructure by increasing incomes, expanding affordable housing, and helping individuals and families access needed services."[377]

Still, when appropriate support services are provided, traditional transitional housing programs can play an important role in addressing homelessness, as evidenced by the success of the Department of Veterans Affairs Grant and Per Diem (GPD) program, which was developed after passage of P.L. 102–590 in 1992. GPD promotes the development and provision of supportive housing and/or supportive services to help homeless veterans achieve residential stability, increase their skill levels and/or income, and gain greater self-determination. Even while working with a high-needs population (with over 75% of admissions reporting alcohol or drug problems, 66% reporting mental health problems, and 73% reporting medical problems), GPD has demonstrated a high success rate placing and keeping veterans in community housing. A recent study of VA discharges determined that 83 percent of those leaving GPD and homeless programs remained housed 1 year after discharge.[378]

Since the 2000 announcement by the National Alliance to End Homelessness, the concept of local planning to end homelessness has taken root, and hundreds of communities have committed to ending homelessness by dramatically transforming their homeless assistance systems. Each community commitment starts with a plan that outlines a framework to guide communitywide efforts. The alliance and the many communities involved see these plans as a critical component in the effort to prevent, reduce, and end homelessness nationwide. Similarly, recent research has demonstrated and argues for efficiencies gained, as well as more humane treatment of people, by focusing on housing first models, prevention, and any form of service and assistance that can keep families or individuals in their homes.[379]

To this end, a significant shift in the last few years has been toward producing more supportive housing and less emergency shelter and transitional housing. As HUD defines it, supportive housing "provides long-term housing with supportive services for

homeless persons with disabilities. This type of supportive housing enables special needs populations to live as independently as possible in a permanent setting. Included in this are permanent supportive housing units developed specifically for people with disabilities and units developed via HUD's Shelter plus Care (S+C) program. As HUD describes the S+C program, it "assists hard to serve homeless individuals with disabilities and their families. These individuals primarily include those with serious mental illness, chronic problems with alcohol and/or drugs, and HIV/AIDS or related diseases."[380]

As of 2008, there were 195,724 "beds" in permanent supportive housing, of which 119,143 were for individual adults and the remaining 76,581 for families. While still not surpassing emergency and transitional housing overall (211,000 and 205,000 beds respectively), permanent supportive housing increased the most in terms of the proportion of programs and number of beds added from 2007 to 2008. Permanent supportive housing has more units and a larger share of housing in central cities than in suburban rural areas in 2007, and are larger in cities (average 37 units) than in suburban and rural areas (average 24 units).

Finally, permanent supportive housing built with these homeless funds requires the person entering the program to be homeless prior to leasing the unit or being admitted. Such requirements, while useful at targeting people in need, nonetheless mean these "permanent" housing units can only play a limited role in meeting the needs of people with disabilities.

Housing Opportunities for People with AIDS (HOPWA)

More than 1 million people in the United States are living with AIDS or HIV.[381] The HOPWA program grew out of the 1990 National Affordable Housing Act as a targeted source of funding to provide stable housing for people with HIV or AIDS who are low income and need housing, often because they are unable to work and have high medical bills. HOPWA grants help governments and nonprofit organizations provide housing and supportive services to low-income people and their families living with

HIV/AIDS. The program assists in creating long-term comprehensive strategies to provide housing, thus reducing the risk of homelessness and improving access to health care and support. HOPWA funds may be used for planning, development, and implementation of rental housing and the accompanying services. They may provide transitional housing, community residences, and single-room occupancy dwellings. Priority now is given for the renewal of projects that provide permanent supportive housing. Grantees are selected in formula allocations or competitively awarded grants:

- Formula program uses a statutory method to allocate HOPWA funds to eligible States and cities on behalf of their metropolitan areas.
- Competitive program is a national competition to select model projects or programs.
- National technical assistance funding makes awards to strengthen the management, operation, and capacity of HOPWA grantees, project sponsors, and potential applicants of HOPWA funding.

Appropriations for formula grants are the largest portion of HOPWA, at about 10 times that of competitive grants ($267 million compared to $29 million in FY 2008). With the exception of the technical assistance fund, which has declined over the years from $2.5 million in FY 2001 to $1.5 million in FY 2008, federal support for HOPWA has increased steadily over time.

Since 1992, the Federal Government has provided more than $4 billion in HOPWA funds to help create and operate HIV/AIDS housing initiatives. HUD estimated that the FY 2004 HOPWA appropriation of nearly $295 million would provide housing assistance to about 74,000 households, which includes family members who reside with the person living with HIV/AIDS.[382] More than half those units (approximately 45,000) were to prevent homelessness though small, short-term payments. An additional 25,000 units received ongoing rental assistance payments. Approximately 5,000 units in supportive housing facilities, single-room occupancy (SRO) dwellings, and community residences were developed or operated with HOPWA funds.

Low Income Housing Tax Credit Program

The Low Income Housing Tax Credit (LIHTC) program is the primary source of funding for affordable housing in the United States. The LIHTC program began in 1986 when the Federal Government changed tax laws to encourage private investment into "affordable" rental housing produced by private nonprofit developers. The LIHTC program is not a HUD program—it is part of the tax code and therefore regulated by the Treasury Department through the Internal Revenue Service (IRS). The basic premise is that tax credits issued by the IRS get turned into equity, which is then used to reduce the cost of development and subsequently the rent the developer needs to charge to cover expenses for developing and operating the housing.[383]

In exchange, the investor (equity partner) gets an annual tax credit for 10 years, as long as the housing development and operator meet the compliance requirements. This includes high-occupancy levels and the "low-income occupancy threshold," which means meeting one of the following.

- 20–50 Rule: At least 20 percent of the units must be rent restricted and occupied by households with incomes at or below 50 percent of the HUD-determined Area Median Income (adjusted for household size).
- 40–60 Rule: At least 40 percent of the units must be rent restricted and occupied by households with incomes at or below 60 percent of the HUD-determined Area Median Income (adjusted for household size).

As a result, most housing produced through the LIHTC program is intended to be affordable to the "working poor"—people usually earning incomes higher than people living in public housing, but who are still unable to afford market-rate housing. To keep the housing affordable, the developers must restrict rents, including utility charges, in low-income units and operate under the rent and income restrictions for 30 years or longer, depending on the agreement with the agency issuing the tax credits.

Unlike HUD funding, tax credits are not budget outlays but rather taxes that are not collected, which is fiscally and politically appealing to many. The allocation of the tax credit is based on a per capita rate for each State.[384] Beginning in 2003, the rate was set at $1.75 per person and is to be adjusted for inflation.[385] Guiding the allocation of the tax credits in each State is a Qualified Allocation Plan (QAP). States use these plans to evaluate development proposals from private and nonprofit developers building affordable housing and give points for different features or aspects of the proposed development. The QAP, which must be consistent with the State's Consolidated Plan, is also required by federal law to give priority to projects that (1) serve the lowest-income families, and (2) are structured to remain affordable for the longest period of time. Federal law also requires that 10 percent of each State's annual housing tax credit allocation be set aside for projects owned by nonprofit organizations.[386] Beyond these requirements, criteria for awarding points vary greatly across the States.

Based on the latest data available, which is 2007, a little over $9 billion dollars in tax credits have been used to produce 1,669,300 units. This is an average of $5,440 tax credit dollars per unit developed. The units produced by the LIHTC program has exceeded the number of housing units built during the 60 years of public housing development, but in a third of the time.[387] While not all these units are targeted as described above, the average "qualifying ratio" was about 95 percent, which means nearly all meet the tax credit requirements and are therefore rent restricted to benefit low-income families. Still, at between 50 and 60 percent of the family Area Median Income (AMI), the corresponding rents charged are not necessarily affordable to most people in public housing, given that most have incomes below 30 percent of the AMI (see above).[388] This limits access to LIHTC units for extremely low income families, because rent is not adjusted for income, but rather set at the price point that these higher-income thresholds can afford. For example, if rent is based on being affordable to a family of four at 50 percent of AMI in Washington, D.C., the monthly rent could be up to $1,200 (estimate, not actual). For extremely low income families to access these units would require substantial rental subsidies to make them affordable (i.e., paying no more than 30% of income for rent).[389] While no current data is available on how many

units of LIHTC are also being subsidized by tenants using Housing Choice Vouchers, a GAO report in 1997 found that about 39 percent of the households living in LIHTC housing also directly received vouchers.[390]

On average, between 1,300 and 1,400 new developments have been completed each year since 1987. Over time, the noticeable trend has been that the average development size increases from just below 40 units in 1992 to around 80 in 2005.[391] Data on the distribution of units by bedroom size of developments built between 1995 and 2005 indicates that, on average, the majority of units are two-bedroom (42%) and one-bedroom units (31%), with some three-bedroom units (20%), and few studio apartments (4%) or four-bedroom units (3%).[392]

While LIHTC is the most important affordable housing production tool in the United States today, we know very little about how it has benefited people with disabilities. For the most part, the reason is that there is limited reporting on who occupies these units other than by income bracket, since that is critical for meeting compliance requirements and assuring that investors continue to receive their tax credit. Still, we know that developers using tax credits sometimes target specific populations, including people with disabilities. Recent data now collected for inclusion in HUD's LIHTC database suggests that 27 percent of the developments put in service between 2003 and 2005 were to be for people with disabilities, and about 12 percent for the elderly (about 41,600 units).[393] However, most of these are likely to be permanent supportive housing for homeless people, and therefore only accessible to people with disabilities who are currently homeless.

A key distinction between HUD housing and LIHTC properties is that tax credit units are not covered by Section 504 regulations, though most are affected by the Fair Housing Act, since most units were built after 1991. However, since many developments use additional sources of funding, including federal dollars that are subject to 504, the assumption would be that if substantial, these dollars would trigger compliance. About 31 percent of developments that target either the elderly or people with disabilities used HOME funding, while fewer used other public sources.[394]

In general, we know that proportionately about half of all LIHTC projects are located in central cities, about 38 percent are in suburban communities, and the remaining 12 percent are in nonmetropolitan areas. The distribution of housing targeted for people with disabilities appears to be about the same for central city, suburban, and nonmetropolitan areas, representing 12 to 13 percent of developments placed in service between 2003 and 2005.[395] In contrast, housing targeting an older population is proportionally higher in suburban locations (35%) than nonmetro areas (28%) and central cities (21%).[396] Since this data does not include units placed in service before 2003, it is not known if this pattern applies to all LIHTC developed since 1987.

Finally, about 22 percent of the units developed in this time period that target people with disabilities are in communities where over 30 percent of the people are below the poverty line. However, less than 16 percent of the LIHTC units that target the elderly are in high-poverty communities.[397]

U.S. Department of Agriculture Rural Housing

The U.S. Department of Agriculture (USDA) housing program began with the 1949 Housing Act (Title V, P.L. 81–171), which authorized USDA to make loans to farmers for the construction of new housing and to refurbish existing homes and other farm buildings to ensure safe, decent housing for themselves and other tenants, lessees, sharecroppers, and farm workers living on their land. Currently, through its Rural Development (RD) division, USDA makes housing loans and grants to rural residents and to developers of properties in rural areas. To date, about $116 million has been expended since 1949, assisting nearly 3.5 million households.[398]

The rural housing programs offered through USDA's RD division fall into two main categories: single-family and multifamily. While a few programs identify people with disabilities and those who are aging as eligible recipients, no RD program targets either group exclusively. This report focuses on RD programs most likely to benefit people with disabilities: 502 loans and grants, 504 loans and grants, 515 multifamily rental housing, 538 multifamily loans, and 521 rental assistance.

As with HUD programs and the LIHTC program, RD programs have income guidelines. However, they also have geographic restrictions, so unlike the other two, eligibility for a RD housing is also determined by the location of the housing for which assistance is being sought, whether development funds, an individual loan, a grant, or rental assistance. In general, USDA Rural Development targets communities with a population of 10,000 or fewer in locations that are not closely associated with urban areas. However, under specific circumstances, loans can be made in towns or cities with populations between 10,000 and 25,000.

Based on the trends in worst-case housing needs identified by HUD, the need for affordable housing in rural areas has increased since 2003.[399] Less is known about the need for accessible housing. The Housing Assistance Council (HAC), which does extensive research on rural housing policy, programs, and needs, points out that:

> Residents of rural areas tend to value independence, self-reliance, and individualism. Although these are positive values, they also contribute to a reluctance to seek help from mental or physical health professionals among persons with disabilities in rural areas. This factor also makes it difficult to assess the need for accessible housing in rural areas.[400]

HAC includes this statement in its fact sheet on people with disabilities, suggesting that meeting the housing needs of people with disabilities in rural areas requires first understanding what will make people respond if assistance is offered. The HAC fact sheet also points out that even if need is identified and people are interested, it can be difficult to develop rural rental housing for people with disabilities if the plan is for group homes, since:

> Local zoning and land use restrictions often limit the siting of group homes in both urban and rural areas. These restrictions include dispersion requirements (prohibiting group homes from locating too close to one another), concentration requirements (prohibiting the location of group homes in certain areas), and occupancy requirements (limiting the number of residents).[401]

Moreover, transportation or the lack thereof is a key barrier for choosing a place to live, which means people with disabilities are likely to make trade-offs between accessibility features and affordability when searching for housing. This is especially important for people who may need regular access to medical treatment. Given the geographic dispersion of households in rural areas, medical facilities—even pharmacies—tend to be concentrated in communities with larger populations (e.g., the county seat) and may serve several counties or a larger urban region. Finally, for the growing aging population, assuming that most people prefer to stay in their own home, assistance with retrofitting existing housing becomes an important factor in determining and meeting need.

Single-Family Housing

About 80 percent of all development dollars available for rural housing has gone to assist in the production and rehabilitation of single-family homes. In general, rural homeownership (75%) continues to be higher than the U.S. overall (66%) and higher

than in urban areas (64%), which means that people who have disabilities and are aging in rural areas are more likely than not to reside in single-family homes.[402] This has implications for accessibility requirements associated with federal housing funds as well as expectations for integration and affordability.

The two primary programs for rural single-family housing assistance are under Section 502, which allows for direct loans and guaranteed loans. A direct loan means the loan is made directly to the applicant via USDA's Housing and Community Facilities Program (HCFP). Guaranteed loans are secured by the household through an approved lender and then guaranteed by USDA. In addition, the Section 504 Housing Repair and Rehabilitation Grant and Loan program helps very low income homeowners with repairs and accessibility improvements.

Section 502 Rural Housing Direct Loans

This is USDA's largest outlay for housing, helping more than 2 million low-income people purchase or construct homes in rural areas. Up to 100 percent financing may be obtained to buy, build, repair, or move a home, as well as to purchase and prepare home sites. Individuals or families may be eligible if they have an income of up to 80 percent of the Area Median Income.[403] They also must be without adequate housing, be able to afford mortgage and other payments, be unable to obtain credit elsewhere, and have a reasonable credit history. Housing must be modest in size, design, and cost, and meet all applicable building codes. Loans are for up to 38 years, with the interest rate set by HCFP and modified by the payment subsidy. The late1970s was the peak of the 502 loan program, averaging up to 140,000 loans in a year. Current loan activity since 1986 has been averaging about 20,000 homes a year.

Section 502 Rural Housing Guaranteed Loans

These loans are generally used to help low-income individuals purchase homes in rural areas. Funds may also be used to build, repair, or move a home, and to purchase and prepare home sites. Low-income individuals may be eligible for this assistance if they have an income of up to 115 percent of the Area Median Income. Because these loans

are provided by outside lenders and guaranteed by USDA, the applicant must be able to afford the mortgage and other payments and have a reasonable credit history. Housing must be modest in size, design, and cost, and meet all applicable building codes and loan limits (value) set by USDA.[404] Loans are guaranteed for 30 years, interest rates and repayment are set by the lender, and no down payment is required. Approved lenders include State Housing Agencies, Farm Credit System institutions with direct lending authority, and lenders participating in USDA Rural Development guaranteed loan programs. Qualified lenders also include those approved by HUD, the U.S. Department of Veterans Affairs, Fannie Mae, and Freddie Mac as qualified family mortgagees. While the program began in 1977, it really did not take off until 1991, which marked the beginning of a steady rise in loans to the peak of 40,000 a year in 2000. This has dropped to between 30,000 and 35,000 per year as of 2007.

Section 504 Rural Housing Repair and Rehabilitation Loans

Loans of up to $20,000 are offered to help very low income individuals who own and occupy a home in need of repairs. Loans can be used to cover costs to repair, improve, modernize, or remove hazards in a home. Homeowners may be eligible if they have an income up to 50 percent of the Area Median Income, are unable to obtain credit elsewhere, and need to make repairs to improve sanitary conditions or remove health and safety hazards in their home. Repaired housing must meet local and other requirements, and only the major health and safety hazards must be removed. Loans are for up to 20 years with 1 percent interest, and mortgage and title are generally required. Since its inception in 1950, about 161,000 loans have been made, and the number, while small, has been steadily increasing since 1990, with about 5,000 loans granted in 2007.

Section 504 Rural Housing Repair and Rehabilitation Grants

Grants are provided to help very low income elderly individuals who own and occupy a home in need of repairs or accessibility improvements. Grants of up to $7,500 may be obtained for repairs and improvements to remove health and safety hazards in a home, including those related to a disability need. Homeowners may be eligible if they are over

62 years old and cannot repay a Section 504 loan. Applicants must have an income of up to 50 percent of the Area Median Income and be unable to obtain credit. Repaired housing must meet local and other requirements, and only the major health and safety hazards must be removed. The grant may be used in conjunction with a Rural Housing Repair and Rehabilitation Loan. Since 1950, about 157,000 grants have been made, and the number of grants has been steadily increasing since 1990, with about 6,000 grants awarded in 2007. It is unknown how many of these grants are in addition to a Section 504 loan, or how many were used to make housing accessible.

Multifamily Housing

As with HUD's multifamily properties, USDA's multifamily housing program was designed to provide private sector—for-profit or nonprofit—developers with loans and grants to assist in the development of rental housing. USDA also makes these funds available to the public sector to produce housing, although not as public housing managed by a Public Housing Agency. Someone looking to rent subsidized affordable housing in a rural area can use the RD online search engine to find housing by location (State, county, town, or ZIP code) or property owner.[405] Property information includes total number of units and number of units by bedroom size and "complex type," which can be family, elderly, mixed, group home, or congregate. Based on a count of all multifamily programs, USDA has helped produce or preserve about 668,000 units, including housing for domestic farm labor. In addition, USDA has provided rental assistance through the Section 221 program to nearly 981,000 households since 1978.

Section 515 Rural Rental Housing Loans

These loans are to help purchase affordable multifamily rental housing for families that are at or below moderate income (slightly above the Area Median Income). Loans can be made to individuals, nonprofit and for-profit corporations, Limited-Equity Cooperatives, American Indian tribes, and public agencies. Applicants must be unable to obtain credit elsewhere at a rate that will allow them to charge affordable rents. Properties can target specific populations, including the elderly and people with disabilities. Loans are competitive and priority is given to projects targeting very low

income households and those living in substandard housing. Evaluation criteria and target communities are identified yearly in a Notice of Funding Availability.

At its peak in 1978, the Section 515 program produced 40,000 units in a year. Soon after, production began dropping, so that by 1996, only about 2,000 units were produced, and in the past few years (2005–2007), fewer than 100 new units have been added annually. Since its inception in 1963, the program has produced 530,536 rental housing units, which are widely distributed across the United States, Puerto Rico, Virgin Islands, and West Pacific territories. Based on a recent analysis by the Housing Assistance Council, nearly 89 percent of all U.S. counties (2,800) have at least one Section 515 development.[406] Half these counties have fewer than 5 projects, and 40 percent have between 5 and 10 properties. Despite the fact that most counties in the United States have at least one Section 515 property, most of the units are located in the Southeast (e.g., Florida, Georgia, Mississippi, Alabama, North Carolina, Arkansas) and Midwest (e.g., Missouri, Michigan, Illinois, Iowa, Indiana, Ohio).

Developing affordable housing requires multiple sources of housing subsidies, which means that when attributing units to a program, there is potential to double count units (or more, depending on how many sources of financing are used). Recent estimates indicate that one-fifth of all Low Income Housing Tax Credit projects (5,542 properties) and 10 percent (1,464 properties) of Section 8 project-based developments also have Section 515 funding. In addition, many project-based developments with 515 funding also receive Section 202 or Section 811 assistance.[407]

Section 538 Rural Rental Housing Guaranteed Loan Program

Begun in 1996, this relatively new program targets the same population as Section 515, but instead of providing the loan directly to a developer, USDA guarantees a loan secured through a lender. As with the guaranteed loan program for single-family homes, the Section 538 program works through USDA's Housing and Community Facilities Program. Loan applicants may be individual developers, nonprofit organizations, local governments, American Indian groups, or for-profit corporations. Eligible lenders include

State Housing Finance Agencies and those approved by the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, Federal Home Loan Bank members, or the Department of Housing and Urban Development. USDA guarantees such loans, which are for up to 40 years and have fixed rates. As a result, about 24,000 units have been developed through FY 2007, with an average of about 2,500 units per year.

Section 521 Rental Assistance Program

As with HUD's voucher program, these subsidies are to be used to help low-income households with their rent. This includes people with disabilities and those who are aging. However, unlike the voucher program, which allows the tenant the "choice" to look anywhere in the housing market, this assistance is tied to properties funded by USDA's Housing and Community Facilities Program. Households are eligible for assistance if the rent they can afford (30% of their adjusted monthly income) is below that of the unit's rent. HCFP establishes 5-year contracts with property owners in which the program pays the difference between the tenant's affordable contribution and the monthly rental rate. Requests for funding are generally initiated by property owners; however, tenants may also petition such owners to obtain funding through this program. This competitive program is designed to give priority to housing with the highest percentage of tenants in need of rental assistance and the areas with the greatest housing need in the State.

Since its inception in 1978, the 521 program has made up the difference between what a tenant can afford to pay and the actual rent for a unit. While this model has assisted nearly 1 million households living in rural rental housing, over the years it has not necessarily ensured sufficient rent to cover the cost of maintaining the housing stock. A 2004 study for USDA concluded that a significant portion of the Section 515 Rural Rental Housing program portfolio was at risk of being lost due to insufficient reserves and inadequate cash flow.[408] As a result, the study concluded that the rate of decline was likely to accelerate in many properties, putting families at risk of losing their rental units and reducing the overall supply of affordable rural rental housing.

Complicating matters is the fact that many properties are eligible to "prepay" and become market-rate housing upon leaving the program, assuming RD determines that there should be no restrictions on keeping rents affordable. While technically this applies to about 60 percent of the Section 515 portfolio, the study concluded that given the poor conditions of many of the rental properties, only about 10 percent would likely choose to prepay early in order to opt out of the program. Between 2001 and 2007, 880 properties, representing nearly 15,000 units, have prepaid. While this number represents only about 5 percent of the total Section 515 housing properties, it does not include a large portion of properties—another 7,300 properties with 195,000 units—that are now eligible to prepay and potentially become unaffordable.[409]

In response to this problem, USDA developed the Rural Development Voucher demonstration program. This 1-year rental subsidy program was intended to "protect tenants of USDA Multi-Family Housing (Section 515) properties who have had their USDA loans foreclosed or prepaid between October 1, 2005 and September 30, 2006."[410] These vouchers are in addition to the rental subsidy provided by Section 521 and can be used with the tenant's current housing to offset higher rents, assuming the owner raises rents to market; or they can be used elsewhere in another rental property, as with any tenant-based voucher. As of FY 2007, nearly $3 million had been committed for 1,100 vouchers. This suggests that many of the families in prepaid housing did not need, were not eligible for, or did not seek voucher assistance.

Location of USDA Rental Housing

A 2008 Housing Assistance Council (HAC) report found the distribution of most Section 515 properties fall into four types of counties:

- Remote, nonmetropolitan counties (5,878 properties).[411] These represent nearly one-half (46%) of total subsidized rental properties and over 36 percent of subsidized rental units in these counties.
- Urbanizing counties (nearly 1,500 properties). These 40,000 units make up 34 percent of the subsidized housing stock in these fast-growing counties. With

population increasing and the economy developing, demand for housing is expected to be causing rents to rise, “giving owners of Section 515 developments a strong economic incentive to prepay their restricted-use mortgages in order to charge market-rate rents.”[412]

- Nonmetropolitan housing stress counties (46,137 properties). HAC identifies “housing stress counties” as those where at least one-third of the households are experiencing some housing problem, such as rent burden, overcrowding, or poor housing quality. Currently, Section 515 accounts for 38 percent of federally subsidized units in these counties, and almost half are eligible for prepayment. A key concern is that “tenants from a Section 515 property in a housing stress county are very unlikely to be able to find alternative rentals nearby.”[413]
- Counties with proportionately high populations of people from diverse racial backgrounds. HAC identified all counties that had a specific racial or ethnic diverse population of one-third or more in 1980, 1990, and 2000. Section 515 units comprise fully 44 percent of subsidized rentals in American Indian counties, 22 percent in African-American counties, 18 percent in Latino (Hispanic) counties, and 7 percent in Asian-American counties.[414] Again, a key concern is that since this is an important part of the housing stock in many of these communities, attention to preservation in light of prepayment and other risks of losing housing is critical to ensure continued housing opportunities for people from diverse racial backgrounds in rural areas.

In addition to locating Section 515 housing, the Housing Assistance Council looked at the spatial relationship of housing options through HUD programs, assuming this is an option if a family wants to relocate to other assisted housing. On average, there is HUD-subsidized housing within about 6 miles of most Section 515 buildings. Most of these units are in public housing, which may or may not be easily attained, depending on the housing authority, its waiting list, and whether the public housing is age restricted, accessible for people with disabilities, and the right fit in terms of bedroom size. The average distance for Section 202 and Section 811 is about three times that, at nearly 16 miles, which means a much greater distance to move if someone is seeking either age-

specific or accessible housing for people with disabilities. On average, Low Income Housing Tax Credit properties are just slightly closer (15 miles from Section 515 housing); however, as noted above, there is no assurance that there will be accessible housing, even though most of these developments are covered by Fair Housing Act requirements.

Accessibility and Integration

Recent estimates suggest that about 58 percent of Section 515 rental units are occupied by people with disabilities and/or the elderly.[415] This does not necessarily mean that units occupied by people with disabilities are accessible. Instead, this is based on the designation of the property, with at least 40 percent being age restricted (i.e., for elderly only), which means only about 18 percent are likely designated for people with disabilities.

As with most HUD housing, a breakdown of USDA accessible housing is not available for either the single-family or multifamily programs. Assuming that the multifamily housing meets the 5 and 2 percent rule, there could be a total of about 33,000 units accessible for people with mobility limitations and 13,000 units for people with sensory impairments. However, a 2004 study by the National Fair Housing Alliance (NFHA) suggests this is likely not the case, as it found that several projects had less than 5 percent accessible units.[416] Moreover, even with sites that might have the minimum number of required accessible units, access might be restricted by age. The same NFHA study found that in extensive paired testing in 24 States where most rural rental housing is located, more than 20 percent of the sites were "illegally denied to potential renters based on their race, national origin, disability, or familial status."[417] Based on paired disability tests, 36 percent "revealed some differential treatment on basis of disability."[418] This included inaccessible offices and entrances to apartment buildings, "blatant statements" about reasonable accommodations that would not be allowed and/or would not be accommodated if requested, and suggesting that fees might be charged for some accommodation requests.[419]

Recent Trends in Federal Housing

This section reviews current conditions and issues affecting the supply of federally funded housing for people with disabilities. Most significant is the decreasing rate of housing assistance that can directly benefit very low income families with housing needs, coupled with the loss of real housing units for the same population.

Funding

Efforts in recent years to reduce domestic spending have led to cuts in housing assistance during a time of significantly increased housing need, as evidenced by the 6 million very low income households with worst-case housing needs—an increase of nearly 800,000 households (16%) between 2003 and 2005.[420] A review of the budget for federal housing assistance points to several concerns that warrant attention. First, HUD's annual budget, which was $37.6 billion in FY 2008, declined or remained relatively flat since 2004 when adjusted for inflation. A significant dip—nearly $3.3 billion—between 2004 and 2006 resulted in a loss of more than 150,000 Housing Choice Vouchers.[421] Second, the largest portion of HUD's annual budget has been and continues to be Tenant-Based Rental Assistance/vouchers ($16.4 billion or about 44% in FY 2008). While it can appear that federal outlays for this program have increased over the past 4 years, this is deceiving since most of the increase has been due to the loss of project-based housing assistance, which began as multifamily property owners chose to "opt out" of federal housing programs when contracts began expiring in the mid-1990s, and the demolition of federal public housing began through the HOPE VI program.

Public housing funding has declined more than 25 percent since passage of the Quality Housing and Work Responsibility Act (QHWRA) in 1998. On the heels of the permanent repeal of the one-for-one replacement rule for public housing in 1995, Congress enacted the QHWRA, which required housing authorities to assess their stock and determine if it would be more cost effective to rehabilitate or demolish units in any development with 250 or more units. If demolition was decided, then the PHA would

"voucher out" residents. PHAs could also seek grant money from HUD to replace many of their housing units through mixed-income housing.[422] While tied to the development of a comprehensive plan for the entire PHA portfolio, which includes rehabilitation as well as demolition, QHWRA signaled a clear turning point away from permanent public housing and toward Housing Choice Vouchers (formerly Section 8 vouchers, newly named to emphasize choice with QHWRA legislation). When adjusted for inflation, the outlay for public housing (both operating and capital) has dropped steadily since 2001. A slight increase rather than decrease occurred in 2007 and 2008; however, this was for operations and not capital.[423]

Lost Housing Units

The inventory of older housing built with public funds has been reduced through changes in different policies over the past 10 to 15 years. This includes efforts to transform public housing with the HOPE VI program and QHWRA, and efforts to reduce the cost of subsidizing privately operated multifamily housing through efforts to refinance outstanding federal loans in the 1990s.

Lost Public Housing Units

HOPE VI, which began in 1993 as a means to transform our "severely distressed" public housing, has demolished more than 150,000 units, but will only replace about 50,000, based on grants as of FY 2007. In 2000, there were approximately 1.28 million public housing units throughout the United States and Puerto Rico. In September 2008, the inventory was at 1.19 million (about a 7.5% reduction). Most of these units were demolished under the HOPE VI program. At that time, it was estimated that nearly 100,000 units fit this category, and the plan was to replace these developments with new "mixed-income" communities that would have a blend of public and private housing and income levels.

To date, the plans approved by HUD have exceeded the target number to be demolished by 50,000 units and have produced much less replacement housing than was expected. Furthermore, while there are "affordable" units included in the

replacement mix, these units usually are built with Low Income Housing Tax Credits and therefore are not affordable to most public housing families. Another concern is that replacement housing resulting from HOPE VI and QHWRA may not be in compliance with Section 504, even though it is subject to the same requirements as public housing and required to be compliant with the Fair Housing Act.[424]

Looking ahead, while few public housing developments specifically serving people with disabilities are "severely distressed," those that are either already have been approved for HOPE VI redevelopment or have housing conditions that might qualify for HOPE VI funding.[425] Severely distressed status is based on design, obsolescence, deferred maintenance, physical deterioration, and/or problems with the physical plant, which can include not meeting physical accessibility requirements under 504—a strong possibility for many older developments. However, it can also be attributed to the high level of poverty in the development and/or the decline of the surrounding community as evidenced by disinvestment.[426] This includes many public housing developments in the United States, though less now than in the past, since many have been demolished under HOPE VI.[427]

Lost Multifamily Housing

Long-term contracts with HUD through the Section 8 program for housing assistance to privately owned multifamily developments began coming due in the 1990s. The Federal Government saw this as an opportunity to refinance high-interest rate mortgages on developments built in the 1970s.[428] While some property owners did refinance, others decided to opt out of the program or prepay their mortgage, often to convert their property to market-rate, unsubsidized housing. This was common in communities where market conditions had improved and overall housing prices were increasing. As a result, many properties that had been part of the inventory of subsidized housing were no longer affordable to rent. While HUD provided tenants a Housing Choice Voucher to offset the increase in rent, the unit itself was no longer automatically affordable to the next qualified low-income tenant. Early on, HUD realized that this would be a problem for specific populations—namely the elderly and people with disabilities—so properties

that targeted these groups, such as Section 202 and 811, were not able to opt out or prepay. This did not prevent nondesignated or targeted properties that had older people or people with disabilities from leaving the program. However, most opt-outs were family developments.[429] Across the board, many properties left the program because of foreclosure rather than prepayment or opting out.

While recent estimates show most project-based Section 8 multifamily developments with expiring contracts are renewing rather than opting out, we should still anticipate losing more permanent affordable units and shifting to tenant-based Housing Choice Vouchers. Current estimates show a 92 percent annual renewal rate the past few years.[430] Still, this means about an 8 percent shrinkage of the overall supply of permanent affordable housing units. And while vouchers are provided to help tenants to either stay or move, given the levels of discrimination coupled with usage rates, it is not necessarily an easy transition for displaced tenants. Furthermore, based on experience in 2004 to 2006, when funding allocations for tenant-based assistance dropped significantly with budget cuts effectively eliminating thousands of vouchers, people are not necessarily feeling secure in using them. Funding cutbacks for project-based units can have devastating effects, but so can cutting a household's rental subsidy, which not only affects the family's ability to pay rent, but also the landlord, who may choose to evict the family. This is why rural housing advocates are concerned about the shift to tenant-based vouchers in the Section 515 program. While the program aims to keep people from losing housing that is either prepaid (opting out) or foreclosed, it does not provide quite the same security as an affordable housing unit.[431]

Lack of Complete Inventory of Accessible Units

Despite Section 504's being in place since 1973, there currently is no complete picture of the accessibility of federally funded housing. In the late 1980s, HUD pushed to get all PHAs to complete a self-study to assess their programs and housing to determine what would be needed to comply with Section 504 requirements. However, no formal count of accessible units has been produced, and in most recent cases, compliance reports are not public because the case is open while HUD and the PHA negotiate. While this limits

researchers' ability to determine the exact number of accessible units for people with disabilities, it also raises concerns that people with disabilities are not getting complete information on what accessible affordable housing is available—or is not—in their communities. Currently, the only way to find out what may have been agreed upon between HUD and the PHA is in the Voluntary Compliance Agreement. While HUD has published some of these agreements (several referred to above), the outcomes of most recent reviews are not known.[432]

The LIHTC, which is the primary source of new construction of affordable housing, is usually not affordable to most lower-income people with disabilities and is not subject 504 regulations, although it is subject to Fair Housing Act requirements if a development is more than four units. Only recently, beginning in 2003, has any data been collected to know how many LIHTC developments are even targeted to the elderly and/or people with disabilities. It is still unknown how much of the current stock conforms to Fair Housing Act requirements, since these units are not technically regulated by Section 504. Still, given the fact that LIHTC has produced so much housing and that many units are built with other federal funds that are subject to 504, they should be included in an inventory as described above. Furthermore, given the cost of these units is higher than what extremely low income households can afford, it would be helpful to know what proportion are also using Housing Choice Vouchers.

Along these lines, there is a broader concern that housing built after the Fair Housing Amendments Act continues to offer fewer physically accessible units than is required by the law. A study completed for HUD in 2003, *Multifamily Building Conformance with the Fair Housing Accessibility Guidelines*, provides some potential insight—at least for housing built during the study period of 1991 to 1997.[433] Based on a survey of a sample of 397 multifamily projects and interviews with 20 architects and builders, the authors developed composite measures to determine conformance with Fair Housing Act guidelines, which includes these seven key items:

- Accessible building entrance on accessible route
- Accessible and usable public and common use area
- Usable doors
- Accessible route into and through the dwelling unit
- Light switches, electrical outlets, thermostats, and environmental controls
- Reinforced walls for grab bars
- Usable kitchens and bathrooms

This survey included both the original approved plans for the development and visits into the field to measure the actual buildings that were constructed to see if they complied with the requirements. Based on the overall composite scores for each of the major requirement areas in the guidelines, plan conformance always scored higher than "field" conformance, which is based on the building inspection survey.[434] The exception was elevators, which scored nearly 15 percent higher in the field than in original plans.

While the HUD report suggests a high level of conformance across the different requirements, none reached 100 percent. On the first criterion, accessible building entrance on an accessible route, the survey estimated that 8 percent of the buildings built between 1991 and 1997 were inaccessible according to Fair Housing Act guidelines, which means that no units in those buildings are technically accessible—even if they meet all the other requirements of the law. Applying this conformance rate to the 1,275,000 units in buildings built between 1991 and 1997, this would mean that at least 102,000 units in multifamily buildings with five or more units are not accessible because the building entrance is not accessible.[435] For those that do have accessible entrances, it still would need to be determined inside the building what units are and are not accessible according to the other criteria. Given the field scores for the other composite measures in the HUD report, it is likely that the number of inaccessible units would increase. At this rate, given the number of new multifamily housing units added since 1997, several hundred thousands of units that should be accessible may not be. Unless they are inspected for purposes of determining compliance, we will never know if

this is the case. And, even when fair housing complaints are filed against developers who fail to comply fully with the law, these cases take years to settle. Perhaps worse, some noncompliant developments are too old relative to the 2-year statute of limitations when discovered, so nothing legally can be done.[436]

Discrimination

Using Housing Choice Vouchers—whether to relocate from public housing or not—continues to mean encountering and dealing with barriers, including discrimination and lack of uniform protections across the country. Recent analysis of Housing Choice Voucher "success" rates indicates that households that had been issued vouchers had difficulty finding units to rent using the voucher. From 1993 until 2001, PHA "success" rates dropped from 81 percent (meaning 81% of households issued vouchers actually found an approvable unit and a willing landlord within the time frame allowed by the PHA) to 69 percent. At the time, many attributed this to the tight rental housing markets in many cities, landlords' being unwilling to accept households with vouchers, and a shrinking supply of units within the voucher program's Fair Market Rent standards. The 2001 data suggests that nonelderly people with disabilities actually do better than average (74% success rate), while elderly people with disabilities do worse (54% success rate).[437]

Still, we know that compounding problems in accessing housing is discrimination in the housing market. A study of the Chicago metropolitan area, *Barriers at Every Step*, completed for the U.S. Department of Housing and Urban Development, provides evidence that discrimination based on disability still occurs.[438] As part of a larger nationwide study, the Chicago area served as a pilot study that focused on the treatment of people who are deaf using the TTY system—a device that allows individuals to make and receive text phone calls—to inquire about advertised rental housing and the treatment of people using wheelchairs when visiting rental properties to inquire about available units. The findings indicate that "adverse treatment against people with disabilities occurs even more often than adverse treatment of African Americans or Hispanic renters in the Chicago-area market."[439] This was evident in lower

rates of service, information provided, and units available, and in higher denial rates when requesting the opportunity to inspect units for home seekers with a disability than for comparable home seekers without a disability.[440]

Enforcement

Compounding the problem of discrimination, HUD continues to lag in handling fair housing complaints, the majority of which are by people with disabilities.[441] Assuming someone knows he or she has been discriminated against—which may not always be the case—a fair housing complaint can be filed up to 1 year after the alleged discrimination (180 days if filing under 504). Once filed, HUD is expected to take action. Currently, HUD outlines the process on its Web site.[442] Up front, HUD states it will "notify you if it cannot complete an investigation within 100 days of receiving your complaint," and then, "If, after investigating your complaint, HUD finds reasonable cause to believe that discrimination occurred, it will inform you. Your case will be heard in an administrative hearing within 120 days, unless you or the respondent wants the case to be heard in Federal district court."[443]

While the speed of the process is subject to many factors, including the cooperation of the person filing the complaint, there is concern that despite these commitments to timeliness, there is sharp evidence to the contrary, especially for people with disabilities. A 2001 National Council on Disability report revealed that cases were open on average nearly 500 days in 2000. Based on a recent review by the National Fair Housing Alliance (NFHA), it appears not much has changed. NFHA found in its review of cases in which a charge was issued between January 2004 and October 21, 2008, that "the average age of cases in which a determination of reasonable cause was made and a charge issued was 502 days. The shortest time period between filing the complaint and the issuance of a charge was 143 days, while the longest was 1,254 days."[444]

On the development side, based on compliance review agreements between HUD and several public housing authorities (e.g., Atlanta, Boston, Chicago, Miami-Dade, Pittsburgh, and Seattle), there is evidence that oversight of new housing built by private

sector developers to replace public housing is the result of advocates and people with disabilities and not HUD's proactively monitoring compliance. At this time, it is not known how much of the new mixed-income public housing is accessible and if it is meeting the minimum rate required under Section 504 and complying with the Fair Housing Act. An underpinning concern is that HUD encouraged use of New Urbanist design concepts to guide these new developments, which include walk-up front entrances that reduce accessibility.[445] In 2004, several disability groups, Access Living, Disability Rights Action Coalition for Housing (DRACH), and Concrete Change, requested that the Congress for New Urbanism (CNU) at least educate developers about visitable standards, including no-step entrances and an accessible first-floor bathroom. Since then, CNU has included images and discussions of visitable and accessible housing in its design resources, with particular attention to the aging population.[446] However, it is unclear how much of this has translated specifically into changing the approach taken in HOPE VI developments, as the CNU actions came after most replacement housing was built.

Advancing Accessibility and Integration

HUD continues to use the UFAS as the standard for accessibility, but it does not uniformly require or even encourage visitability or universal design in its housing programs. In 1996, HUD published *Residential Remodeling and Universal Design*, aimed at private homeowners and remodelers. In 2000, HUD published *Strategies for Providing Accessibility & Visitability for HOPE VI and Mixed Finance Homeownership*. While this is important guidance when remodeling or building replacement housing, it by no means requires applying standards to new construction—the time at which it can be done cost effectively and easily. More important, HUD does not require visitability or universal design in any new construction of federal housing, though it does "strongly encourage" it with the HOME program.[447]

While LIHTC units are subject to the Fair Housing Act, HUD could also require developers to incorporate visitable and/or universal design features in units. Federal housing that is subject to 504 does not ensure that universal design standards are

considered or applied. Clearly, the latter are not substitutes for the UFAS; however, they are means to achieve the end (i.e., access) and can help produce units that do not segregate people with disabilities by design and can help create design spaces that do not prevent people from using services or programs.

Current funding also affects any ability to easily produce integrated housing for people with disabilities. If the goal is to provide more dispersed and less segregated housing throughout our communities, then this requires making it possible to use production dollars that target people with disabilities in ways that can foster integration. While the Section 811 "mixed-finance" regulation published by HUD in 2005 permits Section 811 funding to be combined in federal Low Income Housing Tax Credit–financed properties, glitches have made the regulation difficult to use and have stalled the widespread development of Section 811 mixed-finance housing such as that been produced in Texas.[448]

Going Green

A scan of HUD and rural programs verifies that until recently, green and environmentally sound development practices have not been actively encouraged or systematically pursued for affordable new or rehab housing. While there are incentives through foundations and other public programs that can be used by developers engaged in development using HUD and USDA funding, this is really left up to the discretion of the developer. Given the potentially high upfront cost of many "green" or environmental features, it can be difficult for even a motivated developer to pursue these, especially in higher-cost markets. As a result, while there is a growing collection of local examples of green projects, these are all relatively "one-off" with little documentation to assess cost effectiveness or potential benefits of scaling up these practices.[449] With new attention to sustainable and livable communities, many expect more widespread inclusion of green technology in all federal housing, including for people with disabilities. Furthermore, it presents new opportunities to expand beyond green to consider ways to improve the overall built environment to benefit people with different environmental sensitivities.

Looking Ahead

The following highlights proposed legislation, new programs, and new directions that have only just been implemented or proposed and therefore cannot be evaluated, but nonetheless point to potentially promising practices.

Section 811 Legislation

H.R. 1675, the Frank Melville Supportive Housing Investment Act of 2009, is bipartisan legislation that will make significant reforms and essential improvements to the HUD Section 811 Supportive Housing for Persons with Disabilities program. An identical bill—H.R. 5772—unanimously passed the House of Representatives under Suspension of the Rules in September 2008. H.R. 1675 will help address the serious housing crisis facing millions of extremely low income people with disabilities by:

- Authorizing a new cost-effective Section 811 demonstration program that could triple the number of integrated units created through Section 811 without any increase in the program's appropriation. This demonstration program is designed to highly leverage capital funding provided through other federal affordable housing programs, including the Low Income Housing Tax Credit and HOME programs.
- Enacting long-overdue reforms to the current Section 811 production program to reduce longstanding bureaucratic barriers and improve the program's efficiency and cost effectiveness.
- Authorizing a cost-neutral shift of fiscal responsibility for the Section 811–funded Mainstream Voucher program to the Housing Choice Voucher appropriation. Although funded and renewed from 811 appropriations, an estimated 14,000 Mainstream Vouchers created between 1996 and 2002 have been administered as Housing Choice Vouchers, have never been used for permanent supportive housing, and have never been targeted to people with the most serious and long-term disabilities.

For the past few years, because of Section 811's outdated structure, the program has only produced 800 to 900 new supportive housing units annually. H.R 1675 will reinvigorate the program by creating 3,000 or more new units annually through the demonstration program, and by authorizing more integrated housing approaches and models that are consistent with the housing needs and choices of people with disabilities.

New Funding for Affordable Housing via the National Affordable Housing Trust Fund[450]

On July 30, 2008, President George W. Bush signed the Housing and Economic Recovery Act, which included the establishment of a National Housing Trust Fund (NHTF)—an ongoing, permanent, and dedicated source of revenue to build, rehabilitate, and preserve 1.5 million units of housing for the lowest-income families over the next 10 years. This is the first housing program since 1974 that is directly dedicated to rental housing for very low income households, which can benefit people with disabilities, among others. At least 90 percent of NHTF resources must be spent on rental housing and 75 percent of all rental funds must benefit extremely low income households at or below 30 percent of Area Median Income. These funds are to be administered by States that then make grants to developers with established capacity to build affordable housing, including nonprofit and for-profit organizations. Although no source of dedicated funding for the National Housing Trust Fund has been identified, HUD has requested $1 billion in new funding for this program in its FY 2010 budget request to Congress.

New Vouchers for Nonelderly People with Disabilities

In both the FY 2008 and FY 2009 HUD budgets, Congress provided $30 million each year to fund approximately 3,500 new vouchers for nonelderly people with disabilities. These appropriations signal the willingness of Congress to return to policies adopted between 1997and 2001 to provide new vouchers for nonelderly people with disabilities each year to offset the loss of subsidized public and HUD-assisted housing units from

properties designated “elderly only.” PHAs must be willing to apply for these new vouchers, and could use them to create special initiatives, such as targeting them for people with disabilities who are leaving segregated institutional settings.

New Vouchers for Veterans[451]

In 1992, HUD and the VA collaborated to launch a Supportive Housing Program, known as HUD–VASH. Its objective was to serve homeless mentally ill veterans by providing affordable housing (through HUD’s Section 8 voucher program) and case management services (through the VA). Almost 1,800 vouchers were provided. The housing retention rates of HUD–VASH compare favorably to other supported housing programs. Furthermore, there were significant gains in employment, mental health, and reduction of drug and alcohol problems among participants.[452] In 2008, HUD–VASH was expanded to provide local Public Housing Agencies with approximately 10,000 new rental assistance vouchers specifically targeted to assist homeless veterans and their families. An additional 10,000 vouchers have recently been added with the passage of the Omnibus Appropriation Act of 2009. A joint effort of the Department of Veterans Affairs and HUD will link VA medical centers to local PHAs to provide supportive services and case management to eligible homeless veterans.

Inclusive Home Design Act (H.R. 1408)[453]

This new legislation, introduced on March 10, 2009, by U.S. Representative Jan Schakowsky, aims to increase the number of affordable homes accessible to people with disabilities. The act would require that all newly built single-family homes and townhouses receiving federal funds meet four specific standards:

- Include at least one accessible (“zero-step”) entrance into the home.
- Ensure all doorways on the main floor have a minimum of 32 inches of clear passage space.
- Include at least one wheelchair-accessible bathroom on the main floor.

- Place electrical and climate controls (such as light switches and thermostats) at heights reachable from a wheelchair.

New HOPE VI Legislation[454]

On January 17, 2008 the House of Representatives approved H.R. 3524, the HOPE VI Improvement and Reauthorization Act of 2007, which would reauthorize the program for 7 years and make important improvements to the program. Specifically, improvements include requirements that all units demolished under future HOPE VI awards be replaced (i.e., one-for-one replacement), that the plans include offsite replacement housing in low-poverty areas, and that new HOPE VI projects offer more assistance for displaced families using housing vouchers. While this bill did not progress, advocates of public housing see promise in the groundwork laid. As described by the Center for Budget and Policy Priorities, looking forward, the aim should be "to maximize the program's positive results and minimize any negative impacts it might have on people who are displaced when their homes are demolished."[455]

Section 202 Supportive Housing for the Elderly Act of 2009 (S. 18)

Currently in the Senate, a bill to amend Section 202 of the Housing Act of 1959 would significantly change the funding and operation of developments and how funds are allocated for developments regionally. It would give more discretion and autonomy to owners of such properties.[456] It also would require the HUD Secretary to establish and operate a national senior housing clearinghouse.

HUD's Real Estate Management System (REMS)

At this time, we do not know the level of integration of accessible units or tenants with disabilities within buildings or developments. However, we may be able to learn in the near future the utilization rate in multifamily housing through HUD's integrated Real Estate Management System, which currently does or will collect data on the occupants of housing for people with disabilities and more detailed information about the bedroom size and specific accessibility features.[457] This will include, by bedroom size:

- Number of mobility impaired accessible units
- Number of vision and/or hearing impaired accessible units
- Number of people on waiting lists eligible for accessible units
- Number of accessible units occupied by elderly or family tenants
- Number of accessible units occupied by nonelderly tenants with disabilities that require the features of the unit
- Number of accessible units occupied by elderly tenants with disabilities that require features of the unit

This relatively new data collection system, which is used to independently monitor HUD's portfolio of multifamily housing, is an opportunity to look more closely at how people with disabilities and the elderly are integrated within housing developments and communities.

New Requirements for Low Income Housing Tax Credit Reporting

The Housing and Economic Recovery Act (HERA) of 2008 now requires HUD to collect and report for all LIHTC tenants race, ethnicity, family composition, age, income, use of Section 8 (or similar) rental assistance, disability status, and monthly rental payment. Not only will this data be of use for assessing how well the LIHTC program is serving people with disabilities and the elderly, it will also provide a better understanding of how many LIHTC units are made affordable with the use of additional rental subsidies.

Green Efficient Public Housing

The Council of Large Public Housing Authorities released its *Future of Public Housing Framework* in October 2008, which included a commitment to "fully integrate green building standards to rebuild or retrofit all 1.2 million public housing units as part of the reinvestment strategy," and to raise $10 billion over the next 10 years to accomplish this goal.[458] The 2009 stimulus package includes funds to kick off this initiative.

Promoting Livable Communities

On June 16, 2009, a new partnership among HUD, the Department of Transportation (DOT), and the Environmental Protection Agency (EPA) was announced to support the creation of more sustainable development in urban, suburban, and rural areas. This includes coordinating housing and transportation investment, "while simultaneously protecting the environment, promoting equitable development, and helping to address the challenges of climate change."[459] This includes strategies that:

- Provide more transportation choices
- Promote equitable, affordable housing
- Enhance economic competitiveness
- Support existing communities
- Coordinate policies and leverage investment
- Value communities and neighborhoods

While these strategies are capable of producing livable communities for people with disabilities and the elderly, the initiative—at least in its fact sheet for the public—does not include specific language or discussion of either group.

Recommendations

The following recommendations assume that all policy development and decisions will include people with disabilities in the development of all housing policies, programs, and educational presentations.

Expand the Definition of Disability in Federal Housing

1. Congress and the Administration should develop initiatives to create a more effective and broader definition of people with disabilities in need of federal housing, including people with environmental sensitivities.
    - While the ADA definition of disability is broad, current federal housing policy and practice focus primarily on mobility limitations in the design and development of housing. Growing research on health, as well as “green” design, draws attention to a broader view of the built environment and the needs of people with “invisible” disabilities, such as psychiatric disabilities and chemical sensitivities.
2. Reform existing HUD programs to end the use of definitions that identify people with disabilities as a “special needs” category. Instead of creating “special needs” programs for people with specific types of disabilities, HUD must ensure that all programs, services, and activities are accessible to people with different types of disabilities, including people with environmental sensitivities.
    - Current programs that target people with disabilities and the aging population preclude integration across groups, needs, and incomes, as well as with people without disabilities.

Prevent Further Loss of Affordable, Accessible Housing

3. Congress should review current public housing redevelopment plans to make sure sufficient replacement units are planned for and provided. If not, then a

moratorium on demolition and/or redevelopment should be issued until plans are revised.

- A key concern is that these plans do not ensure sufficient replacement housing, since one-for-one replacement is not required, and because of the design of replacement housing. Also, some PHAs are designating rehabilitated developments as “elderly only,” which restricts access by age. Given the large number of people with disabilities in “worst-case need,” removal and designation of HUD housing may actually exacerbate the problem. Still, any decision should be weighed against keeping people in poor housing that does not meet their needs.

Increase Affordable Housing for People with Disabilities

4. A higher percentage of affordable housing constructed with HUD support should be reserved for people with disabilities.
    - Current formulas based in Section 504 of the Rehabilitation Act set limits that are significantly lower than the current population living in federal housing. Given the large number of people with disabilities with worst-case housing needs, an increase is justified. Under existing regulatory authority (see 24 C.F.R. 8.22[c]), HUD can prescribe a percentage or number higher than the 5 percent requirement for accessibility.
5. Congress and the President should substantially increase funding for construction of accessible, affordable, and integrated housing.
    - Currently, federal funding for accessible housing is segmented and has been historically underfunded. Investment is needed to foster creative strategies to develop integrated housing that is also environmentally accessible and sustainable.
6. Congress and HUD should consider different ways to control the proportion of units in 811 developments that can house people with disabilities.

- The goal to produce integrated, affordable, and accessible housing cannot be attained as long as funding programs continue to encourage/allow segregated housing. For example, a 25 percent cap was introduced in 2008 (under H.R. 5772), which did not move forward. This can also include a percentage of funding that must be used to produce integrated housing with new developments. Also, Congress should eliminate the HUD Secretary's ability to waive the limits on the maximum number of residents in group homes and independent living facilities.

7. HUD should streamline the process for using 811 funding in integrated settings.
    - While Section 811 "mixed-finance" regulations published by HUD in 2005 allow combining 811 funds with Low Income Housing Tax Credits, there are many barriers still within the program that make it very difficult to produce more integrated housing options for people with disabilities.

Increase Access to Existing Units

8. HUD should ensure that units designed for people with disabilities are actually occupied by people who need accessible features.
    - Currently, there is no way to systematically determine if people with disabilities are living in units that are accessible, or what is needed to accommodate these tenants. Section 504 requires PHAs and owners and managers of multifamily properties to take reasonable nondiscriminatory steps to maximize the utilization of accessible units by people with disabilities.

9. Congress and the President should support a well-funded national modification fund to pay for reasonable modifications that are necessary to make private units accessible (or at least usable by people with disabilities).
    - Modification funds currently available are limited relative to need, and not consistently available in all communities. Such a fund could make many more units accessible in the short term and help integrate people with disabilities into the community.

10. HUD should require PHAs to determine local needs and set local preferences for public housing units and designate vouchers for people with disabilities who are leaving institutions.
    - Currently, this is allowed when placing people on waiting lists for vouchers, but it is not required. A PHA can establish local preferences based on housing needs and priorities of its community.

Expand and Focus Voucher Usage

11. Mainstream and Fair Share Vouchers that were turned into regular Housing Choice Vouchers by PHAs due to poor oversight by HUD should be recommitted to people with disabilities.
    - The Fair Share and Mainstream Voucher programs were created to address the housing needs of very low income people with disabilities. However, many of these vouchers were never used by people with disabilities and therefore "lost," since they were never tracked and some PHAs gave them to people without disabilities.
12. HUD should issue a policy requiring that a portion of HOME funds be designated as rental assistance for use by people with disabilities, and especially those who are leaving institutions.
    - Under HOME, this is an option. However, in most States and entitlement communities, HOME funds are used for development. Rental assistance can be a more cost effective way to benefit many more households, especially very low income households. This can also benefit communities with high vacancy rates in rental housing.
13. Congress and the President should create new housing vouchers each year for a fixed period for exclusive use by people transitioning out of nursing facilities or other institutions. This requires HUD and the Centers for Medicaid and Medicare Services to work together to make sure that these vouchers go to people, regardless of type of disability or age, living in nursing facilities and other

institutions. This cooperation has begun with implementation of the Money Follows the Person demonstration program, but needs to be vastly expanded.

14. Congress and the President should develop a permanent “Barrier Elimination Trust Fund” (BETF) for accessibility modifications for people transitioning out of institutions, including nursing homes and group homes, and those at risk of institutionalization. This fund should be increased annually using the Consumer Price Index. It is recommended that funding for the BETF could come from fines for failure to comply with Section 504 and Fair Housing Amendments Act requirements.
15. Sufficient funding is needed for rental assistance and home modifications directly targeting people with disabilities who are at risk of being placed in institutions, including group and nursing homes, to realize fair housing goals and the goals of *Olmstead*.

Educate Fair Housing Act Enforcement on Disability Rights

16. Require and provide regular training that educates various HUD and Fair Housing Act enforcement offices and contractors consistently about the interpretation of the law and new developments, encourages coordination with disability rights organizations/groups, and rewards development of partnerships with the disability community.
    - Currently, the various HUD enforcement offices and grantees have varying levels of expertise and commitment to disability rights issues, resulting in uneven handling of complaints.
17. Require fair housing organizations to develop contractual partnerships with disability-based organizations on testing, education, and enforcement strategies.
    - Partnerships can ensure expertise on disability-related fair housing issues that many fair housing organizations do not have. Given the large number of cases currently filed, systematic testing can help raise awareness and elevate the issue beyond the individual case basis.

Improve and Increase Enforcement

18. Congress should increase funding so that HUD can dramatically ramp up its enforcement efforts in the area of disability.
    - There continues to be a backlog of cases and a large number of complaints filed by people with disabilities. Without enforcement, the laws and various regulations are impotent.
19. Encourage fair housing organizations to do systemic legal work/advocacy and provide incentives to do so and offer longer grant periods than are currently funded to facilitate such work.
    - Because systemic work, especially systemic litigation, can last for several years, fair housing organizations need secure and sufficient funding over multiple years to ensure sufficient staff and resources to pursue cases.
20. HUD should encourage consumer-directed organizations (e.g., Centers for Independent Living) to apply for education and outreach grants.
    - Currently, these activities are separated out in HUD's funding, yet many of the organizations that provide enforcement also offer education with funds from elsewhere. These activities are complementary and not contradictory, and both need greater financial support if the goal is to further fair housing by eliminating impediments.
21. The statute of limitations period for fair housing complaints in new developments should be extended until the violations related to the failure to design and construct accessible housing are corrected.
    - Current interpretation of the law limits ability to enforce and seek redress, since the courts currently interpret the statute of limitations of "last occurrence of discrimination" to be the date of the issuance of the last applicable certificate of occupancy.

Review HUD for Compliance with Section 504 and the Fair Housing Act

22. HUD should ensure that compliance with Section 504 is built into its ongoing monitoring activities for PHAs and enter into Voluntary Compliance Agreements (VCAs) with noncompliant PHAs, and, if necessary, take enforcement action for noncompliance with those requirements. HUD should include disability rights advocates in the development of VCAs.
    - Currently, compliance is not systematically reviewed, and usually only when a complaint is filed. Recent compliance reviews of several large housing agencies found that PHAs were not in compliance and Voluntary Compliance Agreements were entered into with HUD.
23. HUD should evaluate the programs, services, and activities of its Regional Field Offices regarding their respective records on Section 504 and demand improvements as appropriate.
    - HUD recently conducted its own self-evaluation. With this example set, regional offices have not yet done the same, or at least have not made public any results from self-study or evaluation exercises.
24. HUD should take further steps to ensure that Public Housing Agencies know about and comply with all Fair Housing Act provisions, including the accessibility and accommodations requirements of the act.
    - Evidence of fair housing violations within HUD-sponsored housing, including public, multifamily, and tenant assistance, supports the need for education, awareness, and proactive behavior with guidance from HUD.

New Legislation

25. All new legislation should support the Inclusive Home Design Act that will ensure a basic level of accessibility (i.e., visitability).
    - This will target single-family and townhomes built with federal funds that are not covered by the Fair Housing Act.

26. In any new legislation dealing with economic recovery or foreclosures, HUD and other agencies need to include specific requirements and guidance for maximizing benefits to people with disabilities.

    - The Neighborhood Stabilization Program (NSP) and the American Recovery and Rehabilitation Act (ARRA) both had more potential to benefit people with disabilities than was realized in the final legislation and subsequent implementation. Future legislation to extend either NSP or ARRA should include requirements to expand housing opportunities for people with disabilities.

Research and Dissemination

27. HUD should follow up on its *Disability Discrimination Study* as a means to encourage additional comprehensive disability-based testing and as a lever to support future disability-related enforcement and education.

    - *Discrimination Against Persons with Disabilities: Barriers at Every Step* (2005) is a highly cited study that brought to light the systematic discrimination people with disabilities face in their search for housing. This kind of research helps to not only enforce the law, but also to educate all actors about fair housing. As the report introduction reminds us, “Not enough is known about the prevalence of housing discrimination against persons with disabilities. Only slightly more than half of Americans know that it is illegal for landlords to refuse to make reasonable accommodation for persons with disabilities or to permit reasonable modification to a housing unit [based on 2002 HUD report].”[460]

28. HUD should proactively disseminate information about “best practices” with regard to disability-related enforcement activities, testing campaigns, compliance, and educational activities.

    - There are many fair housing and advocacy groups doing interesting work to further fair housing. Being the primary source of funding, HUD is well

positioned to identify those practices that can be translated and transferred to other communities.

Engage and Educate Design and Development Industry

29. HUD should substantially increase funding to educate the public, especially the design and construction industry and housing providers, about disability-based fair housing rights.
    - Education can inform people about regulations and compliance. It can also be used to encourage positive responses to the Fair Housing Act and its amendments by demonstrating the cost effectiveness of complying (as opposed to having to do it later), as well the broader benefits of considering universal design features, through examples of best practices.
30. HUD should convene a small working group, including design and construction professionals and people with disabilities, to consider the propriety of HUD and the Department of Justice charging the U.S. Access Board with the task of developing a single design standard for new construction under the Fair Housing Act. The new standard would be harmonized with ADA/ABA Accessibility Guidelines and model building codes to eliminate conflicts with other federal standards and minimize differences with State and local accessibility codes.
    - With different laws, regulations, and guidance, there is no single standard for construction. As a result, developers, designers, consumers, and even enforcement and fair housing advocates are confused by the ways these laws are interpreted and implemented.
31. Congress should modify the Internal Revenue Code so that LIHTC properties are considered recipients of federal funding and hence are obliged to comply with Section 504.
    - Currently, the Low Income Housing Tax Credit program, which is the primary source of funds to produce affordable housing in the United States, is not

subject to 504. The exception to this is the specific tax credits converted into grants under the American Recovery and Reinvestment Act of 2009.

Data and Reporting

32. Congress and HUD should include people in group quarters, both institutionalized and not, in further analysis for the worst-case needs and other assessments of housing needs among people with disabilities.

    - Currently, group quarter data is excluded from analysis of worst-case needs by HUD as mandated by Congress. This data is needed to plan ahead and to gauge needs of people with disabilities in institutions who under *Olmstead* might be able to integrate in the community.

33. The U.S. Census Bureau should develop household-level reports using Survey of Income and Program Participation (SIPP) data to better understand the needs of households and families with people with disabilities.

    - Currently, SIPP data is analyzed at the individual level to understand disability prevalence and characteristics. Not all people with disabilities live alone and some live with other people with disabilities. Reports should be prepared using household-level data, so as to better understand the housing situation of people with disabilities, including satisfaction with their housing and their community—information currently found in SIPP data.

NCD Topical Brief #2

Private and Nonprofit Sector Housing

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Introduction

This brief explores four key issues that affect the housing and related community integration opportunities available to people with disabilities in the United States: (1) affordability, (2) accessibility, (3) the role of supportive housing, and (4) homeownership. Also highlighted is the role of private and nonprofit entities in providing housing and supportive services solutions to people with disabilities to ensure they have the opportunity to live as independently in the community as possible. Examples of promising practices illustrate the extent to which specific types of housing and supportive services developed or managed by private and nonprofit entities are inextricably linked to overarching federal, State, and local housing laws and policies. These practices relate to the key issues of the brief and include innovative bricks-and-mortar solutions, local policies requiring that “universal design” principles be incorporated in new housing construction, and proactive advocacy by the disability and fair housing communities. Several promising practices involving public housing and seniors-only programs, as well as a specific example of municipal commitment to increasing housing vouchers, are also presented here because they represent new or unique responses to some of the most intransigent housing problems experienced by people with disabilities. The brief also presents recommendations for reform.

Need

Recent federal research estimates that there are 54.4 million people with disabilities in the civilian population living in the United States, representing approximately 18.7 percent of the noninstitutionalized population.[461] Survey estimates suggest that there are about 35,085,550 households with one or more people with a disability; this figure constitutes approximately 31.7 percent of the 110.6 million households in the United States in 2007.[462] In addition, about 2.17 million people live in nursing homes or group homes (1.6 million of these live in nursing homes).[463] If current rates of growth continue without the development of new alternatives that allow people to remain in homes in their communities as they age, it is expected that there will be 3 million nursing home residents by 2030.[464]

In general, people with disabilities are more likely to rent than own their home, as compared to people without disabilities. Homeownership is generally lower among people with disabilities than for the general population, with one notable exception. Among homeowners between the ages of 64 and 84, 94 percent are people with disabilities.[465] Such high levels of ownership are likely due to the fact that many of these individuals purchased their homes before acquiring disabilities as they aged.

Many people with disabilities of any age are able to live independently, although current research suggests that a growing number are unable to find appropriate housing to meet their needs. Reasons include location, quality, physical accessibility, affordability, and an unmet need for supportive services that some individuals require in order to live independently in the community.

Among the various barriers to acquiring housing that people with disabilities experience, poverty and low-income status rank among the highest. A recent report suggests that the number of “worst-case” very low income renters with nonelderly households with people with disabilities may number between 1.3 million and 1.4 million.[466] The U.S. Department of Housing and Urban Development (HUD) defines households with “worst-case needs” as: “Unassisted renters with very low incomes who have one of two

“priority problems”—either paying more than half of their income for housing (‘severe rent burden’) or living in severely substandard housing.”[467]

In addition, the report estimates the existence of nearly 1 million worst-case very low income renter families with children that house nonelderly adults with disabilities. This means that there may be as many as 2.4 million very low income households with disabilities that are classified as worst-case, which is between 35 and 40 percent of the total worst-case housing needs in the United States.

Regardless of income, between 9 and 12 million Americans need help with certain activities of daily living.[468] Using this “functional” definition of disability, current estimates of the population in need of accessible housing and communities who are under age 65 range from between 3.5 to 10 million.[469] These estimates do not include people with disabilities who live in or are trying to transition out of institutional settings such as nursing homes. People with disabilities also live longer, and their housing and supportive requirements are changing. Such trends directly affect these individuals’ community living options. The population of people over age 65 is expected to double by 2030, with 20 percent of people age 65 and over requiring assistance with at least one activity of daily living. This number is expected to increase to 50 percent by age 85. Over the next 30 years, disability rates for people 85 years and older are expected to rise as this population triples.[470] Furthermore, the population of aging baby boomers will soon reach an age where housing accessibility and livable communities will become one of their highest priorities.

Key Issues

Affordability

Lack of affordable housing is one of the most pressing problems faced by low-income people with disabilities. The majority of the 4 million people with disabilities who are not elderly and are living on an average of $632 per month from Supplemental Security Income (SSI) experience the greatest difficulty in affording housing. They have the greatest need for assistance with paying for housing of any group in the United States.[471] According to *Priced Out in 2008,* SSI is equal to 18 percent of the national median income for a one-person household, almost 25 percent below the federal poverty level. The national average rent for a one-bedroom apartment was 112 percent of monthly SSI payments; therefore, those whose income is limited to SSI cannot afford even modestly priced rental housing.[472]

As a result, the core housing issue for most low-income people with disabilities is the need for federal rental subsidies in order to obtain housing that is affordable. While federal initiatives such as the Low Income Housing Tax Credit (LIHTC) program can provide financing that creates below-market-rate housing units for individuals with incomes at 50 to 60 percent of the local median income, few tools are available that subsidize the balance of the rent for individuals living on SSI-level incomes. Limited rental subsidies are available through the federal Housing Choice Voucher program, but the need far outpaces availability. The voucher program assists about 1.95 million households; about 17 percent of these include a person with a disability, but only one in four households that are eligible for vouchers receive any form of federal housing assistance. Most locales have long waiting lists for vouchers, and many housing agencies have even stopped accepting new applications because the backlog is so large.[473] Furthermore, public housing, which has historically accommodated some low-income people with disabilities, is not only very limited, but it is also in decline as a long-term housing solution. Housing for low-income older Americans created through Section 202 Supportive Housing for the Elderly Program, HUD's largest directly funded construction program, have high occupancy levels, low turnover, and lengthy waiting

lists. Construction of Section 202 housing has also been declining; production in 2004 was 58 percent of the production levels of the 1980s.[474]

The crisis in affordable housing forces hundreds of thousands of people with disabilities to live at home with aging parents or in restrictive and costly settings such as nursing homes, board and care facilities, and other institutions. Federal programs such as the U.S. Department of Health and Human Services (HHS) Money Follows the Person (MFP) and Real Choice System Change recognize that it is less expensive for people with disabilities to live in the community than in institutions, and are intended to promote community integration. As a practical matter, however, lack of affordable housing that is most often made possible with rental subsidies has limited the number of people who can move into homes of their own. Increasing the availability of monthly rental subsidies provided through federal programs such as 811 Supportive Housing for People with Disabilities and the Housing Choice Voucher programs can make rents truly affordable for those with the lowest incomes, while still leaving money for other essentials such as food and clothing.[475]

Accessibility

Most private single-family and multifamily housing in the United States is built by commercial developers, yet basic accessibility features (e.g., level primary entrances, sufficiently wide interior doors and hallways, and an adequate turning radius in the bathroom to accommodate a wheelchair user) are limited. The 1988 Fair Housing Amendments Act requires that certain newly constructed private and public multifamily housing meet specific accessibility requirements for entryways and shared public spaces and include adaptability features within the units. Enforcement of the law has been inconsistent, however, and HUD data concerning the number of accessible or adaptable units that comprise current housing stock may not present an accurate or complete picture of accessibility.[476] Consequently, housing advocates suggest that private housing with even minimal accessibility features appears to be in limited supply. A few locales have adopted either mandatory or voluntary “visitability” policies that apply to newly constructed housing that generally include level entrances, first-floor

bathrooms, and 32-inch doorways. An estimated 30,000 new housing units have been constructed under primarily mandatory legislation and are now considered visitable.[477]

Private and nonprofit housing built with diverse public and private funding and aimed at specific demographic populations and groups, including people with disabilities, generally include some accessibility features and accessible units. But by far the greatest number of single-family and multifamily homes are provided through the private market, thus limiting housing options and choices available to those people with disabilities who require accessibility features, irrespective of their income or need for supportive services.

Further complicating matters, people with disabilities face unequal treatment and discrimination when they search for rental housing. A 2005 HUD study revealed that they experience discrimination in up to half of rental inquiries. In addition, up to one-third of rental properties advertised in the Chicago area, one of the locales where the study was conducted, were not accessible to wheelchair users.[478] A similar study of private rental properties conducted in Newton, Massachusetts, revealed evidence of discrimination in 48 percent of tests conducted.[479] Supporting these findings, in 2005 HUD found that 41 percent of over 9,000 complaints received by the agency involved disability discrimination.[480]

Even as disability-based housing discrimination complaints make up the largest percentage of fair housing complaints filed with HUD, national studies have reported that HUD enforcement of fair housing laws that afford remedies to housing discrimination for people with disabilities is inadequate.[481] Although complaints must be investigated within 100 days of being filed under most circumstances, long delays in investigation of complaints and complaint backlogs persist. While federal compliance reviews also serve as an effective tool for investigation of systemic violations of fair housing laws, this mechanism has been underutilized, thus limiting its potential impact on people with disabilities who experience housing discrimination. These and other weaknesses in fair housing enforcement add to the systemic difficulties people with disabilities face when they seek homes of their own.[482]

In light of documented weaknesses in federal enforcement of fair housing laws, qualified private fair housing centers play an especially important role in conducting certain enforcement activities and educating the public about their fair housing rights and responsibilities. Enactment of the 1987 Fair Housing Initiatives Program (FHIP) legislation acknowledged the important role of such organizations. During the past 5 years, private fair housing organizations have processed 65 percent of the fair housing complaints in the United States. Most of the remaining cases were handled by State and local fair housing enforcement agencies (25% of cases) responsible for laws that are generally equivalent to the Fair Housing Act, and HUD processed 10 percent of the cases.[483]

Supportive Housing

The disability community has long advocated for policies and programs that enable individuals to live as independently as possible in homes of their own rather than in restrictive institutions and settings, such as nursing and board and care homes, that constrain freedom of choice and decision making. Until the 1990s, predominant public policy linked supportive services such as personal assistance to housing, in effect requiring that people with significant disabilities live in institutional settings. The principle of independent living espoused by disability advocates and the impact of the landmark U.S. Supreme Court decision in the *Olmstead v. L.C.* (*Olmstead*) case,[484] which found that the institutionalization of people with disabilities violates the 1990 Americans with Disabilities Act (ADA), have together spurred efforts to move institutionalized individuals into homes in the community and delink supportive services from housing. People with disabilities prefer integrated housing on sites located throughout the community (often referred to as scattered-site development), because this model helps dispel disability stereotypes and reduces stigma, thus contributing to meaningful community inclusion and participation.[485] In spite of both the legal mandate established by *Olmstead* and the preference of people with disabilities to live in homes of their own, however, systemic obstacles, barriers, and challenges to achieving this goal still remain.

In order to help people with disabilities to achieve independent living in the community, some organizations have developed new and innovative program models that promote housing options and provide voluntary, self-directed services for people with a variety of disabilities, including developmental and intellectual disabilities and mental health and substance abuse needs (see examples discussed below under “Support for Independent Living”).[486] Such models have proved adaptable for a range of individual needs and aspirations. Moreover, housing provided by nonprofit housing organizations for people with disabilities must generally meet certain standards of affordability and accessibility. At the same time, based on federal funding restrictions, much of this housing has been targeted for people with specific disabilities (e.g., developmental, psychiatric) or for older Americans. While attempting to address the needs of discrete populations, disability-specific funding policies often serve to undercut community integration by fostering the creation of segregated buildings and facilities that house exclusively or predominantly people with disabilities. In particular, and despite the independent living advances of the 1990s, some organizations that own or manage housing developments for people with disabilities may continue to require a tenant to participate in programs or services as a condition of the rent contract. In addition to limiting choice and control, programs organized in this manner deprive renters of their housing if at some point they fail to participate, potentially sparking a cycle of homelessness or reinstitutionalization.

States also play a central role in implementing federal housing policy and in creating incentives for the development of supportive services that people with disabilities might require in order to live independently. A few States are creatively coordinating multiple public and private funding sources and allocating new funds to increase housing and supportive services in order to reduce the number of people forced to live in institutions. Some States, however, have been slow to adopt policies that would foster the State agency coordination required to make supportive housing a reality, and communication among housing, social service, and other related agencies frequently remains poor.[487]

The concept of supportive housing is evolving to ensure that people with diverse disabilities have the opportunity to live in the community in homes of their own or in other settings they choose, while having access to supportive services they may require to live independently to the maximum extent possible. Best and promising practices in supportive housing ensure that housing is permanent and that residents have control over their environment. Individualized services must be delinked from housing and available to residents who want or need them. Housing also should be integrated and dispersed throughout the community on scattered sites near stores, transportation, and other amenities.[488]

Homeownership

Historically, many people with disabilities who wished to purchase their own homes found it very difficult to do so. Traditional hurdles to homeownership have included developing a credit history, saving money for a down payment, documenting a stable source of income, and resource and employment limits imposed by federal income replacement and support programs such as Supplemental Security Income and Social Security Disability Insurance. Incorrect assumptions about the ability of some people with disabilities to manage the responsibilities of homeownership have also dissuaded some disability professionals from encouraging clients with disabilities to investigate or pursue homeownership. Current federal budget deficits and credit restrictions may add additional problems for low-income people with disabilities who aspire to homeownership in the near future.

Owning a home of one's own became more realistic in the early 1990s, when various federal home loan and financing programs were created specifically to reduce the inequity in homeownership experienced by low-income communities. People with disabilities, families, and advocates began taking advantage of these resources, which included a combination of rental subsidies, low- and no-interest financing, and public and private grants to help bridge the gap between the income of people with disabilities and the cost of housing determined by the market. Additional legislation enacted in 2000 permits the use of housing rental vouchers as down payments on home

purchases, as well as monthly mortgage payments for eligible people with disabilities and their families. This legislation increases the probability that very low income people with disabilities can afford to pay the mortgage on a home of their own. While owning a home may not be for everyone, it is one of the most important mechanisms available to Americans to build assets, and it can reduce social perception that people with disabilities are dependent and noncontributing members of the community.[489]

Purchasing a home can be a complicated and difficult process for anyone, including people with disabilities. But various funding sources and programs can provide assistance, including the Federal Home Loan Bank, the HOME program, Fannie Mae's Community HomeChoice program, and State Housing Finance Agencies. In addition, the 1977 Community Reinvestment Act (CRA)[490] established the importance of financial institutions in meeting the credit needs of community members, particularly those in low- and moderate-income neighborhoods. In light of the goals of the *Olmstead* decision, CRA can serve as a tool to assist financial institutions and those concerned about housing opportunities for people with disabilities to form mutually beneficial partnerships.[491] Other economic development tools are also being used by people with disabilities to build the resources needed to purchase a home. For example, special savings accounts called Individualized Development Accounts (IDAs) assist people with low incomes in achieving ownership through matched savings and financial education. Medicaid policies, such as the Live-In Care Provision created by the 1990 amended Medicaid Home- and Community-Based Services (HCBS) waiver statute, allows States to claim federal Medicaid reimbursement for the "room and board" (food and shelter) costs associated with having an individual live in a waiver recipient's home and provide them with support.

Promising Practices

While accessible, affordable, integrated housing remains elusive for many people with disabilities, various private and nonprofit organizations have tackled the problem by challenging federal and State policies that foster segregation and institutionalization, by capitalizing on federal, State, and local programs that offer various financial incentives and resources, and by building, operating, and managing housing that fosters the spirit and goals of independent living and self-determination for people with diverse disabilities. In some cases, multiple community partners working together have found ways to tap a variety of funding sources to ensure that residents have access to housing that is affordable, accessible, and integrated, and also provide voluntary supportive services as needed.

Most housing and supportive services that people with disabilities require to live as independently as possible exist in large measure because federal, State, and local housing policies dictate specific goals and allocate annual funding. Private and nonprofit organizations that develop, manage, or operate housing or provide supportive services are dependent to a significant degree upon a combination of these public resources, as well as on certain private sources of funding that vary regionally. Consequently, any discussion of promising housing practices must acknowledge the extent to which public policy drives the development of projects, as well as the influence of effective disability advocacy on both policies and final projects. Many of the following promising housing policies and practices illustrate the extent to which these factors are inseparable.

Described below are examples of innovative policies, partnerships, and programs that increase access to homeownership for low-income people with disabilities; facilitate, promote, or illustrate the principles of integration, affordability, accessibility, and scattered-site placement; and exemplify supportive housing. Examples of local and State policies calling for universal design or visitability are also presented. Several multiuse, low-income, integrated housing projects are described that embody principles of universal design. Outcomes of several disability rights lawsuits illustrate how the

promise of increasing integrated, accessible, affordable housing can be realized through litigation.

Intensive Homeownership and Housing Support

United Cerebral Palsy of Texas, Austin, Texas

Founded in 1954, the nonprofit United Cerebral Palsy of Texas (UCP Texas), Austin, Texas, is the State affiliate of United Cerebral Palsy, a national advocacy and support network for people with disabilities. The mission of UCP Texas is "to ensure that people with cerebral palsy and similar disabilities have the opportunity to participate fully and equally in every aspect of our society."[492] Serving all ages and people with all disabilities, UCP Texas provides technical assistance and support to families and individuals, advocates for people with disabilities, and organizes a variety of programs and services. A central component of UCP Texas's work focuses on assisting people with disabilities and their families to find housing. This work is driven by four goals: "to increase homeownership opportunities for people with disabilities; to increase the housing stock of accessible homes; to increase awareness of the need for more affordable, accessible, and integrated housing; and to educate people with disabilities on how to be successful homeowners."[493] These goals guide innovative housing programs that aim to provide affordable, accessible, and integrated residences for people with disabilities. Program descriptions follow.

The **Texas Home of Your Own (HOYO) program,** supported by HOME funds awarded through the Texas Department of Housing and Community Affairs, began in 1995 as part of the now-defunct National Home of Your Own Alliance and is now offered by UCP Texas. HOYO provides first-time homebuyers who are eligible with up to $15,000 in down payment assistance. These funds are awarded as a 10-year, deferred, no-interest, and forgivable loan that depreciates 10 percent each year; a second lien is placed on the home for 10 years. After that period of time, the loan is forgiven if the homeowner does not foreclose or sell the home, seek a home equity loan, or cease using the home as a primary residence. As of 2007, approximately 320 households or individuals had become homeowners through the HOYO program. In order to be eligible

for assistance, household income (typically SSI or SSDI) cannot exceed 80 percent of Area Median Income (AMI), and most of the individuals UCP Texas has served through this program have had incomes at or near 50 percent of AMI.[494]

UCP Texas also provides **affordable integrated, accessible apartments** for very low income people with disabilities to rent. Using Section 811 funds from HUD, UCP Texas purchased two sets of condominium units, the first in March 2005 and the second in April 2008. Section 811 funds are frequently used to construct segregated group homes or apartment complexes for people with disabilities. However, UCP opted to use its section 811 money to purchase 16 units integrated within two buildings populated primarily by professionals, students, and retired individuals.[495] It then found tenants by advertising through disability organizations and quickly filled the units.

UCP Texas also provides **support, training, research, and advocacy** to promote housing opportunities for people with disabilities. The organization's direct involvement with housing for people with disabilities has helped promote affordable, accessible, and integrated housing. UCP developed a comprehensive training package that the organization has used to train more than 100 public housing authority staff members. In addition, UCP trains nonprofit housing, social service, and disability advocacy professionals on how to promote consumer-directed barrier removal, and it provides technical assistance to the city of Austin as it undergoes an architectural barrier removal program.[496]

UCP Texas has successfully created integrated, affordable, and accessible housing for people with disabilities through HOYO and its use of section 811 funds, "doing something that very few people thought was possible 10 years ago."[497] Furthermore, the program's support to homebuyers enabled them to weather the recent subprime mortgage crisis. None of the individuals who took advantage of HOYO financial assistance faced foreclosures, an unexpected benefit that came from stringent requirements UCP Texas places on its homebuyers: loans that UCP supports must be more than 1.25 percent above prime rate.[498]

Yet this work has not been without its share of challenges. Housing programs are expensive and federal and State funding is limited. Home prices have increased from as little as $55,000, when HOYO began, to today, when "potential homebuyers have a hard time finding anything less than $100,000."[499] New State funding restrictions on HOME funds have forced UCP Texas to discontinue its home rehabilitation program, which supported accessibility modifications for new home purchasers. Furthermore, the organization not only has to plan and implement its programs, but it also has to challenge the perception that people with disabilities are dependent. UCP Texas found that they have to educate lenders about the disability community, many of whom rely on nontraditional income sources like (SSDI/SSI): "Early on, we had to do a lot of education, telling lenders [that SSI/SSD] income is steady income."[500] Moreover, UCP Texas had to sell the idea of scattered-site rentals to both HUD and the State of Texas because the norm is segregated disability communities.[501]

Housing Initiatives Program, Institute for Disability Studies, University of Southern Mississippi, Hattiesburg, Jackson, and Gulf Park, Mississippi

Based in Hattiesburg, with satellite offices in Jackson and Gulf Park, the Institute for Disability Studies (IDS) of the University of Southern Mississippi is the State's University Center for Excellence in Developmental Disabilities (UCEDD). A university-based nonprofit, IDS serves people with disabilities through a range of activities, including direct service, training, technical assistance, and research. Among these activities is IDS's Housing Initiatives program, which provides or facilitates homeownership assistance and loans, technical assistance, and training opportunities, as well as direct service to homeless people with disabilities. These efforts aim to serve people with diverse disabilities, including mental health issues and chronic illnesses. IDS's Housing Initiatives began in 1997 with a $25,000 HOME funds grant from the Mississippi Department of Economic and Community Development.[502] The program has expanded through subsequent competitive grants and now has an annually allocated, noncompetitive budget.

The largest component of IDS's Housing Initiatives is its **Home of Your Own (HOYO)** program, which provides home purchasing assistance grants of $10,000 and $15,000 to low- to moderate-income people with disabilities and families with a member with a disability. Along with these grants, HOYO offers its participants person-centered planning through individualized support and guidance. This includes helping participants secure a loan for the remainder of the house's cost, pre- and post-purchase homebuyer counseling, referrals to services as needed, and advocacy with lenders. HOYO grants may be used for down payment, closing costs, principal reduction, and modifications necessary for accessibility. HOYO participants then choose from one of 15 partner lenders, many of whom use Fannie Mae's Community HomeChoice product for low- to moderate-income people with disabilities. The HOYO program has three primary components as determined by its funding sources. The first is HOME funds set aside by the Mississippi Development Authority ($500,000), Mississippi HOYO, which has assisted 256 individuals in obtaining homeownership in 44 of the State's 82 counties.[503] Second, drawing on HOME funds from the city of Jackson, Community Service Division ($264,000), HOYO has helped 52 individuals and their families to secure homes within Jackson's city limits. The third component, funded by the city of Hattiesburg, Community Development Division, provides counseling and $15,000 HOME grants to Hattiesburg residents.

The income for approximately 75 percent of HOYO participants comes primarily from Social Security benefits, while the income of the remaining 25 percent comes from employment.[504] In spite of problems that confront current would-be homeowners, HOYO participants have less than a 2 percent default rate on mortgages.[505] IDS staff attribute this success to HOYO's "wraparound" support services, which involve counseling and advocacy.[506] These successes have been recognized with the HUD 100 Best of the Best Practices Award (2000) and the Mississippi Governor's Communities of Excellence Award for the State's best homebuyer program (2002 and 2007).

The IDS administers several other programs supported by the Federal Home Loan Bank (FHLB) that provide funds and support to assist people with disabilities in

becoming homeowners. First, the **FHLB Disability Initiative** has provided a $10,000 home purchase assistance grant for down payment, closing costs, and principal reduction to 10 very low income, 10 low-income, and 3 moderate-income families with a member with a disability.[507] Second, the **Special Needs Assistance Program (SNAP)** grant has provided $5,000 to 8 eligible families whose gross household income exceeds 80 percent of the median income level (adjusted by household size and county) to support home rehabilitation to make the homes accessible.[508] Finally, the **Mississippi Disability Initiative** has provided a $15,000 grant to each of 30 very low income to moderate-income families with a member with a disability in rural communities.

In addition to the financial assistance programs, IDS runs six other outreach, counseling, education, and direct support programs relating to housing for people with disabilities. First, the Delta Housing Initiative**,** funded by the F. B. Heron Foundation and started in January 2007, provides pre- and post-purchase counseling to 120 households and offers assistance to people with disabilities to find safe, affordable housing and community-based supports.[509] Second, IDS provides credit counseling, homebuyer education, and counseling services to Mississippi residents with funds from the Mississippi Home Corporation (MHC)/Freddie Mac Comprehensive Housing Counseling Grant. Third, IDS's HousingSmart program provides outreach to individuals with disabilities. To date, it has sponsored a total of 40 workshops that trained 657 people and disseminated printed and electronic fair housing information to an estimated 71,276 individuals.[510] Fourth, the Individual Development Account (IDA) initiative is designed to help low-income individuals and families who meet requirements set by the supporting foundation to become homeowners with a 3 to 1 match on funds to use for down payment or closing costs.[511]

The last two programs target homeless individuals with disabilities and their families. HUD-funded efforts, the **Shelter for All** and **Comprehensive Housing Counseling** programs, together provide one-on-one counseling, referrals, and specialized disability-related case management to eligible potential homebuyers. These services involve optional person-centered planning sessions that allow people with disabilities to gather

relevant people (family, advocates, etc.) to collectively identify goals and challenges and plan how to secure permanent housing.[512] As of May 2008, these homelessness-related efforts have served over 805 individuals.[513]

The Lease-to-Own Model: The Arc of the Central Chesapeake Region (formerly The Arc of Anne Arundel County), Maryland

The Arc of the Chesapeake Region in Annapolis, Maryland, a nonprofit service and support provider for people with developmental disabilities, started a project called **Opening Doors** in 1999, with a 2003 follow-up project called **More Doors to Open**. The Arc seeks to provide people with disabilities housing opportunities that are integrated, affordable, and emphasize self-determination. The Arc's housing efforts involve several components, including independent living counseling.[514] When Opening Doors began, the organization recruited four people with disabilities interested in living at a development through a lease-to-own model, and two others interested in renting other apartments. At the same time, the Arc helped people with disabilities attain Section 8 rental vouchers and State supports, published two guides related to housing for people with disabilities, and developed a "designated representative" role to allow a person with a disability to select someone to act on his or her behalf in housing matters.

The Arc's homeownership efforts culminated in a 56-unit complex named Homes at the Glen**,** the residents of which are restricted to 50 percent of Area Median Income.[515] Monthly rent payments include $15 payments to accounts that will be used to help buy the unit at the conclusion of the 15-year lease. Residents are responsible for home maintenance, volunteering, and taking part in self-governance activities. Service coordination and case management is provided by an agency funded by the Maryland Developmental Disabilities Administration. Anecdotal evidence suggests the Homes at the Glen initiatives have been very successful.[516] Resident comments are positive and they report satisfaction with living independently in places they have chosen, they volunteer and participate in other community activities, and they appear to have improved their employment and health stability.[517] Currently, the Arc is working to

expand its efforts with a new financial literacy program, a plan to replicate the program elsewhere, and by increasing the participation of communities of color.[518]

A combination of private, State, and local funds and support, together with innovative State policies, paved the way for the successes of the Opening Doors and More Doors to Open projects. Residents of the Homes at the Glen development benefited from Maryland's 1915(c) waiver, which allows States to offer Home- and Community-Based Services (HCBS) waivers that provide individuals with support (employment, direct personal care, home modifications, etc.) to remain in their own homes rather than in institutions. Direct grants came from private foundations, the Maryland Developmental Disabilities Council, and the Maryland Developmental Disabilities Administration.[519] The Maryland Department of Housing and Community Development (MDHCD) provided a second mortgage to the project and an annual allocation of $501,447 in equity-generating tax credit.[520] On the local level, the Anne Arundel County Housing Commission granted a $700,000 HOME loan, and the city of Annapolis and Anne Arundel County granted low payments in lieu of real estate taxes to make rent affordable. Another important State resource for this project was a 2002 MDHCD amendment to the State Qualified Allocation Plan.[521] The amendment provides bonus points in the competition for federal Low Income Housing Tax Credits (LIHTCs), as well as gap financing to applicants who build units for people with disabilities. LIHTC and gap-financing applicants who seek the points must reserve and market as much as 10 percent of the proposed project's units to people with disabilities for at least 30 days, beginning when the project is 80 percent complete. When completed, the project must be marketed exclusively to people with disabilities for 30 days.

Support for Independent Living

Neighbors, Inc., Franklin Park, New Jersey

Founded in 1995, nonprofit Neighbors, Inc., of Franklin Park, New Jersey, aims to support people with disabilities in living self-directed lives. Supporting more than 100 people in New Jersey and Pennsylvania, Neighbors emphasizes empowering individuals and their families rather than agencies, listening to people's aspirations and

working to realize them, and helping them find friends, jobs, and homes.[522] Based on the founders' experiences with agencies with costly offices and overhead, they selected an alternative model of organization and support.[523] With no central office, the staff is small, with an executive director, an agency director, and five advisors who coordinate support for five to seven people.

Neighbors employees view themselves as agents for the people they support.[524] To this end, Neighbors will work with anyone who chooses the agency to develop a support plan based on a budget determined by the individual. With support from Neighbors, many people who once lived in group homes or other institutions have been able to move on their own or with housemates into integrated housing that include apartments, condos, rentals, and homes they own.[525] Neighbors also provides daytime support for employment, volunteering, business ventures, and other community activities as alternatives to sheltered employment and day habilitation facilities. Meeting once a week or more, advisors assist each person with a variety of tasks, including hiring personal assistants (PAs), scheduling and managing PAs, and searching for employment or volunteer opportunities. By supporting people who may need assistance in managing PA services, Neighbors enables them to make use of another resource for increasing self-direction.[526] Finally, advisors also facilitate meetings between each person and his or her family, PAs, and case managers to further planning.

Neighbors has succeeded in supporting people with disabilities who want to live in integrated community settings. However, the organization faces challenges, such as limited funding, which mostly comes from State contracts through Medicaid waivers and private donations.[527] The Neighbors director explains that the flexibility and openness of relevant State officials to the organization's alternative service model and a New Jersey Division of Developmental Disabilities program called Real Life Choices assists the organization's work. Real Life Choices promotes greater self-determination through individual budgets, which it arranges through allocations from Medicaid waivers guided by individually based reviews of support needs.[528]

Onondaga Community Living (OCL), Syracuse, New York

Based in Syracuse, New York, Onondaga Community Living (OCL) is a nonprofit that seeks to "empower and individually support people with developmental disabilities in their efforts to live full lives as integral, respected members of their community."[529] Started in 1987, OCL's current efforts grew out of lessons learned from operating group homes. OCL staff perceived that such homes were not meeting the needs or desires of their residents. In an effort to individualize and personalize services, the organization closed two of the homes and implemented a support model based on the needs, desires, and aspirations of the individual. The support enables the individual to live in integrated housing that is neither linked to services nor removed from participation in the wider community.

OCL's support takes several forms, including residential support, which is provided to approximately 50 people throughout Syracuse and the surrounding area in both urban and rural settings.[530] This support helps individuals remain in their own housing, which includes rentals and homes they own or that are held in trust. Support ranges from a few hours per week up to 24 hours a day through OCL-facilitated live-in housemates. General support may include personal care, housekeeping, cooking, nursing, or other services, but emphasis is always placed on the belief that everyone's home life is different and that everyone has unique desires and needs. Support outside the home includes service coordination, vocational assistance, and an academic initiative that enables people to attend college classes and activities (e.g., labs and social events) at Syracuse University.

OCL's support services are funded through Medicaid waivers.[531] Historically, federal and State policies have not encouraged or emphasized person-centered residential support services. In the absence of such policies, the OCL's executive director attributes its successes to its personalized model and philosophy of support, as well encouragement from and the flexibility of the New York State Office of Mental Retardation and Developmental Disabilities. In light of the predominance of relatively traditional group and congregate homes and related service systems for people with

developmental disabilities, the State has nonetheless been open to alternative strategies for the use of funding. Further testifying to the promise of its support model, OCL is replicating its efforts elsewhere. To support greater numbers of people while remaining relatively small, the organization has developed a new organization called Connections of CNY, Inc., Syracuse, New York, which is currently in the process of raising start-up funds.

Options in Community Living, Madison, Wisconsin

Founded in 1981, the nonprofit Options in Community Living in Madison, Wisconsin, provides residential support to 102 people with developmental disabilities, ages 23 to 30. By using Section 8 rental subsidies, these individuals live in housing dispersed through the Madison metropolitan area, rather than remaining in congregate facilities. Approximately 45 of those participating in the program have roommates, 11 are homeowners, 2 live in homes held by family members on their behalf, and almost all the remaining individuals hold leases on rental units.[532] Options aims to support these individuals so they can participate as full community members. The organization does this by "approach[ing] support by building relationships with individuals," emphasizing each person's "hopes, dreams, and interests," and collaborating with family members when possible.[533] Intended to assist each person to "live life without life being about services," support is based on the model of self-direction.[534] The organization begins by carefully matching individuals seeking support with staff members who fit their personalities and can help address their needs. Service coordinators provide organizational oversight and help address challenges with other agencies, but the focus remains on the needs and desires of each individual being supported. Services, which range from a few hours a week to 24 hours a day, might include personal care, household management, dealing with a landlord, assisting with financial management or energy assistance, and access to transportation systems, including paratransit.

Options has benefited from strong county support, including a commitment to self-directed services and the county's exceeding the required match on Medicaid waiver funds available for services that promote dispersed housing.[535] The organization also

benefits from Wisconsin's relatively minimal requirements for service providers to qualify for funds from Medicaid waivers. The organization's director explains that this flexibility allows them to support people as active leaders in their own process, instead of having to follow conventional models focused on providing services to passive clients.

Recently, however, county budget cuts have undermined the organization's capacity. Consequently, in order to continue being supported, 11 individuals have moved to a 60-unit building with affordable units rather than remaining in housing dispersed throughout the community. Though this has allowed these individuals to continue with support, the organization views this "clustering" unfavorably, since it undercuts the commitment to dispersed, integrated housing and the principle of supporting individuals rather than groups.[536]

LifeLong Supportive Housing Program (Alameda County Health, Housing, and Integrated Services Network), Oakland and Berkeley, California

LifeLong Medical Care (LMC), which currently provides a broad range of health and social services to people of all ages, began as a storefront operation by the Gray Panthers, a senior citizens advocacy organization that merged with Berkeley Primary Care Access Clinic in the mid-1990s and rapidly expanded to become a community health center (CHC) with clinics located on five sites. LMC is a "safety net" provider of medical services to people who are uninsured and who experience complex health needs in Berkeley, Albany, Emeryville, and parts of Oakland, California.

LMC's Supportive Housing Program (SHP), also known as the Alameda County Health, Housing, and Integrated Services Network, is a collaboration of public and private agencies that provide permanent housing and social and health services to formerly homeless people with disabilities. SHP provides onsite support services to approximately 600 tenants living in eight subsidized housing sites scattered throughout Berkeley and Oakland. Services provided by SHP are optional and available to all tenants living in this housing. LMC collaborates with nonprofit housing development corporations that create and operate affordable housing in Alameda and

Contra Costa counties. Supportive services include outreach, intensive case management, housing stabilization, eviction prevention, benefits advocacy, money management, medical care, mental health and substance abuse services, community building and social activities, and employment and vocational support.

Affordable, Accessible, Integrated, Mixed-Use Housing Development

University Neighborhood Apartments, Berkeley, California

The nonprofit developer Affordable Housing Associates, Inc., built the University Neighborhood Apartments to increase affordable, accessible housing for individuals and families, including people with disabilities. All the apartments are designed using universal design principles and are fully accessible. Universal features include "one-story living; wide doorways and hallways; low countertops, cabinets, and keyholes; extra floor space to accommodate a wide turning radius; pull-out cutting boards; stoves with buttons on the front; push/pull lever faucets; and roll-in showers."[537] All the units are available to households with 30 to 60 percent of Area Median Income, including 20 project-based Section 8 units and 9 units designated for households that include individuals with disabilities.

This building consists of 29 apartments, residential common areas that include a multipurpose room, management and service spaces, a large outdoor courtyard, ground-floor commercial areas, and a tenant parking garage. The building is located on a main transportation corridor in the city of Berkeley and is approximately two blocks from the downtown area. The building is four stories, including three residential and one commercial story. A restaurant featuring ethnic African meals recently opened on the first floor of the commercial space. The 29 apartments are made up of 1 studio apartment, 3 one-bedroom, 14 two-bedroom, and 11 three-bedroom units.[538]

The building is designed so that all apartments are adjacent to a large interior central courtyard, which includes natural landscaping, seating, and a play area. A multipurpose/community room is located near the outdoor courtyard and offers a computer work area, service office, and kitchenette. The multipurpose room is used for

educational classes, computer workstations, crafts, exercise classes, social gatherings, and meetings. The services office is used for counseling and for coordinating educational classes. A laundry room is located on the first floor and the manager's office is located adjacent to the courtyard.[539]

The development was funded by Bank of America, N.A., the Low Income Housing Tax Credit program, the State of California's Multifamily Housing Program, the Federal Home Loan Bank, Alameda County Housing Opportunities for People with AIDS, the city of Berkeley's Housing Trust Fund Program, and a HUD 108 loan. A California Housing Enabled by Local Partnerships Program loan was made by the city of Berkeley to assist with the initial acquisition of the property site.

Helios Corner, Berkeley, California

The nonprofit developer Satellite Housing, Inc., built Helios Corner, which provides affordable senior rental housing. All 80 units are affordable to seniors with incomes between 30 and 60 percent of Area Median Income. All units can be adapted for accessible features, 10 units are already accessible, and 40 units are project-based Section 8. Two of the accessible units also include features that enhance access for people with sight and/or hearing impairments, such as blinking doorbells and louder-than-average buzzers.

This four-story mixed-use building consists of three residential levels above 5,900 square feet of ground-floor commercial/office space and parking. The site is within short walking distance of community services and amenities, and is surrounded by a mixture of uses—single-family neighborhoods are to the north and west, and neighborhood commercial settings are to the south and east. A bus stop is located outside the front steps of the apartment complex and the North Berkeley BART station is just two blocks away.

The building consists of ground-floor office space for Satellite Housing and the Salvation Army. The main floor of the building houses the property manager's office, the service

coordinator's office, a multipurpose room, and a large community room with a landscaped courtyard that is open to residents for daily recreational activities, family gatherings, community parties and meetings, movies, music, and classes. Satellite Housing focuses on tailored coordination, case management, and referral by its in-house service coordinators who work directly with service providers to ensure residents are able to access the services they need. Supportive services are also available onsite.

The development was financed by Low Income Housing Tax Credits, Silicon Valley Bank, the Federal Home Loan Bank, and city of Berkeley Housing Trust Fund. A California Housing Enabled by Local Partnerships Program loan was made by the city of Berkeley to assist with the initial acquisition of the property site.

Housing Cooperatives (Co-ops)

Housing Cooperatives allow residents to own and control their apartment through a corporation in which they own stock and are actively involved in management and programming. Maintaining affordability is difficult, but it may be achieved by restricting resale prices, as in the case of Limited-Equity Cooperatives (LECs). Collectively owned and governed, LECs cap resale prices of shares by either regulating the resale price or the income levels of buyers.[540] A significant percentage of housing in Scandinavian countries, LECs are also growing in significance in the United States. A 2003 survey by the National Association of Housing Cooperatives reported 425,000 limited- and zero-equity co-ops throughout the nation.[541] LECs enable stable affordable housing and the security this ensures, greater levels of tenant control and satisfaction, and neighborhood revitalization in economically depressed areas.[542]

LECs have promise for people with disabilities as a means to self-determination and affordable, accessible, integrated housing, with the possibility of support and services as needed. Services may or may not be offered onsite, can be informal or formal, and might involve either joint purchasing and/or scheduling of services or a coordinated and managed services program staffed by community agencies or the cooperative itself. Potential benefits for low-income people with disabilities include a relatively low financial

investment and greater control over housing and the environment.[543] Moreover, research on Canadian LECs reveals that there they provide accessible, affordable, and integrated housing for people with disabilities.[544] Anecdotal evidence from the United States suggests these findings hold elsewhere. A resident of the integrated and accessible Connecticut LEC, A Common Thread Cooperative, in Manchester, Connecticut, observes that her co-op is cheaper than an apartment, enables her to influence the decisions of an active community, and allows her to participate in networks of mutual support among neighbors.[545] She adds, "If I get in a jam, I know people I can call. I know all my neighbors. I know they will be there for me."[546]

Penn South Cooperative, New York, New York

Penn South Cooperative, New York, New York, is a Limited-Equity Cooperative built in 1961 with 2,820 units, 6,200 residents, and 15 buildings spread over 20 acres. With the co-op geared toward individuals with low to moderate incomes, 55 percent of co-op residents have gross incomes under $40,000.[547] To preserve affordable rent, the co-op has also secured "shelter-rent" status from the city of New York, which bases property taxes on property income rather than value. With more than 50 percent of its residents over the age of 60, Penn South is also a Naturally Occurring Retirement Community (NORC) (see NORC, below).[548] As residents began to age, the co-op set up a collaborative program with community agencies to provide supportive services. Now a separate nonprofit agency offers cultural and educational programs, case management, home care services, personal care, primary health care and wellness services, and a variety of other supportive services. All buildings are accessible, and people with disabilities make individualized access modifications to their units as needed.

Aging in Place

The "aging in place" movement is driven by the insight that most individuals prefer to remain in their homes rather than move to nursing homes or other facilities as they grow older. A 2005 AARP nationwide survey found that 89 percent of people ages 50 and over want to remain in their homes as long as possible.[549] Aging in place is made possible when individuals have access to appropriate support and services, including

home modifications. Different models embody various aging in place ideals. All these models, however, recognize the preferences of people who wish to remain in their own homes in the context of an integrated community that mitigates social isolation and enables the accessibility and affordability of home care and personal assistance, house maintenance, shopping, and transportation.

Prominent examples of aging in place models include the “Village” and Naturally Occurring Retirement Communities (NORCs). A relatively new concept, Villages are community-initiated, -governed, and -operated organizations designed to meet the long-term support needs of older adults in the neighborhoods where they live. The Village model was initiated by Boston’s Beacon Hill Village, which is creating a technical assistance support center in conjunction with the nonprofit NCB Capital Impact to support Villages throughout the nation.

NORCs are typically defined as a geographic area, neighborhood, or building originally inhabited by people of all ages, which has evolved over time to contain a high proportion of older adults. In many NORCs, residents have collaborated with community service providers to develop supportive services that respond to the evolving requirements of aging residents. NORCs frequently provide supportive services to all residents regardless of income, disability, or health status.

Vladeck Cares/NORC Supportive Services Program, New York, New York

Vladeck Cares/NORC Supportive Services Program is operated by the Henry Street Settlement, which delivers a wide range of social services to New York residents. Henry Street Settlement’s NORC program brings comprehensive supportive services to the Lower East Side community’s older residents in response to their unique needs and cultural diversity. Vladeck Cares serves seniors living in Vladeck House, a public housing project with 27 buildings and 3,000 residents, 860 of who are elderly, many with disabilities.

The Vladeck Cares/NORC Supportive Services Program is a financial and cooperative partnership between the Henry Street Settlement and the New York City Housing Authority. This model brings social and health care services to Vladeck House, the first NORC located in public housing. Funded by the city, the State Department on Aging, and private sources, the program provides preventative health and social services, medical and health services, case management, mental health counseling, and educational and cultural opportunities.[550] The Vladeck NORC program helps develop, host, and link supportive services because they increase the autonomy and independence of seniors living in the community. In turn, the supportive services are able to provide more organized and comprehensive care to the populations they serve.

Increasing Very Low Income Housing Through the Low Income Housing Tax Credit (LIHTC) Program

The LIHTC program, which is based on Section 42 of the Internal Revenue Code, was enacted by Congress in 1986 to provide the private market with an incentive to invest in affordable rental housing. Federal housing tax credits are awarded to developers of qualified projects, who then sell these credits to investors to raise capital (or equity) for their projects, which reduces the debt that the developer would otherwise have to incur. Because the debt is lower, a tax credit property can, in turn, offer lower, more affordable rents.

Provided the property maintains compliance with the program requirements, investors receive a dollar-for-dollar credit against their federal tax liability each year over a period of 10 years. The amount of the annual credit is based on the amount invested in the affordable housing.[551] State Housing Agencies allocate LIHTCs through a competitive process. These agencies must develop an annual plan, called a Qualified Allocation Plan (QAP), for allocating the credits that is consistent with the State's Consolidated Plan. QAPs establish criteria for awarding points in the competition for tax credits, and they tend to vary greatly across the States because they are often written to meet State priorities. Federal law requires that a QAP give priority to projects that serve the lowest-income families, and are structured to remain affordable for the longest period of time.

Federal law also requires that 10 percent of each State's annual housing tax credit allocation be set aside for projects owned by nonprofit organizations.[552]

Typically, LIHTCs have not been used to create housing for the lowest-income groups, including people at or below poverty level. In most States, only up to 10 percent of LIHTCs are targeted at people at or below 30 percent of AMI.[553] That is changing, however. To meet a demand that outpaces the supply, some States are increasing the number of units for individuals whose income is at the SSI level by awarding points for projects that target units for those individuals. LIHTCs hold a similar promise for people with disabilities, including very low income and low-income people with disabilities. Recent nationwide financial difficulties may have affected the demand for LIHTCs, but a revitalized housing market should reinvigorate this lag.

North Carolina LIHTC Development

Stemming from cooperation between the North Carolina Department of Health and Human Services and the North Carolina Housing Finance Agency, the State's QAP requires that all LIHTC developments must develop a Targeting Plan that reserves 10 percent of total units for people with disabilities or homeless populations, and at least five units must be reserved regardless of development size.[554] Furthermore, 5 percent of all units in new developments must be fully accessible beyond federal and State accessibility requirements. Also required is a memorandum of understanding among all relevant parties (the developer, property manager, and local lead agencies) to ensure the availability of and access to supportive services and accommodations for residents. Further safeguards include marketing priorities and vacancy reservations for people with disabilities for 90 days after the units are finished. Importantly, tenancy cannot be conditioned on participation in these supportive services.

Targeting units for people with disabilities within LIHTC-financed properties is a promising strategy for ensuring housing accessibility, affordability, integration, and the delinking of housing from services.[555] Because North Carolina's housing initiatives for people with disabilities center on LIHTCs, they remain reasonably insulated from

fluctuating State budgets. They have also supported the construction of substantial numbers of affordable housing. Between 2002 and 2006, approximately 900 units with voluntary services for people with disabilities were funded.[556] Other States have replicated these efforts. The Louisiana Housing Finance Agency, for example, is administering a tax-credit initiative for people with disabilities intended to create up to 3,000 units of housing with voluntary services.[557]

Disability Organizations Advocate for Very Low Income Housing with LIHTCs

Boston's Disability Law Center (DLC) and nine Independent Living Centers throughout Massachusetts filed comments with the Massachusetts Department of Housing and Community Development (DHCD). These organizations called for more housing resources under the LIHTC program to be set aside for very low income people with disabilities, even though the Massachusetts LIHTC program had exceeded the national average by requiring that 10 percent of all LIHTC target households whose incomes are at or below 30 percent of the Area Median Income (AMI). DLC and the ILCs recommended that an additional 10 percent of the units be targeted for people with disabilities with SSI-level incomes (well below 30% of AMI) through project-based vouchers. They also called for developers who are awarded LIHTC as a result of the competitive process to be required to submit a plan to ensure that the additional 10 percent of the units be made available to very low income individuals with disabilities. To ensure people with disabilities are integrated, the DLC and ILCs recommended that Massachusetts establish a policy that calls for LIHTC projects to ensure integration by having no more than 15 percent of the total units in a project occupied by people with disabilities (absent a compelling programmatic reason to do otherwise). Finally, the groups called for visitability to be a threshold requirement for all new construction and renovation of existing housing units.

Increasing Accessible, Integrated, Supportive Housing Through Legal Advocacy

Laguna Honda Hospital Settlement, San Francisco, California

A class action settlement in the civil rights class action lawsuit *Chambers et al. v. City and County of San Francisco,* filed to prevent unnecessary institutionalization of people with disabilities at Laguna Honda Hospital, promises to greatly increase community-based housing and service options in San Francisco and improve coordination of care. The settlement creates an innovative program to coordinate services across city departments, enabling San Franciscans with disabilities who live at, or are referred to, Laguna Honda, one of the country's largest nursing homes, to instead receive community-based housing and services. Eligible individuals will be assessed for, referred to, and provided with subsidized housing, personal assistance, nursing care, case management, substance abuse treatment, mental health services, and assistance with meals.

Several hundred Medi-Cal Home- and Community-Based Waiver slots, which allow people to receive long-term health care in their homes instead of in institutions, will be made available to those who qualify. Another innovative aspect of the settlement agreement is the development of a rental subsidy program, through which San Francisco will, over the next 5 years, secure and subsidize scattered-site, accessible, independent housing for approximately 500 people with disabilities and seniors who are eligible for community-based services.

Fair Housing and Americans with Disabilities Act Housing Access Settlements

Based in Washington, D.C., the Equal Rights Center (ERC) conducted a survey of multifamily construction covered by the Fair Housing Amendments Act (FHAA) and ADA. The survey uncovered widespread violations by some of the largest American apartment and condominium developers. Several sets of surveys, reaching about 390 properties throughout the Washington, D.C., metro area and several States, uncovered some form of FHAA accessibility noncompliance in 100 percent of those properties.[558]

Following up on this research, ERC initiated in-depth investigations into the practices of several prominent developers that led to a series of lawsuits and settlements.

By using litigation and related negotiations to ensure compliance with fair housing regulations, ERC has effected the retrofitting for federally mandated accessibility of more than 20,000 units in multifamily homes throughout the United States.[559] These legal successes have also yielded benefits beyond accessibility in a substantial number of homes. One of these settlements, with Trammell Crow Residential, led the developer to contribute $1.5 million to support ERC's Multifamily Housing Resource Program, which promotes compliance with housing laws through training and education, best practices, and compliance monitoring. Following another settlement that resulted in the retrofitting of more than 2,000 units, the developer, Bozzuto & Associates, adopted accessibility standards in townhomes and single-family homes that go beyond federal requirements.[560] These features draw on "aging in place" concepts and include no steps between areas in the same level, wide hallways and entries, accessible doorbells, handrails, and at least one wheelchair-maneuverable main level bathroom. Bozzuto committed to incorporating these features for at least 5 years in 75 percent of its upper-level garden-style condominium units and 50 percent of its single-family homes and townhomes.

Universal Design

6 North Apartments, St. Louis, Missouri

6 North Apartments is one of the nation's first examples of a multifamily residential building featuring 100 percent universal design (UD). All 80 of the project's one- and two-bedroom apartments—as well as its common spaces, coffeehouse, and live/work units—are fully usable by people with and without disabilities. The residential/mixed-use and mixed-income building is located at the corner of Laclede Avenue and Sarah Street in St. Louis's central-west end. UD features incorporated at 6 North include stepless entries, open floor plans, adjustable countertops and shelves, and high-contrast color and surface texture schemes. The three-story project contains 56 percent market-rate

and 44 percent affordable units. As of 2006 it was fully leased, with eight apartments currently occupied by households that include at least one disabled member.

The project was spearheaded by Brinkmann Construction and real estate developer McCormack Baron Salazar. The project apartments and the concept for creating universal design were in the making for several years at McCormack and arose out of a need for affordable housing in the city and effective advocacy by Paraquad, the local Independent Living Center. The $12.9 million development was funded in part by U.S. Bank, a $540,000 loan from the Missouri Housing Commission, and the St. Louis Affordable Housing Commission.[561] The project was awarded the John M. Clancy Award for Socially Responsible Housing.

University Neighborhood Apartments, Berkeley, California

The nonprofit developer Affordable Housing Associates, Inc., built the University Neighborhood Apartments to increase affordable, accessible housing for individuals and families, including people with disabilities. All the apartments are designed using universal design principles and are fully accessible. All the units are available to households having 30 to 60 percent of Area Median Income, including 20 project-based Section 8 units and 9 units designated for households that include individuals with disabilities. Fourteen of the apartments are set aside for tenants with disabilities. (See above for additional information about this project.)

Universal Design and Visitability: Mandatory and Voluntary Policy Models

As of January 2008, the Rehabilitation Engineering Research Center (RERC) on universal design, School of Architecture and Planning, at the State University of New York at Buffalo, reports that 37 U.S. cities have adopted either voluntary or mandatory requirements for some level of universal design or visitability. These policies vary widely in terms of the type of homes to which the policies apply, building specifications, and whether the requirement is triggered only when federal, State, or local subsidies are involved. According to RERC, 15 cities have adopted voluntary policies and 22 have

mandatory rules. Estimates by RERC and also by Concrete Change indicate that nearly 30,000 homes have been constructed that include visitability-related aspects of accessibility (e.g., zero-step entries, 32-inch-minimum interior doorways, levered handles, reinforced bathrooms for later grab bar installation, lowered electrical controls.)[562] Several of these policies are highlighted below.

Concrete Change and Habitat for Humanity, Atlanta, Georgia

Beginning in 1987, the group Concrete Change developed a principle called "basic home access," later known as "visitability," and promoted it to housing developers and others. The basic features of visitability include a zero-step entrance, wide interior doors, and a half-bathroom on the main floor.[563] In 1989, Concrete Change persuaded the Atlanta chapter of Habitat for Humanity to include this basic access in new homes. By early 2006, Habitat Atlanta had built more than 600 visitable houses.[564] In 1992, following outreach efforts by Concrete Change, the city of Atlanta passed the first U.S. visitability ordinance, requiring basic visitability in all private single-family homes and duplexes that receive tax incentives, city loans, land grants, fee waivers, and/or federal block grants.[565] Because of the ordinance, more than 600 homes have been constructed in Atlanta in compliance with the visitability standard as of 2002.[566] Moreover, similar requirements have been passed in cities throughout the United States, as well as at the State level in Texas, Georgia, and Kansas. Visitability standards have been successfully replicated because of their affordability, especially when compared to the cost of retrofitting, among other reasons. While visitability dramatically expands the number of people who can visit or live in a house, the costs at the time of construction are relatively small. Concrete Change estimates that a zero-step entrance on a concrete slab should cost around $200, with an extra $50 for expanded doors.[567]

Minimum Universal Design Requirements for New Construction Using Affordable Housing Trust Funds from the City of St. Louis

In 2004, the city of St. Louis adopted policy to require that universal design principles be applied to new construction using Affordable Housing Trust Funds. All developers hire a

registered project architect to produce detailed construction drawings prior to commencing construction and to oversee construction of the project. All new construction projects require written architectural certification at the time of application, at execution of the loan agreement, and at closeout by the project architect and the developer that the project is designed and built in compliance with universal design requirements. If construction begins prior to the review of the required documents, affordable housing funds may be revoked. The first certification requires that the project will be drawn and built in compliance with universal design requirements. Following the awarding of funds and prior to construction, the developer and architect must sign a second certification that includes a verification checklist.[568]

Design for Life Montgomery, Montgomery County, Maryland

Design for Life Montgomery is the first voluntary certification program in Maryland for visitability and "livability" in single-family attached and detached homes located in Montgomery County. Its guidelines apply to both new construction and renovation of existing homes. The program features two optional standards of accessibility and is voluntary, following the National Association of Home Builders' guidelines that support voluntary programs. New construction and renovation of existing homes are targeted by the program, which represents a successful informal partnership involving county, building, and business interests and advocates. The program is administered by the county as part of the regular permitting process and is not a special process. A checkbox for review and certification can be found on the standard application for permit, and there are no additional permitting costs beyond the standard fees.

The program started in March 2007. As of August 2008, 12 permits have been issued. Eight are for new construction, three for additions to existing buildings, and one for alteration of an existing structure. The program generally follows visitability principles and does not meet FHAA or ADA requirements or universal design guidelines.

California Model Universal Design Ordinance

Assembly Bill 2787, enacted in 2002, requires the California Department of Housing and Community Development to develop and certify one or more model universal design ordinances applicable to new construction and alterations for voluntary adoption by cities and counties. The department's model ordinance identifies rooms and denotes features that must be offered by a builder in residential units subject to the ordinance that are being newly constructed or substantially rehabilitated, but are only installed if requested by the buyer/owner and which would not cause an unreasonable delay or significant nonreimbursable costs to the developer or builder. In general, the model ordinance provides (1) definitions for critical terms, (2) local option as to types of units (owner-occupied and/or rental) and number of units, and (3) specific exemptions and enforcement mechanisms.

While voluntary models like A.B. 2787 and Design for Life Montgomery do not have the same impact as mandatory requirements, they are often important first steps, spurring the testing of a new concept that brings needed attention to the issue, while demonstrating it is both affordable and practical. They eventually contribute to the critical mass that is needed to generate stronger legislation or adoption of more comprehensive policies.

Conclusion

Housing for people with disabilities is not simply a matter of bricks and mortar. Creating and sustaining safe, accessible, affordable, and integrated housing can involve challenging and complex barriers that arise from the interaction of poverty, inaccessibility, Byzantine funding rules related to acquiring supportive services, and a disability policy system rooted in the outmoded model of segregating people with disabilities from the mainstream community. Potential best practices and models that respond to the most intractable barriers almost always involve public policy that supports, or can be interpreted to support, a particular solution, multiple public and private funding sources, local ingenuity and community commitment, and, in some situations, the courts. While examples of effective housing solutions exist, they generally are not yet sufficiently scaled to meet the need. For example, progressive nonprofit developers are responding to demands from the disability community and others for affordable, accessible scattered-site housing, yet they can only provide homes for a small number of the people who need and want them. Such a development opened recently in northern California, where 3,000 low-income individuals applied for 79 apartments,[569] illustrating that the demand for affordable housing among people with disabilities and other low-income communities far outstrips what is available, and that many locales are unable to meet such needs.

Some low-income people with disabilities have been able to purchase their own homes. Yet, while the actual number of people who have become homeowners is not known, it is likely to be small, and the hurdles that prospective buyers encounter, such as securing financing, can be daunting. Although commercial rental housing is generally readily available in most locales, it is frequently unaffordable for many people with disabilities. The cost of most market-rate housing in the United States exceeds the entire monthly budget of people with disabilities living on SS-level incomes. The single greatest barrier to the efforts of people with disabilities to acquire homes of their own may be the combination of too little subsidized housing and inadequate federal, State, and local funding for Housing Choice Vouchers that close the gap between very low

incomes and housing rental costs. Furthermore, most market-rate housing also lacks basic accessibility, and some private building industry groups oppose additional mandatory accessibility requirements for new home construction. Bureaucratic complexities tied to acquiring funding for supportive services, such as personal assistance, provided outside of institutional settings add additional challenges and layers of difficulty. Many people with disabilities therefore continue to face dire problems acquiring appropriate housing.

At a minimum, long-range solutions must include comprehensive changes in public policy. Such changes include substantially increasing funding for housing vouchers, creating incentives for inclusion of housing units for very low income people with disabilities in all federal and State programs that support housing development and construction, and adopting accessibility standards and universal design principles for all home construction by States, counties, and cities, as well as by the building and housing construction industry.

Although serious problems remain, some notable successes suggest that momentum is building for broader reforms. For example, the movement for housing to be constructed according either to universal design or visitability principles appears to be gaining currency. Designers, architects, and homebuyers are growing increasingly interested in these principles. Thirty-seven cities across the nation have adopted either mandatory or voluntary policies that are beginning to generate results: because of such policies, roughly 30,000 homes have been constructed with some level of accessibility.[570] These advances are serving as models for other locales that demonstrate that features like visitability can be achieved without undue cost or administrative burden. As part of the recovery plan developed following the devastation wrought by Hurricane Katrina, Louisiana plans to create 3,000 new supportive housing units for people with disabilities using multiple sources of funding.

Exemplary models of scattered, affordable, accessible mixed-income and mixed-use housing are being created by for-profit and nonprofit developers that set the bar for what can be accomplished. Other housing models are evolving that hold promise for people

with disabilities, including Naturally Occurring Retirement Communities (NORCs) and Limited-Equity Cooperatives (LECs). Supportive living programs ensure that people with disabilities receive the help they want and need to live as independently as possible in their own homes. The evolution of these programs nationwide has helped significantly reduce the number of people who are forced to live in restrictive institutions. Much remains to be done, but these and other areas of progress reveal that an important shift is taking place that eventually will lead to an increase in and improvement of housing and supportive service options for people with disabilities.

Recommendations

1. **Congress should pass legislation to modernize the Section 811 Supportive Housing for Persons with Disabilities program.**
   The Section 811 Supportive Housing for Persons with Disabilities program (Section 811) provides capital funding and project rental assistance for nonprofits to develop new permanent supportive housing for people with disabilities. Section 811 is the only HUD permanent Supportive Housing Program exclusively serving people with disabilities. H.R. 5772, the Frank Melville Supportive Housing Investment Act of 2008, was passed unanimously by the U.S. House of Representatives in September 2008 and has been reintroduced in 2009 as H.R. 1675. The bill will create a Project-Rental Assistance demonstration program to expand the supply of permanent supportive housing for low-income people with disabilities by including integrated supportive housing units in federal LIHTC- and HOME-funded properties that also provide housing for people without disabilities. It will also permanently set aside rental subsidies for people with disabilities and authorize that these vouchers be permanently funded through the Housing Choice Voucher program.

2. **Congress should increase Housing Choice Voucher funding targeted to people with disabilities.**
   The HUD FY 2008 and 2009 budgets both contained $30 million in appropriations for an estimated 7,000 new Housing Choice Vouchers. These funds offer a new opportunity for collaboration among State and federal agencies and Public Housing Agencies to establish initiatives that support the goal of increasing community integration for people with disabilities. Such integration can be achieved by using Housing Choice Vouchers to close the gap between the cost of market-rate housing and the very low incomes of many people with disabilities. However, the increase is still insufficient to ensure that many who need assistance will receive it. Additional funding for

Housing Choice Vouchers is required annually to ensure that those with the lowest incomes can compete successfully for units in the private rental market.

3. **States should call for an increase in HOME funds to allow for the allocation of more funds for Tenant-Based Rental Assistance by participating jurisdictions when developing Consolidated Plans.**
The HOME program is one of the largest federally funded housing programs that affect low-income people with disabilities. HOME funds can be used for new construction, rehabilitation, homebuyer assistance, and Tenant-Based Rental Assistance. State agencies receive about 40 percent of the total HOME funds and the remaining 60 percent is divided among local participating jurisdictions, based on the size of their populations. Only about 2 percent of HOME funds are used for Tenant-Based Rental Assistance.[571] Income targets for HOME funds vary dramatically by State and are discretionary within specific limits. In light of the extraordinary need for rental assistance by very low income people with disabilities, States should identify the need to increase use of HOME funds for this purpose when developing Consolidated Plans.

4. **Housing authorities should participate in HUD-approved programs to assist low-income people with disabilities to pursue homeownership using Housing Choice Vouchers as one source for funding.**
Congress and HUD have authorized Public Housing Agencies throughout the country to work with and assist low-income individuals and families in purchasing their homes, yet fewer than 800 housing authorities out of nearly 3,000 have done so.[572]

5. **States should adopt policies that award points under the Low Income Housing Tax Credit (LIHTC) program for projects that (1) target housing units for people with disabilities whose incomes are either at the SSI level or at less than 30 percent of AMI for the area, (2) include visitability features in all projects, (3) include Universal Design principles in all designs, and (4) ensure integration by limiting the total units in a project occupied by people with disabilities to 15 percent, unless there exists a**

compelling reason to do otherwise.

Historically, LIHTCs have not been targeted to individuals with the lowest incomes. States should use the demand for tax credits, where it exists, as a mechanism to leverage developer interest in projects that are targeted to very low income people with disabilities, feature elements of visitability and universal design, and promote integration.

6. **Congress should amend the Assets for Independence Act (P.L. 105–285) to specifically include individuals with disabilities among the target populations, require related reporting from Assets for Independence (AFI) projects to include information on participants with disabilities, and encourage funders who match AFI dollars to eliminate categorical restrictions that serve as additional barriers to participation by people with disabilities.**

   The Assets for Independence Act, which established an assets-based approach to assist targeted low-income individuals to move out of poverty, does not specifically identify individuals with disabilities as a target population. While some people with disabilities may be eligible based on income, AFI projects do not collect and report data on people with disabilities who participate in the program. Furthermore, some sources that provide matching funds target specific subpopulations, which create additional barriers for people with disabilities who do not meet these criteria.

7. **Disability organizations should actively participate in HUD's Consolidated Plan process in order to help expand homeownership and affordable rental housing for people with disabilities.**

   State and local officials and Public Housing Agencies must create strategic plans that identify how the jurisdiction will use federal housing funding to meet the affordable housing needs of the community. The plans also identify which population groups will receive priority for federally subsidized housing units and housing vouchers. Disability community involvement is critical in order to ensure that the housing needs of people with disabilities are both considered and met.

8. **Public and private entities such as HUD, State and local housing agencies, private foundations, and housing referral and advocacy organizations should form a partnership to establish and fund a new disability and housing technical assistance initiative.**
   In order to become more involved in the process of developing affordable housing for people with disabilities, disability organizations need access to information, technical assistance, and examples of successful strategies that will enhance their capacity to participate effectively in efforts to establish integrated, affordable, and accessible housing. They also need information that will enable them to become involved with State and local activities that promote affordable housing and to integrate the needs and interests of people with disabilities into well-established State and local fair housing networks. A national housing technical assistance center would fill this role. It could also undertake targeted research on topics including potential advantages and drawbacks of housing models, such as Limited-Equity Cooperatives and other co-ops, as housing alternatives to single-family homes, lifelong rentals, and congregate housing.

9. **Public and private entities (examples as named above) should form a partnership to establish and fund an active housing registry.**
   The need for affordable accessible housing is significant, yet people with disabilities do not have access to a coordinated, accurate, and up-to-date source of information about accessible and affordable rental units, units designated as rentals with options to purchase, and accessible and affordable homes for sale nationwide. Such a service would ensure that people seeking housing have the option to consider available units in their geographic area and to take appropriate steps to establish eligibility and gain access to these units.

10. **Public and private partners should draw on the experience of the Arc of the Central Chesapeake Region, Maryland, to create other lease-to-own projects for very low income people with disabilities.**
    This lease-to-own model appears to offer very low income individuals with

disabilities a unique homeownership option. The model provides a long-term lease, and a portion of the rent is applied toward the eventual purchase of the rented unit. People with disabilities are currently using this program to purchase homes. This model should be replicated by private and public partners in other States to determine if it will achieve effective outcomes in situations with different geographical and demographic characteristics. Federal incentives should be established to spur the evaluation and development of this model.

11. **Congress should increase funding for HUD's Fair Housing Initiatives Program (FHIP) to ensure enforcement of the Fair Housing Act's accessibility requirements.**

    Such funding will allow a significant increase in the presence and effectiveness of FHIP. By supporting organizations to partner with HUD in addressing housing discrimination complaints, the program can improve public awareness about fair housing rights and support increased fair housing enforcement. Disability-based complaints make up the largest percentage of fair housing complaints filed with HUD. Additional support for FHIP will help to bolster the currently inadequate enforcement of fair housing laws, thus alleviating some of the systemic difficulties people with disabilities face in finding homes of their own.

NCD Topical Brief #3

Mental Health Issues—
Housing for People with
Psychiatric Disabilities

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Introduction

Housing for people with psychiatric disabilities continues to be a largely unmet need in America, with tragic results. A national survey conducted in 1996 found that more than 40 percent of homeless people reported mental health problems.[573] Insufficient housing, in turn, contributes to the large number of incarcerated people with psychiatric disabilities.[574] A report issued in 2006 by the Federal Bureau of Justice Statistics found that more than half the nation's prison and jail inmates have a mental health problem.[575]

The lack of adequate housing for people with psychiatric disabilities is particularly compelling in the face of emerging consensus that recovery from mental illness is possible, and that stable housing provides a foundation for achieving it.[576] This report will briefly trace the evolution of housing for people with psychiatric disabilities, describe some of the models of housing currently in use, highlight best practices, and recommend policy changes needed to provide the type of housing that is most conducive to recovery and that provides the greatest degree of dignity and integration for people with psychiatric disabilities.[577]

Setting the Stage: Deinstitutionalization and Board and Care Homes

Housing for people with psychiatric disabilities is a relatively recent public policy concern. Before the 1960s, people diagnosed with serious mental illness were considered incapable of living outside of institutions. Most residents in mental institutions lived there for many years, receiving custodial care rather than treatment. In 1956, 559,000 people diagnosed with mental illness lived in public institutions.[578] The development of psychotropic medications, a desire to save public funds, and growing concern about conditions in institutions led to a nationwide movement to deinstitutionalize hospital residents.

By 1980, the number of people diagnosed with mental illness living in public institutions had been reduced to154,000.[579] People released from mental institutions were supposed to receive treatment and support services in the community, but the promise of community-based treatment proved illusory, and the lack of support services coupled with the dearth of affordable housing swelled the ranks of people with mental illness living without shelter. Those who were unable to negotiate the streets often found themselves reinstitutionalized in nursing homes or correctional facilities.

The need for housing for people with psychiatric disabilities sparked the development of a new type of institution called the board and care home.[580] Board and care homes range in size from 2 to more than 200 residents, with the majority housing more than 50 people. They provide 24-hour supervision and food to residents.

Most board and care homes function as mini-institutions within the community. They provide very little privacy, a limited scope of services, and little opportunity to interact with people without disabilities in the community. In most board and care homes, residents have no opportunity to exercise choice in their day-to-day lives over roommates, meals, bedtimes, or other daily functions. Few board and care homes help residents develop independent living skills or move on to independent housing.[581] Virtually all resident income goes directly to the home, making it impossible for residents

to save sufficient funds to consider moving to private housing.[582] "In such settings, residents who receive only SSI [Supplemental Security Income] are typically required to turn over their entire monthly benefit check, and they get back a personal needs allowance of as little as $25 per month to cover all expenses beyond room and board."[583]

Approximately 330,000 people with psychiatric disabilities live in board and care homes. There is little oversight, most homes are unlicensed, and there have been multiple press stories about abusive conditions in board and care homes.[584] Board and care homes are not designed to lead to recovery—they simply filled the housing gap created by deinstitutionalization.

The dearth of affordable alternatives also keeps people trapped in board and care homes. "In 2006—for the first time—national average rents for both one-bedroom and efficiency units were more than the entire monthly income of an individual relying solely on SSI income. As growth in the cost of modest rental housing continued to outpace cost-of-living increases in SSI payments, the national average rent for a one-bedroom apartment rose to 113.1 percent of monthly SSI—up from 109.6 percent in 2004."[585]

It is important to note that providing rental subsidies for existing units rather than funding new construction is the fastest and most cost effective way to address the lack of affordable housing for people with psychiatric disabilities. As discussed below, rental subsidies also facilitate community integration and other benefits. However, the need for affordable housing is great, so all possible strategies should be used to create it. For example, the use of creative strategies, such as inclusionary zoning requirements for new construction, should be used alongside rental subsidies for existing housing to maximize the number of affordable housing units for people with psychiatric disabilities.[586]

Although most mental health housing is congregate, studies have repeatedly shown that people with psychiatric disabilities prefer to live in integrated housing where they can exercise choice over the type of supportive services they receive.[587]

> Participants wanted services that emphasized social interaction and the development of social networks. Survivors described a variety of supports such as peer supports, employment supports, family, friends, and professionals as essential components of a support network. Survivor organizations, peer support, and drop-in centers were all seen as examples of services that can specifically address the issues of isolation and loneliness.[588]

The exercise of choice over housing and support services and the quality of housing, in turn, lead to better outcomes, because they are "important contributors to the subjective quality of life and adaptation to community living of people with mental illness…."[589]

Olmstead and the Embrace of Recovery

In 1999, the Supreme Court decided a case that upheld the right of people with disabilities to integrated housing. *Olmstead v. L.C.*[590] involved two women with mental disabilities who had been voluntarily admitted to Georgia Regional Hospital in Atlanta. Although their doctors determined that the women were ready for release to community care, they were not offered community placements by the State, so they sought relief through the courts. When their case finally reached the Supreme Court, it ruled that unnecessary segregation constituted discrimination under the Americans with Disabilities Act.

In reaching its decision, the Supreme Court noted that ADA explicitly identifies unjustified segregation as a form of discrimination,[591] and that ADA's implementing regulations state that "[A] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[592] The Court stated that the regulations define such a setting as one that "enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."[593]

Hence, in assessing whether housing for people with psychiatric disabilities meets ADA's integration mandate, a key determination is whether the housing facilitates and maximizes the residents' ability to interact with people without disabilities. The Court underscored the importance of integration by describing the harm caused by segregation:

> Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.[594]

The *Olmstead* decision added support to a concept that emerged from the psychiatric survivor movement: that recovery from mental illness is possible, and that housing and support services should be designed to support it. The recovery concept was embraced by the President's New Freedom Commission on Mental Health, which was charged by President George W. Bush in 2002 with recommending policies to help States embrace the goals of the *Olmstead* decision. The commission's final report defined recovery as: "The process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms."[595] The commission went on to note that:

> After a year of study, and after reviewing research and testimony, the Commission finds that recovery from mental illness is now a real possibility. The promise of the New Freedom Initiative—a life in the community for everyone—can be realized. Yet, for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.[596]

The Supreme Court's recognition of ADA's integration mandate and the growing acceptance that people can recover from mental illness reinforced the development of supportive housing for people with psychiatric disabilities.

Supportive Housing

The term *supportive housing* has been used to describe a broad range of housing for people with disabilities. The common characteristic that runs across all types of supportive housing is the provision of support services meant to enable people with disabilities to live in the community. Supportive housing has been used to describe:

- Transitional or permanent congregate housing with onsite support services
- Group homes with onsite or offsite support services
- Single-room occupancy buildings with onsite services that exclusively or partially house people with disabilities
- Apartment buildings with onsite or offsite services that exclusively or partially house people with disabilities
- Scattered-site apartments leased on the open market with offsite support services

Some types of supportive housing require participation in services as a condition of obtaining or maintaining housing. This requirement is problematic for several reasons. It makes participation in support programs coercive rather than voluntary, which makes such programs less desirable and effective.[597] Also, it forces tenants to adapt to preexisting programs rather than allows people with disabilities to choose the specific services they need.

Requiring participation in support services also runs counter to the Fair Housing Act, by creating a burden based on disability that tenants without disabilities do not have to meet. Like all tenants, people with disabilities are expected to comply with a lease, but requirements that go beyond that, such as participation in specific programs and services, create special hurdles that make it more difficult for tenants with disabilities than those without to obtain and maintain housing.

The best types of supportive housing maximize tenant empowerment by unlinking housing from support services and allowing tenants to choose from a broad array of voluntary support services that can be provided onsite or offsite at the tenant's option. Scattered-site supportive housing that is indistinguishable from private market housing provides tenants with fully integrated homes that encourage independence and allow tenants to avoid the stigma associated with housing set aside for people with psychiatric disabilities. One of the prerequisites for recovery is overcoming the stigma about mental illness that permeates society: "Simply by virtue of their diagnosis or label, people labeled with psychiatric disabilities are perceived as second-class citizens, murderers, people to be feared, people too incompetent to make their own decisions, malingerers, and many other stereotypes."[598]

Segregated housing by its very nature invites stigma and makes recovery more difficult.

People with psychiatric disabilities who experience more independence and less depersonalization have corresponding gains in social integration.[599]

Fully integrated scattered-site housing also avoids the "not in my backyard" reaction from neighbors who fear that housing for people with psychiatric disabilities will bring crime and lower property values, despite ample evidence to the contrary.[600]

Scattered-site supportive housing can help foster a sense of community and support by offering an offsite clubhouse or building for tenants to participate in classes and other types of social activities. Such programs are particularly effective when run by psychiatric survivors who can help create an accepting, nonjudgmental atmosphere and serve as recovery role models.

Support services can also facilitate recovery by offering help in the community. Aides offer assistance and companionship to tenants who need support with grocery shopping, cooking, errands, laundry, doctor visits, participating in recreational and social activities, attending classes and vocational training, accessing substance abuse treatment programs, and similar community-based tasks. Support services that are

flexible and allow tenants access 24 hours a day and 7 days a week, and permit tenants to pick from a broad array of services, offer the best chance for recovery and successful independent and integrated living. Just as the Americans with Disabilities Act and the *Olmstead* decision require housing integration, providing support and rehabilitation services in integrated settings rather than offices is also required, both because it is more effective to learn these skills where they are used, and also because it allows access to services in settings that maximize the opportunity to interact with people without disabilities.[601]

Another crucial characteristic of successful supportive housing is permanence. Time-limited housing makes it difficult for tenants to stabilize and focus on recovery. Tenants who time out of transitional housing often become homeless and experience a resurgence of psychiatric disability as a result of the stress from life on the streets. As one report noted, “Extensive consumer preference studies show a desire to live in one’s own house or apartment, a disregard for segregated settings, and greater housing and neighborhood satisfaction with the permanent supportive housing model.”[602]

Cost effectiveness is another hallmark of successful supportive housing. Well-designed supportive housing is far less expensive than the mix of shelters, psychiatric hospital beds, and jail cells that people with severe psychiatric disabilities often cycle through when stable housing with support services is not available.[603]

Housing for People with Psychiatric Disabilities Released from Correctional Facilities

As noted earlier, deinstitutionalization without adequate community-based support services and the lack of affordable housing have contributed to the dramatic increase in the number of prisoners with psychiatric disabilities over recent years. Without meaningful discharge planning and access to supportive housing, released prisoners with psychiatric disabilities face difficult challenges to remain in the community. Welfare and subsidized housing programs often exclude ex-inmates, the stigma of incarceration makes private landlords and employers reluctant to rent or hire, and parolees and probationers must meet the specific requirements of their respective programs to maintain their freedom.

Given these reentry barriers, it is not surprising that returning prisoners consider housing to be perhaps the most crucial component to community reintegration.[604] But although the need to link ex-inmates to stable housing may be obvious, meaningful discharge planning from correctional facilities is rare. In a precedent-setting case, the city of New York agreed to provide discharge planning for prisoners with serious mental illnesses to settle a lawsuit. The settlement agreement in *Brad H. v. City of New York* was finalized in 2003. It requires individualized assessments and help obtaining services in several areas, including housing, public benefits, and mental health services.

Before the lawsuit, the city had simply released jail inmates between 2 a.m. and 6 a.m. in Queens Plaza with $1.50 in cash and a $3 Metrocard. The *New York Times* had described the lead plaintiff in the case as:

> A 44-year-old homeless man with schizophrenia who grew up in a psychiatric hospital and has been treated for mental illness each of 26 times he has been jailed as an adult, most recently for jumping a subway turnstile. On none of these occasions, the lawsuit charges, did anyone plan for how the man would continue to receive medication and other mental health services on his release from jail, or how he would obtain Medicaid benefits, Social Security disability payments, or supportive housing.[605]

Although there is insufficient research to evaluate the effectiveness of reentry housing programs,[606] it makes sense to assume that the same characteristics that have been found to meet the housing needs of people with psychiatric disabilities will also serve the needs of returning prisoners with mental illness. Indeed, the Pathways to Housing Program profiled below accepts clients directly released from Rikers Island, New York City's largest correctional facility.

In conclusion, permanent supportive housing that is fully integrated and offers tenants with psychiatric disabilities a broad and flexible array of voluntary support services, a sense of community and acceptance, and role models through program staff who are psychiatric survivors offers the best chance for stable housing and support for recovery from mental illness.

Examples of Supportive Housing Programs for People with Psychiatric Disabilities

The following offers a closer look at three types of permanent housing programs for people with psychiatric disabilities. Pathways to Housing is the nation's oldest "housing first" program and has been heavily studied. It provides permanent, scattered-site supportive housing with voluntary, flexible, and individualized support services delivered by a staff that is heavily composed of peer providers. There are no requirements to use support services or abstain from substance abuse to either obtain or maintain housing, and tenants are accepted directly from the streets, homeless shelters, psychiatric wards, and correctional facilities.

The Mental Health Association of New Jersey's Residential Intensive Support Team (RIST) program is a modified housing first program because it requires agreement to continue psychiatric medications and participate in a treatment plan as a condition of obtaining housing, but not as a condition of maintaining it. Until 2009, all its tenants came from a psychiatric hospital through a discharge planning program. It provides individualized onsite support services in scattered-site housing delivered primarily through psychiatric survivors.

Main Street Housing does not meet the definition of permanent supportive housing because it offers only housing. Rather than directly offering support services, it provides referrals to community-based support services upon request. It offers a mix of congregate and single-residency housing, and does not accept tenants with co-occurring substance abuse or who have committed violent crimes. Because it does not offer support services, it only accepts tenants who can demonstrate an acceptable degree of "wellness." However, it is included here because it appears to be the nation's only housing program for people with psychiatric disabilities that is entirely run by psychiatric survivors, and service provision by peers has been found to be an important predictor of housing success for people with psychiatric disabilities.

Pathways to Housing

In 1992, Pathways to Housing (Pathways) pioneered a new way of housing people with psychiatric disabilities that has come to be known as the "housing first" model.[607] Based in New York City, the program was founded by Dr. Sam Tsemberis, a clinical psychologist who had worked with homeless people with psychiatric disabilities. Tsemberis believes that housing is a basic human right, and should therefore be offered without any precondition, whether or not tenants agree to pursue treatment.[608]

Pathways provides housing to homeless people with mental illness and co-occurring substance abuse—the population that other homeless prevention programs have found most difficult to place. Tenants are offered independent private housing in the community when they enter the program. The only requirements to obtain housing are to agree to participate in biweekly visits by a service coordinator, attend a money management program, agree to pay 30 percent of income toward rent, and abide by a standard lease.

Pathways rents apartments via a network of landlords, and sublets the units to its tenants. By making timely rent payments and intervening quickly to solve tenancy problems, Pathways is able to maintain a stable number of units. Tenants are offered up to three units to choose from when they enter the program.

To ensure full community integration, the program does not rent more than 10 to 20 percent of the units in a building. Tenants are free to stay as long as they wish. There is no requirement to participate in mental health or substance abuse treatment. Tenants choose whatever support services, if any, they want.

Services are delivered onsite and are available 24 hours a day, 7 days a week, via an Assertive Community Treatment (ACT) team or at Pathways offices. ACT teams consist of a case manager—typically a peer counselor or former consumer—and a nurse, psychiatrist, social worker, vocational rehabilitation counselor, drug counselor, and

administrative assistant. Approximately half of Pathways staff are in recovery from mental illness, substance abuse, or homelessness.

Staff help tenants develop independent living skills by accompanying them on trips to buy groceries, visit doctors, and perform other activities in the community. Depending on what a client wants, case managers can work directly with the client or, as tenants proceed toward recovery, can provide referrals to community services. The intensity of services is adjusted relative to a client's evolving abilities.

Pathways offices offer a range of support services and opportunities for socializing and recreation. There are writing groups, photography groups, computer classes, science groups, and people go to the movies together and socialize.

A person with a psychiatric disability's need for housing is no different from anyone else's. Housing is constant, while services vary as a function of disability. Unlike Supportive Housing Programs that preceded Pathways, tenants who refuse mental health and/or substance abuse treatment and those who continue to abuse drugs or alcohol are not threatened with loss of housing, so long as they continue to comply with their lease.

Tsemberis believes that people with psychiatric disabilities have the capacity to immediately move into their own home in the community. He points out that homeless people have substantial survival skills that are masked by their disability. Homeless people know where to go for meals, where to collect SSI checks, where to seek medical care, the location and eligibility rules for shelters, where to sleep when shelters are full, and what parts of the town are relatively safe to travel through. Tsemberis also believes that relief from the daily stress of life on the streets allows tenants to begin to focus on addressing other needs and developing the skills that can foster recovery.

> Pathways to Housing provides people with an apartment of their own first, so that they may find a reprieve from the war zone that is homelessness. Assistance is provided every step of the way so that tenants have all the

> support necessary to move and integrate into their community, and to begin the long journey through the recovery and rehabilitation process.[609]

Research substantiates the effectiveness of the housing first approach. One study demonstrated a direct relationship between participating in a housing first program and decreased homelessness and increased perceived choice.[610] This study also suggested that this approach may have a distal effect on decreased psychiatric symptoms. People in the housing first program obtained housing earlier, remained stably housed, and reported higher perceived choice.[611] Living in their own apartment through a housing first program and having choices also had a great impact on the psychological and social integration of people with mental illnesses.[612]

> Pathways to Housing separates housing from treatment. It treats homelessness by providing people with individual apartments, and then treats mental illness by intensive and individualized programs that seek out and actively work with tenants as long as they need, in order to address their emotional, psychiatric, medical and human needs, and on a twenty-four-hour, seven-day-a-week basis.[613]

Tsemberis believes the housing first approach is far superior to the status quo: "People with mental illness are in jail, or homeless, or in and out of psychiatric institutions. This is better, and far more cost-effective…. A housing first approach requires an agency to take the risk of putting people with mental illness and addiction into apartments and assume liability for that. Most programs want a containment/supervision model—that's not based on data, but rather on prejudice about mental illness."[614]

Finally, Pathways has an 80 percent tenant retention rate and is far more cost effective than emergency services used by homeless people with severe mental illness.[615]

Mental Health Association of Morris County, New Jersey: Residential Intensive Support Team (RIST)

The Mental Health Association of Morris County, New Jersey, operates a permanent Supportive Housing Program for patients leaving Greystone Park Psychiatric

Hospital.[616] It is known as the RIST program because it uses a Residential Intensive Support Team to provide support services. The program began housing 21 people in 2004 and has grown slowly since. By the end of 2008, the program served 36 people, and a total of 49 people had been housed directly from hospital discharge since the program's inception.

RIST staff meet with potential tenants before they are discharged from Greystone. They help patients locate private, single-residency, scattered-site housing in the neighborhood of their choice. The patients are then discharged directly into their new homes. The lease is in the tenant's name.

RIST is a modified housing first program, in that it seeks to serve "recovery-oriented" patients deemed ready for discharge. Patients must agree to continue to take their medication and participate in a treatment plan to win acceptance into the program. However, patients—referred to as "customers" by RIST staff—are not removed from their housing or from the program if they refuse to take medication or adhere to their treatment plan. The only criterion for maintaining housing is lease compliance.

Housing is permanent, with allowance for periods of absence from the unit of up to approximately 6 months, and sometimes longer on a case-by-case basis. If a customer cannot comply with the lease and is evicted, RIST staff will offer a new placement. Customers are allowed three housing placements before they are turned away from the program.

RIST customers are offered a rich array of support services in their units, in the community, and at a RIST drop-in center/social club. Most services consist of developing independent living skills, such as cooking, housekeeping, hiking, and accompaniment to spiritual services. Services are delivered by nine community life coaches, all of whom are consumer providers. RIST staff also help customers access vocational rehabilitation programs and educational programs. One customer obtained a massage therapy license, another completed a program in heating and air conditioning

repair, and a third graduated from the RIST program and is pursuing a degree in pastoral counseling. Services are available 24 hours a day, 7 days a week.

In addition to community life coaches, RIST staff include one master's level residential coordinator, one full-time assistant coordinator, three full-time senior residence counselors (one of whom is a consumer provider), and a part-time nurse consultant. In addition, the program shares a bookkeeper, a housing development specialist, and a psychiatrist with other Mental Health Association of Morris County programs.

The RIST program defines successful community integration by several measures, including avoidance of hospital and jail stays, positive relationships with friends and family, and involvement in educational or vocational training. RIST has a goal that 80 percent or more of housed customers will participate in three or more different social/leisure activities each quarter. Social participation per quarter in 2008 ranged from 81 percent to 92 percent.

RIST has a goal that 75 percent or more of housed customers will be involved in one or more prevocational or vocational activities. Vocational and prevocational participation per quarter in 2008 ranged from 79 percent to 82 percent. This included 12 customers who were employed either part-time or full-time during the year.

RIST attributes much of its success to its use of consumer providers, who make up 71 percent of its staff. The key component of the program is the relationship between life coaches and customers, who are matched carefully to foster trust and teamwork. Having experienced psychiatric disabilities as well as recovery, life coaches can offer more empathy, understanding, and tolerance, and can "meet their customers where they're at," while serving as role models.

Main Street Housing

Another emerging model of housing for people with psychiatric disabilities is Main Street Housing (MSH) in Maryland. A subsidiary of On Our Own of Maryland, an organization

of psychiatric survivors, MSH was incorporated in 2001 as a nonprofit and began offering housing the following year. It was formed to provide an alternative to board and care homes and residential settings tied to service provision.[617]

MSH offers a consumer-run “housing only” model that differs from Pathways and RIST in several ways. It only offers housing, with no support services provided, although MSH staff are familiar with local services and will refer tenants to support services in their communities.

Today, MSH owns 15 buildings in nine Maryland counties that contain a total of 27 units and house 53 adults and families. Approximately half the tenants live alone; the rest are families or adult roommates. Units include efficiencies, one- and two-bedroom units, and three-bedroom units for families.

Unlike Pathways, MSH owns its homes and leases them directly to its tenants. MSH’s Executive Director, Ken Wineman, says homeownership enables his organization to build equity it can use to leverage the purchase of new homes, and to offer the opportunity for tenants to sign leases and experience the responsibilities and privileges of tenancy.

MSH chooses its tenants carefully. Each applicant is screened by Ken Wineman, who is both a consumer and a social worker. Although treatment is not a prerequisite to obtain housing, applicants must demonstrate a “certain wellness level” to be accepted. Current substance abuse is not permitted, nor is a history of arrest for violent crimes.

Tenants must agree to monthly inspections for safety and cleanliness. If the home is not kept well, staff offer, but do not force, referrals for support services. When adults live together, each tenant must agree to be responsible for the upkeep of a specific common area. Housemates are expected to work out any problems that come up, and house meetings are the usual method used to do so. Staff are available to informally mediate disputes upon request. When a new tenant first moves in, staff will visit more frequently to help ensure a smooth transition. Staff will sometimes contact a tenant’s case

manager or other support staff if needed. Alcohol and tobacco use is discouraged but not prohibited—however, in shared living situations a tenant can request that his or her roommate not use either in the home.

Rent is kept low—typically it ranges from $200 to $275 per month. Section 8 vouchers are accepted, and MSH has adopted the housing authority rules of occupancy to ensure that Section 8 vouchers will be offered to its tenants.

Wineman explained, “People in the mental health system see us as a model. We get referrals from State hospitals—and that enables workers there to see that it’s possible to offer housing separate from support services.”[618]

Housing is permanent—tenants can stay as long as they wish. Wineman is particularly proud that MSH was able to help a mother regain custody of her child by offering stable housing for both.

MSH has successfully avoided “not in my backyard” (NIMBY) problems. When a home is purchased, no neighborhood notification occurs. If neighbors drop by while a home is being prepared for occupancy or when staff are doing repairs and maintenance, neighbors are welcomed and told that MSH is the landlord and will quickly respond to calls about any concerns neighbors may have. Wineman says that neighbors have responded well to this approach, which satisfies concerns without stigmatizing tenants by announcing the presence of mental health consumers.

Although MSH has not yet conducted studies, Wineman states that his experience at MSH has convinced him that stable housing leads to employment and more stability and grounding in nonpatient roles. To avoid segregation, MSH purchases buildings that range from single-family homes to buildings that contain no more than four units. No more than six people reside per multiunit building. He explained, “I don’t buy anything I wouldn’t live in.”[619]

Finally, Wineman believes that the fact that MSH is completely consumer run provides significant advantages that contribute to the success of the program. Consumer staff provide role models and hope for tenants, and educate the broader mental health community that recovery is possible. Wineman also believes that a consumer-run program fosters a greater degree of tenant accountability, because staff have higher expectations of tenants to be self-sufficient. Tenants feel more comfortable interacting with staff who have faced similar mental health challenges. Tenants find the staff to be compassionate and nonjudgmental, and hence easier to approach for help. The presence of role models and the sense of acceptance help tenants develop their self-esteem. Research implies that peer support empowers people with psychiatric disabilities to make decisions relatively autonomous from professional staff.[620]

Recommendations

1. As required under the Fair Housing Amendments Act, the Americans with Disabilities Act, and *Olmstead*, people with psychiatric disabilities are entitled to and should be offered fully integrated housing in the community. Prospective tenants should participate in choosing their housing, and such choice should be preceded by a meaningful opportunity to observe and understand what is being offered and resolve any concerns they may have. People who prefer not to live in such housing should not be forced to do so.
2. Housing must be offered without being tied to treatment or use of supports as a condition of obtaining or maintaining housing. Lease compliance should be the only criterion for maintaining housing.
3. People with psychiatric disabilities are entitled to permanent housing, and to the legal protections offered all tenants.
4. Brief absences should be tolerated without loss of housing, and program staff should stay in close touch with tenants and landlords to maximize the chances that tenants will return to their homes.
5. Tenants should be offered individualized, flexible support services that are available 24 hours a day, 7 days a week. Tenants should be free to request the type of services they need, and when and how they want to receive them.
6. Whenever possible, housing and support services should be staffed by people who have recovered from mental illness. For programs that serve tenants with both psychiatric disabilities and substance abuse problems, staff should include people who have recovered from drug and/or alcohol abuse.
7. Program staff should be responsive to concerns from property managers, landlords, and neighbors, and intervene promptly to resolve tenancy problems to help tenants avoid eviction.
8. Program staff, tenants, and landlords should be educated about fair housing rights and responsibilities, with emphasis on the right to reasonable

accommodation. Housing staff should have formal backup support from fair housing attorneys for training, advice, and help in resolving disputes.

9. Government housing and treatment funds should be redirected from board and care homes, nursing facilities, and psychiatric hospitals to housing first programs that maximize client choice and community integration and that reflect the characteristics contained in these recommendations.

10. Jails and prisons should be required to provide meaningful discharge planning that helps prisoners with psychiatric disabilities identify and apply for quality supportive housing prior to release, to minimize recidivism and maximize successful transition to independent living in the community. Similarly, probation services should help people with psychiatric disabilities obtain stable supportive housing and support services that foster independence and meaningful participation in community life.

NCD Topical Brief #4

Homeland Security and Emergency Housing Evaluation

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Introduction

The purpose of this brief is to present an overview and analysis of emergency housing issues of concern to people with disabilities. The report describes general needs and identifies key issues that influence the provision of emergency, post-disaster housing.

Historically, few communities or organizations have made disabilities a key issue, either before or after a disaster. As a result, there are problems that begin with initial notification of an impending emergency or disaster, and then continue with evacuation, transportation to a shelter with trained staff ready to provide appropriate accommodations, providing temporary housing, and developing permanent housing.

This report describes the process of securing emergency housing and includes the perspectives of people involved in providing and receiving this housing: people with disabilities, disability advocates, service providers, caregivers, and public officials. Observed problems include the lack of available accessible and affordable units lengthening shelter stays, lack of proximity to accessible transportation and key health and social services during a temporary relocation, challenges faced by caseworkers in assisting people with disabilities into temporary or permanent housing, and the failure of most communities to conduct pre-disaster recovery planning.

The brief concludes with a review of evolving practices that are consistent with recommended practices for housing people with disabilities in an emergency context.

Need

Arguably the most regionally widespread disaster ever to face the United States, Hurricane Katrina revealed stark gaps in emergency housing for people with disabilities.[621] This massive, widespread event stressed the abilities of agencies and organizations to provide accessible shelters and temporary and permanent housing solutions. Evacuees often had to leave behind critical resources during the evacuation, including durable medical equipment, assistive technologies, and prescriptions, and were separated from service animals, caregivers, and service providers. Those receiving evacuees struggled to respond to their needs.

Hundreds of communities opened ad hoc shelters, but many were not equipped with specialized equipment or resources to assist people with disabilities.[622] It is clear that people with disabilities were not accommodated well, and in a number of instances were sent inappropriately to special needs shelters.[623] Some shelters also reportedly refused access to service animals.

Caseworkers, who usually assist dislocated people in the recovery process, experienced difficulty with assisting people with disabilities to move from shelters into temporary or permanent housing.[624] Issues included replacement of equipment and finding accessible housing close to key social and health services.[625] People with disabilities appear to have stayed in temporary shelter or with family, friends, or others for longer periods of time than people without disabilities.[626] Social service providers and advocacy organizations stepped in to assist, but often found that their efforts were constrained by a lack of available resources or knowledge. Transitioning to temporary housing became a stressful, lengthy ordeal.

A study by the U.S. Government Accountability Office indicates that “special needs populations are often overlooked in planning for disaster housing assistance.”[627] As subsequently demonstrated in *Brou v. FEMA*, there were neither sufficient numbers of accessible emergency housing units (e.g., trailers) nor a process for providing accessible units in place after Hurricane Katrina. In January 2009, the Federal

Emergency Management Agency (FEMA) issued its National Disaster Housing Strategy, with a recommendation to create national and State disaster housing task forces that include people with disabilities and representatives of disability organizations and agencies.

There is reason to believe that Hurricane Katrina was not an exception in how people with disabilities experience emergency housing. Wildfires in California, floods in the Midwest, and September 11 all revealed considerable challenges across hazards and locations with finding and providing accessible housing in settings supportive of people with disabilities.[628] In short, post-disaster emergency housing for people with disabilities is problematic. Efforts to address the need through policy, practice, and research are emerging, although most of those efforts remain to be assessed. A careful look at the issues associated with emergency housing is thus required.

Overview of Key Issues

A number of reports published by the National Council on Disability, the National Organization on Disability, the U.S. Government Accountability Office, Congress, and independent researchers indicate that in disaster situations certain issues recur for people with disabilities. Problems start when officials notify the public of an impending emergency. Such notifications appear more likely to reach people who can see, hear, and are physically able to take protective action. To illustrate, people who are deaf and hard of hearing experience problems with receiving emergency notifications. For example, notifications concerning rapid onset of weather events (e.g., a tornado) often fail to reach people who are deaf,[629] a situation described as a "hole" in the warning system. Closed captioning during emergencies is often not consistently available, despite Federal Communication Commission (FCC) policies requiring such dissemination of information. Even when interpreters are present, cameras cut away and coverage is lost.[630]

Accessible public transportation to reach areas of safety is limited and typically depends on advance knowledge prior to an event. Because disasters are not salient events for most people in general,[631] and because disaster is just another challenge among many experienced daily by people with disabilities, personal planning tends to be insufficient for people with disabilities.[632] In short, the process of informing and moving people with disabilities to safe shelter remains a significant problem in the United States. Once people are in the shelter, their stay can be lengthy and traumatic.

People with disabilities appear to experience longer stays in shelters or other accommodations before moving into temporary housing because of a lack of accessible and affordable temporary units, including public housing, rental units, and government-provided trailers. Rental units are typically sought as a first strategy to solve housing needs. Those units may not be in a location convenient to people with disabilities and may have features different from what is familiar and/or needed. In some disasters, the Federal Government may authorize mobile homes or travel trailers, though such units are far from ideal. These units take time to transport and place, a particularly lengthy

process if an area requires the construction of roads and utilities. For Hurricane Katrina, the massive needs generated by the storm meant that everyone, regardless of disability, waited a long time to secure a unit. After Hurricane Katrina, the U.S. Department of Housing and Urban Development (HUD) created a National Housing Locator System that helps people search for accessible units. However, those units at times are located at a considerable distance from an individual's workplace and social network. FEMA has also established a Housing Portal that indicates if a unit offers basic accessibility.

Once people have been relocated into such temporary units, other problems tend to arise, including finding accessible public transportation from the new unit to and from work, social or health care services, veterinary services, grocery stores, and/or laundry facilities. Caregivers may not be able to live in the units or may now be at a further distance. Reliable and established relationships that may be critical to daily activities are disrupted. The new neighborhood and neighbors may be unfamiliar. Pets, a source of comfort, may not be allowed. Service animals may be disoriented and stressed.

The process of permanent housing reconstruction can be time consuming. For homeowners, insurance must be claimed, federal assistance acquired, permits sought, contractors hired, and building materials purchased. In an area hard hit by disaster, such contractors and supplies may be difficult to secure—particularly contractors familiar with disability issues and supplies that are accessible. In Louisiana, reconstruction shortages and "scam artists" damaged local trust so badly that Louisiana State University established a Web site for construction contractors to list their licenses and skill levels. For renters, the displacement may be permanent. After the 1994 Northridge earthquake in California, renters faced lengthy displacement because a regional recession and poor cash flow meant that apartment building owners could not afford reconstruction for some time. A combination of bank, State, and federal programs had to be initiated for rebuilding.[633] For many families, rebuilding is cumbersome and exhausting. Without the assistance of voluntary and community organizations, many are not able to rebuild their homes or secure appropriate housing. This appears to be

especially true for people with disabilities, and even more prevalent among those marginalized further by lower incomes.

More broadly, the community itself typically moves through a recovery planning process. The post-disaster housing recovery process requires that construction be authorized through a permitting process, although not all communities take advantage of this as an opportunity to increase access for people with disabilities. Recovery planning processes allow for the consideration of new philosophies, building codes, and designs to be integrated into the rebuilt homes and community. The U.S. Access Board has led an Emergency Transportable Housing Work Group that includes FEMA and representatives of the disability community and the manufactured housing businesses. Through the work of this group, substantial progress has been made. The U.S. Department of Justice, through Project Civic Access, provided technical assistance to Mississippi and Louisiana to enhance compliance with ADA requirements for post-disaster reconstruction.[634]

Analysis

This section examines the emergency housing process people are likely to follow to reestablish the continuity of their lives after a disaster. Overall, the emergency housing process involves four phases,[635] starting with dislocation from one's home into either emergency or temporary shelter, and then moving into either temporary housing or (eventually) some form of permanent housing. In the subsections below, the process of moving through these phases is defined and illustrated from the perspectives of individuals, agencies, and officials.

Emergency Shelter

The first phase that an individual faced by disaster might experience is emergency shelter.[636] This phase is typically ad hoc and short lived. People may seek out locations such as cars, tents, or lawns to stay for a short duration before moving to a more amenable location. For Hurricane Katrina, those emergency shelter locations included overpasses, rooftops, and places like the New Orleans convention center. Even for a smaller event like Hurricane Gustav, some people sheltered in their cars. Such locations typically vary in their access to food, water, medical assistance, and personal security. Such circumstances can range from being places of simple discomfort to acute and life-threatening locales for anyone, and especially so for those who are medically fragile.

Temporary Shelter

Temporary shelter, the second phase, provides basic amenities that include, at a minimum, food, water, and a place to sleep that is free of exposure to the elements. General population shelters, such as those managed or supported by the American Red Cross, usually offer shower facilities, first aid, psychological support, case management, and more. Typically, less than 20 percent of the population goes to a public shelter, preferring instead to stay with family or friends, stay in a motel, or try and remain in their own homes.[637] People who do go to a public shelter tend to be lower income. Because people with disabilities tend to have lower-than-average incomes, it seems more likely

they would go to public shelters. However, some research suggests that if people with disabilities do not believe shelters are ready for them, they will not evacuate and may remain in their homes at considerable personal risk.[638] People with disabilities also may not use shelters if they cannot get there because evacuation, accessible transportation procedures, or buddy systems fail. Significant problems may then develop when people with disabilities remain at home and, for example, are unable to operate critically needed medical or mobility equipment because of power outages.[639]

For those who do make it to temporary shelter, two kinds may be available. Usually, emergency managers identify and announce predesignated general population (GP) shelter locations, which are most commonly managed by the American Red Cross. These locations must accept and accommodate people with disabilities and service animals. Some areas may choose an alternative system, where the Red Cross provides support. In Texas, for example, a shelter hub system is used under the State's emergency response plan. This mass care system is managed by a designated liaison between voluntary organizations and the State, with support from a variety of health, medical, and voluntary organizations.

Whether a shelter is run by the Red Cross or not, a triage system based on specific criteria is usually used to determine if an individual should go to a general population or to an advanced care facility, such as a medical/special needs shelter, a nursing home, or a hospital. At both general population and medical/special needs shelters, there is an intake or registration process, which can vary from minimal to extensive. Ideally, registration processes identify the specific needs of an individual, including those related to disabilities, language barriers, and health problems. Medical needs shelters, particularly those in areas of repetitive risks, have improved since Hurricane Katrina, but planning and implementation for such facilities are still inconsistent across the nation.

It is not unusual for organizations, communities, and officials other than the Red Cross to open their doors to displaced people. Such independent shelters can vary from a local place of worship that sets up cots and offers food provided by congregants, to the Katrina mega-shelters established by Texas officials in large facilities to host massive

numbers of evacuees. The abilities of ad hoc shelters to accommodate people with disabilities can vary widely. For Hurricane Katrina, ad hoc shelter providers often sought out local resources or used their personal networks to find sign language interpreters, medical supplies, nutritional services, wheelchairs and other devices, veterinarians, and health care providers. How well shelter staff understand disability issues can also vary. In general, many Katrina shelters lacked adequate training for their staff and volunteers for them to understand and support even basic needs.[640] Some progress has been made in this area since Katrina, with general population shelters more likely to accept people with disabilities and service animals. States at higher risk for hurricanes have implemented plans for medical and/or special needs shelters.

Planning is vital to accommodating people with disabilities in shelters. The best strategy to accomplish effective planning is to actively include people with disabilities and/or disability organizations and advocates in the planning process. These experts can also participate as shelter staff and/or volunteers throughout the life of the shelter, from intake and registration through daily activities and discharge. Their insights can help shelter managers avoid misdirecting people with disabilities to inappropriate locations and can ease the discomfort associated with shelter life. By involving people with disabilities in shelter planning and management, the usual challenges associated with mobility, communication, nutrition, and facility use can be addressed and overcome. Incorporating disability organizations into the intake/registration and discharge planning process can expedite the movement of people with disabilities out of the shelter and into appropriate temporary or permanent housing post-disaster.

Transitioning into Temporary or Permanent Housing

The ultimate goal of shelter managers, other than to provide basic relief to those displaced by disaster, is to move shelter residents back into their own homes or into temporary housing until permanent housing becomes available. Temporary housing is defined as housing that allows for reestablishing normal household routines that may include cooking, laundry, and sleeping in a safe, secure location.[641] For people with disabilities, temporary housing may also require particular accommodations, such as

ramps, communication devices, or kitchen counters at an appropriate height. Permanent housing means that no more moves are necessary. It is not unusual for people to move many times before finding or rebuilding a permanent home.

Moving people from the sheltering stage into temporary or permanent housing is a time-consuming process that depends on several conditions. First, such units must be available in the community. Depending on the extent of the disaster, including impacts on critical infrastructure and services such as police, fire, ambulance, road clearance, power, water, and sewage, housing units may be in short supply. Many markets also experience seasonal or low availability outside of disasters, further reducing the temporary or permanent housing supply. For people with disabilities, available units must be accessible and provide an environment well suited to the individual's particular type of disability. Insurance companies must provide settlements to those holding policies, a process that can take years depending on the type of disaster, the wording of the policy, and lawsuits that inevitably follow most denials.

To move out of a temporary shelter into temporary or permanent housing also means that resources must be secured to offset expenses such as moving, storage, and the cost of a rental unit. To obtain government assistance, a Presidential Disaster Declaration must be issued. When that occurs, FEMA makes Individual Assistance payments to those affected. To qualify, individuals must first apply to the U.S. Small Business Administration for a loan. If rejected (usually because of income, credit history, or inability to repay), then applicants can then seek a federal grant. In 2009, the maximum grant amount was $33,300, an amount that changes with the fiscal year every October 1. Grants are provided to those who meet income requirements; FEMA must inspect the property in question to verify the claim, often with little to no recourse or appeal process for the homeowner if declined.

Though FEMA opens Disaster Recovery Centers (DRCs) in many locations after an event, most applicants are encouraged to use the online application system at www.disasterassistance.gov or a national 1-800 number. The application process can result in a check from FEMA quickly, or the process may be lengthier. Federal

assistance may not cover all needs. After a 2008 ice storm in Oklahoma, for example, elderly families, including those with disabilities, had to rely heavily on local volunteers to remove debris.

For individuals to return home, shelter discharge planners must make a final determination. When an earthquake strikes, homes damaged by the disaster must be cleared of interior debris so that people with mobility devices or people with visual limitations can move about. Utilities must be restored so that power is available for the devices, technologies, and resources used by people with disabilities. After Hurricane Andrew in 1992, utilities were down in southern Dade County for more than a month. After Hurricane Ike in 2008, Texas opened post-disaster shelters particularly for seniors and people with disabilities because of extended power outages. As noted by one Hurricane Ike survivor:

> In my naïveté about how the world works, I never realized that without electricity, gasoline pumps won't work, air pumps won't work, and water purification plants shut down. Generators only run about 10 hours before you have to put in more gas. No gasoline stations were open or functioning. The fact that our water was contaminated was the final straw, propelling us down the road to Austin. After visiting two abandoned gasoline stations, we finally figured out why the air pumps weren't working, so we filled up our tires using an old-fashioned hand pump my neighbor had in her garage. We finally got to the hotel in Austin by midnight.[642]

To help people with the transition from shelters into temporary or permanent housing, a discharge process identifies issues that can impede relocation and link the evacuee with appropriate support services, including public housing authorities, faith-based organizations, disability organizations, and home health care agencies. In some communities, a case management process may develop.

A professional case management process for disaster victims has only recently been developed. After Hurricane Katrina, the United Methodist Committee on Relief (UMCOR) developed case management materials and trained caseworkers. Known as Katrina Aid Today (KAT), the effort represents a critical advancement in helping disaster

victims. The case manager helps the evacuee work through a recovery plan, identify resources, and solve problems. However, even with help, transitioning into temporary housing can be difficult and even impossible for some. For example, through the KAT program, case managers served 1,713 individuals with disabilities and their families. Yet out of the total intakes, less than half (about 818 cases) have been closed. There are many reasons these cases have not been closed. For many, recovery plans could not be met because resources including affordable accessible housing were not available in Mississippi.[643]

In an assessment of the Katrina Aid Today case management process, Stough and Sharp found considerable value in a case manager approach for disaster survivors with disabilities. Case managers know and understand local social systems, which are often bureaucratic, confusing, and foreign, especially for survivors who are at a distance from their original communities and providers. Case managers thus serve as important conduits for those seeking recovery. In an assessment of focus groups with survivors, Stough and Smith found that:

> The largest majority of respondents reported housing or home repair as the primary need preventing their recovery. Most respondents had received FEMA housing assistance at some time during the previous two years. However, responses indicated that ongoing FEMA assistance was fraught with uncertainties, required complicated and excessive recordkeeping, and was maintained only through repeated and sometimes stressful interactions.[644]

Case managers also reported that their clients required more specialized knowledge than did those without disabilities and they needed additional guidance on recovery issues. As another measure, the case managers had more frequent and longer contacts with clients with disabilities than those without disabilities. These client cases tended to be complex, as these clients often received State and federal entitlements that had to be restored or transferred along with finding new providers. Case managers also served as advocates for survivors with disabilities. Agencies in communities new to the survivors did not know the clients well. Case managers reported that they observed agencies (local and federal) that did not understand people with disabilities and they

believed that those agencies unfairly and inappropriately judged the clients as trying to abuse the system.[645]

Case managers reported that clients with disabilities went through the recovery experience with far fewer resources than others, often a reflection of lower incomes or lack of employment. These clients were also less likely to be homeowners and indicated that some FEMA Individual Assistance Programs were not useful. For example, many clients could not qualify for loans because they were renters. Because of a lack of accessible trailers, both homeowners and renters had trouble securing temporary housing. The lower incomes also meant that clients experienced difficulties in establishing and paying utilities and buying replacement furniture. Case managers perceived that the recovery process was far more difficult for clients with disabilities and observed higher rates of depression and anxiety among these clients.[646]

The process of moving from warning/notification through emergency and temporary shelter is a trying time for anyone, and can be particularly so for people with disabilities. Unfortunately, arriving at a presumably more stable temporary housing unit may bring an additional set of challenges. As noted by the U.S. Department of Homeland Security Office of Civil Rights and Civil Liberties, after Hurricane Ike:

> NGO [nongovernmental organization] advocacy and service organizations reported that a number of elderly individuals and individuals with disabilities, who originally lived in community residences with supports, have been displaced into congregate living settings such as nursing homes. Experience following Katrina and Rita showed that individuals who were displaced in this manner were unable to return to their community living situations because they lacked the mobility or capacity to find new housing situations on their own. Following Katrina, foundation grant funding was obtained by advocacy organizations, enabling them to send personnel on visits to congregate living settings to locate displaced individuals and connect them with FEMA registration, and link them to case managers to obtain the supports needed to return to their communities. Similar strategies will be needed to identify, assist, and advocate on behalf of individuals displaced into congregate settings as a result of Hurricane Ike so that they can return to their communities.[647]

Case managers appear to be helpful in assisting a survivor through the bureaucratic process of applying for aid, and particularly when they require advocacy with the aid application process.

Attaining Temporary and Permanent Housing After a Disaster

Temporary housing allows an individual to leave a shelter or move from staying in a motel or with family or friends. Temporary housing means that people can reestablish a household routine, including activities like cooking, traveling to work, and doing laundry. A temporary housing situation, however, also means that the person has not yet returned to her or his original home or to a permanent alternative, and that another move will be required. Once in the permanent housing stage, a person does not have to move again.

As noted above, in most disasters people tend to leave shelters fairly quickly. However, doing so depends on a number of factors. The scope and magnitude of the disaster can influence a transition into temporary or permanent housing. A small-scale tornado that damages a portion of an urban area will probably not be a problem, as alternative temporary or permanent housing is likely available nearby. In a massive event, such as Hurricane Andrew in Florida (1992) or the Midwest floods (1994), housing availability can be compromised regionally, thus extending a shelter stay. Hurricane Katrina was a catastrophic regional event that required significant resources at all government levels and taxed relief agencies that were struggling to provide aid across a vast area. While Katrina should not be considered a representative event, it does reveal issues that appear to lesser degrees in other disasters.

Other factors also influence the transition into temporary or permanent housing. For a renter, the availability of rental units is necessary. After the Northridge earthquake in 1992, in which multistory apartment buildings suffered significant damage, southern Californians faced challenges in locating comparable rental units in proximity to their work, as well as to the important health and social services and networks that enhance their quality of life.[648] The local market can also compromise availability. A tight rental market means that few apartments or houses can be found to rent. Concurrently, a tight market usually results in higher costs. In some areas, such as urban or coastal areas, the costs of rental units can be high even before disaster. Because people with

disabilities and senior citizens tend to have lower incomes than others, the affordability of rental units as a permanent housing solution becomes a significant barrier to relocation. It is not unusual for many people, particularly those at lower incomes or with insufficient insurance, to have to downsize their homes or move into inferior permanent housing as a post-disaster solution. When such choices must be made, a consequence is that the relocated individual or family may now be in an unfamiliar location, away from important social and health networks, and at risk for economic, medical, and even psychological trauma. In previous disasters, including Katrina, Rita, and Ike, people with disabilities reported considerable difficulty in finding appropriate housing.

Although rental and homeowner units increasingly feature accessibility, the built environment contains many units that have not been upgraded, a particular problem in older neighborhoods or communities and especially in older rural areas. Locating accessible units or adding accessible features requires time, which extends the transition from shelter to housing. Searching for these units (or providing certification for federal payment) may require expertise and resources not readily available to some people with disabilities, especially those who are elderly, lack computer access, or remain isolated.

The case management process, which may or may not be present in a stricken area, also requires some degree of expertise to assist with the transition. Local social services may be able to help, but may also experience damage from the disaster or be overwhelmed by a new caseload. A local housing authority can be of assistance to those who qualify, but may also be subject to the same demands as local social service agencies. Long-term recovery committees can help, if they have been established and are aware of and familiar with working with people with disabilities. In short, the transition from shelter to either temporary or permanent housing can be overwhelming, challenging, and certainly problematic.

Moving into temporary housing requires resources. Americans tend to be overly generous with donations at the time of disaster, so much so that the abundant donations are commonly referred to as the second disaster. Unfortunately, the majority

of the donations typically include used clothing, canned goods, and bottled water, which tend to go unused. When media attention wanes, so do public donations—just at the time when they are sorely needed for transition into either temporary or permanent housing. Few people donate bedroom furniture, kitchen appliances, washers, dryers, or other key households necessary to reestablishing a household routine. Few donations include those appropriate to replace items lost by people with disabilities and their service animals. Durable medical equipment, technological and assistive devices, and even service animals remain expensive to replace and may not be covered by insurance, federal programs, or voluntary organizations. Though disaster organizations can provide some funds and goods, many remain dependent on the generosity of monetary donations for individually specific needs.

Funding is a particular problem for people with disabilities and those trying to help them. The National Council on Disability held its January 2008 Quarterly Meeting in New Orleans. One participant said:

> While there was a lot of funding sent to Louisiana post-Katrina, there was not a lot of money specifically for assisting people with disabilities. The money was not distributed and prorated in terms of specific services for people with disabilities, except for some limited resources aimed toward housing. In terms of other resources, additional funding has gone to healthcare services, but again, not specific to serve those with disabilities. There was specific funding for people with mental health issues. However, because infrastructure was so devastated, it has made it difficult to provide these services. The infrastructure collapse has made it extremely difficult to utilize that money in an efficient manner.[649]

Finally, individual circumstances can influence the transition. Even though temporary or permanent options may be available, they may not be appropriate for each individual. Relocation, whether temporary or permanent, means that people may have to travel farther to work. It is also necessary to learn new routes to grocery stores, pharmacies, and places of worship and recreation. People may be dependent on nearby medical care or social services, which will need to be transferred or reestablished. A new neighborhood can be frightening, particularly to a senior with a disability. Service animals have to acclimate as well. In new locations, people do not know their neighbors.

They may have lost social relationships (neighbors, family, friends) important to them personally, financially, and perhaps even to their daily activities. Agencies may have been hard hit by the disaster and cannot reestablish services. One hopes that accessible transportation is available in the new location, new providers can be secured, and friends can be made. Relocation, however, is difficult for anyone. For people with disabilities, there are added layers that require additional sensitivity. It may be understandable, then, that people with disabilities may be reluctant to accept temporary or even permanent relocation options given the significant potential impact on their personal and professional lives.

Direct Assistance

Federal resources and assistance programs are vitally important in helping survivors transition into temporary or permanent housing. Several federal agencies provide direct assistance to disaster survivors to help them transition after disasters, including FEMA, the U.S. Small Business Administration (SBA), the U.S. Department of Housing and Urban Development (HUD), and the U.S. Department of Justice (DOJ).

To secure **FEMA** assistance, disaster survivors must apply for assistance, be verified as a qualified applicant, and then be routed to the correct program. Housing assistance for survivors is made available through the Individual Assistance Program. FEMA covers:[650]

- Temporary housing (a place to live for a limited period of time), providing funds to help rent a place to live or a government-provided housing unit when rental properties are not available.
- Repair assistance to help homeowners repair damage on their primary residence that is not covered by insurance, so that the home is safe, sanitary, and functional.
- Funding to help homeowners replace their home destroyed in the disaster when it is not covered by insurance.

- Direct assistance for new home construction, though usually limited to insular areas or remote locations specified by FEMA where no other type of housing assistance is possible.

FEMA provides additional funds to cover costs such as medical, dental, funeral, burial, clothing, household items, tools related to employment, some educational resources, fuel for heating a home, resources to clean a damaged home, vehicle damage from the disaster, moving and storage, and other "necessary expenses or serious needs as determined by FEMA" that are "authorized by law." Many of these funds are necessary to reestablish a household routine, which serves as a measure of "housing recovery" and movement into either temporary or permanent housing. FEMA operates a special needs desk that responds to questions regarding disabilities. The FEMA Office of Equal Rights exists to promote equal access to programs and benefits, and provides technical assistance and complaint resolution through its civil rights program.[651]

The **U.S. Small Business Administration** makes disaster loans to homeowners or renters for repairs or replacement of "damaged real estate or personal property owned by the victim." As observed by the case managers and noted earlier, "renters are eligible for their personal property losses, including automobiles."[652] SBA loans require that applicants have an acceptable credit history and demonstrate an ability to repay loans. They require collateral for loans over $14,000, and interest rates vary from 2.187 percent to 4.375 percent, as of January 30, 2009. Home loans are limited to $200,000 for real estate repairs and $40,000 for personal property damage. Loan recipients are also required to carry insurance.

After the 2008 Gulf hurricanes and flooding across Iowa, Indiana, and Wisconsin, **HUD** granted a 90-day moratorium on foreclosures of FHA-insured mortgages and encouraged that "loan services take such actions as special forbearance, loan modification, refinancing, and waiver of late charges."[653] Under a Presidential Disaster Declaration, HUD may allow States to use their Community Development Block Grant (CDBG) and HOME programs for housing victims. HUD also has the capacity to provide mortgage insurance under its Section 203(h) program for disaster victims and can give

local and State governments Section 108 loan guarantees for housing rehabilitation, economic development, and repair of public infrastructure.

The **U.S. Department of Justice** offers support to communities damaged by disasters through its Project Civil Access,[654] which provides technical assistance to communities to increase compliance with ADA and is not based on any complaints. Ultimately, the technical assistance can result in new codes and construction that is more accessible. Case examples after Hurricane Katrina (Mississippi and Louisiana) and a toolkit can be found at the Project Civil Access Web site.

FEMA Trailers

One option that may be made available is a FEMA trailer. In most disasters, FEMA is reluctant to provide trailers because they are not an ideal temporary solution, particularly for an individual with a disability. A number of issues exist with providing trailers. A location with appropriate utilities and roads must exist or be created, along with a means for access to basic services, such as accessible public transportation to work, laundry, grocery stores, faith locations, social services, and health care. Months can pass before such locations become available in even a small-scale disaster. Additional accommodations specific to a disability may also be needed. Safe, accessible trailers must then be located, transported, and connected to utilities. Either mobile homes or smaller travel trailers may be made available. The latter are particularly unpleasant, as such units provide cramped conditions not conducive to quality of life, let alone the ability to maintain independence with a disability.

Such conditions existed after Hurricane Katrina, an event that challenged federal capacities to deliver accessible, temporary housing in a widespread, large-scale event. The Manufactured Housing Institute (MHI) issued a “Statement on Accessibility Guidelines for Emergency Transportable Housing.” The institute indicated that “it is unreasonable to require that 100 percent of the homes have accessibility features,” and preferred the 5 percent benchmark under the Uniform Federal Accessibility Standard. Further, it stated that the requirements “must allow for design flexibility and greater ease

in incorporating accessible features," in part because of the challenge in securing resources to provide accommodations during disasters. The MHI produced more than 23,000 units for FEMA in 2005, and noted that "accessibility was not a primary function of the home procurement effort."[655]

In *Brou v. FEMA*, an advocacy group sued based on the claim that FEMA had not allotted sufficient numbers of accessible trailers that allowed for people with disabilities to use kitchens, bathrooms, bedrooms, or even enter the front door. The basis of the lawsuit was that FEMA had not provided such units and could not or would not in the foreseeable future. According to the Louisiana Advocacy Center, "FEMA's published reports indicate that as of February 3, 2006, five months after the disaster, of the 34,808 trailers FEMA has provided to Mississippi, only 417 units, or just over 1 percent of all trailers, comply with access guidelines." Approximately 15 months later, the lawsuit was settled with a solution in place to address accessibility issues. That process included identifying needs and providing accessible units. FEMA established a toll-free number for people with disabilities and a complaint process. Advocacy groups were brought in to the process to provide insights. The Louisiana Advocacy Center indicates that 2,553 people called, with 1,260 receiving accessible trailers and 256 awarded modifications close to 2 years after the disaster had occurred.[656]

Trailer units have also been critiqued as bearing health hazards. After Katrina and floods in Iowa, formaldehyde and mold emerged as concerns. The Centers for Disease Control and Prevention conducted a study regarding the formaldehyde, and found that levels were "higher than usual in indoor air in these trailers than in most homes in the United States" and recommended "that FEMA move residents of the Gulf Coast area displaced by Hurricanes Katrina and Rita out of travel trailers and mobile homes. We recommend that people with symptoms that could be linked to formaldehyde and vulnerable populations such as children, elderly, and individuals with chronic diseases be moved first."[657] The mold in Iowa trailers appeared to originate on water heaters, but may have moved to interior areas. FEMA's response included working with the State on testing, informing trailer residents, relocating families, and removing the units.

Rebuilding Permanent Housing

Even more challenges exist for those seeking to rebuild their homes. Depending on the extent of a disaster, it may be extremely difficult to secure the key resources needed to rebuild. From permission to rebuild through securing funding, contractors, subcontractors, labor, and supplies, the rebuilding process is cumbersome and exhausting for anyone. For a person with a disability, particularly a senior citizen, the rebuilding process may be too daunting. The loss of community, social networks, and home associated with a disaster, and having to face the rebuilding process, may mean that a person cannot return home. In this section, we examine some of the factors that can impede or expedite permanent housing reconstruction for people with disabilities.

When a community experiences a disaster, local officials typically act to improve the quality and disaster resistance of local housing. Doing so takes planning and time to implement, which can delay the reconstruction process. In a large-scale disaster, the delays can be considerable, as local, State, and federal officials conduct assessments to determine recommendations. When people remain at a distance from their homes and cannot afford to return, reconstruction may not be an option at all. Contractors, subcontractors, voluntary organizations providing labor, and building inspectors all must become familiar with new codes and ordinances, and the local offices responsible for implementing and monitoring the new procedures must take on additional work. People must learn how this system works, which is often a new, confusing experience for those facing reconstruction. All factors interact to slow the reconstruction process—and not only for people with disabilities. Although the anticipated outcome is desirable, the time and personal cost to someone with a disability living in a temporary situation can be burdensome.

Further, renters remain dependent on building owners to reconstruct their properties. After the 1994 Northridge earthquake, a local recession meant that owners faced difficulty with rebuilding.[658] Local banks, State officials, and federal authorities all worked to create innovative funding or forgiveness programs to assist. Regardless, building a multistory unit takes considerably more time than a typical single-family unit.

People living in public housing may have several options. If availability exists, they can relocate to a new unit or another location can be approved by the local housing authority. After the California wildfires of 2005 and 2007 and Hurricane Katrina, people were given the option of relocating across the country, but unfortunately with the same problems mentioned earlier—moving away from familiar social, medical, and economic resources. All the public housing across multiple Louisiana parishes was condemned. Though it is being rebuilt, the new design style incorporates mixed-income units into the locations.[659] Critics argue that such a design philosophy unduly reduces the number of low-income units and disproportionately affects low-income people with disabilities and seniors.

For homeowners, insurance is the key to recovery. However, insurance remains expensive and in some areas, such as earthquake and hurricane zones, coverage may be prohibitively expensive, especially for those at low incomes. Some insurance companies will not cover all kinds of disasters or all expenses associated with the event. The cost of insurance may mean that policyholders carry coverage insufficient for the cost of rebuilding. Regardless, the first step for a homeowner to rebuild is usually to pursue an insurance claim. If a Presidential Disaster Declaration is issued, the homeowner may qualify for either an SBA loan or a grant from FEMA. State and local programs may also develop, although such efforts are not typical. Few programs specifically target the kinds of rebuilding needs associated with disabilities. For example, the maximum FEMA Individual Assistance of $33,300 is for rebuilding, although accessible design elements may add costs for ramps, accessible bathrooms, kitchen counters of certain heights, and other features that allow for appliances to be used. Some additional funds may be available for disability concerns, but survivors report they must pursue those funds aggressively. Regardless, the FEMA Individual Assistance amount is assumed to be supplemented by personal insurance and personal funds. These assumptions, coupled with the realities of living at lower incomes, mean that many people fall through the cracks of federal assistance and face considerable trouble in rebuilding.

To assist, a long-term recovery committee often forms in disaster-stricken communities. Such a committee can take the place of a formal planning unit with elected or appointed officials and/or representatives, or it may evolve from an interfaith group of faith-based organizations. Most such entities tend to bring in voluntary organizations and labor teams to rebuild homes. These voluntary organizations (e.g., Presbyterian Disaster Assistance, Mennonite Disaster Service, Lutheran Disaster Response) usually work within the case management system described earlier to target the homes of those with low incomes, senior citizens, single parents, and people with disabilities. Faith-based voluntary organizations are often the key to helping people return home, as they provide labor, expertise, and resources to rebuild cost effectively. Such organizations, though, may require some guidance and advice as they rebuild, so that they incorporate accessibility into the projects. Contractors and subcontractors may also need guidance. Some communities offer housing fairs to encourage various kinds of rebuilding, including green rebuilding and energy-efficient designs. However, such events typically fail to offer insight into universal design, ADA compliance, or accessibility features. Project Civil Access mentioned earlier, which links federal technical assistance to State and local government on access issues, can provide a means to do so.

Further, local commitment to the permanent housing process can vary in regard to accessibility and affordability. Although affordable housing remains a concern across the nation, few communities specifically plan for post-disaster housing, let alone take into consideration issues of affordability or accessibility. However, the city of Watsonville, California, did so in 1989 after the Loma Prieta earthquake, by passing an ordinance that requires 25 percent of all new housing to meet standards for affordability.[660] Communities facing disaster could do the same by adding elements to their recovery plans that emphasize accessibility and affordability. ADA standards beyond basic levels could be mandated, and universal design elements could be required as part of building codes. Disaster represents not only an unfortunate circumstance; it is also an opportunity for change.

Congregate Care and Group Locations

Little is known about the reconstruction process for larger facilities, which tend to be privately owned and are usually covered by sufficient insurance. It is fairly clear that facilities owned by larger chains are more likely to be able to relocate their residents. Smaller, independent facilities face considerable challenges from evacuation to relocation. While many plan for evacuation, just as many fail to drill or to think through the consequences of long-term or permanent relocation.[661] In one creative response for temporary housing, an effort in Santa Cruz, California, relocated residents who were low income, elderly, and/or with disabilities from a downtown, earthquake-damaged hotel into a vacant nursing home facility for nearly 2 years.[662] A local day care provider for adults with dementia served as the facility administrator with support and funding from local social services and FEMA. Some permanent housing solutions for the population included moving back in with family or to an assisted living or nursing home facility. After Katrina, Louisiana and Mississippi social workers also reported a similar pattern. Individuals who could not return to their facilities or their homes moved into congregate care locations either by choice or not.

Risk Mitigation

Ideally, reconstruction allows for mitigation of the risk that prompted relocation. Mitigation may include either structural or nonstructural measures. Structural measures might allow for elevations, (re)building levees, hurricane lamps, shutters, or safe rooms. Nonstructural measures include building codes, insurance programs, and public education. Structural mitigation measures have not been assessed for their impact, positive or negative, on people with disabilities. Presumably, mitigation would reduce risk for them, too. However, some mitigation efforts, such as creating new standards for building elevations, have been critiqued as displacing people with disabilities permanently from their homes, if the new standards make it difficult to make housing accessible. Existing codes and plans for large-scale safe rooms usually fail to address accessibility issues.[663] In Mississippi after Katrina, some social workers reported that some residents felt compelled to move into congregate care facilities, thus losing their

independence. A few elevations along the Louisiana coast after Hurricane Andrew (1992) included elevators so that people could return to their home communities. Ramps may also provide access, but organizations involved in rebuilding may require education and resources to provide these features. At present, federal programs do not provide funds specifically for disability mitigation needs. Some funds may be added to an SBA loan for mitigation purposes, although this information is not widely advertised.

A nonstructural mitigation measure that has been attempted, particularly in areas of repetitive flooding, is relocation. In a relocation, also called a federal buyout, the Federal Government can offer fair market value for a home. Yet, relocation buyouts can still be difficult for the individual, because moves undermine established relationships, resources, and services that may be critical to independence. Relocation efforts must be worked out in the context of potential impacts such programs can have on people with disabilities. Successful relocation efforts integrate the needs of an individual with a disability in the relocation planning process. The individual, their advocates or representatives, and those providing the relocation must negotiate a new environment thoughtfully. Ideally, relocation will afford greater safety and allow the resident to remain in a set of social, economic, and health care relationships that allow that individual to retain or return to his or her original quality of life.

Promising Practices

Clearly, a number of challenges exist with sheltering and housing people with disabilities after a disaster. Several principles should undergird efforts to strengthen emergency housing. First, forethought and planning for people with disabilities and special needs should serve as the main strategy for emergency housing. Second, including and actively involving people with disabilities, disability organizations, and advocates will provide planners and those involved in all aspects of emergency housing with a means to identify problems and address solutions. Third, resources must be made to support these recommendations. This section reviews a number of promising practices based on a majority of these principles.

Much of the progress made in the promising practices below derives from two sources. First, post-Katrina legislation drove changes in awareness and prompted the creation of guidance and planning materials. Second, community and organizational initiatives have served as agents of change.

A Functional Model

Historically, disabilities have been viewed as a limitation and have been "treated" with some type of remediation that is often medical in nature. This medical model can be observed when general population shelters refer people with disabilities to special needs or medical shelters rather than provide accommodations. An alternative model has emerged called the "functional" approach.[664]

The term *special needs* has historically been used to include a wide variety of people, which carries considerable challenges for planning. A functional approach to special needs looks at specific assistance that is required, centering on communication, medical needs, independence, supervision, and transportation, also called the C-MIST model.[665] These groups may include people with disabilities, but also include people with morbid obesity, high-risk pregnancies, kidney problems requiring dialysis, and people lacking transportation. The diversity that exists across disabilities means that

while some may require C-MIST assistance, many others will not. As Kailes and Enders explain, “most people with disabilities and functional limitations are integrated into and actively involved in society,” because many have aged into disability.[666] The implications for emergency housing are significant. To illustrate, a general population shelter manager would need to plan for a variety of communication needs across a diverse set of potential shelter residents. People with disabilities should not be automatically assumed to have medical needs and be sent to a special needs shelter. Intake, triage, registration, and discharge procedures can screen for functional independence needs. Staff and volunteers can be trained to supervise people with dementia, disorientation, and other conditions in either general population or special needs shelters as deemed appropriate. Transportation can be provided that is accessible and allows for people with mobility concerns to travel from their homes to the safety of a shelter. Officials and organizations involved in securing temporary housing can attend to the same issues.

Although the C-MIST approach is recommended for special needs planning, the ideas within the model can be applied to think through basic needs in emergency housing. For example, what kind of communication needs exist? Do communication devices need to be replaced due to the disaster? Are special services required to support communication devices? Are any durable medical equipment or related services needed in either temporary or permanent housing locations? Are there medical risks in the dwelling unit and immediate environment? What is necessary to promote functional independence? Has debris been removed from roads and interiors so that people can navigate? Is the replacement housing accessible so that people can return to a household routine? Does the housing provide for personal care attendants or family caregivers if needed? Is the housing located in a secure area that reduces the potential for crime, disasters, and other threats? Is it near to adult day care or is there an appropriate level of security within the assisted living, group, or congregate care facility? Is the housing situated in a place that allows for people to move about, either by themselves, with service animals or personal mobility equipment, or through accessible

public transportation? Can people move easily to and from key points including work, grocery stores, worship, recreational areas, schools, health and medical services?

The functional model serves as a means to identify and address issues associated with those at highest risk and provides a lens to think through what is truly needed in all types of emergency housing.

U.S. Department of Justice Guidance for Emergency Shelters

The U.S. Department of Justice (DOJ) has created a useful set of materials that provide guidance for shelters and rely implicitly on the functional model. The documents include why people with disabilities should be accommodated in general population shelters, descriptions of ways to provide such accommodations, and checklists for planning purposes. These documents can be used at the local, State, regional, and national levels by any entity involved in sheltering. It is not known, however, how influential these materials are or how extensively they are used. The *ADA Best Practices Toolkit for State and Local Governments* includes:

- Basic guidance on accessibility for shelters, social services, temporary lodging or housing, and other benefit programs (Chapter 7)[667]
- *Title II Checklist*, which walks the planning team through decisions about shelter and housing (Chapter 7, Addendum I)[668]
- *The ADA and Emergency Shelters: Access for All in Emergencies and Disasters* (Chapter 7, Addendum II)[669]
- *The ADA Checklist for Emergency Shelters*[670]

The DOJ materials guide users through an inclusive planning process. An example of one Addendum I checklist question for the planning team is:

> Do you have written procedures to ensure that you regularly seek and use input from persons with a variety of disabilities and organizations with expertise in disability issues in all phases of your emergency planning, such as those

> addressing preparation, notification, evacuation, transportation, sheltering, medical and social services, temporary lodging and/or housing, clean-up, and remediation?[671]

As the user/team moves through the checklist, problems are identified and action steps are offered. The DOJ/ADA materials strongly advise involvement of a diverse set of people with disabilities and disability organizations in order to identify and manage all potential issues across the full spectrum of preparedness, planning, warning, evacuation, transportation, shelter, and housing. Addendum II advises readers on shelter practices that ensure equal access and accessibility, address shelter resident eligibility, offer modification suggestions, improve communications and shelter life, guide shelter managers on necessary services and supplies, and provide insight on transitioning out of a shelter. The *ADA Checklist for Emergency Shelters* walks the user through measuring or assessing specific areas including doorways, sideways, walkways, parking spaces, sloped surfaces, entrances, toilets, telephones, fountains, showers, sleeping areas, and related areas.

The DOJ materials on temporary housing, though less comprehensive, also alert planners and managers to issues related to repairing and rebuilding. According to Chapter 7 in the manual, governments must comply with Title II of ADA. Title II allows for a choice between two construction standards: “either the Uniform Federal Accessibility Standards (UFAS) or the ADA Standards for Accessible Design (ADA Standards).” If a government location was constructed after 1992, alterations must comply with Title II of ADA. Otherwise, governments must allow a “path of travel…from the entrance to the altered area” that includes phones, restrooms, and fountains. Locations that are reconstructed with a “substantial alteration” must provide accessible routes, entrances, and restrooms. *Substantial* is defined by UFAS as “where the total cost of alterations in a 12-month period amounts to 50 percent or more of the value of the building.”[672]

The DOJ materials emphasize involvement of people with disabilities and a process that mobilizes an inclusive planning team to identify and address solutions collectively. The

guides walk the team through a series of assessments and corrective steps that are easy to follow and result in accessible emergency shelters. The materials also encourage critical thinking about disability issues, such as providing alternative means to communicate, inviting accessible social and psychological services to be present, and working through the implications of closing a shelter for people with disabilities.

Search Tools

The U.S. Department of Housing and Urban Development (HUD) initiated a National Housing Locator System as a result of Hurricane Katrina and implemented it after the 2007 California wildfires.[673] To help evacuees after Hurricane Ike, HUD's National Housing Locator System (NHLS) was supplemented with government and local databases. The NHLS required those listing rentals to comply with the Fair Housing Act and to make reasonable accommodations for people with disabilities.[674] The NHLS includes a Housing Neighbors in Disaster option that allows a "neighbor to neighbor" connection for "mom and pop" landlords willing to rent to people displaced by disaster, though they must also comply with the Fair Housing Act.

Similarly, the U.S. Access Board initiatives include links and information for accessible housing after a disaster. A key link is to the National Network of ADA Centers, which was used after Hurricane Katrina.[675] In a related vein, FEMA has created a National Housing Portal to assist people with finding suitable post-disaster homes.[676] The portal allows for basic and advanced searches by State, county, city, ZIP code, number of bedrooms, and cost. The advanced search allows a user to look for accessible units, although detailed information on the nature of that accommodation may not be provided. These types of tools represent promising practices because they provide a resource for both individuals and case managers to search for suitable emergency housing.

U.S. Department of Housing and Urban Development

HUD's participation in disaster relief has varied over the last 30 years. Generally, HUD's participation in disaster housing primarily focuses on temporary and permanent housing. Specifically, the Department:

- Administers two mortgage insurance programs (Section 203[h] and Section 203[k]), which assist disaster survivors in purchasing, renovating, or rebuilding housing.
- Administers an insured housing rehabilitation loan program (Title I).
- Makes its foreclosed housing portfolio available for purchase by disaster survivors at a discount in areas affected by a declared disaster.
- Provides annual grants (grants through supplemental appropriations may also be available) that may be reprogrammed post-disaster (Community Development Block Grant and HOME Investment Partnerships Program) to local, county, and State governments that would directly assist eligible recipients to purchase, rehabilitate, or construct housing.
- Provides a 90-day moratorium on the repayment of FHA-insured mortgages for homes damaged in a declared disaster area.
- Encourages private mortgage lenders to take special forbearance, loan modification, refinancing, and waivers of late charges on loans they hold.

An example of HUD's efforts in New Orleans post-Katrina:

> Approximately 123,000 homes were damaged or destroyed in New Orleans as a result of the hurricane. 82,000 of those were rental units [approximately 55 percent of all rental units were lost]. The Road Home small landlord rental program brings federal community development block grant dollars for property restoration. A small percentage of these units will be designated as both affordable and accessible…. Section 8 rentals are also very limited. This has resulted in some tenants not being able to afford the increases as landlords have doubled their rents in some cases. Power bills have also increased. It was reported that some people have not been able to catch up on their utility bills following Katrina, especially those with disabilities who live on limited income.[677]

The Road Home program used Community Development Block Grants (CDBGs) to provide landlord incentives. Those who rebuild using the funds must maintain units at affordable prices for up to 5 years, which qualifies the landlord for loan forgiveness. Approximately 10,000 units were estimated to result from this program.

HUD also offers the Disaster Housing Assistance Program (DHAP), which provides for the public housing authority to pay landlords a Fair Market Rent (FMR) for 6 months. Thereafter, the tenant pays $50 of the rent, an amount that increases $50 monthly until the full rent is being paid or the renter leaves the program. For Hurricanes Ike and Gustav, FEMA identified 6,500 eligible families. The Ike program is designated to end on March 13, 2010.[678]

The Disaster Voucher Program applies to families living in public housing, including seniors and people with disabilities. After a disaster, HUD transfers those in Section 8 or the Housing Choice Voucher (HCV) program to the Disaster Voucher Program. Approximately 7,600 families benefited from this program after Hurricane Katrina. HUD and public housing offices also worked to locate comparable housing across the nation for those who were displaced. People affected by Ike were able to transfer their Section 8 housing voucher by working through the closest public housing authority that was mandated to assist with issues of accessibility and barriers.[679] However, gaps existed in serving those entitled to public housing assistance: “a comprehensive tracking/counting system of individual accessible housing needs is currently not available to inform the public housing authorities (PHAs) and federal funders.”[680] Mississippi, however, reported that such Section 8 rentals were “very limited.”[681] Further, increases in rents and power bills increased, causing economic hardship particularly for “people with disabilities living on limited income.”[682]

Mortgage and Rental Relief

The Mortgage and Rental Assistance Act of 2007 served to help people keep their homes under the duress of a disaster event. The intent of the legislation was to reinstate funding that had been lost after a revision of the Stafford Act dropped the

program. Eligibility is income based, although exceptions can be made in areas with high costs of living.[683] In addition, FHA under Section 203(h) offers insurance that protects lenders of qualified disaster victims. The intent of the program is to support those with low and moderate incomes and is limited by HUD by amount, home type, and location.[684]

FEMA Comprehensive Planning Guides

FEMA is creating a series of Comprehensive Planning Guides (CPGs) that includes CPG-301 (*Emergency Management Planning Guide for Special Needs Populations*) and CPG-302 (*State, Territorial, Tribal, and Local Government Household Pets and Service Animals Plan*). As of August 2009, both remain in interim versions. The current sheltering and mass care section describes basic guidelines for shelters and refers users to DOJ and FEMA Office of Equal Rights guidance materials. A shorter section indicates that jurisdictions should provide communication services to assist people with special needs through the disaster assistance application process and that "accessibility of both temporary and permanent housing is crucial. Timely allocation of adequate stock of accessible housing safeguards against individuals with disabilities (e.g., physical impairments) having to remain in a shelter environment longer than others or being inappropriately relocated to a congregate setting."[685] The document indicates that housing provided through government sources must comply with the Fair Housing Act and "meet physical accessibility requirements."[686] CPG-301 also recommends that recovery planners involve special needs populations and use the recovery as an opportunity to meet accessibility requirements.

CPG-302 resulted from Katrina experiences, particularly the unwillingness of people to evacuate without their pets. This observation prompted Congress to pass the Pets Evacuation and Transportation Standards (PETS) Act in 2006. The intent of CPG-302 is to aid jurisdictions to plan for and evacuate pets and service animals, and was created through a joint effort of emergency managers, the Centers for Disease Control and Prevention, the Humane Society of the United States, the American Humane Association, the American Veterinary Medical Association, and others.[687] A

predecisional draft was released in March 2009, but not to third parties and not for citation or quotation. A FEMA fact sheet indicates that the content will discuss integration with the National Incident Management System (NIMS), as well as planning principles and strategies for household pet and service animals. The content will include transportation, shelter options, veterinary care, search and rescue, and nutritional standards. Appendixes will include planning checklists, resources, and templates.

Such guidance is key to motivating evacuation among people at risk and particularly important to sensitize first responders and emergency managers to the value and importance of service animals. The content of both documents will sensitize and guide planning teams and community groups as they address key issues, particularly those related to shelter.

National Disaster Housing Strategy

In January 2009, FEMA approved a National Disaster Housing Strategy.[688] Sections specifically address disability issues, beginning with recommending that "local governments should build partnerships with disability groups/organizations and advocates [and the U.S. Access Board], as well as disabled persons in the affected community to assist in the evaluation and identification of those special needs."[689] It references Section 504 of the Rehabilitation Act of 1973 regarding shelter buildings and the requirement for ADA compliance for shelters. For interim housing, local groups and organizations are deemed particularly valuable because they know local populations and contexts best. A National Disaster Housing Joint Task Force is to be convened to enhance existing outreach programs by involving disability organizations. State-led Disaster Housing Task Forces should also be convened to do the same.

Annex 3 of the National Disaster Housing Strategy offers a 23-page set of resources that acknowledge that "very few housing programs exist exclusively to assist these populations in disaster-specific instances, but a number of programs are relevant and could offer support if called upon. Well-coordinated housing assistance programs must be available to individuals with special needs, disabilities, and/or low incomes who are

displaced by a disaster."[690] A number of legal requirements are noted, including compliance with the Architectural Barriers Act, ADA, UFAS, Section 504, the Fair Housing Amendments Act (FHAA), the Developmental Disabilities Assistance and Bill of Rights Act of 2000, Executive Order 13347, the Civil Rights Act of 1964 Title VI, the Age Discrimination Act of 1974, the Pets Evacuation and Transportation Act of 2006, and the Post-Katrina Emergency Management Reform Act of 2006. These policies promote several key principles:

- Accessibility and nondiscrimination in all locations, particularly those supported by federal funding. This pertains not only to shelter and housing but also to application processes for assistance.
- Housing initiatives must fit with the local community and its populations.
- The flexibility of NGOs offers a broader array of options and less restrictive guidelines than can federally funded programs. Involving NGOs is key.
- It is important to provide case management and for survivors to access it.

Though federal programs exist to help people with disabilities, those noted in the Annex are admittedly limited due to the pre-disaster, existing waiting lists. Some allow for disaster victims to receive priority, such as Section 811 Supportive Housing for People with Disabilities and Section 202 Supportive Housing for the Elderly. The Older Americans Act also allows for some small awards to State agencies if a Presidential Disaster is declared.

The National Disaster Housing Strategy and Annex 3 represent an important step forward in a national commitment to people with disabilities affected by disaster. The strategy emphasizes key principles important to any housing initiative, particularly the involvement of disability organizations and advocates. However, it is equally clear in Annex 3 that, although existing disaster assistance programs apply to everyone, there are no standalone disaster housing programs specifically for people with disabilities. As noted in a number of places throughout this topical brief, this appears to translate into a

small percentage of federal assistance that directly applies to those most likely to languish in shelters and have trouble finding temporary or permanent housing.

Concerns About Federal Guidance

At the January 2008 National Council on Disability Quarterly Meeting, participants raised public comments about the guidance materials and new criteria for special needs planning. The main concerns centered on a lack of funds or resources available to implement the planning recommendations and that "the worry is that local jurisdictions are being set up to fail and not meet new criteria." A related critique of the National Response Framework, which includes ESF#6 Mass Care (shelter) and ESF#14 (recovery), did not "provide clear direction to the States and local jurisdictions about how to operationalize the concepts."[691]

Hurricane Ike Impact Report

One way in which ESF#14 is often operationalized is through consulting with communities on key issues. In October 2008, the U.S. Department of Homeland Security Office for Civil Rights and Civil Liberties issued a *Special Needs Populations Impact Assessment Source* document as an activity under the National Response Framework Emergency Support Function #14, Long Term Community Recovery. Such types of reports are rare, and this one provides important initial insights into the emergency housing challenges after Hurricane Ike (thus this report is commonly referred to as the Ike impact report). The report initiative involved local, State, and nongovernment officials in assessing C-MIST related functional needs. Observations related to housing included:

- Choice of housing units should be available, including renting, owning, geographic location, and single-family versus multifamily units. Housing choice also helps retain the "cultural integrity of communities."[692]
- Affordability and accessibility are particularly important for senior citizens and people with disabilities. Those living on fixed incomes are a special concern.

- Community and faith-based organizations are crucial in helping people with disabilities to secure housing.
- Realtors and others involved in finding accessible units, as well as those who underwrite home modifications, are important partners in relocating housing.

The Ike impact report also indicated that some individuals, including senior citizens and people with significant mental health needs, tended to stay in shelters longer than others. Individuals who had left retirement communities were reportedly having difficulty finding out if they could go home. Elderly residents also remained in their homes, even in inferior and health-threatening conditions. Both government and NGOs were said to be assisting with cleanup so that seniors could return to a safe environment. The report recommended that resources be applied to "rental assistance, debris removal, or emergency repairs…funding will also be needed to purchase appliances…bedding, furniture, food, clothing and prescription medication."[693]

Similar to Katrina, "NGO advocacy and service organizations reported that a number of elderly individuals and individuals with disabilities, who originally lived in community residences with supports, have been displaced into congregate living settings such as nursing homes."[694] Advocates secured funding from foundations to assist Katrina and Rita evacuees, including helping evacuees in congregate care facilities to register for FEMA assistance and "link them to case managers."[695]

Mitigation, particularly minimal flood elevations, was noted in the report as problematic, because of the potential to displace the elderly and people with disabilities: "there is a need for a strategy to reconcile minimum flood elevation requirements with housing accessibility requirements in locations such as Galveston."[696] The report recommended that community planners, building groups, and voluntary organizations work together to increase accessible and affordable housing through joint efforts, educational outreach to the construction sector, and focused use of volunteer teams. Further, the report recommended that housing be located close to public transportation, particularly paratransit options.

The Ike impact report is consistent with observations after Katrina, as noted by participants at the NCD Quarterly Meeting held in New Orleans. Participants there encouraged that FEMA funds be used to increase accessibility in rebuilding streets, schools, civic centers, and even privately owned buildings.[697] Such an approach would provide benefits to people with disabilities and the broader community.

Formalizing this type of post-impact assessment, particularly if it involves disability organizations and is coupled with funding and other resources, represents a potentially promising practice. Funding the initiatives and providing resources is crucial.

FEMA Disability Coordinator(s)

The 2006 Post-Katrina Emergency Reform Act allowed for the appointment of a Disability Coordinator to assist with and provide support to address issues related to disabilities in disasters. The FEMA position was posted and filled in 2007. Since then, the Disability Coordinator has been onsite for multiple disasters and continues to provide guidance on disability issues. The Disability Coordinator position is situated in the FEMA Office of Equal Rights. In 2008, FEMA Director Paulison noted the value of the Disability Coordinator in speaking before the National Council on Disability in April 2008: “we realized after Katrina that we needed a better way to reach out to these communities and also to have open channels of communication so we could better understand their needs.”[698]

For the 2007 California wildfires, the Disability Coordinator was able to put efforts into place in advance, including daily conference calls with the disability community, sending teams into shelters to assist with durable medical equipment and assistive devices, educating shelter staff, and supporting service animals. As of January 2008, FEMA had provided 400 people with such resources as “motorized wheelchairs, manual wheelchairs, raised toilet seats, grab bars, TTYs, hearing aids, and dentures.”[699]

In December 2008, the FEMA National Advisory Council (NAC) released a memo (dated August 18, 2008) to the FEMA Director recommending the creation of Regional

Disability Coordinator positions for each of the 10 FEMA regional offices. The NAC noted that many States have officials or offices that deal with disability issues and indicated that regional-level coordinators would serve as useful liaisons between the State and federal levels. Further, the NAC believed that "regional disability coordinators would multiply FEMA personnel available to be present in Joint Field Offices to coordinate and support outreach to victims with special needs when disaster strikes." On March 17, 2009, Executive Director Mary Troupe of the Mississippi Coalition of Citizens with Disabilities testified before the U.S. House Subcommittee on Emergency Communications, Preparedness, and Response. Troupe concurred with the recommendation to appoint Regional Disability Coordinators to help the National Disability Coordinator, assist with response, and provide liaison with voluntary agencies. Further, she recommended that "the Obama Administration should also encourage or mandate that each of the FEMA Region Administrators establish a Regional Advisory Council (RAC) to include a Special Needs Subcommittee as former Region II Administrator Steve Kempf, Jr., announced in August 2008. This would mirror the structure already established at the National Advisory Council (NAC) level."[700] The National Council on Disability issued a report in August 2009 recommending that FEMA "[h]ire regional disability coordinators for all ten regional FEMA offices" and "[e]stablish special needs subcommittees under regional advisory committees."[701]

The Disability Coordinators are a promising practice because of their ability to link survivors with resources, to advocate for specific needs, and to point out viable accommodations and solutions.

Voluntary and Community Organizations and Advocates

As noted at the January 2008 NCD Quarterly Meeting in New Orleans, housing emerged as and remained a significant problem after Katrina and Rita. A number of local, State, regional, and national organizations and advocates became involved in dealing with emergency housing. The Mississippi Protection and Advocacy Center, LIFE of Mississippi, and others shared information and participated in the Katrina Aid Today case management process. At the NCD meeting, such advocates noted, "there is no

accessible affordable housing in Mississippi, so that makes a recovery plan addressing that issue impossible to achieve right now."[702] The National Disability Rights Network tried to assist clients from the Gulfport Armed Forces Retirement Home, which was severely damaged, and advocated for an expedited rebuilding of the original facility. The building, which housed more than 1,700 residents, is scheduled for completion in 2010, a full 5 years after the hurricane.

Local organizations have also stepped in to advocate for disaster survivors with disabilities. After evacuees from Hurricane Katrina relocated to Texas, the Houston Independent Living Center began:

> …working with the housing committee to establish and provide accessible housing. The ILC developed a checklist based on the Uniform Federal Accessibility Standards (UFAS) so that people would have basic entry and ability to move around. There was a good organized effort to try to find accessible housing, but in the end, people with disabilities took it upon themselves to find housing and make modifications later.[703]

The Katrina Aid Today program served 1,713 clients by January of 2008 with about 800 cases now closed. Case managers trying to close the remaining cases report that a lack of resources prevents resolution.[704] The State of Louisiana Office for Citizens with Developmental Disabilities indicated that post-Katrina housing needs may include "retrofitting homes and accessibility issues as well as access to…dialysis centers, physicians, senior centers." Notably, "what remain missing are the vouchers that allow for subsidies…[which] prevents people who receive SSI from actually obtaining the housing. This situation has made it difficult for some people with disabilities to return."[705]

Funds and resources often flow through long-term recovery committees or voluntary organizations, but those seeking to assist people with disabilities must compete with others seeking those funds. At the January 2008 NCD meeting, participants observed that while there was a significant amount of funding for Katrina, "there was not a lot of

money specifically for assisting people with disabilities…except for some limited resources aimed toward housing."[706]

Voluntary and community organizations and advocates have proved critically important to assisting people with disabilities to regain housing. Particularly noteworthy are the faith-based organizations that often seek out and support those needing reconstruction assistance. Organizations like the Mennonite Disaster Service, Presbyterian Disaster Assistance, Lutheran Disaster Response, and others have worked diligently for decades to rebuild low-income housing. They often dedicate their efforts to the homes of people with disabilities and seniors. Without their free labor, construction expertise, and commitment, many people with disabilities would never be able to return home again.

Conclusion

Post-disaster housing remains problematic across the nation. People with disabilities tend to stay longer in temporary shelter locations and to experience considerable challenges with finding suitable, accessible, and affordable temporary or permanent housing. Existing guidance tends to emphasize the inclusion and involvement of people with disabilities, disability organizations, and advocates. More specific guidance, coupled with adequate funding, needs to target the complete cycle of emergency housing that people experience from dislocation to finally never having to move again. To date, the process of helping people appears to be stop-gap and ad hoc.

In order to better address the concerns of post-disaster housing, basic and applied research is required. Such empirical work should address at a minimum:

- Enumerating how many people with disabilities are affected by disasters and what types of disabilities are most challenging for emergency housing.
- Assessing the use of DOJ/ADA guidelines for shelters and identification of the conditions that block or expedite implementation.
- Identifying the barriers to effective case management and ways to improve the success rate of recovery plans for people with disabilities.
- Looking at the online search tools for post-disaster housing, how they are used, and their effectiveness.
- Comparing and contrasting the various forms of temporary housing as experienced by people with disabilities, including rental units, mobile homes, trailers, and similar units.
- Following people with disabilities through the process of finding or rebuilding housing in order to document the common challenges and identify strategies for relocation. Research should address the diversity of people with disabilities and their income levels.

- Examining building codes and local commitment to accessibility standards as well as identifying locations that exceed minimal commitment to ADA and other federal standards.
- Studying the ways in which voluntary organizations commit to and work with people with disabilities in the housing reconstruction period.
- Finding out the best strategies for relocating congregate care populations for temporary shelter, temporary housing, and permanent relocation.
- Assessing the effects of relocations or buyouts on people with disabilities and identifying various means to ease the transition.
- Understanding the effects of mitigation measures on people with disabilities and identifying alternatives that enhance safety but do not dislocate the individual.
- Researching the ways in which inclusive housing and recovery planning efforts involve people with disabilities and address issues of accessibility.

To complete a thorough study of post-disaster housing, it is essential to actively involve people with disabilities and disability organizations in the research process. Funding for this research needs to be expedited.

Recommendations

The following follows the four-phase emergency housing model described in this chapter in order to identify appropriate recommendations for post-disaster housing.[707] Several principles underlie these recommendations. First, inclusion of people with disabilities and their advocates in emergency programs and services is the single most important action to take. Planning programs and services with people with disabilities should also proceed holistically to link emergency housing with transportation, health and social services, employment opportunities, and other critical areas of the infrastructure.

Emergency Shelter

The use of emergency shelter, such as living in cars, on lawns, and under overpasses, is to be avoided. Doing so requires dedication from all levels:

1. Getting people out of harm's way is crucial to helping people to avoid using these emergency sheltering options. To provide guidance, FEMA should publish CPG-301 and CPG-302 as soon as possible and provide resources to publicize, train, and implement plan elements at the State and local levels.
2. FEMA should create and fill the Regional Disability Coordinator positions in FEMA and add Regional Advisory Committees to support the positions as soon as possible.
3. Emergency managers and social service agencies must encourage individuals to develop personal preparedness plans. The lowest-income individuals will require resources to develop emergency preparedness kits and transportation options. With resources, individuals can become increasingly accountable for their own safety.
4. Warning systems must be accessible to alert the public to impending danger and activate networks that link to those at highest risk. Warning message content must include protective action directions specific for people with

disabilities. Academic and outreach programs must educate meteorologists and the media on the importance of providing clear and specific information on watches, warnings, and protective action for people with disabilities. Doing so is especially important in rapid onset events.

5. Local and State governments need to provide (or continue to provide) accessible transportation that is preplanned vis-à-vis local population needs. Those at highest risk who lack transportation must be evacuated well in advance of impact when possible.
6. Individuals and agencies must practice protective action, evacuation, and shelter plans. Drills and exercises must involve people with disabilities in planning, executing, and evaluating efforts.

Temporary Shelter

7. Shelter site selection teams must include and involve people with disabilities.
8. The DOJ/ADA guidelines and checklists need to be more widely promoted, along with resources to implement key guidelines for accommodation of people with disabilities. Efforts should be made to publicize accessibility of shelters prior to an event to encourage evacuation. Co-located pet shelters should be added to motivate evacuation.
9. Efforts to identify locations and organizations that have opened ad hoc shelters in previous disasters should be made. Those involved in coordinating shelter efforts should provide training and integrate ad hoc groups into shelter planning.
10. Shelter coordinators can deepen a community's shelter capacities by training staff and volunteers on disability sensitivity, including use of durable medical equipment, communication devices and strategies, assistive technologies and devices, and the support of service animals.
11. All shelters under federal law must accept and support service animals.

12. Disability experts should be involved during intake, registration, triage, and discharge planning in shelters in order to identify and address specific needs.
13. Shelter teams must be ready to open new shelters after an event for those who could not or did not evacuate or who are affected by storm effects, such as loss of power.
14. Low-income populations generally use shelters and often arrive without sufficient funds to return home. Voluntary organizations and the faith community should be tapped to help with the transition from temporary shelter into temporary or permanent housing. Due to the recent recession, these organizations may require funds.
15. Many agencies experience personnel turnover from disaster to disaster. It is thus imperative to provide continual training to those taking applications from people with disabilities. Those taking applications for aid should ask additional questions about disability-related needs to maximize the full potential of federal aid.

Temporary Housing

The following recommendations provide direction designed to renew dedication and expedite commitment to the provision of temporary emergency housing.

16. Temporary housing search teams should locate and publicize accessible housing locations. Information about accessible housing should be disseminated widely through available search tools, social media, local media, and advocacy organizations.
17. Local organizations and agencies can be useful in finding and transitioning those in temporary shelter into temporary or permanent housing. However, such organizations may have also suffered losses in the disaster. Thus, local and State efforts to transition people into temporary or permanent housing is best served through a coordinated team approach. Voluntary Organizations

Active in Disaster (VOADs) and similar organizations should be integrally involved.

18. A transition team (that often emerges through a long-term recovery committee) based on case management planning should be created to help people move from temporary shelter into temporary housing.
19. Teams or organizations that can quickly modify temporary units, such as adding ramps and other accessible features, should be contracted prior to a disaster.
20. Those involved in transitioning people out of shelter into housing should seek a location and environment comparable to or geographically near the original location to restore social and health care relationships and access to employment.
21. Additional federal funding beyond the Individual Assistance maximum is needed to replace disability-specific items like durable medical equipment, assistive technologies, service animal needs, and similar resources.
22. Trailers and similar options must be made available in sufficient numbers for people with disabilities and must remain free of interior health hazards.
23. Temporary locations such as trailer parks must include accessible transportation, so that people can travel to work, grocery stores, senior centers, Centers for Independent Living, medical facilities, and other locations. Evacuation planning and accessible transportation should be provided for trailer parks.
24. Congregate facilities should be required by law to locate appropriate temporary locations in advance of disaster as part of their annual disaster planning. Facilities should plan to transfer residents and their caregivers, family, and medical records to reduce transfer trauma.
25. Funding for creative solutions should be offered to local health and social service providers in order to secure safe temporary housing for congregate populations.

26. Renters often experience considerable problems finding housing after disaster. Local and State governments should commit to affordable and accessible rental housing, including multifamily, single-family, and public housing options.

27. Programs such as Katrina Aid Today offered professional case managers. The Katrina Aid Today case management materials need to be placed on as many Web sites as possible, including FEMA and the national Voluntary Organizations Active in Disaster.[708] Recovery case managers require funding and/or resources to help move clients into permanent housing. Providing such support will reduce longer stays in shelters and dependency on public assistance.

Permanent Housing

28. The new National Disability Housing Strategy needs to be integrated into State and local planning efforts. The strategy calls for the inclusion of disability organizations in State Disaster Housing Task Forces. Funding and training may be needed to help States plan and implement their strategy.

29. In order to increase visibility of programs and efforts, FEMA may wish to consider establishing a standalone disaster housing program specifically for people with disabilities.

30. After Hurricane Ike, FEMA funded an ESF #14–based long-term recovery report to identify special needs. These efforts should become institutionalized. Resources to implement recommendations need to be provided.

31. Ideally, jurisdictions should design a recovery plan in advance of a future event that incorporates accessibility, affordability, and universal design elements.

32. Planning for post-disaster recovery must involve people with disabilities in an active role. Increasing accessibility in rebuilt housing beyond minimal ADA levels is ideal. Using universal design philosophies for individual homes and public places means that a broad array of people with and without disabilities can benefit, including people who develop disabilities as they age.

33. Planning for post-disaster recovery must be encouraged to embrace a vision that enhances accessibility across all locations and sectors of a community and its infrastructure. A holistic philosophy that connects rebuilt housing to public, accessible transportation systems and features (e.g., audible traffic light alerts, curb cuts, and tactile signage) so that people can travel from home to work and other locations more easily is ideal.

34. Outreach to people with disabilities should be offered to provide education and support on the process of rebuilding one's home. Those offering assistance to people with disabilities need to publicize that assistance widely, frequently, and through networks linked to people with disabilities and disability organizations.

35. Local government should commit a portion of rebuilding and reconstruction funds to increase accessible and affordable units. For example, the city of Watsonville, California, mandated that 25 percent of all post-disaster housing construction be built at affordable levels after the 1989 Loma Prieta earthquake.

36. Those involved in disaster response and recovery should encourage monetary donations to pay for items that enhance accessibility and the transition into permanent housing, such as hearing aid batteries, wheelchair ramps, and personal motorized vehicles, as well as household items that require assistive technologies (e.g., telephones, televisions, cooking utensils).

37. Federal funds are needed to support volunteer labor efforts and purchase resources dedicated to rebuilding accessible homes and congregate locations for people with disabilities.

38. HUD must continue to expedite the certification of new Section 8 units and supplement these units with post-disaster funds that pay for increased utilities.

39. States must expand UFAS minimum criteria for accessible units beyond the 5 percent mark.

40. Local and State governments should revise building codes to enhance accessibility, including use of universal design features, which also benefit the general population.

41. Federal, State, and local government should sponsor events like housing fairs that teach the public, construction companies, contractors, and voluntary labor organizations about accessibility and universal design. Government programs could offer incentives to homeowners, apartment owners, and construction companies to exceed federal standards for accessibility.
42. Local and State governments can certify contractors on issues related to accessible construction so that people know whom to trust.
43. Many homeowners and renters struggle to secure insurance for hazards in their area. Federal assistance can be helpful in this important mitigation measure.
44. Local and State government can mitigate future risks by enhancing structural design to resist disasters and afford greater protection. For example, features could include earthquake retrofit of housing, elevations that remain accessible, hurricane clips, and the introduction of an accessible safe room in homes and public locations. Specific programs that fund these mitigation measures for low-income households of people with disabilities should be considered.
45. Communities may opt to remove structures from hazardous areas through FEMA's relocation/buyout program. Such relocations must be done carefully so as to minimize the impact on people with disabilities who rely on nearby work, transportation, and key social and health services.
46. Programs like HUD's DHAP should be continued, and HUD could ensure that a portion of funds are set aside for accessibility needs.
47. A portion of mortgage relief funds could be set aside for people with disabilities, particularly those at the lowest income levels.
48. Increase funding for and publicize SBA mitigation funds usable for enhancing accessibility in post-disaster housing more widely. Ultimately, mitigation can reduce the need for disaster assistance.

NCD Topical Brief #5

State Evaluation

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Introduction

This brief examines the wide range of issues shaping what States do to promote two closely related goals or outcomes, particularly for people with disabilities living on limited or low incomes: (1) accessible, affordable, and integrated housing; and (2) long-term supports and services to live in least restrictive situations of choice in the community and prevent institutionalization. Although interrelated, these goals have been shaped and governed by very different systems, policies, and funding sources at the federal and State levels. To address the first goal specific to housing, the focus has been on civil rights related to fair housing and the development and availability of equitable housing opportunities, with people with disabilities being one of many societal groups covered. In the second goal related to long-term community living supports, the focus has been on civil rights related to the Americans with Disabilities Act and equitable participation in society, including the right to have a choice over where one lives and access to supports to do so. In this case, community living and integration are disability specific and cut across federal and State legislation, case law, and systems change, particularly Medicaid initiatives to ensure choice and to rebalance funding to support community-based options.

These two different but very interrelated and interdependent outcomes are realized, implemented, and enforced to varying degrees at the State, regional, and community levels. We can identify and examine existing housing and community integration needs, issues, and disparities experienced by people with disabilities within and across States, as well as the impact of advocacy to further realize civil rights and increase housing and community living opportunities. Of central concern is the need for people with disabilities to have to navigate many different systems, policies, and funding sources at the State and local levels, and the development of recent initiatives to coordinate across housing and community living systems to realize full participation, choice, and control by citizens with disabilities.

This brief examines State-level statutes, issues, trends, and promising practices in developing, maintaining, and enforcing accessible, affordable, and integrated housing

and community living supports for citizens with disabilities. Specific focus is placed upon the needs of and disparities faced by people with disabilities living on very low incomes or extremely low incomes, defined as below 50 percent and below 30 percent of the Area Median Income (AMI), respectively. This brief includes (1) a brief historical overview and comparison of housing and community integration legislation, policies, and systems most influencing “real choice”; (2) a detailed analysis of key issues related to equitable delivery and implementation of these polices within and between States; (3) promising practices emerging within States; and (4) summary recommendations for promoting future development, systems change, and legislation.

Background History, Legislation, and Policy

Housing systems do not operate in isolation, and State issues related to housing, long-term services and supports, and disability cut across multiple systems. Two primary, yet often uncoordinated and conflicting, State systems that people with disabilities need to navigate and negotiate are (1) State and local (e.g., city, town, county, metropolitan, and rural) housing systems, which manage resources such as housing subsidies, vouchers, development, and homeownership programs; and (2) long-term service and support systems, primarily State Medicaid agencies, that manage resources such as Home- and Community-Based (HCBS) Waivers to support least restrictive community options. We outline the history of these different systems and describe key State issues in implementing policy and systems change to more fully realize the housing rights of people with disabilities.

State and Local Housing History

Since the early part of the 20th century, the development and location of any type of housing in the United States have been primarily determined by building codes and zoning enacted through local and State government. The roots of current funding that can be used to help make housing affordable, accessible, and integrated can be traced to federal programs from around the same period, although many States also now manage their own Affordable Housing Trust Funds derived from different sources.[709] Here we examine more closely how these two spheres—State and local regulation and federal funding—affect the location and availability of affordable, accessible, and integrated housing for people with disabilities, particularly for households with incomes at or below 50 percent of AMI who are eligible for virtually all federal affordable housing programs.

Zoning primarily affects the location and density of housing and whether it is single-family or multifamily in design, as well as if it is integrated with or segregated from other land uses, such as open space, commercial uses, or industrial activities. While zoning has often been used to separate housing from “noxious” land uses, recent efforts to

redevelop and revitalize urban and suburban communities have introduced mixed-use zoning to integrate housing with spaces for work and play.[710] Many communities employing mixed-use development often aim to house a mix of income and/or age groups, including retirees who are interested in downsizing but wish to stay in the community. These mixed-use areas are also offered as partial solutions to the negative impacts on the environment resulting from the need to drive to work, school, shop, and play. Broader efforts, including compact development, smart growth, and new urbanism, aim to reduce the distance between uses so that people can walk, bike, and use public transit rather than drive. These efforts obviously can benefit people with disabilities and an aging population, as long as modes of transit and paths accommodate different and diverse disability needs, including physical, sensory (hearing, vision, tactile), developmental, cognitive, psychological, social, and environmental sensitivity.

Building codes aim to ensure housing meets health, safety, welfare, and property protection goals. However, as a 2001 U.S. Department of Housing and Urban Development (HUD) report points out, these "have been expanded in recent years to include other societal goals, including energy conservation, accessibility, disaster mitigation, historic preservation, and affordability."[711]

While building codes are locally controlled, communities have long adopted standard building codes. In 2000, the International Building Code (IBC) was developed by the International Code Council (ICC)[712] to provide guidance for accessibility from the American National Standard Institute and the U.S. Access Board. In addition to building codes, local ordinances and State legislation also provide specific instructions for making housing visitable. However, these are often voluntary, although they frequently come with incentives to encourage visitability.

Despite movement toward uniform building codes across the United States, regulatory barriers, including zoning, local politics, and planning practices, among other things, greatly affect where and if affordable, integrated, and accessible housing is built.[713] To a certain extent, federal policy and subsequent funding streams that flow into States and local jurisdictions to produce affordable housing acknowledge these variations by

devolving to State and local government the ability to develop localized plans to expend federal funds. HUD requires each State to produce a Consolidated Plan, which outlines how federal funding will be allocated to address housing and community development needs in each State. This plan must also include an analysis of barriers to fair housing and plans to remove or reduce these barriers that are in line with the goals of the Fair Housing Act and its amendments (FHAA).

The federally mandated Consolidated Plan identifies housing needs for different groups, including people with disabilities, and then outlines how funds will be used to meet those needs given current and near future housing conditions. Developed for a 5-year window, the purpose of the Consolidated Plan is to guide the use of all federal housing funds, including Community Development Block Grants (CDBGs), HOME, Section 202, Section 811, emergency shelter and homeless services grants, Neighborhood Stabilization Program (NSP), and other federal grants awarded either to or through the State. Each State and local jurisdiction receiving CDBG and HOME funds is required to develop the plan with citizen participation and public review prior to submission to HUD for approval. An annual plan report is used to monitor progress and also make adjustments, if needed, to the 5-year plan in order to respond to new conditions or opportunities. There are more than 500 Consolidated Plans in the United States. Typically, local plans have little to no relationship to the State's Consolidated Plan, which means they can completely contradict one another.

The Consolidated Plan uses census data provided by HUD to assess needs among people with disabilities.[714] Appendix A, "Data Tables," provides detailed data on the distribution of people with disabilities (defined on a limited basis by mobility limitations) that have "housing problems" by income, tenure, and age, for each State. A housing problem is identified as having one or more of substandard or poor-quality housing (lacking complete plumbing facilities or lacking complete kitchen facilities), living in overcrowded conditions (with 1.01 or more people per habitable room), or being cost burdened (paying more than 30% of income for housing).

Overall, the Consolidated Plan data shows that for all households with at least one person with a disability and some sort of housing problem, twice as many own their homes (12.8 million) than rent (6.3 million).[715] Among renters, the largest number and proportion of renters of any income group with mobility impairments and housing problems in the United States is in California (13% of renters; 811,000 households), New York (10%; 645,000 households), Texas (6%; 391,000 households), Florida (5%; 330,000 households), and Pennsylvania (4%; 258,000 households). The majority of these renters are very low income, so it is likely that the housing problem is due to housing cost burden.

Consolidated Plan data also reveals that nearly 13 million homeowners in the United States with mobility impairments have a housing problem. Unlike renters, the majority of these homeowners are in the higher income bracket (6.9 million are above 80% of Area Median Income), which means they may not qualify for some or most public housing assistance (with the exception of some local programs for owners).

A review of Consolidated Plans on HUD's Web site illustrates the variety of approaches States take to meet their affordable housing needs.[716] However, there is not always a clear connection made between need and the objectives/targets outlined in the plan when it comes to housing for people with disabilities, other than what is minimally required by law. In part, this may be due to the limited guidance HUD provides on using funds to meet the housing needs of people with disabilities and the aging population.[717] Still, some of these Consolidated Plans demonstrate promise, at least in terms of initiatives that respond specifically to people with disabilities:

- **Maryland: Bridge Subsidy Demonstration Program.** This 1-year pilot program for people with disabilities provides short-term rental assistance for up to 3 years. This program was funded by a reallocation of existing resources from the Maryland Department of Housing and Community Development and other State agencies.

- **Iowa: Money Follows the Person initiative.** The State agency that administers the Consolidated Plan, the Iowa Department of Economic Development (IDED), is participating in a Statewide collaboration to address the needs of people with disabilities as defined by the *Olmstead* decision. A major focus of the State of Iowa Olmstead Task Force is adequate and appropriate housing. In addition, this task force is working on a film and toolkit to "educate elected officials, policy makers, advocates, and the general public on its over-reliance on institutional-based care in Iowa."[718]

HUD recently began an initiative to improve the Consolidated Plans, including providing examples from existing plans and research on planning, reporting, outcomes, and performance measures. As HUD describes this initiative, the goal is to reduce meaningless compliance burdens, streamline the plan into a concise, readable document that is easy to understand, make the plan more useful and results oriented by linking it to performance reporting, make better use of technology to decrease the reporting burden, and promote use of the plan as a management tool for tracking results over time.[719]

While these are good and necessary changes to the process, the Consolidated Plan content for the most part has not changed. This means that people with disabilities are still in the "special needs" category, which includes:

> …various subpopulations that are not homeless but may require housing or supportive services, including the elderly, frail elderly, persons with disabilities (mental, physical, developmental, persons with HIV/AIDS and their families), persons with alcohol or other drug addiction, victims of domestic violence, and any other categories the jurisdiction may specify and describe their supportive housing needs.[720]

As a means to ensure that planners take into consideration the housing needs of the aging population and people with disabilities, this catch-all category restricts housing options for this group to supportive housing, rather than opens up the possibility to include people with disabilities in other types of affordable housing. As stated in the

guide for developing Consolidated Plans, “If the jurisdiction plans to use HOME or other tenant-based rental assistance to assist one or more of these subpopulations, it must justify the need for such assistance in the plan.”[721] People with disabilities do need specific housing features; however, not all need or want supportive services attached to their housing. The question remains as to why people with disabilities should have to justify the need or desire to live in other types of affordable and integrated housing.

In conjunction with the Consolidated Plan, States also are required to produce an Analysis of Impediments to Fair Housing Choice and Fair Housing Action Plan. Guidance from HUD states that the purpose of these plans are to affirmatively further fair housing by (1) conducting an analysis to identify impediments to fair housing choice within the jurisdiction, (2) taking appropriate actions to overcome the effects of any impediments identified through the analysis, and (3) maintaining records reflecting the analysis and actions taken in this regard. HUD’s *Fair Housing Planning Guide* recognizes that any ability to affirmatively further fair housing is challenged by the devolution of power down to State and local jurisdictions:

> Perhaps nowhere in the Department’s mission is the prospect of devolution more challenging than in fair housing. Since 1968 the Department has been under an obligation to affirmatively further fair housing in the programs it administers. Its failures to do so have come most dramatically when that policy is not embraced or is actively resisted by local communities. There are those who do not believe that “devolution” is compatible with strong and effective fair housing enforcement. They fear that without detailed and prescriptive directives, local communities will even more aggressively ignore the need for fairness and equal opportunity by individuals and groups who are covered by the Fair Housing Act. We all know that there is a basis for that concern.[722]

As part of the Consolidated Plan, States and localities should be identifying impediments, although not all States do so. A common impediment is the lack of resources to enforce fair housing rights, deal with complaints in a timely fashion, and engage in effective outreach and education. As with Consolidated Plans, States and localities respond to these impediments in a variety of ways. Nothing is uniform across States, in part because of the variation in local resources, but also because of the variation in the roles played by local government and fair housing advocates and the

extent to which each proactively furthers fair housing. Furthermore, enforcement and addressing complaints vary, since this also depends on resources. For example, some States have local entities that are HUD-certified fair housing enforcement agencies, while others rely on regional HUD offices, which can add time to the process of addressing complaints. Enforcement can be further complicated in that HUD deals with discrimination in State and local public housing and in housing assistance and referrals, while other forms of discrimination fall under ADA, which is the jurisdiction of the U.S. Department of Justice (DOJ). In other words, even though all States are required to uphold the same fair housing laws, this has not ensured consistency across States when it comes to efforts to affirmatively further fair housing.

Another area where the Federal Government provides guidance to States is the Qualified Allocation Plan (QAP)**,** which is used to allocate the Low Income Housing Tax Credits issued to States. States use these plans to evaluate development proposals from private and nonprofit developers building affordable housing. In other words, this is where States convey to developers what they are looking for in terms of housing development proposals via the points they award for different features or aspects of the proposed developments. While it is assumed that the QAP will be consistent with the State's Consolidated Plan, the only federal guidance is that QAPs give priority to projects that serve the lowest-income families and are structured to remain affordable for the longest period of time. Federal law also requires that 10 percent of each State's annual housing tax credit allocation be set aside for projects owned by nonprofit organizations.[723] Beyond these requirements, QAPs establish a variety of different criteria for awarding points in the competition for tax credits. As a result, these plans can vary greatly across the States because they are often written to meet State priorities that often change from year to year.

Since the tax credit program is not covered by Section 504, there is no mandatory inclusion of accessible housing units beyond what is required by the Fair Housing Act. The QAP could use priority points to incentivize development of more integrated, accessible housing; however, national data shows that this is not currently happening.

Based on HUD's latest report, 12 percent of the tax credit developments built between 2003 and 2005 were to target people with disabilities. Most are assumed to be supportive housing facilities for people who are homeless. Furthermore, most of these developments (87%) are larger facilities with 21 units or more, so these represent segregated rather than integrated housing, given the developments are for a targeted population.[724]

State Long-Term Services and Supports and Least Restrictive Community Living: The History of "Real Choice"

The prior section of this brief focused on fair housing rights and planning processes. Housing rights are further expanded upon in the Americans with Disabilities Act (ADA) to include community integration and full participation of citizens with disabilities in society.[725] In 1999, the application of this right to "least restrictive" community living choice was put to fore within the U.S. Supreme Court case *Olmstead v. L.C.* (98-536) 527 U.S. 581,138 F.3d 893 (1999),[726] referred to as the *Olmstead* decision. At the crux of this case was the issue of integration, that is, whether people with disabilities have a right to live in the least restrictive settings of choice, including community-based options, and whether States have responsibilities related to providing community living supports equitable to those given to people living in institutional and nursing home settings to realize this "real choice." The *Olmstead* decision enforced this right and the State's responsibilities, mandating each State to develop "comprehensive, effectively working plans," referred to as Olmstead plans. The purpose of these plans is to show what States would do to support community reintegration (e.g., from nursing home to community) and long-term community living (e.g., maintaining choice and preventing institutionalization). However, States vary as to whether Olmstead plans exist, are available to people with disabilities in accessible formats, the level of detail in the plans in relation to proposed actions to rebalance funding and address institutional bias within the State, inclusion of methods to monitor and enforce plan implementation, outcomes realized, and actions taken to address continuing needs and gaps.[727]

Movement to Coordinate Housing and Community Living Supports and Systems

In addition to planning, the *Olmstead* decision also sparked disability advocacy and resulting systems changes within States to rebalance funding to address issues of institutional bias. Starting in 2000, the Centers for Medicare and Medicaid (CMS) was instrumental in coordinating Real Choice Systems Change Grants for Community Living to fund the needed infrastructure, systems change, and policy revisions to offer real choice related to community living with supports. This systems change was further reinforced within the New Freedom Initiative and President George W. Bush's Executive Order 13217 titled Community-Based Alternatives for Individuals with Disabilities.[728]

A number of significant changes were made to Medicaid's coverage of long-term care services within the 2005 Deficit Reduction Act (DRA) to further support use of funds toward community living options. Through March 2008, CMS also awarded approximately $285 million (see CMS 2006, 2007) in Real Choice Grants that were used to support States in providing community reintegration supports (e.g., transition from nursing home or institution to community), cross-system coordination and infrastructure, and resource rebalancing to address institutional bias. For many States, this involved the creation and expansion of Home- and Community-Based Waivers (HCBSs) and long-term community living programs. For some States, such as Texas with its Rider 37, this systems change was also legislated. However, many States remained challenged in implementing real choice, with great disparities between States on implementation and resource rebalancing.[729]

The concept of Money Follows the Person (MFP) then was proposed and advocated for as a mechanism for monies to follow the person into the community at levels equitable to those allocated for institutional/nursing home care. The MFP movement also brought to the fore the coordination of information, supports, services, and funding across systems, and the need for consumer direction and control throughout the process. CMS funded over $1.75 billion in MFP demonstration grants in 31 States, with States estimating to transition more than 27,000 people out of nursing homes and other

institutions to the community using these initiatives. Of note, States needed to also show a plan to maintain these MFP initiatives long term after the demonstration period.

At the same time, disability activists rallied for accompanying MFP-related legislation that has since been enacted or is now pending in several States. This advocacy continues nationally with the Community Choice Act and other related legislation. Additionally, many class action lawsuits were brought against States in relation to violation of ADA civil rights and the *Olmstead* decision, further influencing systems change and funding rebalancing within specific States.[730] In some cases, these resulted in the creation of promising practices from which other States can learn.

From this brief historical overview, we can see how and why different systems and funding mechanisms exist, their differing foci and philosophies, and the complexity of housing and community living choice at the legislative and policy levels.

Key Issues Influencing "Real Choice"

States, and citizens with disabilities living in them, are facing several key issues influencing "real choice" access to affordable, accessible, and integrated housing.[731] These include differences in (1) definitions related to housing and community living/integration, (2) eligibility criteria, (3) system funding levels and disparities, (4) information access, (5) coordinated, consumer-directed system delivery, and (6) monitoring and enforcement across systems.

Differences in Definitions

One key issue facing States is the variation in definitions related to disability, housing features such as accessibility and affordability, and community integration.

Defining Disability

For States providing housing services through HUD and community living supports through CMS, how disability is defined determines who receives services. For CMS and State providers, a disability determination is criteria-based and complex. By law, disability is defined as "the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."[732] This definition centers on showing proof of long-term medical need and economic need related to productive employment/gainful activity. Additional criteria related to medical necessity, functional performance status, and age further influence specific CMS program eligibility.

For HUD housing programs and providers, disability is defined at both the individual and household levels. A person with a disability is defined as an individual who "has a disability as defined in Section 223 of the Social Security Act; or is determined to have a physical, mental, or emotional impairment which is: expected to be of long, continued and indefinite duration; and substantially impedes his or her ability to live independently; and is of such a nature that such ability could be improved by more suitable housing

conditions; or has a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act."[733] A disabled household is defined as a "family whose head, spouse, or sole member is an adult with a disability. Disabled households can be a single individual with a disability living alone; a related family in which the head of household or spouse is a disabled person; two or more related adults with disabilities living together; two or more unrelated adults with disabilities living together; or one or more unrelated adults with disabilities living with one or more live-in aides."[734]

In comparison to these systems definitions, the Americans with Disabilities Act and ensuing systems change initiatives are based upon the civil rights framing of disability, which is "The term 'disability' means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such impairment; or being regarded as having such an impairment."[735] This definition was used in the *Olmstead* decision to assert the right to least restrictive choice; however, the systems involved in implementing those rights continue to use existing medical and economic-based definitions that shift the onus to the individual to demonstrate need, versus to society and the systems within it to support the civil rights of citizens with disabilities.

Defining Accessibility

The other side of the coin relates to how we then define the environment, as in housing and environmental modifications, at the federal, State, and local levels. This brings to the fore definitions related to accessibility, most often defined by the Architectural Barriers Act, the Federal Fair Housing Act of 1988 accessibility guidelines,[736] and Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. 794). Additionally, many housing developers point to Uniform Building Code or the International Building Code standards of accessibility, as well as to State and local codes and regulations.[737]

Each of these offers differing versions of "accessibility," which are further complicated by terms such as *adaptable* and *visitable*. Adaptable housing does not implement full

accessibility features and is built to allow for easier adaptation or addition of these features should the person need it in the future. For example, the housing may have a closet or storage space built in a way that could accommodate an elevator or lift addition if needed. “Visitability” focuses on building in a minimal set of access features so people with disabilities can visit others in the community and be able to move around and use the first-floor entrance and bathroom.[738] Neither “adaptable” nor “visitable” corresponds to full accessibility, and many consumers are confused by the differences in these terms and the accessibility or lack thereof when they move in. Many also are not aware that it would be their responsibility to pay for such adaptations to make the housing accessible, even though it is their right to add it. Additionally, “accessible” primarily pertains to physical and sensory access, with far less coverage and consideration of diverse issues related to cognitive, social, psychological, and environmental sensitivity.

Another area of confusion—and contention—is that many people believe that townhouses and single-family detached homes are not covered by these accessibility regulations, therefore excluding a large section of housing supply from scrutiny and requirements. While these regulations may not directly require that some types of housing include accessibility features when developed or rehabilitated, all housing is subject to requirements of reasonable accommodation. Furthermore, all public housing programs are subject to 504 requirements, so if this type of housing is produced with federal funds, it must comply with these laws.

Defining Affordable

Among the different State plans, private and nonprofit housing is expected to be built and/or made affordable through use of a diverse collection of public and private funds. Since the 1960s, the Federal Government has gauged affordability relative to assumptions about precisely how much all consumers *should* pay for housing as a portion of their incomes, which currently is 30 percent of income. For renters, this cost includes monthly contract rent plus utilities. For owners, it includes monthly mortgage payments, insurance, utilities, and taxes. For both renters and owners, regardless of

income level, housing is not affordable if a household has to use more than 30 percent of its income on it.

Eligibility for housing that is built with or in any way made affordable by federal funds is determined by income limits regardless of age or disability status. Federal requirements provide specific guidance on what is included in determining eligibility, such as assets and other forms of income. Most HUD programs target "very low income" households, which means their income is at or below 50 percent of the family Area Median Income (AMI). The AMI is based on family size and adjusted annually using the annual American Community Survey (ACS).[739] In addition, there are further subdivisions: households with an income below 30 percent of AMI are considered "extremely low income" (ELI), while an income below 50 percent of AMI is "very low income." Still, in addition to these categories, other funding streams use other ranges of income when targeting assistance. For example, the Low Income Housing Tax Credit (LIHTC) program uses formulas that include people earning between 50 and 60 percent of AMI. The new Neighborhood Stabilization Program introduced "middle-income" (between 80 and120% of AMI) and now refers to households with incomes below 120 percent of AMI as "mid-mod-low-income."[740] While all States can fund projects that target incomes below these marks, many affordable housing programs have benefitted people at the higher end of the eligible income group rather than the lower end. Furthermore, rents in LIHTC projects are based on what is affordable to a specific income level (e.g., 50% of AMI), so any family below that income cannot afford to live there using the 30 percent of income standard.[741] All these different income targets and corresponding requirements make it difficult to develop affordable housing for people with disabilities.

Defining Integration

States have not specifically defined "integration," but instead rely on ADA and *Olmstead* decision terminology related to "least restrictive" choice to guide the provision of integrated housing, programs, and services. This framing focuses on what integrated choice is not—placement in nursing homes or other institutional settings without choice about community-based options—rather than describing what it is. More recently, MFP

legislation and policies have referred to specific numbers in which “community-based” options may not include more than four people with disabilities living together, such as a group home with 8 to10 people in it. However, these criteria and their enforcement differ by State. There is great variance within States, and particularly among housing developers and providers within them, in what “integrated” or “least restrictive” choice includes, often leading to class action lawsuits to put parameters around integration and enforcement related to it.

Why Are Definitions Important?

These different framings and multiple definitions make it very difficult not only to deliver coordinated housing and community living services, but also to show need versus supply disparities, to compare issues and outcomes across States, and to monitor enforcement and learn from promising practices.

Differences in Qualifying and Eligibility Criteria

For the most part, States defer to funding sources to set qualification and eligibility criteria, and different funding sources use different criteria.[742] As an example, both CMS and HUD use income/asset criteria; however, each uses different thresholds to determine initial and continuing eligibility (e.g., HUD uses median income in relation to national poverty and income thresholds, while Medicaid uses income/asset thresholds determined via individual State statute).

Qualifications are not just based on income. For those individuals who also need to obtain community living supports through Medicaid, States also use functional needs determination and risk management assessments to determine eligibility, criteria that may vary significantly among States. Additionally, type of disability (e.g., physical, psychiatric, developmental) or age may preclude people with disabilities from accessing specific State programs even if they have a need. For people who identify with multiple disabilities or acquire them as they age, access to housing and community living supports becomes much more complicated. They may lose access or be offered very

different services when transitioning between or among systems, again placing them at risk for premature or unwanted institutionalization or homelessness.

Differences in Funding and Parity of Supports and Services

States also face significant issues related to funding of housing and community living supports, as well as disparities among different disability and aging constituencies in accessing this funding.

Housing System Funding

As part of States' Consolidated Plans, allocation of housing resources is to be guided by need; however, need far exceeds what is available. This is true also for the LIHTC program; while it is based on a per capita formula, the actual dollars it can generate per State are quite small relative to the cost of building new housing. In addition, as noted previously, the complexity of using multiple layers of financing makes it quite difficult for many affordable housing developers to juggle the different eligibility requirements of different funding streams, which can deter or derail efforts to produce quality integrated housing. Finally, while State plans provide counts of units for people with disabilities and seniors, it is very difficult to ascertain the number of people with disabilities who actually receive housing units, housing subsidies, or monies for eligible housing retrofitting, rehabilitation, and supportive services. Also, the data does not examine differences by different disability type. All these issues significantly influence whether people have "real choice" in deciding where they live, whether they are able to support or maintain that living over time, and the quality of their living situation.

Community Living and Long-Term Services and Supports Funding

To live in community-based housing options, many people with disabilities also need accompanying community living supports that are often funded by Home- and Community-Based or related Medicaid waiver programs, and/or other State long-term services and supports programs that fall outside waiver designations. One indicator of whether States have progressed in rebalancing funds to address institutional bias and

provide community-based living choice is to compare funds spent on institutional long-term care (including nursing homes, State institutions, ICFs, etc.) to those spent on Medicaid waiver programs to support community living and trends over time. Based on federal data, a recent analysis by Thomson Reuters[743] shows that significant progress has been made nationally in this rebalancing, moving from institutional to community funding ratios of 85 percent institutional/15 percent community in 2000, to 58 percent institutional/42 percent community as of 2007, with an average growth of 10 percent a year in community-based funding from 2002 to 2007. However, this data is limiting and can be misleading. First, the data does not tell us about community-based housing funding needs and trends, as they only reflect long-term care system funding. The data also does not reflect the number of people who are on waiting lists for community-based services, or those who cannot find affordable and accessible housing and therefore remain in institutional settings.

Additionally, this data is complex to interpret. Although we have made gains in rebalancing on a national level, the funding ratios vary significantly by State. As of 2007, only 11 States had rebalanced their spending to support community-based options at levels of 50 percent or more of their total long-term care budget (New Mexico, Oregon, Arizona, Minnesota, Alaska, Washington, Wyoming, California, Kansas, Colorado, and Maine). In comparison, the rest of the States spent less than 50 percent on community-based services, with several reporting 30 percent or less (Mississippi, North Dakota, Pennsylvania, Alabama, New Jersey, Tennessee, Arkansas, Ohio, and Kentucky). Thus, the State in which you live influences real choice.

Another example of State differences is how funds are allocated between different programs (e.g., aging, and physical, psychiatric, or developmental disability). The national ratio of 58 percent institution to 42 percent community across all disability groups shifts to 69 percent institution to 31 percent community when looking specifically at aging and physical disability group funding, with 16 States reporting less than 20 percent allocated for community waivers for these groups. Thus, one's age or disability designation as defined by each State also influences real choice. For example,

in some States, older adults with disabilities may be able to access funding for either personal attendant or homemaker supports depending on their level of need, while in other States, their choice is limited to homemakers who may not be trained or authorized to help with heavy lifting or personal care tasks such as bathing. In many States, waiver programs are not available to people with psychiatric disabilities, significantly limiting their choices. For people with developmental disabilities, some States offer funding for a full range of living options, including innovative family and least restrictive shared living options of four or less, while other States continue to primarily fund more segregated living options such as Intermediate Care Facilities or shared living situations of more than four people, thus also limiting real choice. Additionally, some States impose service limits, or caps, on individual funding that may further restrict community-based services, while other States using a more flexible Money Follows the Person (MFP) approach in which funds that would have been spent on institutional services follow the person to the community to be used more flexibly, as needed and as directed by the individual. In summary, although States have progressed in addressing institutional bias issues, significant disparities continue to exist among States in regard to real choice and long-term control in housing and community living.

Differences in Information Access

The need for accurate, accessible, and transparent information also is critical for people with disabilities to have “real choice,” so they can make informed decisions about where and how they live. Information access, quality, and coordination are key issues within States, especially for people with disabilities who may be trying to access information during times of housing or health crises or emergencies, or from within settings where information access is difficult, unavailable, or withheld. Additionally, information needs to be accessible via alternative formats if consumers and significant others in their lives are to actually use that information to make a “real choice.” Accessibility may also involve modifications in policies or strategies, such as increased time to process information before making decisions, or use of peer supports or other accommodations during the process. Accessibility also relates to information technology use, such as cell phones, computers, Internet, and email. In some States, emergency cell phones and

basic Internet access have been integrated into housing and community living support services and funding.

Information about choices also needs to be accurate and consistent across different systems and providers, such as homeless shelters, emergency systems, information hotlines/centers, community organizations, medical and rehabilitation systems, nursing homes, and other long-term care settings. Disability advocates also point to problems providing this information in a way that is unbiased, highlighting the potential role of Centers for Independent Living, Senior Centers, and Disability and Aging Resource Centers to collaborate on offering access to information and to support consumers in navigating across different systems. Some States also have collaborated with these groups to implement housing locator systems that provide information on accessible and affordable housing; however, the availability, quality, accuracy, and level of accessibility detail vary widely among these systems.[744]

Differences in Coordination of Supports and Services Across Systems and Quality Control, Monitoring, and Enforcement

As referenced throughout this report, States have shifted toward coordination of housing and community living systems, particularly within Real Choice and MFP demonstration grants and related State initiatives. However, coordination of services and funding sources currently varies widely by State. In many States, housing systems have not been coordinated with community living and long-term services and supports systems, making it very difficult for people with disabilities to coordinate housing vouchers or subsidies with needed community living supports. As shown previously, many States continue to use silo systems, with services based on different disability or funding systems, such as those related to aging, physical disability, psychiatric disability, and developmental disability. In comparison, some States have used Real Choice and MFP grants to break down these silos and offer coordinated information and services, as well as equitable access to community living supports across systems. Coordination of services and funding is also an issue for people with disabilities who move to different communities within States, as well as those who relocate to another State. The

challenge is to provide “no wrong door,” that is, coordinated points of entry so that consumers can understand their rights and access housing and community living information and supports. This also means that States need to develop and fund infrastructure to coordinate policies and monitor access to and provision of coordinated services. This coordination is especially important to consistently and rigorously compare outcomes, impact, needs, and disparities across States and across the Nation.

Housing and Community Living Promising Practices

In this section, we feature promising practices that have been or are being implemented by and within States in the areas of systems change, information access, legislation, monitoring and enforcement, and research related to housing and community living.

Systems Change and Coordination

One of the most promising trends at the State level has been the increasing cross-coordination of housing with community living and support systems, funding, and service delivery. These have been referred to as Single Access Points, One Stop Shop, No Wrong Door, and Comprehensive Entry Point systems. These systems enable consumers to enter through many different "doors," or systems/programs, yet still receive coordinated, consistent, and quality information, counseling, housing, and community living supports and services. The Rutgers Center for State Health Policy/NASHP Community Living Exchange Collaborative reported 43 single entry points operating across Medicaid programs in 32 States.[745] Many of these initiatives were developed with systems change demonstration grants from CMS and related national initiatives (e.g., Robert Wood Johnson's self-determination and cash and counseling projects).[746]

Although many States used these initiatives to streamline entry within specific Medicaid programs, some States have used them to break down silos created by categorizing people by disability type (e.g., developmental, physical) or age across all State programs, so no matter how or where people enter, they receive information about their choices and coordinated access housing and community living supports.[747] Such commitment to long-term, cross-systems change has been especially useful to people who are transitioning between living situations (such as moving from a nursing home, institution, or ICF to community living) or people having to navigate multiple systems (such as people with disabilities as they age, people who identify with multiple disabilities, or families in which multiple people with disabilities are living and aging together and need supports across systems). They are also useful for maintaining

community living choices over a lifetime (including coordination of young child, adult, and older adult systems), and preventing or responding to institutional placements that are not of choice at any time.

These initiatives offer valuable strategies to States to formally integrate consumer direction and control across systems.[748] They also offer infrastructure and strategies for States to document needs, service delivery, costs, and outcomes over time across systems,[749] contributing to research that documents their impacts and cost effectiveness.[750]

Even more promising, several States are expanding to coordinate community living with housing systems and delivery. Many of these initiatives are based upon a Money Follows the Person framework to offer cross-system, consumer-directed choice. These involve development of new policies to enable States to fund and deliver this coordinated package across systems. Current promising practices include:

- State initiatives to coordinate HCB waivers with housing vouchers or subsidies via innovative funding collaborations, including use of HOME funds for rental assistance during transition to the community (e.g., Kentucky's Housing Finance Agency has allocated $50,000 in HOME funds to fund bridge subsidies, and Ohio's Dayton Metropolitan Housing Authority announced the use of HOME funds to fund tenant-based assistance and Section 8 funds for project-based vouchers for people with mental illness who are homeless).
- Development of Home Modification/Barrier Free Housing Trust Funds.
- Reuse of funds from institutional downsizing and closures for expanded housing vouchers, rental assistance, and community support packages.

As an example, Pennsylvania is implementing several of these practices in its Statewide systems change initiative, which coordinates between the Pennsylvania Department of Public Welfare and the Pennsylvania Housing Finance Agency (PHFA).

Two States, North Carolina and Louisiana, have been featured as examples for implementing Statewide, cross-systems change initiatives to coordinate mainstream affordable housing and community living systems for people with long-term disabilities, including people with disabilities who are homeless.[751] These include a targeted collaboration of health and human services systems and housing authorities across the State, including the use of bonus points within Qualified Allocation Plans (QAPs) with housing developers to target 10 percent set-asides for people with disabilities with extremely low incomes (below 30% of AMI), and the use of Targeting Plans and Local Lead Agencies to ensure coordination among community service providers and property managers with tenants with disabilities, and the provision of reasonable accommodations and supports. Louisiana replicated North Carolina's systems change to further target the needs of people with disabilities post-Katrina, adding the use of CDBG funds to support infrastructure and long-term support provision.

Cross-System Navigation

Several of these systems change coordination initiatives have formally incorporated coordination with regional Aging and Disability Resource Centers, Area Agencies on Aging, and Centers for Independent Living to provide information, case management, peer mentoring, legal assistance, and connections to related community living, transportation, social participation, and employment opportunities. Coordination also involves continuous education of staff across systems and delivery programs. Public Housing Agencies have used service coordinators to assist consumers with locating housing, employment, and social service information. Several States are using Centers for Independent Living (CILs) and peer mentors to support consumers in navigating complex housing and community living systems and programs. For example, Pennsylvania is funding regional housing coordinators whose role is to provide coordinated information and assistance to individuals and organizations that help people with disabilities transition from institutions to community living, to educate property managers and housing developers on how to develop and market least restrictive housing options to people with disabilities, and to monitor that the housing needs of people with disabilities are being addressed.

Another example of such an initiative has been facilitated by Access Living, a Center for Independent Living in Chicago, Illinois.[752] Access Living has collaborated with the Chicago Housing Authority (CHA) to promote coordinated housing and community living information, increased access to and use of housing vouchers (Home Choice) by people with disabilities, and designated vouchers for people moving out of nursing homes and institutions to community-based options. This close collaboration has resulted in actions, such as the creation of an Office on Disability Policy within the CHA, a 504 self-evaluation, a 504 Voluntary Compliance Agreement, audits of accessibility of new housing by an architectural firm specializing in disability-related access, funding of a home modification fund for people receiving Home Choice Vouchers, time extensions and transportation support during the housing search, and creation of a targeted program and vouchers for people moving out of nursing homes to the community. Joint counseling sessions by Access Living and the CHA are conducted at Access Living to support people during this process and ensure the successful use of vouchers.

Promoting Integrated and Least Restrictive Choice

Several States have targeted initiatives to create and expand integrated housing choices. As an example, Washington is using federal demonstration grant funding to collaborate with local housing authorities throughout the State to develop more integrated and less restrictive (four or fewer) community living choice models and evaluate their impact. Oregon continues to expand community housing in small neighborhood homes, and is also developing individual apartment housing in which consumers can share support services with other consumers with developmental disabilities. Virginia is working to revise legislation and policies to enable people with developmental disabilities to share an apartment or single-family home with supports.

Increasing Information Access with Housing Locator Systems

Access to consistent, quality, and current information about affordable, accessible, and integrated housing choices and features is critical. A number of States have developed housing locator systems that allow online searches of affordable housing units.[753]

These systems range from minimal databases of State-financed developments to more sophisticated sites with multiple search options, detailed accessibility information, updated vacancy and occupancy status, and links to local service agencies and resources. Following are some examples of housing locator promising practices.

Socialserve.com

Socialserve.com is a nonprofit agency and the largest database provider of multistate housing registry services. Registries include listings of affordable rental properties in 27 States, and affordable housing for sale in 8 States and 1 county. Socialserve.com includes a toll-free call center with multilingual staff members who help landlords and tenants search the database. They can work with a particular State or community to customize a housing registry to meet specific needs. For example, registries can include a filter for searching for specific accessible features, such as bathrooms with grab bars and/or roll-in showers, kitchens with low counters, or entryways with flat or no-step entry.[754]

Mass Access: The Accessible Housing Registry

Maintained by the Citizen's Housing and Planning Association, Mass Access helps people with disabilities find barrier-free, accessible housing in Massachusetts. This housing locator includes information on the availability of affordable and accessible apartments, waiting list openings, information on homeownership opportunities, and links to housing locators in other States. Users can also search for specific accessible/adaptable features.[755]

Access Virginia: Virginia's Accessible Housing Registry

Access Virginia is sponsored by the Virginia Housing Development Authority and the Virginia Board for People with Disabilities. Access Virginia includes information on affordable and accessible apartments, as well as information about accessibility requirements and universal design. The site includes an Accessible Apartment Finder, an index of accessible housing resources, an interactive map to Centers for

Independent Living (CILs) in Virginia, and links to related housing services and retailers of accessible appliances.[756]

National Accessible Apartment Clearinghouse

This clearinghouse is a national database of more than 80,000 accessible apartments across 50 States. The clearinghouse is a public service program of the National Apartment Association, the Virginia Housing Development Authority, and other organizations. Information is available from the clearinghouse via the Web, fax, or a toll-free hotline.[757]

Housing Connections

In Portland, Oregon, Housing Connections is an example of a city-sponsored site maintained by the city's Bureau of Housing and Community Development, with data provided by landlords on rental, for-sale, and shared housing.[758]

To link locators to long-term systems change, some States, such as Louisiana, have incorporated housing locators into housing developer contracts to make it easier for individuals to identify available housing options and to improve marketing of affordable and accessible units by developers to consumers.

Legislative Promising Practices

Many States have been hampered by current policies that restrict how monies can be used to provide services in a least restrictive, community-based setting. Given ongoing disability advocacy, some States have enacted legislation to rebalance Medicaid monies toward community-based options. Two examples are Texas and Vermont. Texas Rider 37 of the General Appropriations Act of the 77th Legislature enables the Texas Department of Human Services to allow money to follow the person (MFP) from a nursing facility to the community. Funds were transferred from nursing home appropriations to the HCBS waiver program to provide "real choice." Texas was one of the first States to enact such State legislation and policy, and it estimates that as of 2007, 13,300 people will have transitioned from nursing homes to the community via

this initiative.[759] Passed in 1996, Vermont Act 160 allows funds appropriated for nursing home care to be used for home- and community-based services, including for people who have the most significant support needs. In addition, the act created a Statewide system of Long-Term Care Community Coalitions to improve the infrastructure for Medicaid waivers and the long-term services and supports programs.[760]

Recommendations

Formally Linking State Plans to Actions

1. States should be required and given resources to revisit Consolidated Plans and Olmstead plans to report on actual actions taken, impact/outcomes of actions, and specific action plans to address continuing or newly emerging needs and disparities.
2. States should be encouraged to offer priority points within Qualified Allocation Plans (QAPs) that guide the local allocation of Low Income Housing Tax Credits for affordable housing for development that (1) produces more than the minimum number or percent of accessible housing, and (2) demonstrates integrated choice within projects and across communities.
3. States should provide incentives to developers to use tax credits to build visitable and adaptable housing through QAP priority points.
4. There should be an annual systematic review of QAPs to make sure that States are meeting the minimum requirements set by the Federal Government.

Housing and Community Living Systems Change and Coordination

5. In collaboration with the National Conference of State Legislatures and national disability and aging advocacy organizations, convene a task force to examine federal policies to support cross-system delivery of housing and community living supports within States and make it easier for States to provide these in a timely fashion.
6. Expand cross-agency funding of Money Follows the Person and Community Choice Act systems change demonstration projects (across CMS and HUD) to focus on cross-system, coordinated delivery, and funding of housing and community living supports, especially in States that have not shown significant progress in rebalancing funding to address institutional bias.

7. Similar to CMS's promising practices resources, CMS and HUD together should collaborate with States to continually highlight and widely disseminate effective plans, policies, and practices for coordinating housing with community living/long-term care supports across State systems, using a consumer-directed approach.
8. Provide resources for States that have effectively accomplished systems change and coordination to partner with States that have not, in order to share expertise, policies, data collection, financing, and monitoring systems.
9. Provide resources for States to consistently monitor and enforce fair housing and least restrictive choice and control rights with resources to actively involve external parties, including community and disability-run organizations, in this enforcement.
10. Across States, implement systems for periodic assessment with people with disabilities living in institutional and long-term care settings, such as nursing homes, to determine if least restrictive choice and options have been offered, and if chosen, how to efficiently and effectively support timely transitions and offer cross-systems support to transition.
11. Jointly sponsor research (CMS and HUD) for States to evaluate the impact and cost effectiveness of these systems change initiatives and their long-term maintenance within States and nationally, and to document system- and policy-level barriers to doing so.

Housing and Community Living Financing

12. Expand housing vouchers and rental assistance subsidies within State and local housing authorities, targeting people with disabilities transitioning out of nursing homes/institutions/Intermediate Care Facilities (ICFs) to community-based options.
13. Sponsor and share innovative models of financing of least restrictive, community-based options, such as use of combined waiver and voucher

funding, use of HOME funds toward rental assistance, bridge subsidies during transitions, and home modification trust funds and programs.

Information Access

14. Replicate and expand model housing locator information systems:
    - Using Socialserve.com and other housing registry examples, fund the development of a network of housing registry systems and infrastructure to use the same criteria for reporting accessibility and affordability across regions and States.
    - Provide incentives for housing developers to contribute to the funding of these systems as a method to market housing to people with disabilities.
    - Model the inclusion of diverse accessibility features within registries, such as features for people with sensory (vision, hearing, tactile), developmental, and psychiatric disabilities, autism, and environmental sensitivities.
    - Model the inclusion of universal design, visitability, and livability features for housing and surrounding communities/neighborhoods.
15. Coordinate housing locator systems with least restrictive community living information resources and community-based navigator services:
    - Coordinate housing information with community living support and program information so consumers can have real choice and make informed decisions.
    - Fund mechanisms for community-based organizations, such as Centers for Independent Living, Area Agencies on Aging, and Aging and Disability Resource Centers, to coordinate and maintain these resources.
    - Fund mechanisms for Housing and Community Living Navigators from community-based organizations, including use of a pool of trained peer mentors, to support people with disabilities during this complex decision-making process.

- Formally link supports and navigator services with legal protection and advocacy supports for consumers.

State Legislation

16. Advocate for State legislation related to Community Choice Act and Money Follows the Person to put policies and funding mechanisms in place at the State level to realize the civil rights of citizens with disabilities and address existing disparities.

Education

17. Fund quality education on housing and community living rights, policies, and system delivery for housing developers and agency staff across housing and community living systems at the State and local levels, particularly in collaboration with community organizations with such expertise, such as Centers for Independent Living.
18. Increase and improve accessibility of outreach and education to people with disabilities and their families/supports, including at key entry points, such as emergency rooms, homeless shelters, medical and rehabilitation centers, and nursing homes.

Data Collection and Continuous Quality Improvement Research

19. Convene a consortium of stakeholders (consumers, federal agencies and funders, State policymakers, housing and community living organizations, developers) to develop a blueprint to:
    - Establish common definitions and criteria for assessing needs and disparities that people with disabilities face related to affordable, accessible, and integrated housing choice that can be used and compared nationally and within States.

- Incorporate an ADA and Fair Housing Act civil rights framing of disability, integration, and accessibility within data collection systems and across federal housing, long-term care, and community living systems and policies.
- Use findings to inform national data collection systems, such as Census Bureau and ACS, so data can be used to advocate for State systems change and to compare trends and outcomes over time.

20. Conduct rigorous evaluations and future trend analyses of the need for and supply of affordable, accessible, and integrated housing nationally and within States that:
    - Include people who are homeless and living in institutional settings
    - Include children under age 5 and longitudinal data across the lifespan
    - Include targeted outreach to communities and people with disabilities who are not currently receiving services or supports
    - Include data on diverse disability constituencies
    - Include data at family and household levels, including families with multiple disability needs and those with aging caregivers
    - Present findings in accessible formats that can be used by different stakeholders (e.g., policymakers, State systems, advocates, consumers)
21. Collect data on post-occupancy use of publicly funded, affordable, and accessible housing options by people with disabilities.
22. Fund rigorous evaluations and periodic audits of fair housing and civil rights programs and practices at State and local levels.
23. Fund cross-agency research (Interagency Committee on Disability Research, the National Institutes of Health, National Institute on Disability and Rehabilitation Research, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, Administration on Aging, Department of Veterans Affairs, Substance Abuse and Mental Health Services Administration,

Administration on Developmental Disabilities, etc.) to rigorously evaluate and compare outcomes and impact (costs, function, health, safety, quality of life, community participation, employment) of least restrictive, integrated housing options and programming with existing models, such as nursing home/institutions and Intermediate Care Facilities, to inform evidence-based State systems change and practice.

24. Use a participatory action research approach to all data collection and research that actively involves people with disabilities in all aspects of this research, and provides funding to support this participation.

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Table 1. Noninstitutionalized People with Disabilities: Number by States, 2007

Location	Estimate (#)	95% CI (#) *	Base Population	Location	Estimate (#)	95% CI (#) *	Base Population
Alabama	888,000	± 23,100	4,256,000	Montana	143,000	± 9,500	884,000
Alaska	96,000	± 7,300	624,000	Nebraska	210,000	± 11,700	1,617,000
Arizona	828,000	± 23,200	5,779,000	Nevada	295,000	± 13,900	2,350,000
Arkansas	541,000	± 18,100	2,594,000	New Hampshire	163,000	± 10,300	1,226,000
California	4,279,000	± 53,100	33,452,000	New Jersey	957,000	± 25,200	8,026,000
Colorado	543,000	± 19,000	4,453,000	New Mexico	299,000	± 13,800	1,808,000
Connecticut	414,000	± 16,500	3,229,000	New York	2,533,000	± 40,500	17,839,000
Delaware	116,000	± 8,700	797,000	North Carolina	1,386,000	± 29,600	8,316,000
D.C.	80,000	± 7,200	542,000	North Dakota	80,000	± 7,200	586,000
Florida	2,610,000	± 40,800	16,850,000	Ohio	1,699,000	± 32,800	10,554,000
Georgia	1,237,000	± 28,300	8,682,000	Oklahoma	617,000	± 19,500	3,289,000
Hawaii	163,000	± 10,300	1,190,000	Oregon	568,000	± 19,000	3,474,000
Idaho	192,000	± 11,200	1,362,000	Pennsylvania	1,865,000	± 34,400	11,471,000
Illinois	1,507,000	± 31,500	11,787,000	Puerto Rico	963,000	± 21,600	3,671,000
Indiana	893,000	± 23,900	5,804,000	Rhode Island	155,000	± 9,900	984,000
Iowa	405,000	± 16,200	2,742,000	South Carolina	677,000	± 20,700	4,049,000
Kansas	364,000	± 15,400	2,535,000	South Dakota	106,000	± 8,300	724,000
Kentucky	822,000	± 22,200	3,892,000	Tennessee	1,054,000	± 25,500	5,661,000
Louisiana	711,000	± 21,000	3,918,000	Texas	3,050,000	± 44,500	21,529,000
Maine	246,000	± 12,200	1,232,000	Utah	281,000	± 13,700	2,369,000
Maryland	677,000	± 21,100	5,169,000	Vermont	92,000	± 7,600	582,000
Massachusetts	830,000	± 23,200	5,990,000	Virginia	952,000	± 24,900	7,093,000
Michigan	1,523,000	± 31,000	9,317,000	Washington	936,000	± 24,400	5,988,000
Minnesota	591,000	± 19,800	4,771,000	West Virginia	397,000	± 14,100	1,680,000
Mississippi	548,000	± 18,200	2,650,000	Wisconsin	699,000	± 21,400	5,171,000
Missouri	911,000	± 24,000	5,392,000	Wyoming	76,000	± 6,400	478,000

* CI = Confidence Interval. The 95% CI can be constructed by adding and subtracting the amount in the column from the estimate.

Source: American Community Survey data tabulated by Cornell University, at http://www.ilr.cornell.edu/edi/DisabilityStatistics/acs.cfm.

Table 2. Noninstitutionalized People with Disabilities: Prevalence Rates by States, 2007

Location	Estimate (%)	95% CI* (%)	Location	Estimate (%)	95% CI* (%)
Alabama	20.9	±0.5	Montana	16.2	±1.1
Alaska	15.3	±1.2	Nebraska	13.0	±0.7
Arizona	14.3	±0.4	Nevada	12.5	±0.6
Arkansas	20.9	±0.7	New Hampshire	13.3	±0.8
California	12.8	±0.2	New Jersey	11.9	±0.3
Colorado	12.2	±0.4	New Mexico	16.6	±0.8
Connecticut	12.8	±0.5	New York	14.2	±0.2
Delaware	14.6	±1.1	North Carolina	16.7	±0.4
D.C.	14.7	±1.3	North Dakota	13.6	±1.2
Florida	15.5	±0.2	Ohio	16.1	±0.3
Georgia	14.2	±0.3	Oklahoma	18.8	±0.6
Hawaii	13.7	±0.9	Oregon	16.4	±0.5
Idaho	14.1	±0.8	Pennsylvania	16.3	±0.3
Illinois	12.8	±0.3	Puerto Rico	26.2	±0.6
Indiana	15.4	±0.4	Rhode Island	15.7	±1.0
Iowa	14.8	±0.6	South Carolina	16.7	±0.5
Kansas	14.4	±0.6	South Dakota	14.7	±1.1
Kentucky	21.1	±0.6	Tennessee	18.6	±0.5
Louisiana	18.2	±0.5	Texas	14.2	±0.2
Maine	20.0	±1.0	Utah	11.8	±0.6
Maryland	13.1	±0.4	Vermont	15.8	±1.3
Massachusetts	13.9	±0.4	Virginia	13.4	±0.4
Michigan	16.4	±0.3	Washington	15.6	±0.4
Minnesota	12.4	±0.4	West Virginia	23.6	±0.8
Mississippi	20.7	±0.7	Wisconsin	13.5	±0.4
Missouri	16.9	±0.4	Wyoming	15.8	±1.3

* CI = Confidence Interval. The 95% CI can be constructed by adding and subtracting the amount in the column from the estimate.

Source: American Community Survey data tabulated by Cornell University, at http://www.ilr.cornell.edu/edi/DisabilityStatistics/acs.cfm.

Table 3. Housing Problems Among People with Mobility and Self-Care Limitations: All Households, 2000

State	Renters			Owners			Households	
	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Owners	Percent of State Total Households	Number In State	National Percent
Alabama	102,665	1.6%	25.8%	295,460	2.3%	74.2%	398,125	2.1%
Alaska	11,449	0.2%	35.0%	21,220	0.2%	65.0%	32,669	0.2%
Arizona	95,765	1.5%	28.0%	246,125	1.9%	72.0%	341,890	1.8%
Arkansas	70,530	1.1%	28.1%	180,250	1.4%	71.9%	250,780	1.3%
California	810,675	12.8%	41.0%	1,168,955	9.1%	59.0%	1,979,630	10.3%
Colorado	79,180	1.2%	33.1%	159,809	1.2%	66.9%	238,989	1.2%
Connecticut	78,350	1.2%	39.2%	121,485	0.9%	60.8%	199,835	1.0%
Connecticut	78,350	1.2%	39.2%	121,485	0.9%	60.8%	199,835	1.0%
Delaware	14,030	0.2%	26.7%	38,550	0.3%	73.3%	52,580	0.3%
District of Columbia	22,455	0.4%	58.1%	16,178	0.1%	41.9%	38,633	0.2%
Florida	329,995	5.2%	26.1%	934,060	7.3%	73.9%	1,264,055	6.6%
Georgia	162,620	2.6%	30.0%	378,670	2.9%	70.0%	541,290	2.8%
Hawaii	25,955	0.4%	38.3%	41,819	0.3%	61.7%	67,774	0.4%
Idaho	21,800	0.3%	26.5%	60,453	0.5%	73.5%	82,253	0.4%
Illinois	253,095	4.0%	33.8%	496,495	3.9%	66.2%	749,590	3.9%
Indiana	124,220	2.0%	29.6%	295,860	2.3%	70.4%	420,080	2.2%
Iowa	52,800	0.8%	29.1%	128,509	1.0%	70.9%	181,309	0.9%
Kansas	54,940	0.9%	30.7%	123,795	1.0%	69.3%	178,735	0.9%
Kentucky	108,405	1.7%	27.8%	281,705	2.2%	72.2%	390,110	2.0%
Louisiana	102,065	1.6%	28.9%	251,400	2.0%	71.1%	353,465	1.8%
Maine	31,489	0.5%	31.5%	68,485	0.5%	68.5%	99,974	0.5%
Maryland	103,015	1.6%	33.1%	208,030	1.6%	66.9%	311,045	1.6%
Massachusetts	171,155	2.7%	44.5%	213,800	1.7%	55.5%	384,955	2.0%

Table 3. Housing Problems Among People with Mobility and Self-Care Limitations: All Households, 2000 (cont'd)

State	Renters			Owners			Households	
	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Owners	Percent of State Total Households	Number In State	National Percent
Michigan	186,105	2.9%	27.4%	493,300	3.8%	72.6%	679,405	3.5%
Minnesota	80,465	1.3%	30.9%	179,860	1.4%	69.1%	260,325	1.4%
Mississippi	62,285	1.0%	24.4%	192,840	1.5%	75.6%	255,125	1.3%
Missouri	123,235	1.9%	29.6%	292,710	2.3%	70.4%	415,945	2.2%
Montana	20,009	0.3%	31.6%	43,274	0.3%	68.4%	63,283	0.3%
Nebraska	32,209	0.5%	32.3%	67,380	0.5%	67.7%	99,589	0.5%
Nevada	46,790	0.7%	35.8%	84,020	0.7%	64.2%	130,810	0.7%
New Hampshire	26,444	0.4%	34.9%	49,219	0.4%	65.1%	75,663	0.4%
New Jersey	182,205	2.9%	36.6%	315,470	2.5%	63.4%	497,675	2.6%
New Mexico	35,050	0.6%	26.4%	97,750	0.8%	73.6%	132,800	0.7%
New York	645,265	10.2%	50.8%	625,455	4.9%	49.2%	1,270,720	6.6%
North Carolina	170,960	2.7%	28.4%	432,040	3.4%	71.6%	603,000	3.1%
North Dakota	13,295	0.2%	35.0%	24,718	0.2%	65.0%	38,013	0.2%
Ohio	257,585	4.1%	32.4%	536,445	4.2%	67.6%	794,030	4.1%
Oklahoma	83,455	1.3%	28.2%	212,355	1.7%	71.8%	295,810	1.5%
Oregon	86,950	1.4%	35.9%	155,070	1.2%	64.1%	242,020	1.3%
Pennsylvania	258,260	4.1%	30.2%	598,305	4.7%	69.8%	856,565	4.5%
Rhode Island	31,489	0.5%	45.1%	38,258	0.3%	54.9%	69,747	0.4%
South Carolina	79,155	1.2%	25.4%	232,295	1.8%	74.6%	311,450	1.6%
South Dakota	16,515	0.3%	35.3%	30,268	0.2%	64.7%	46,783	0.2%
Tennessee	138,430	2.2%	28.6%	345,970	2.7%	71.4%	484,400	2.5%
Texas	391,105	6.2%	30.3%	898,240	7.0%	69.7%	1,289,345	6.7%

Table 3. Housing Problems Among People with Mobility and Self-Care Limitations: All Households, 2000 (cont'd)

State	Renters			Owners			Households	
	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Owners	Percent of State Total Households	Number In State	National Percent
Utah	27,105	0.4%	25.5%	79,350	0.6%	74.5%	106,455	0.6%
Vermont	13,112	0.2%	33.1%	26,442	0.2%	66.9%	39,554	0.2%
Virginia	132,350	2.1%	29.6%	315,350	2.5%	70.4%	447,700	2.3%
Washington	140,685	2.2%	36.2%	248,465	1.9%	63.8%	389,150	2.0%
West Virginia	46,295	0.7%	23.8%	148,525	1.2%	76.2%	194,820	1.0%
Wisconsin	108,605	1.7%	35.1%	200,595	1.6%	64.9%	309,200	1.6%
Wyoming	9,150	0.1%	29.1%	22,272	0.2%	70.9%	31,422	0.2%
TOTAL	**6,349,566**			**12,838,839**			**19,188,405**	

Source: U.S. Department of Housing and Urban Development, Consolidated Plan/Comprehensive Housing Affordability Strategy 2000 Data, http://www.huduser.org/datasets/cp.html.

People with Disabilities = All people with Mobility and Self-Care Limitations identified in the 2000 U.S. Census.

Housing Problems = Lacking complete plumbing facilities or lacking complete kitchen facilities (quality), or with 1.01 or more people per room (overcrowding), or with cost burden more than 30% (Note: Most are cost burdened).

Table 4. Housing Problems Among People with Mobility and Self-Care Limitations: Low-Income, 2000

State	Renters			Owners			Households	
	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Total
Alabama	17,585	1.5%	23.6%	56,930	2.2%	76.4%	74,515	2.0%
Alaska	2,265	0.2%	37.8%	3,725	0.1%	62.2%	5,990	0.2%
Arizona	20,075	1.7%	28.8%	49,690	1.9%	71.2%	69,765	1.9%
Arkansas	13,520	1.2%	27.3%	36,080	1.4%	72.7%	49,600	1.3%
California	157,120	13.5%	42.9%	209,460	8.1%	57.1%	366,580	9.8%
Colorado	16,135	1.4%	32.6%	33,315	1.3%	67.4%	49,450	1.3%
Connecticut	12,465	1.1%	36.3%	21,880	0.8%	63.7%	34,345	0.9%
Connecticut	12,465	1.1%	36.3%	21,880	0.8%	63.7%	34,345	0.9%
Delaware	2,510	0.2%	23.8%	8,045	0.3%	76.2%	10,555	0.3%
District of Columbia	2,230	0.2%	49.3%	2,295	0.1%	50.7%	4,525	0.1%
Florida	64,855	5.6%	25.6%	188,495	7.3%	74.4%	253,350	6.8%
Georgia	30,170	2.6%	29.1%	73,365	2.8%	70.9%	103,535	2.8%
Hawaii	4,930	0.4%	41.1%	7,060	0.3%	58.9%	11,990	0.3%
Idaho	4,525	0.4%	25.7%	13,070	0.5%	74.3%	17,595	0.5%
Illinois	44,835	3.8%	29.7%	106,220	4.1%	70.3%	151,055	4.0%
Indiana	24,680	2.1%	26.9%	67,235	2.6%	73.1%	91,915	2.5%
Iowa	10,220	0.9%	25.1%	30,545	1.2%	74.9%	40,765	1.1%
Kansas	10,875	0.9%	28.5%	27,265	1.1%	71.5%	38,140	1.0%
Kentucky	19,300	1.7%	24.8%	58,650	2.3%	75.2%	77,950	2.1%
Louisiana	17,965	1.5%	27.0%	48,520	1.9%	73.0%	66,485	1.8%
Maine	5,785	0.5%	28.4%	14,615	0.6%	71.6%	20,400	0.5%
Maryland	16,545	1.4%	31.8%	35,415	1.4%	68.2%	51,960	1.4%
Massachusetts	24,375	2.1%	37.5%	40,620	1.6%	62.5%	64,995	1.7%

Table 4. Housing Problems Among People with Mobility and Self-Care Limitations: Low-Income, 2000 (cont'd)

State	Renters			Owners			Households	
	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Total
Michigan	32,945	2.8%	23.4%	107,905	4.2%	76.6%	140,850	3.8%
Minnesota	14,165	1.2%	27.0%	38,320	1.5%	73.0%	52,485	1.4%
Mississippi	10,890	0.9%	22.9%	36,620	1.4%	77.1%	47,510	1.3%
Missouri	24,445	2.1%	27.8%	63,345	2.5%	72.2%	87,790	2.3%
Montana	3,965	0.3%	29.5%	9,490	0.4%	70.5%	13,455	0.4%
Nebraska	6,485	0.6%	30.0%	15,155	0.6%	70.0%	21,640	0.6%
Nevada	10,130	0.9%	38.5%	16,190	0.6%	61.5%	26,320	0.7%
New Hampshire	5,175	0.4%	32.6%	10,675	0.4%	67.4%	15,850	0.4%
New Jersey	29,260	2.5%	36.0%	51,990	2.0%	64.0%	81,250	2.2%
New Mexico	6,580	0.6%	26.1%	18,600	0.7%	73.9%	25,180	0.7%
New York	103,035	8.8%	47.8%	112,410	4.4%	52.2%	215,445	5.8%
North Carolina	32,165	2.8%	27.2%	85,970	3.3%	72.8%	118,135	3.2%
North Dakota	2,665	0.2%	32.5%	5,540	0.2%	67.5%	8,205	0.2%
Ohio	48,415	4.2%	28.6%	120,835	4.7%	71.4%	169,250	4.5%
Oklahoma	16,830	1.4%	27.8%	43,685	1.7%	72.2%	60,515	1.6%
Oregon	18,720	1.6%	36.9%	32,050	1.2%	63.1%	50,770	1.4%
Pennsylvania	48,350	4.2%	26.6%	133,725	5.2%	73.4%	182,075	4.9%
Rhode Island	5,070	0.4%	38.1%	8,235	0.3%	61.9%	13,305	0.4%
South Carolina	14,030	1.2%	23.9%	44,620	1.7%	76.1%	58,650	1.6%
South Dakota	3,225	0.3%	32.5%	6,700	0.3%	67.5%	9,925	0.3%
Tennessee	24,830	2.1%	26.5%	68,815	2.7%	73.5%	93,645	2.5%
Texas	75,270	6.5%	30.2%	174,065	6.8%	69.8%	249,335	6.7%
Utah	5,890	0.5%	26.4%	16,450	0.6%	73.6%	22,340	0.6%
Vermont	2,550	0.2%	29.6%	6,075	0.2%	70.4%	8,625	0.2%

Table 4. Housing Problems Among People with Mobility and Self-Care Limitations: Low-Income, 2000 (cont'd)

State	Renters			Owners			Households	
	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Total
Virginia	24,105	2.1%	29.1%	58,770	2.3%	70.9%	82,875	2.2%
Washington	28,040	2.4%	35.7%	50,555	2.0%	64.3%	78,595	2.1%
West Virginia	8,075	0.7%	19.9%	32,580	1.3%	80.1%	40,655	1.1%
Wisconsin	22,115	1.9%	32.3%	46,335	1.8%	67.7%	68,450	1.8%
Wyoming	1,895	0.2%	27.9%	4,900	0.2%	72.1%	6,795	0.2%
TOTAL	**1,164,745**			**2,574,980**			**3,739,725**	

Source: U.S. Department of Housing and Urban Development, Consolidated Plan/CHAS 2000 Data, http://www.huduser.org/datasets/cp.html.

People with Disabilities = All people with Mobility and Self-Care Limitations identified in the 2000 U.S. Census.

Housing Problems = Lacking complete plumbing facilities or lacking complete kitchen facilities (quality), or with 1.01 or more people per room (overcrowding), or with cost burden more than 30% (Note: Most are cost burdened).

Table 5. Housing Problems Among People with Mobility and Self-Care Limitations: Very Low Income, 2000

State	Renters			Owners			Households	
	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Total
Alabama	22,895	1.7%	33.5%	45,500	2.5%	66.5%	68,395	2.2%
Alaska	2,760	0.2%	50.1%	2,754	0.2%	49.9%	5,514	0.2%
Arizona	19,840	1.5%	37.7%	32,720	1.8%	62.3%	52,560	1.7%
Arkansas	16,150	1.2%	37.4%	27,000	1.5%	62.6%	43,150	1.4%
California	172,765	12.8%	55.1%	140,980	7.7%	44.9%	313,745	9.9%
Colorado	16,245	1.2%	41.8%	22,665	1.2%	58.2%	38,910	1.2%
Connecticut	16,050	1.2%	48.4%	17,100	0.9%	51.6%	33,150	1.0%
Connecticut	16,050	1.2%	48.4%	17,100	0.9%	51.6%	33,150	1.0%
Delaware	3,010	0.2%	36.8%	5,175	0.3%	63.2%	8,185	0.3%
District of Columbia	3,675	0.3%	63.4%	2,120	0.1%	36.6%	5,795	0.2%
Florida	67,290	5.0%	35.6%	121,940	6.7%	64.4%	189,230	6.0%
Georgia	33,180	2.5%	37.5%	55,225	3.0%	62.5%	88,405	2.8%
Hawaii	4,745	0.4%	54.6%	3,950	0.2%	45.4%	8,695	0.3%
Idaho	5,175	0.4%	36.8%	8,905	0.5%	63.2%	14,080	0.4%
Illinois	51,635	3.8%	41.3%	73,395	4.0%	58.7%	125,030	3.9%
Indiana	29,030	2.2%	39.4%	44,625	2.4%	60.6%	73,655	2.3%
Iowa	13,000	1.0%	38.6%	20,680	1.1%	61.4%	33,680	1.1%
Kansas	12,290	0.9%	41.2%	17,560	1.0%	58.8%	29,850	0.9%
Kentucky	24,705	1.8%	34.5%	46,995	2.6%	65.5%	71,700	2.3%
Louisiana	21,500	1.6%	35.9%	38,350	2.1%	64.1%	59,850	1.9%
Maine	8,085	0.6%	42.7%	10,860	0.6%	57.3%	18,945	0.6%
Maryland	20,080	1.5%	43.3%	26,345	1.4%	56.7%	46,425	1.5%
Massachusetts	35,025	2.6%	53.0%	31,035	1.7%	47.0%	66,060	2.1%
Michigan	40,470	3.0%	35.1%	74,970	4.1%	64.9%	115,440	3.6%

Table 5. Housing Problems Among People with Mobility and Self-Care Limitations: Very Low Income, 2000 (cont'd)

State	Renters			Owners			Households	
	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Total
Minnesota	18,810	1.4%	40.9%	27,175	1.5%	59.1%	45,985	1.4%
Mississippi	13,145	1.0%	30.5%	29,955	1.6%	69.5%	43,100	1.4%
Missouri	28,695	2.1%	39.0%	44,950	2.5%	61.0%	73,645	2.3%
Montana	5,010	0.4%	43.3%	6,570	0.4%	56.7%	11,580	0.4%
Nebraska	7,305	0.5%	42.7%	9,790	0.5%	57.3%	17,095	0.5%
Nevada	8,605	0.6%	48.7%	9,080	0.5%	51.3%	17,685	0.6%
New Hampshire	5,855	0.4%	45.1%	7,130	0.4%	54.9%	12,985	0.4%
New Jersey	37,215	2.8%	45.6%	44,470	2.4%	54.4%	81,685	2.6%
New Mexico	7,285	0.5%	35.1%	13,485	0.7%	64.9%	20,770	0.7%
New York	126,390	9.4%	61.0%	80,935	4.4%	39.0%	207,325	6.5%
North Carolina	34,795	2.6%	35.3%	63,905	3.5%	64.7%	98,700	3.1%
North Dakota	3,150	0.2%	45.7%	3,745	0.2%	54.3%	6,895	0.2%
Ohio	56,120	4.2%	41.5%	79,020	4.3%	58.5%	135,140	4.3%
Oklahoma	19,280	1.4%	37.6%	31,985	1.8%	62.4%	51,265	1.6%
Oregon	18,525	1.4%	47.5%	20,440	1.1%	52.5%	38,965	1.2%
Pennsylvania	59,635	4.4%	39.1%	92,990	5.1%	60.9%	152,625	4.8%
Rhode Island	6,445	0.5%	54.6%	5,350	0.3%	45.4%	11,795	0.4%
South Carolina	16,850	1.3%	32.7%	34,740	1.9%	67.3%	51,590	1.6%
South Dakota	4,115	0.3%	47.8%	4,495	0.2%	52.2%	8,610	0.3%
Tennessee	29,185	2.2%	35.8%	52,375	2.9%	64.2%	81,560	2.6%
Texas	80,440	6.0%	38.1%	130,480	7.2%	61.9%	210,920	6.6%
Utah	5,785	0.4%	36.2%	10,180	0.6%	63.8%	15,965	0.5%
Vermont	3,195	0.2%	42.1%	4,390	0.2%	57.9%	7,585	0.2%
Virginia	27,655	2.1%	39.1%	43,130	2.4%	60.9%	70,785	2.2%

Table 5. Housing Problems Among People with Mobility and Self-Care Limitations: Very Low Income, 2000 (cont'd)

State	Renters			Owners			Households	
	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Total
Washington	28,700	2.1%	48.7%	30,215	1.7%	51.3%	58,915	1.9%
West Virginia	11,735	0.9%	33.6%	23,170	1.3%	66.4%	34,905	1.1%
Wisconsin	25,305	1.9%	46.4%	29,245	1.6%	53.6%	54,550	1.7%
Wyoming	2,325	0.2%	40.9%	3,365	0.2%	59.1%	5,690	0.2%
TOTAL	**1,347,205**			**1,824,709**			**3,171,914**	

Source: U.S. Department of Housing and Urban Development, Consolidated Plan/CHAS 2000 Data, http://www.huduser.org/datasets/cp.html.

People with Disabilities = All people with Mobility and Self-Care Limitations identified in the 2000 U.S. Census.

Housing Problems = Lacking complete plumbing facilities or lacking complete kitchen facilities (quality), or with 1.01 or more people per room (overcrowding), or with cost burden more than 30% (Note: Most are cost burdened).

Table 6. Housing Problems Among People with Mobility and Self-Care Limitations: Extremely Low Income, 2000

State	Renters			Owners			Households	
	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Total
Alabama	41,190	1.8%	46.9%	46,715	3.0%	53.1%	87,905	2.3%
Alaska	3,295	0.1%	59.4%	2,253	0.1%	40.6%	5,548	0.1%
Arizona	27,275	1.2%	51.1%	26,115	1.7%	48.9%	53,390	1.4%
Arkansas	23,740	1.0%	51.2%	22,655	1.4%	48.8%	46,395	1.2%
California	253,150	10.9%	68.7%	115,250	7.4%	31.3%	368,400	9.5%
Colorado	28,300	1.2%	61.4%	17,810	1.1%	38.6%	46,110	1.2%
Connecticut	34,565	1.5%	71.1%	14,040	0.9%	28.9%	48,605	1.3%
Connecticut	34,565	1.5%	71.1%	14,040	0.9%	28.9%	48,605	1.3%
Delaware	5,040	0.2%	53.0%	4,475	0.3%	47.0%	9,515	0.2%
District of Columbia	12,645	0.5%	81.1%	2,944	0.2%	18.9%	15,589	0.4%
Florida	97,545	4.2%	49.3%	100,240	6.4%	50.7%	197,785	5.1%
Georgia	61,350	2.6%	53.1%	54,150	3.5%	46.9%	115,500	3.0%
Hawaii	8,840	0.4%	71.7%	3,494	0.2%	28.3%	12,334	0.3%
Idaho	6,375	0.3%	50.6%	6,215	0.4%	49.4%	12,590	0.3%
Illinois	106,130	4.6%	64.6%	58,035	3.7%	35.4%	164,165	4.2%
Indiana	44,030	1.9%	57.5%	32,480	2.1%	42.5%	76,510	2.0%
Iowa	18,755	0.8%	57.3%	13,985	0.9%	42.7%	32,740	0.8%
Kansas	18,770	0.8%	58.5%	13,295	0.8%	41.5%	32,065	0.8%
Kentucky	42,560	1.8%	48.9%	44,445	2.8%	51.1%	87,005	2.2%
Louisiana	38,480	1.7%	49.6%	39,140	2.5%	50.4%	77,620	2.0%
Maine	11,950	0.5%	57.5%	8,825	0.6%	42.5%	20,775	0.5%
Maryland	40,960	1.8%	63.9%	23,140	1.5%	36.1%	64,100	1.6%
Massachusetts	81,335	3.5%	75.4%	26,520	1.7%	24.6%	107,855	2.8%
Michigan	75,530	3.3%	53.9%	64,505	4.1%	46.1%	140,035	3.6%

Table 6. Housing Problems Among People with Mobility and Self-Care Limitations: Extremely Low Income, 2000 (cont'd)

State	Renters			Owners			Households	
	Number in State	Percent of National Renters	Number in State	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Total
Minnesota	32,415	1.4%	60.7%	20,985	1.3%	39.3%	53,400	1.4%
Mississippi	23,350	1.0%	42.6%	31,460	2.0%	57.4%	54,810	1.4%
Missouri	43,805	1.9%	55.9%	34,530	2.2%	44.1%	78,335	2.0%
Montana	6,665	0.3%	58.6%	4,700	0.3%	41.4%	11,365	0.3%
Nebraska	10,445	0.5%	59.1%	7,240	0.5%	40.9%	17,685	0.5%
Nevada	11,815	0.5%	62.5%	7,095	0.5%	37.5%	18,910	0.5%
New Hampshire	9,770	0.4%	64.4%	5,395	0.3%	35.6%	15,165	0.4%
New Jersey	71,190	3.1%	65.7%	37,215	2.4%	34.3%	108,405	2.8%
New Mexico	11,345	0.5%	47.5%	12,525	0.8%	52.5%	23,870	0.6%
New York	265,155	11.4%	79.4%	68,890	4.4%	20.6%	334,045	8.6%
North Carolina	64,005	2.8%	50.0%	64,035	4.1%	50.0%	128,040	3.3%
North Dakota	4,510	0.2%	61.9%	2,774	0.2%	38.1%	7,284	0.2%
Ohio	99,205	4.3%	61.3%	62,600	4.0%	38.7%	161,805	4.2%
Oklahoma	26,655	1.1%	50.8%	25,860	1.7%	49.2%	52,515	1.4%
Oregon	26,155	1.1%	64.7%	14,280	0.9%	35.3%	40,435	1.0%
Pennsylvania	98,070	4.2%	55.9%	77,320	4.9%	44.1%	175,390	4.5%
Rhode Island	15,050	0.6%	75.0%	5,024	0.3%	25.0%	20,074	0.5%
South Carolina	30,065	1.3%	44.9%	36,925	2.4%	55.1%	66,990	1.7%
South Dakota	5,530	0.2%	63.2%	3,224	0.2%	36.8%	8,754	0.2%
Tennessee	52,855	2.3%	51.3%	50,250	3.2%	48.7%	103,105	2.7%
Texas	131,495	5.7%	51.3%	124,855	8.0%	48.7%	256,350	6.6%
Utah	8,510	0.4%	54.9%	7,005	0.4%	45.1%	15,515	0.4%
Vermont	4,870	0.2%	63.0%	2,864	0.2%	37.0%	7,734	0.2%
Virginia	45,620	2.0%	55.3%	36,875	2.4%	44.7%	82,495	2.1%

Table 6. Housing Problems Among People with Mobility and Self-Care Limitations: Extremely Low Income, 2000 (cont'd)

State	Renters			Owners			Households	
	Number in State	Percent of National Renters	Number in State	Number in State	Percent of National Renters	Percent of State Total Households	Number in State	Percent of National Total
Washington	47,485	2.0%	66.4%	24,015	1.5%	33.6%	71,500	1.8%
West Virginia	17,055	0.7%	46.8%	19,420	1.2%	53.2%	36,475	0.9%
Wisconsin	38,760	1.7%	65.1%	20,815	1.3%	34.9%	59,575	1.5%
Wyoming	2,875	0.1%	52.1%	2,643	0.2%	47.9%	5,518	0.1%
TOTAL	**2,321,100**			**1,565,585**			**3,886,685**	

Source: U.S. Department of Housing and Urban Development, Consolidated Plan/CHAS 2000 Data, http://www.huduser.org/datasets/cp.html.

People with Disabilities = All people with Mobility and Self-Care Limitations identified in the 2000 U.S. Census.

Housing Problems = Lacking complete plumbing facilities or lacking complete kitchen facilities (quality), or with 1.01 or more people per room (overcrowding), or with cost burden more than 30% (Note: Most are cost burdened).

Table 7. People with Disabilities Receiving SSI; Monthly SSI Payment; Proportion of SSI Needed to Rent Average-Priced Studio and One-Bedroom Unit; and Estimated Housing Wage Needed to Afford Housing by State, 2008

State	Number of People with Disabilities	Number of SSI Recipients	Percent with Disability Receiving SSI	SSI Monthly Payment	Percent of SSI Needed to Rent Studio	Percent of SSI Needed to Rent One-Bedroom	Estimated Hourly Housing Wage *
Alabama	888,000	103,548	11.7%	$637	75.4%	84.0%	$9.85
Alaska	96,000	7,242	7.5%	$999	69.1%	80.6%	$14.85
Arizona	828,000	58,263	7.0%	$637	92.9%	107.5%	$13.00
Arkansas	541,000	56,803	10.5%	$637	70.0%	77.7%	$9.58
California	4,279,000	601,744	14.1%	$870	103.0%	119.8%	$19.65
Colorado	543,000	36,680	6.8%	$662	89.9%	102.1%	$12.83
Connecticut	414,000	34,289	8.3%	$805	95.8%	116.3%	$17.42
Delaware	116,000	8,555	7.4%	$637	108.6%	122.3%	$14.20
District of Columbia	80,000	13,334	16.7%	$637	157.3%	177.6%	$22.46
Florida	2,610,000	205,086	7.9%	$637	119.0%	133.1%	$15.24
Georgia	1,237,000	121,421	9.8%	$637	97.0%	104.9%	$12.36
Hawaii	163,000	13,186	8.1%	$637	169.9%	198.1%	$24.15
Idaho	192,000	15,913	8.3%	$669	72.3%	81.8%	$9.99
Illinois	1,507,000	158,219	10.5%	$637	104.9%	119.6%	$14.10
Indiana	893,000	69,239	7.8%	$637	78.6%	89.0%	$10.64
Iowa	405,000	30,238	7.5%	$637	68.0%	77.4%	$9.43
Kansas	364,000	26,245	7.2%	$637	73.5%	83.0%	$9.79
Kentucky	822,000	121,965	14.8%	$637	69.5%	79.0%	$9.65
Louisiana	711,000	97,246	13.7%	$637	91.5%	100.5%	$12.21
Maine	246,000	24,381	9.9%	$647	83.5%	96.1%	$12.03
Maryland	677,000	57,438	8.5%	$637	131.2%	149.5%	$18.11
Massachusetts	830,000	109,847	13.2%	$751	119.0%	131.5%	$19.20
Michigan	1,523,000	152,184	10.0%	$651	84.2%	94.0%	$11.80
Minnesota	591,000	48,963	8.3%	$718	75.3%	87.7%	$11.99

Table 7. People with Disabilities Receiving SSI; Monthly SSI Payment; Proportion of SSI Needed to Rent Average-Priced Studio and One-Bedroom Unit; and Estimated Housing Wage Needed to Afford Housing by State, 2008 (cont'd)

State	Number of People with Disabilities	Number of SSI Recipients	Percent with Disability Receiving SSI	SSI Monthly Payment	Percent of SSI Needed to Rent Studio	Percent of SSI Needed to Rent One-Bedroom	Estimated Hourly Housing Wage *
Mississippi	548,000	71,252	13.0%	$637	77.4%	86.7%	$10.15
Missouri	911,000	81,421	8.9%	$637	75.8%	85.1%	$10.17
Montana	143,000	10,880	7.6%	$637	68.6%	79.0%	$9.50
Nebraska	210,000	15,395	7.3%	$644	73.1%	80.7%	$9.68
Nevada	295,000	19,539	6.6%	$637	109.3%	128.9%	$15.52
New Hampshire	163,000	11,236	6.9%	$698	100.1%	117.3%	$15.65
New Jersey	957,000	81,012	8.5%	$668	135.7%	153.2%	$19.12
New Mexico	299,000	32,411	10.8%	$637	74.6%	85.2%	$10.37
New York	2,533,000	339,576	13.4%	$724	129.4%	141.4%	$20.30
North Carolina	1,386,000	119,131	8.6%	$637	83.8%	93.9%	$11.44
North Dakota	80,000	5,241	6.6%	$637	61.7%	70.5%	$8.38
Ohio	1,699,000	175,657	10.3%	$637	74.4%	85.4%	$10.52
Oklahoma	617,000	54,624	8.9%	$683	69.5%	76.6%	$9.59
Oregon	568,000	41,913	7.4%	$638	84.2%	98.2%	$11.60
Pennsylvania	1,865,000	208,600	11.2%	$664	86.8%	99.0%	$12.08
Rhode Island	155,000	19,547	12.6%	$694	107.7%	121.0%	$16.88
South Carolina	677,000	62,812	9.3%	$637	83.4%	91.8%	$11.36
South Dakota	106,000	7,807	7.4%	$652	64.4%	71.5%	$8.75
Tennessee	1,054,000	105,618	10.0%	$637	79.0%	87.4%	$10.57
Texas	3,050,000	275,695	9.0%	$637	91.5%	101.1%	$12.35
Utah	281,000	15,722	5.6%	$637	85.9%	95.4%	$11.26
Vermont	92,000	9,665	10.5%	$689	93.8%	107.8%	$13.12
Virginia	952,000	82,629	8.7%	$637	115.4%	126.7%	$15.74
Washington	936,000	77,872	8.3%	$683	89.9%	102.9%	$13.01

Table 7. People with Disabilities Receiving SSI; Monthly SSI Payment; Proportion of SSI Needed to Rent Average-Priced Studio and One-Bedroom Unit; and Estimated Housing Wage Needed to Afford Housing by State, 2008 (cont'd)

State	Number of People with Disabilities	Number of SSI Recipients	Percent with Disability Receiving SSI	SSI Monthly Payment	Percent of SSI Needed to Rent Studio	Percent of SSI Needed to Rent One-Bedroom	Estimated Hourly Housing Wage *
West Virginia	397,000	57,768	14.6%	$637	68.6%	76.9%	$9.00
Wisconsin	699,000	62,254	8.9%	$720	70.9%	82.3%	$11.31
Wyoming	76,000	4,140	5.4%	$662	74.8%	82.0%	$9.67
National	41,305,000	4,221,920	10.2%	$667	99.3%	112.1%	$14.40

Source: *Priced Out in 2008: The Housing Crisis for People with Disabilities*, Technical Assistance Collaborative, Inc., Consortium for Citizens with Disabilities, Housing Task Force, April 2009.

* The National Low Income Housing Coalition estimates the 2008 housing wage by determining how much a household must earn per hour (based on a 40-hour work week) to be able to afford the average rent for a one-bedroom rental unit based on HUD's 2008 Fair Market Rents. Monthly SSI income is equivalent to an hourly wage of only $3.86—less than one-third of the national housing wage.

Table 8. Disability Status of Households in Public Housing and Using Housing Choice Vouchers, 2008

State Name	Public Housing				Voucher			
	Elderly Family	Disabled Family	Neither	Both	Elderly Family	Disabled Family	Neither	Both
Alabama	5,283	7,763	18,586	2,485	1,334	6,349	18,179	1,291
Alaska	180	272	780	139	338	1,457	1,851	296
Arizona	559	1,303	3,543	702	1,322	6,160	10,280	2,210
Arkansas	2,175	3,443	6,028	1,272	1,571	6,111	11,564	1,570
California	3,589	6,601	19,246	5,917	28,329	73,260	133,495	54,736
Colorado	1,488	1,751	3,562	965	2,283	10,231	13,125	2,783
Connecticut	3,083	2,312	4,567	1,353	1,908	6,955	17,511	2,356
Delaware	203	464	1,011	192	330	1,273	2,267	387
Florida	5,211	6,059	15,141	4,975	7,227	17,932	47,339	8,952
Georgia	5,708	7,756	21,507	3,690	3,391	8,994	33,747	3,813
Hawaii	1,121	981	2,210	479	750	2,882	4,912	1,033
Idaho	199	284	201	118	288	2,815	2,768	772
Illinois	9,236	9,023	16,565	6,730	3,674	17,359	45,845	7,718
Indiana	2,112	3,428	6,652	1,780	1,767	9,597	19,583	3,026
Iowa	1,534	886	1,006	399	2,374	7,372	9,385	1,784
Kansas	2,156	2,206	3,063	820	831	4,230	5,192	1,014
Kentucky	2,704	5,375	11,034	2,781	1,535	10,657	18,616	2,851
Louisiana	1,893	3,350	10,031	2,172	1,422	6,260	19,901	2,177
Maine	1,142	857	1,556	397	1,144	5,563	4,243	1,181
Maryland	2,072	2,987	5,058	1,982	3,140	8,599	18,555	4,338
Massachusetts	7,027	8,099	9,463	5,570	4,020	27,144	32,721	7,250
Michigan	4,814	5,681	7,742	2,334	2,960	15,410	29,024	4,016
Minnesota	4,399	5,985	6,936	2,573	2,233	10,371	14,463	2,644
Mississippi	1,429	2,679	6,680	1,107	775	4,383	11,829	916
Missouri	3,082	4,408	6,681	1,876	1,940	11,074	22,908	2,751
Montana	142	500	1,157	174	267	2,155	2,380	688
Nebraska	1,925	1,497	2,625	643	836	3,134	6,303	836

Table 8. Disability Status of Households in Public Housing and Using Housing Choice Vouchers, 2008 (cont'd)

State Name	Public Housing				Voucher			
	Elderly Family	Disabled Family	Neither	Both	Elderly Family	Disabled Family	Neither	Both
Nevada	629	616	1,822	623	1,216	3,387	6,430	1,695
New Hampshire	1,573	1,222	941	473	1,087	4,086	3,202	877
New Jersey	11,637	6,313	11,789	4,389	6,301	13,107	32,033	6,035
New Mexico	460	888	1,949	567	657	3,818	6,241	1,527
New York	37,030	33,761	96,750	37,349	25,656	50,465	111,207	27,863
North Carolina	3,051	7,094	19,851	3,656	2,980	14,551	29,145	5,871
North Dakota	364	452	684	209	964	2,018	3,279	660
Ohio	3,891	10,243	23,233	5,226	3,174	27,710	49,000	8,066
Oklahoma	1,448	2,687	6,041	1,981	967	6,667	12,672	2,367
Oregon	611	1,761	1,872	630	2,509	10,971	14,824	3,656
Pennsylvania	10,774	12,934	20,812	7,598	6,049	21,446	33,489	6,803
Rhode Island	3,669	2,020	2,500	1,133	513	2,697	4,319	621
South Carolina	1,205	2,751	8,554	1,322	1,211	5,426	14,141	2,280
South Dakota	588	382	392	176	660	1,658	2,603	474
Tennessee	3,318	8,063	16,875	3,892	1,064	8,745	19,618	2,520
Texas	8,289	10,014	26,900	5,942	7,461	29,657	80,005	13,366
Utah	538	242	712	236	563	3,988	4,806	1,060
Vermont	628	513	393	260	578	2,531	2,067	729
Virginia	1,781	3,626	10,933	1,861	2,484	11,717	23,650	4,399
Washington	2,036	4,121	4,348	1,952	3,115	17,500	18,118	5,490
West Virginia	1,048	1,582	2,821	708	454	4,808	7,478	1,148
Wisconsin	3,384	3,352	4,034	1,370	2,318	8,417	13,386	2,430
Wyoming	145	170	319	37	316	746	854	197
TOTAL	**172,564**	**210,760**	**457,182**	**135,218**	**150,499**	**544,561**	**1,052,906**	**223,766**

Source: U.S. Department of Housing and Urban Development, Resident Characteristic report generated by HUD for this report. Resident data reflects tenants in public housing between January 1 and December 31, 2008.

Table 9. HUD Multifamily Housing Inventory Survey of Units for the Elderly and Disabled, 2008

State	Total Units	Total Assisted Units	Total Units Designated for Elderly	Total Units Designated for People with Disabilities	Total Units with Accessible Features	Percent Assisted	Percent Designated for Elderly	Percent Designated for People with Disabilities	Percent Units with Accessible Features
Alabama	19,646	16,057	5,675	1,371	1,659	81.7%	28.9%	7.0%	8.4%
Alaska	2,408	1,660	248	133	257	68.9%	10.3%	5.5%	10.7%
Arkansas	17,516	11,577	3,881	1,760	2,275	66.1%	22.2%	10.0%	13.0%
Arizona	13,178	8,358	4,078	603	1,349	63.4%	30.9%	4.6%	10.2%
California	98,583	81,949	39,257	5,073	12,241	83.1%	39.8%	5.1%	12.4%
Colorado	22,650	16,172	6,194	1,019	2,376	71.4%	27.3%	4.5%	10.5%
Connecticut	32,291	23,001	8,476	912	2,646	71.2%	26.2%	2.8%	8.2%
District of Columbia	12,512	9,933	779	271	784	79.4%	6.2%	2.2%	6.3%
Delaware	5,595	4,710	2,132	252	844	84.2%	38.1%	4.5%	15.1%
Florida	53,929	43,899	23,115	3,157	5,920	81.4%	42.9%	5.9%	11.0%
Georgia	41,108	28,020	10,302	1,500	4,439	68.2%	25.1%	3.6%	10.8%
Hawaii	5,964	3,667	1,088	528	425	61.5%	18.2%	8.9%	7.1%
Iowa	13,659	12,421	3,145	998	1,835	90.9%	23.0%	7.3%	13.4%
Idaho	4,355	3,826	781	196	590	87.9%	17.9%	4.5%	13.5%
Illinois	48,927	42,708	14,225	2,670	4,695	87.3%	29.1%	5.5%	9.6%
Indiana	37,749	29,404	4,959	1,241	2,590	77.9%	13.1%	3.3%	6.9%
Kansas	14,309	11,192	4,790	1,171	2,000	78.2%	33.5%	8.2%	14.0%
Kentucky	28,688	23,595	7,690	1,449	2,751	82.2%	26.8%	5.1%	9.6%
Louisiana	18,114	13,394	3,648	1,012	2,142	73.9%	20.1%	5.6%	11.8%
Massachusetts	60,430	49,458	16,039	2,182	4,236	81.8%	26.5%	3.6%	7.0%
Maryland	32,136	23,306	8,302	1,660	2,826	72.5%	25.8%	5.2%	8.8%
Maine	7,962	7,142	1,860	397	767	89.7%	23.4%	5.0%	9.6%
Michigan	66,918	50,559	22,394	2,797	5,054	75.6%	33.5%	4.2%	7.6%

Table 9. HUD Multifamily Housing Inventory Survey of Units for the Elderly and Disabled, 2008 (cont'd)

State	Total Units	Total Assisted Units	Total Units Designated for Elderly	Total Units Designated for People with Disabilities	Total Units with Accessible Features	Percent Assisted	Percent Designated for Elderly	Percent Designated for People with Disabilities	Percent Units with Accessible Features
Minnesota	47,168	32,767	11,958	2,505	5,768	69.5%	25.4%	5.3%	12.2%
Missouri	28,591	23,534	8,445	1,606	3,145	82.3%	29.5%	5.6%	11.0%
Mississippi	17,332	14,276	2,598	626	862	82.4%	15.0%	3.6%	5.0%
Montana	5,283	4,197	622	138	1,069	79.4%	11.8%	2.6%	20.2%
North Carolina	38,007	8,045	8,031	3,229	4,745	73.8%	21.1%	8.5%	12.5%
Nebraska	10,799	7,257	2,885	790	2,212	67.2%	26.7%	7.3%	20.5%
New Hampshire	6,795	6,284	2,482	349	776	92.5%	36.5%	5.1%	11.4%
New Jersey	25,157	3,476	9,741	1,257	3,383	93.3%	38.7%	5.0%	13.4%
New Mexico	8,248	5,565	1,493	532	716	67.5%	18.1%	6.5%	8.7%
Nevada	4,745	3,636	1,091	284	346	76.6%	23.0%	6.0%	7.3%
New York	108,720	4,687	25,263	4,258	12,309	87.1%	23.2%	3.9%	11.3%
Ohio	82,488	70,061	21,854	3,962	8,432	84.9%	26.5%	4.8%	10.2%
Oklahoma	16,432	14,347	3,186	1,027	1,883	87.3%	19.4%	6.3%	11.5%
Oregon	12,264	8,643	3,424	721	1,894	70.5%	27.9%	5.9%	15.4%
Pennsylvania	69,730	60,120	25,431	3,931	6,842	86.2%	36.5%	5.6%	9.8%
Puerto Rico	21,486	18,180	5,206	676	1,289	84.6%	24.2%	3.1%	6.0%
Rhode Island	16,409	15,703	2,079	890	1,609	95.7%	12.7%	5.4%	9.8%
South Carolina	20,003	17,777	2,756	634	1,142	88.9%	13.8%	3.2%	5.7%
South Dakota	5,541	5,150	552	413	719	92.9%	10.0%	7.5%	13.0%
Tennessee	44,798	32,540	10,591	2,553	5,384	72.6%	23.6%	5.7%	12.0%
Texas	107,639	53,797	14,305	2,871	12,589	50.0%	13.3%	2.7%	11.7%
Utah	5,012	4,155	1,152	327	1,022	82.9%	23.0%	6.5%	20.4%

Table 9. HUD Multifamily Housing Inventory Survey of Units for the Elderly and Disabled, 2008 (cont'd)

State	Total Units	Total Assisted Units	Total Units Designated for Elderly	Total Units Designated for People with Disabilities	Total Units with Accessible Features	Percent Assisted	Percent Designated for Elderly	Percent Designated for People with Disabilities	Percent Units with Accessible Features
Virginia	41,541	30,730	7,860	2,041	4,753	74.0%	18.9%	4.9%	11.4%
Virgin Islands	566	566	-	8	8	100.0%	0.0%	1.4%	1.4%
Vermont	2,757	2,505	447	176	268	90.9%	16.2%	6.4%	9.7%
Washington	13,834	12,011	6,353	863	2,138	86.8%	45.9%	6.2%	15.5%
Wisconsin	34,654	31,618	10,258	2,541	4,428	91.2%	29.6%	7.3%	12.8%
West Virginia	11,843	11,027	2,382	917	1,558	93.1%	20.1%	7.7%	13.2%
Wyoming	2,546	2,178	409	205	216	85.5%	16.1%	8.1%	8.5%
TOTAL	**1,469,015**	**1,150,840**	**385,912**	**72,682**	**156,206**	**78.3%**	**26.3%**	**4.9%**	**10.6%**

Source: U.S. Department of Housing and Urban Development, at http://www.hud.gov/offices/hsg/mfh/hto/inventorysurvey.cfm.

Table 10. Existing State Visitability Laws and Programs

Date	Location	Name	Types of Homes	Subsidized/ Unsubsidized	Mandatory/ Voluntary
1989	Florida	Florida Bathroom Law		Subsidized and unsubsidized	Mandatory
1998	Georgia	Tax Credit Incentive Program	New single-family homes that include all four accessibility features or retrofitting of an existing home that has one or more features		Voluntary
1999	Texas		New single-family affordable housing	Subsidized (State or federal funds)	Mandatory
1999	Virginia	Tax Credit Incentive Program			Voluntary
2000	Georgia		New single-family affordable housing	Subsidized (State or federal funds)	Mandatory
2000	Vermont		New residential homes, one family or multifamily	Unsubsidized and subsidized (State or federal funds)	Mandatory
2001	Minnesota		New residential homes, one family or multifamily	Applies only to projects financed in whole or in part by the Minnesota Housing Finance Agency	Mandatory if MHFA funds are used
2002	New Mexico	“UD Package”	All public and private homes		Voluntary
2002	Kansas		New single-family houses, duplexes, and triplexes	Subsidized (State or federal funds)	Mandatory
2002	Georgia	Easy Living Home Project	Single-family homes, townhomes, and attached home of fewer than four units.		Voluntary/ Certificate based

Table 10. Existing State Visitability Laws and Programs (cont'd)

Date	Location	Name	Types of Homes	Subsidized/ Unsubsidized	Mandatory/ Voluntary
2002–2004	Illinois	Accessible Housing Demonstration Grant Program	Spec homes—private single residence constructed by a builder or individual for sale on the open market		Voluntary/ Incentive based
2003	Oregon		New rental housing	Subsidized (State or federal funds) from the Oregon Housing and Community Services Department	Mandatory
2003	Kentucky	KHC Universal Design Standards Policy	Subsidized with Kentucky Housing Corporation (KHC) financing	Subsidized with Kentucky Housing Corporation (KHC) financing	Mandatory
2005	New Jersey	New Jersey's Barrier Free Subcode	Buildings with four or more dwelling units in a single structure		Mandatory
2006	Michigan	Public Act 182	Newly constructed for residential purposes and intended for occupancy by a single family, two families, or three families	Housing that uses Michigan State Housing Development Authority (MSHDA) funding	Mandatory
2006	Pennsylvania			Residential Visitability Tax Credit Act (Senate Bill 1158)	Voluntary
2007	Ohio		Newly constructed units in properties that receive tax credits		Mandatory

Source: University of Buffalo, School of Architecture and Planning and Concrete Change.

Table 11. U.S. City Visitability Ordinances

Date	Location	Types of Homes	Subsidized/ Unsubsidized	Mandatory/ Voluntary
1992	Atlanta, GA	Single-family homes	Any federal, State, or city financial benefits dispersed through the city	Mandatory
1997	Freehold Borough, NJ	Public and private dwellings		Voluntary/ Incentive
1998	Austin, TX	New single-family homes, duplexes, triplexes	Subsidized (any public funds)	Mandatory
1999	Irvine, CA	New single-family homes		Voluntary
2000	Urbana, IL	New single-family dwellings or one to four units, duplexes and triplexes	Subsidized (city funds)	Mandatory
2001	Visalia, CA	New single-family homes		Voluntary/ Certificate program
2001	San Mateo County, CA			Consumer awareness
2001	Howard County, MD			Consumer awareness
2001–2002	Albuquerque, NM	All new homes	Subsidized and unsubsidized	Consumer awareness/ Voluntary
2002	San Antonio,TX	New single-family homes, duplexes, triplexes	Subsidized (city, State, or federal funds)	Mandatory
2002	Onondaga County, NY	New single-family homes and duplexes	Subsidized (county assistance)	Voluntary
2002	Southampton, NY	New one- and two-family detached housing		Voluntary/Incentive based
2002	Naperville, IL	All new single-family homes	All homes (subsidized and unsubsidized)	Mandatory

Table 11. U.S. City Visitability Ordinances (cont'd)

Date	Location	Types of Homes	Subsidized/ Unsubsidized	Mandatory/ Voluntary
2002	Pima County, AZ (Tucson)	All new single-family homes	All homes (subsidized and unsubsidized)	Mandatory
2002	Long Beach, CA	All single-family or duplex dwelling units	Subsidized (city funds)	Mandatory
2002	Iowa City, IA	All dwelling units	All subsidized	Mandatory
2003	Syracuse, NY	New single-family homes		Voluntary
2003	Bolingbrook, IL	All new single detached dwelling units	All homes (subsidized and unsubsidized)	Mandatory
2003	Escanaba, MI	Property owners	All homes	Voluntary/Consumer incentive
2003	Chicago, IL	20% single-family homes and townhomes in planned developments must be "adaptable" or "visitable"	All homes	Mandatory
2003	St. Louis County, MO	Any homes built with county funds	All homes: New construction and substantial rehabilitation	Mandatory
2004	Houston, TX		Affordable housing	Voluntary/Incentives to developers
2004	Pittsburgh, PA	Pittsburgh Visitability Ordinance	Newly constructed or substantially renovated single-family dwellings, duplexes, triplexes, townhouses and row houses	Tax incentive
2004	St. Petersburg, FL	All new one- to three-unit homes	Subsidized (city funds)	Mandatory
2005	Toledo, OH	All new one- to three-unit homes	Subsidized (any government funds) and built within the city of Toledo	Mandatory

Table 11. U.S. City Visitability Ordinances (cont'd)

Date	Location	Types of Homes	Subsidized/ Unsubsidized	Mandatory/ Voluntary
2005	Auburn, NY	All new one- to three-unit homes	Subsidized (city funds)—single-family homes, duplexes, and triplexes that are constructed with public funds	Mandatory
2005	Prescott Valley, AZ			Voluntary
2005	Scranton, PA	All new one- to three-unit homes	Subsidized (city funds)—single-family homes, duplexes, and triplexes that are constructed with public funds	Mandatory
2005	Arvada, CO	15% of all new dwelling units must be visitable or visitable adaptable; an additional 15% must include interior visitable features		Mandatory
2006	Pittsburgh, PA		Residential Visitability Tax Credit Act (Senate Bill 1158)	Voluntary
2006	Milwaukee, WI	New/substantially rehabilitated multifamily	Subsidized—Recipients of the city's Housing Trust Fund	Mandatory
2007	Montgomery County, MD	All new home building and renovation in single-family attached and detached homes		Voluntary
2007	Rockford, IL	All new one- to three-unit homes	Subsidized (city funds)—in new residential structure(s) constructed with public funds or with financial assistance originating from or flowing through the city of Rockford	Mandatory

Table 11. U.S. City Visitability Ordinances (cont'd)

Date	Location	Types of Homes	Subsidized/ Unsubsidized	Mandatory/ Voluntary
2007	Davis, CA	100% of all new market-rate and middle-income single-family residential units shall be developed with visitability and all new single-family affordable residential units shall be developed with first-floor accessibility (includes bedroom)	Target of 100% visitability	Voluntary (facilitate inclusion of accessibility and visitability features to the greatest extent possible, including use of incentives)
2007	Lafayette, CO	All new housing	The 25% requirement would apply regardless of whether the development consisted of single-family detached or multifamily units. Mixed-use developments that include a vertical mix of uses and have greater than 75% of the units located above the ground floor	Mandatory
2007	Dublin City, CA	All new housing	The universal design ordinance requires developers building more than 20 houses in a given project to install UD features. The ordinance requires the developer to offer a list of optional features to make homes more accessible, such as a zero-step entrance.	Mandatory
2007	Birmingham, AL	All new single-family homes	Subsidized (city funds)	Mandatory

Table 11. U.S. City Visitability Ordinances (cont'd)

Date	Location	Types of Homes	Subsidized/ Unsubsidized	Mandatory/ Voluntary
2007 (takes effect Jan. 1, 2008)	Tucson, AZ	All new single-family homes	All homes (subsidized and unsubsidized)	Mandatory
2007				

Source: University of Buffalo, School of Architecture and Planning and Concrete Change.

APPENDIX B. Mission of the National Council on Disability

Overview and Purpose

The National Council on Disability (NCD) is an independent federal agency, composed of 15 members appointed by the President, by and with the consent of the U.S. Senate.

The purpose of NCD is to promote policies, programs, practices, and procedures that guarantee equal opportunity for all people with disabilities, and that empower people with disabilities to achieve economic self-sufficiency, independent living, and inclusion and integration into all aspects of society.

To carry out this mandate we gather public and stakeholder input, including that received at our public meetings held around the country; review and evaluate federal programs and legislation; and provide the President, Congress, and federal agencies with advice and recommendations.

Specific Duties

The current statutory mandate of NCD includes the following:

- Reviewing and evaluating, on a continuing basis, policies, programs, practices, and procedures concerning people with disabilities conducted or assisted by federal departments and agencies, including programs established or assisted under the Rehabilitation Act of 1973, as amended, or under the Developmental Disabilities Assistance and Bill of Rights Act, as well as all statutes and regulations pertaining to federal programs that assist such people with disabilities, to assess the effectiveness of such policies, programs, practices, procedures, statutes, and regulations in meeting the needs of people with disabilities.

- Reviewing and evaluating, on a continuing basis, new and emerging disability policy issues affecting people with disabilities in the Federal Government, at the State and local government levels, and in the private sector, including the need for and coordination of adult services, access to personal assistance services, school reform efforts and the impact of such efforts on people with disabilities, access to health care, and policies that act as disincentives for individuals to seek and retain employment.
- Making recommendations to the President, Congress, the Secretary of Education, the director of the National Institute on Disability and Rehabilitation Research, and other officials of federal agencies about ways to better promote equal opportunity, economic self-sufficiency, independent living, and inclusion and integration into all aspects of society for Americans with disabilities.
- Providing Congress, on a continuing basis, with advice, recommendations, legislative proposals, and any additional information that NCD or Congress deems appropriate.
- Gathering information about the implementation, effectiveness, and impact of the Americans with Disabilities Act of 1990 (ADA) (42 U.S.C. § 12101 et seq.).
- Advising the President, Congress, the commissioner of the Rehabilitation Services Administration, the assistant secretary for Special Education and Rehabilitative Services within the Department of Education, and the director of the National Institute on Disability and Rehabilitation Research on the development of the programs to be carried out under the Rehabilitation Act of 1973, as amended.
- Providing advice to the commissioner of the Rehabilitation Services Administration with respect to the policies and conduct of the administration.
- Making recommendations to the director of the National Institute on Disability and Rehabilitation Research on ways to improve research, service, administration, and the collection, dissemination, and implementation of research findings affecting people with disabilities.

- Providing advice regarding priorities for the activities of the Interagency Disability Coordinating Council and reviewing the recommendations of this council for legislative and administrative changes to ensure that such recommendations are consistent with NCD's purpose of promoting the full integration, independence, and productivity of people with disabilities.
- Preparing and submitting to the President and Congress an annual report titled *National Disability Policy: A Progress Report*.

Statutory History

NCD was established in 1978 as an advisory board within the Department of Education (P.L. 95–602). The Rehabilitation Act Amendments of 1984 (P.L. 98–221) transformed NCD into an independent agency.

Endnotes

[1] National Council on Disability, *Creating Livable Communities* (Washington, DC: NCD, 2006).

[2] See, for example, the Housing and Urban Development PIC system data.

[3] See, for example, www.socialserve.com, a nonprofit organization that has developed housing locator Web sites for at least 22 States. Most have search features that include some level of accessibility and affordability.

[4] The research focuses on best practices in the United States and does not include specific international examples because given the local nature of housing development, it is difficult to translate housing programs and policy from other countries for use in the United States.

[5] J. Smith, *Housing Needs of People with Disability in the U.S.* (Chicago: Nathalie P. Voorhees Center for Neighborhood and Community Improvement, University of Illinois at Chicago, 2009). Data was from the 2005 Survey of Income and Program Participation (SIPP) and the 2007 American Community Survey (ACS). This number is expected to be higher if data on institutionalized people was available to include.

[6] M.W. Brault, J. Hootman, K.A. Theis, "Prevalence and Most Common Causes of Disability Among Adults—United States, 2005," *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention (May 1, 2009), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5816a2.htm.

[7] http://www.infouse.com/disabilitydata/workdisability/appendices_glossary.php.

[8] In the SIPP, people ages 15 years and older were identified as having a severe disability if they were unable to perform one or more functional activities; needed personal assistance with an ADL or IADL; used a wheelchair; were a long-term user of a cane, crutches, or a walker; had a developmental disability or Alzheimer's disease; were unable to do housework; were receiving federal disability benefits; or were 16 to 67 years old and unable to work at a job or business.

[9] Smith, *Housing Needs*. This is based on American Housing Survey data, which estimates 110.6 million households in 2007. The 2007 American Community Survey estimates 112.4 million households.

[10] Ibid.

[11] Smith, *Housing Needs*. Data is from the 2007 American Housing Survey.

[12] U.S. Census Bureau, *Population in Group Quarters by Type, Sex and Age, for the United States: 1990 and 2000* (PHC-T-26), accessed January 30, 2009, from http://www.census.gov/population/www/cen2000/briefs/phc-t26/index.html.

[13] A. Pathania, "Nursing Homes in U.S. Register a 41% Increase in Occupancy," March 23, 2009. Data analysis done by the Associated Press, http://topnews.us/content/24540-nursing-homes-us-register-41-increase-occupancy.

[14] U.S. Centers for Disease Control and Prevention, Fact Sheets, accessed January 27, 2009, from http://www.cdc.gov/ncipc/factsheets/nursing.htm.

[15] U.S. Department of Housing and Urban Development, *The 2008 Annual Homeless Assessment Report* (Washington, DC: HUD, Office of Community Planning and Development, 2009).

[16] U.S. Department of Housing and Urban Development, *Affordable Housing Needs 2005: Report to Congress* (Washington, DC: HUD, May 2007).

[17] K.P. Nelson, *The Hidden Housing Crisis: Worst Case Housing Needs Among Adults with Disabilities*, prepared for the Housing Task Force of the Consortium for Citizens with Disabilities, p. 2. http://www.tacinc.org/Docs/HH/HiddenHousingCrisis.pdf.

[18] Ibid.

[19] U.S. Department of Housing and Urban Development, *Affordable Housing Needs 2005*.

[20] Ibid.

[21] Smith, *Housing Needs.* This number is expected to be higher if data on institutionalized people was available to include.

[22] E. Cooper, H. Korman, A. O'Hara, and A. Zovistoski, *Priced Out in 2008: The Housing Crisis for People with Disabilities*, Technical Assistance Collaborative, Inc., Consortium for Citizens with Disabilities, Housing Task Force, April 2009.

[23] National Low Income Housing Coalition, "Out of Reach 2009 U.S. Statistics," http://www.nlihc.org/oor/oor2009/OOR_US-Fact-Sheet.pdf.

[24] Ibid.

[25] Based on data from a special one-time supplement on disability and housing modifications to the 1995 American Housing Survey. Summary tables from Michael Shae, *Housing Choice Voucher Tenant Accessibility Study: 2001–2002*, prepared for the U.S. Department of Housing and Urban Development, Office of Policy Development and Research, 2004.

[26] This includes people with chemical sensitivities and electromagnetic sensitivities. For more information, contact the National Center for Environmental Health Strategies (NCEHS), http://www.ncehs.org.

[27] Ibid.

[28] National Council on Disability, *The State of 21st Century Long-Term Services and Supports: Financing and Systems Reform for Americans with Disabilities* (Washington, DC: NCD, 2005).

[29] Ibid.

[30] S. Golant, "The Housing Problems of the Future Elderly Population," *Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, A Quiet Crisis in America: A Report to Congress*, Appendix G-1 (Washington, DC: U.S. Government Printing Office, 2002), pp. 189–370; Federal Interagency Forum on Aging-

Related Statistics, *Older Americans Update 2006: Key Indicators of Well-Being* (Washington, DC: U.S. Government Printing Office, 2006); and U.S. Department of Health and Human Services, *A Profile of Older Americans 2002* (Washington, DC: Administration on Aging, 2002).

[31] C. Koyanagi, *Learning from History: Deinstitutionalization of People with Mental Illness as Precursor to Long Term Care Reform*: Kaiser Commission on Medicaid and the Uninsured, 2007). See also Ann Braden Johnson, *Out of Bedlam: The Truth About Deinstitutionalization* (New York: Basic Books, 1992).

[32] Board and care homes are also called "adult homes" and "halfway houses."

[33] Substance Abuse and Mental Health Services Administration (SAMHSA), *Transforming Housing for People with Psychiatric Disorders Report* (Washington, DC: SAMHSA, 2006).

[34] Ibid.

[35] G. Nelson, H.G. Brent, and R. Walsh-Bowers, "Predictors of the Adaptation of People with Psychiatric Disabilities in Group Homes, Supportive Apartments, and Board-and-Care Homes," *Psychiatric Rehabilitation Journal* 22, no. 4 (1999): 381–390.

[36] National Council on Disability, *Inclusive Livable Communities for People with Psychiatric Disabilities* (Washington, DC: NCD, 2008).

[37] AARP, *These Four Walls…Americans 45+ Talk About Home and Community* (Washington, DC: AARP Public Policy Institute, 2003).

[38] M. Minkler, J. Hammel, et al., "Moving Out of the Nursing Home: Building Community Capacity and Fostering Public Policy Change Through Community Based Participatory Research," *Journal of Disability Policy Studies*, forthcoming.

[39] S.H. Kaye, *Is the Status of People with Disabilities Improving?* (Washington, DC: U.S. Department of Education, 1998).

[40] T. Wilson, *Survey of Nursing Home Placement and Community Living Options,* Access Living Report, Chicago: 2000); J. Charlton, *Nothing About Us Without Us* (Berkeley, CA: University of California Press, 1998); J. Hammel, R. Jones, A. Gossett, and E. Morgan, "Examining Barriers and Supports to Community Living and Participation After a Stroke from a Participatory Action Research Approach," *Topics in Stroke Rehabilitation* (2006): 43–58; S.H. Kaye, *Disability and the Digital Divide* (Washington, DC: U.S. Department of Education, 2000).

[41] The U.S. Department of Housing and Urban Development is in the process of updating its ABA standards, which apply to federally funded residential facilities.

[42] See NCD Topical Brief #2: "Private and Nonprofit Sector Housing" and NCD Topical Brief #5: "State Evaluation."

[43] 2007American Housing Survey estimates of rental housing based on year built.

[44] Joint Statement of the U.S. Department of Housing and Urban Development and the U.S. Department of Justice, Reasonable Accommodations Under the Fair Housing Act, June 17, 2004.

[45] The Urban Institute, *Discrimination Against Persons with Disabilities: Barriers at Every Step* (Washington, DC: HUD, Office of Policy Development and Research, 2005).

[46] Ibid., p. 2.

[47] Ibid.

[48] National Fair Housing Alliance, *The Future of Fair Housing: Report of the National Commission on Fair Housing and Equal Opportunity,* December 2008 http://www.nationalfairhousing.org/.

[49] http://www.hud.gov/offices/fheo/FHLaws/yourrights.cfm.

[50] http://www.hud.gov/offices/fheo/FHLaws/yourrights.cfm.

[51] National Fair Housing Alliance, *The Future of Fair Housing*, p. 15.

[52] A very thorough review of all the HUD programs for people with disabilities, including the history and evolution of each, can be found in Libby Perl, *Section 811 and Other HUD Housing Programs for Persons with Disabilities* (Washington, DC: Congressional Research Service, Domestic Social Policy Division, November 3, 2008), http://assets.opencrs.com/rpts/RL34728_20081103.pdf.

[53] Before the ACS, HUD would produce annually adjusted estimates of the decennial census. These calculations do not include tax credit properties covered under the Housing and Economic Recovery Act of 2008 (P.L. 110–289), which have special income limits. For those limits, see http://www.huduser.org/datasets/mtsp.html.

[54] For all income limits, go to HUD's FY 2009 Income Limits Documentation System at http://www.huduser.org/datasets/il/il2009/select_Geography.odb.

[55] U.S. Department of Housing and Urban Development. Median in some cases is lower than the 80 percent of median value; the values are taken directly from HUD's FY 2009 Income Limit Calculation Documentation System at http://www.huduser.org/datasets/il/index_il2009.html. Cities selected were included in HUD's *Affordable Housing Needs 2005: Report to Congress*.

[56] See HUD's Admission and Occupancy FAQ at http://www.hud.gov/offices/pih/phr/about/ao_faq2.cfm.

[57] U.S. Department of Housing and Urban Development Resident Characteristic report generated by HUD for this NCD report. Resident data reflects tenants in public housing between January 1 and December 31, 2008.

[58] B. Sard and W. Fischer, *Preserving Safe, High Quality Public Housing Should Be a Priority of Federal Housing Policy* (Washington, DC: Center for Budget and Policy Priorities, 2008), http://www.cbpp.org/cms/index.cfm?fa=view&id=655.

[59] Ibid.

[60] U.S. Department of Housing and Urban Development Resident Characteristic report generated by HUD for this NCD report. Resident data reflects tenants in public housing between January 1 and December 31, 2008.

[61] For an estimate by State and housing authority, see Steve Gold, "Recent HUD Section 504 Compliance Reviews," Information Bulletin #185, December 2006, at http://www.stevegoldada.com/stevegoldada/archive.php?mode=A&id=186.

[62] See the U.S. Department of Housing and Urban Development's Voluntary Compliance Agreements online via the Fair Housing and Equal Opportunity Library at http://www.hud.gov/offices/fheo/library/index.cfm#vca.

[63] This particular CVA came out of advocacy on the part of Access Living of Metropolitan Chicago.

[64] HUD Designated Housing Status Report, accessed August 18, 2009, from http://nhl.gov/offices/pih/programs/ph/dhp/designated.cfm.

[65] Ibid.

[66] Fair Market Rent is calculated by HUD and is based on annual estimates of median rent for a region based on U.S. Census Bureau data. See http://www.huduser.org/datasets/fmr.html.

[67] M. Shae, *Housing Choice Voucher Tenant Accessibility Study: 2001–2002*, prepared for the U.S. Department of Housing and Urban Development, Office of Policy Development and Research, 2004.

[68] The survey, which included a random sample of 400 HCV recipients from six public housing authorities, is not meant to be representative of all HCV uses in the United States.

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[70] J. Khadduri, K. Burnett, and D. Rodda, *Targeting Housing Production Subsidies Literature Review* (Washington, DC: HUD, 2007).

[71] HUD, *Affordable Housing Needs 2005*.

[72] 2008 IREMS reports for each State were downloaded from the HUD Web site at http://www.hud.gov/offices/hsg/hsgmulti.cfm, and totals by each category—elderly designated, disabled designated, and accessible—were tallied by the author to produce these totals.

[73] Ibid.

[74] U.S. Department of Housing and Urban Development, *FY 2007 Performance and Accountability Report*, November 15, 2007, p. 439, http://www.hud.gov/offices/cfo/reports/2007/2007par.pdf.

[75] 811 funds specify that no more than six individuals with disabilities may live in a group home. U.S. Department of Housing and Urban Development, FY2008 SuperNOFA for HUD's Discretionary Programs, *Federal Register*, vol. 73, no. 92, May 12, 2008, p. 27320. The NOFA is available on the HUD website with different pagination at http://www.hud.gov/offices/adm/grants/nofa08/811sec.pdf.

[76] G. Locke, C. Nagler, and K. Lam, *Implications of Project Size in Section 811 and Section 202 Housing for People with Disabilities,* prepared for the U.S. Department of Housing and Urban Development, Office of Policy Development and Research, 2004.

[77] HUD Community Development Allocations and Appropriations, accessed August 18, 2009, from http://www.hud.gov/offices/cpd/communitydevelopment/budget/.

[78] This has been consistent for the past 8 years based on HUD data going back to FY 2001. See http://www.hud.gov/offices/cpd/communitydevelopment/budget/disbursementreports/index.cfm.

[79] The number of housing units "benefitting" is available in entitlement community reports but not in aggregated data in the national performance report.

[80] Data from the HUD Integrated Disbursement and Information System (IDIS), http://www.hud.gov/offices/cpd/systems/idis/index.cfm.

[81] HUD, HOME Program National Production Report as of 01/31/09, accessed March 2009 from http://www.hud.gov/offices/cpd/affordablehousing/reports/#npr.

[82] Ibid.

[83] For more on the history preceding the 1986 act, see the National Coalition for the Homeless at http://www.nationalhomeless.org/index.html.

[84] http://www.hudhre.info/index.cfm?do=viewSupportiveHousingProgram.

[85] http://www.hudhre.info/index.cfm?do=viewShelterPlusCare.

[86] http://www.hud.gov/offices/cpd/affordablehousing/training/web/lihtc/basics/. Also see U.S. Government Accountability Office, *Tax Credits: Opportunities to Improve Oversight of the Low Income Housing Program* (GAO/T-GGD/RCED-97-149) (Washington, DC: GAO, 1997).

[87] In addition, the city of Chicago has its own allocation of tax credits outside the State of Illinois. No other city has its own allocation.

[88] For current distribution and analysis of LIHTC allocations per State, go to http://www.danter.com/taxcredit/.

[89] *Allocating Housing Tax Credits*, U.S. Department of Housing and Urban Development, Community Planning and Development, accessed January 11, 2009, from http://www.fhasecure.gov/offices/cpd/affordablehousing/training/web/lihtc/basics/allocating.cfm.

[90] http://www.huduser.org/datasets/lihtc.html.

[91] Abt Associates, *HUD National Low Income Housing Tax Credit (LIHTC) Database: Projects Placed in Service Through 2005*, prepared for the U.S. Department of Housing and Urban Development, 2007, http://www.huduser.org/datasets/lihtc.html.

[92] See HUD USER http://www.huduser.org/datasets/lihtc.html.

[93] Rents cannot exceed local market rents, which in some cases then will be less than these maximum rent caps.

[94] According to HUD, "Certain rental assistance programs can be used to raise the total rent above the LIHTC rent limit. For example, project-based Section 8 contract rents can exceed the LIHTC limit, but tenant-based Section 8 contract rents cannot." See http://www.hud.gov/offices/cpd/affordablehousing/training/web/lihtc/basics/eligibility.cfm.

[95] U.S. Government Accountability Office, *Tax Credits Opportunities to Improve Oversight of the Low-Income Housing Program: Testimony Before the Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives,* April 23, 1997.

[96] The categories are not necessarily mutually exclusive, since developers can target more than one population.

[97] Abt Associates, *HUD National Low Income Housing Tax Credit (LIHTC) Database.*

[98] Ibid.

[99] It is not determined if these rates are statistically significant.

[100] A very good source of current and historical data for all rural housing programs and issues is the Housing Assistance Council, http://www.ruralhome.org

[101] Housing Assistance Council data portal at http://www.ruralhome.org/dataportal/.

[102] The 2009 income limits can be found at http://www.rurdev.usda.gov/rhs/sfh/DSFH_Income_Limits/IL%20Direct.pdf.

[103] http://www.rurdev.usda.gov/rhs/sfh/area%20loan%20limit%20pdf%20files/CA.pdf.

[104] Search for rural multifamily property at http://rdmfhrentals.sc.egov.usda.gov/RDMFHRentals/select_state.jsp.

[105] L. George, L. Strauss, and M. Kudlowitz, *Connecting the Dots: A Location Analysis of USDA's Section 515 Rental Housing and Other Federally Subsidized Rental Properties in Rural America,* Housing Assistance Council, May 2008 http://www.huduser.org/search/Bibliography.asp?id=200849

[106] Ibid.

[107] National Fair Housing Alliance, *USDA Rural Rental Testing Project*, prepared for USDA, October 12, 2004. Unpublished report was attained via Freedom of Information Act request by NCD; received April 2009.

[108] Ibid.

[109] Ibid., p. 3.

[110] Ibid., p. 3.

[111] ICF Consulting Team, *Rural Rental Housing—Comprehensive Property Assessment and Portfolio Analysis,* prepared for the U.S. Department of Agriculture, Rural Development, November 2004, http://peerta.acf.hhs.gov/uploadedFiles/Rural%20Rental%20Housing_ICF.pdf.

[112] The Housing Assistance Council estimates about 7,300 properties with 195,000 units are eligible to prepay.

[113] See S. Crowley, "The Truth About the Housing Trust Fund," 2008, at http://www.nlihc.org/detail/article.cfm?article_id=5552&id=48.

[114] See http://www.hud.gov/offices/pih/programs/hcv/vash/index.cfm.

[115] See K. Mulligan, "VA Excels in Reaching Homeless Mentally Ill Vets," *Psychiatric News* 39, no. 12 (June 18, 2004), http://pn.psychiatryonline.org/cgi/content/full/39/12/12.

[116] http://www.govtrack.us/congress/bill.xpd?bill=h111-1408. This bill was first introduced by Representative Schakowsky in 2002 (H.R. 5683).

[117] Center for Budget and Public Policy (CBPP), "House Bill Makes Significant Improvements in 'HOPE VI' Public Housing Revitalization Program," 2008, http://www.cbpp.org/1-16-08hous.htm.

[118] Ibid. CBPP does raise concerns about the House bill's not addressing the issue of employment/work requirements that can either prevent people from using housing or push them out if they do not comply.

[119] For more detail, see http://www.washingtonwatch.com/bills/show/111_SN_118.html#toc1.

[120] U.S. Department of Housing and Urban Development, based on data entry screen shots from *Integrated Real Estate Management System, HUD User's Guide for PBCA's Chapter 7: Occupancy,* May 2008, to be completed by Performance Based Contract Administrators (PBCA), http://www.hud.gov/offices/hsg/mfh/rems/ug/7caoccu.pdf.

[121] http://www.clpha.org/uploads/10.24.08__Policy_Framework-_Final.pdf.

[122] See "HUD, DOT and EPA Partnership: Sustainable Communities," June 16, 2009, http://www.hud.gov/content/releases/pr2009-06-16factsheet.pdf.

[123] *Smart Codes in Your Community: A Guide to Building Rehabilitation Codes*, U.S. Department of Housing and Urban Development, 2001, http://www.huduser.org/Publications/pdf/smartcodes.pdf.

[124] For more information, go to http://www.iccsafe.org.

[125] See Regulatory Barriers Clearinghouse maintained by the U.S. Department of Housing and Urban Development, Policy Development and Research, at http://www.huduser.org/rbc/. Also see M. Lugar and K. Temkin, *Red Tape and Housing Costs: How Regulation Affects New Residential Development* (New Brunswick, NJ: CUPR Press, 2000).

[126] Consolidated Plan/CHAS 2000 Data available by State, accessed January 2009 from http://www.huduser.org/datasets/cp.html.

[127] State and local Consolidated Plans available at http://www.hud.gov/offices/cpd/about/conplan/local/index.cfm.

[128] See *Guidelines for Preparing Consolidated Plan and Performance and Evaluation Report Submissions for Local Jurisdictions*, U.S. Department of Housing and Urban Development, Office of Community Planning and Development, http://www.hud.gov/offices/cpd/about/conplan/toolsandguidance/guidance/, accessed November 4, 2009.

[129] ADA defined discrimination as "a failure to make reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations." For more information, go to http://www.ada.gov/.

[130] As cited in *Olmstead*: "States are required to place persons with mental disabilities in community settings rather than in institutions when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."

[131] See W. Fox-Grage, B. Coleman, and D. Fleer, *The States' Response to the* Olmstead *Decision: A 2003 Update*, National Conference of State Legislatures (NCSL) and AARP Public Policy Institute, 2004; Mathis, "Community Integration of Individuals with Disabilities: An Update on *Olmstead* Implementation," *Journal of Poverty Law and Policy* (November–December 2001), http://www.bazelon.org/issues/disabilityrights/resources/olmstead.

[132] The New Freedom Initiative was announced by President George W. Bush on February 1, 2001, followed up by the Executive Order 13217 on June 18, 2001.

[133] See Fox-Grage et al., *The States' Response to the* Olmstead *Decision*.

[134] See M. Kitchener, M. Willmott, M. Alameida, A. Wong, and C. Harrington, *Introduction to* Olmstead *Lawsuits and Olmstead Plans,* 2008, http://pascenter.org/olmstead/index.php; S. Rosenbaum, J. Teitelbaum, and A. Stewart, *An Analysis of* Olmstead *Complaints: Implications for Policy and Long-Term Planning* (Washington, DC: Center for Health Care Strategies, Inc., 2001), http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/olmsteadcomplaints.pdf

[135] See W. Fox-Grage, B. Coleman, and D. Fleer, *The States' Response to the* Olmstead *Decision: A 2003 Update*, National Conference of State Legislatures (NCSL) and AARP Public Policy Institute, 2004; Mathis, "Community Integration of Individuals with Disabilities: An Update on *Olmstead* Implementation," *Journal of Poverty Law and Policy* (November–December 2001), http://www.bazelon.org/issues/disabilityrights/resources/olmstead; National Council on Disability, Olmstead: *Reclaiming Institutionalized Lives* (abridged version), 2003, http://www.ncd.gov/newsroom/publications/2003/reclaimabridged.htm.

[136] CMS definition, http://www.ssa.gov/disability/professionals/bluebook/general-info.htm. For further information on how medical necessity can impact a person with disabilities trying to receive medical services (e.g., CMS-funded), see "Medical Necessity Determination in the Medicare Program: Are the Interests of Beneficiaries with Chronic Conditions Being Met?" http://www.partnershipforsolutions.org/DMS/files/MedNec1202.pdf.

[137] P.L. 101–336.

[138] Seven broad architectural guidelines: (1) accessible entrance on an accessible route; (2) accessible public and common use areas; (3) usable doors; (4) accessible routes into and through a dwelling unit; (5) reinforced bathroom walls; (6) useable kitchens and bathrooms; and (7) accessible light switches, electrical outlets, and environmental controls. For further information, see http://www.hud.gov/offices/fheo/disabilities/fhguidelines/fhefha5.cfm#sect5.

[139] For further information, see http://www.iccsafe.org/cs/codes/

[140] See NCD Topical Brief #2 for more information.

[141] See NCD Topical Brief #1 for an overview.

[142] See T. Reuters, *Medicaid Long-Term Care Expenditures in FY 2007 and Medicaid HCBS Waiver Expenditures FY 2002 Through FY 2006,* 2008, at the Clearinghouse for Home- and Community-Based Services, http://www.hcbs.org/.

[143] See, for example, www.socialserve.com, a nonprofit organization that has developed housing locator Web sites for more than half the States (number is in flux as some are in development and not yet active), most of which have search features that include some level of accessibility and affordability.

[144] Rutgers Center for State Health Policy/NASHP, Community Living Exchange Collaborative, *Single Entry Point Systems: State Survey Results,* August 2003, http://www.nashp.org/Files/SEPReport11.7.03.pdf.

[145] See http://www.cms.hhs.gov/NewFreedomInitiative/01_Overview.asp#TopOfPage for overview and State profiles featured in CMS Promising Practice resources.

[146] See http://www.cms.hhs.gov/PromisingPractices/HCBSPPR/list.asp?intNumPerPage=all&submit=Go for specific State examples.

[147] See summary overview of effective policy and strategies: O'Keeffe, Crisp, Doty, Flanagan, Smith, et al., *Developing and Implementing Self-Direction Programs and Policies: A Handbook,* National Resource Center for Participant-Directed Services and Robert Wood Johnson Foundation, 2009, http://www.cashandcounseling.org/resources/handbook.

[148] See, for example, New Hampshire's infrastructure to track participants and monitor provision of services and supports over time. The system is designed to improve funding and service coordination, as well as to provide check-in points for consumers so risks of community living can be proactively identified and managed to prevent future institutionalization.

[149] See http://www.hpm.umn.edu/ltcresourcecenter/research/rebalancing/Rebalancing_state_ltc_systems.htm for long-term research of systems change initiatives.

[150] A. O'Hara, "Using Mainstream Affordable Housing and Service Systems Resources to Create Permanent Supportive Housing for Cross-Disability Homeless and At-Risk Populations," in *A New PSH Approach: The Louisiana and North Carolina PSA Initiatives* (Boston: Technical Assistance Collaborative, Inc., 2009).

[151] Access Living was contracted to assist in writing this report. As one of the oldest Centers for Independent Living in the country, Access Living is a recognized leader in developing innovative programs aimed at improving system change and coordination.

[152] Few States have included housing locator information in their Consolidated Plans, while some States have housing locator services available. States that are implementing Money Follows the Person are using such services.

[153] Only cities that have 30 or more units listed on Socialserve.com receive a housing filter component, particularly regarding accessible features.

[154] See http://www.massaccesshousingregistry.org/.

[155] See http://www.accessva.org/.

[156] See http://www.accessibleapartments.org.

[157] See http://www.housingconnections.org.

[158] See http://www.dads.state.tx.us/providers/pi/mfp_demonstration/ for additional information and reports.

[159] See http://dail.vermont.gov/dail-publications; See also NCD Topical Brief #1 for overview of new 811 legislation, H.R. 1675.

[160] "About UCP Texas," UCP Texas homepage, accessed January 12, 2009, from http://www.ucptexas.org/about_UCP_Texas.html.

[161] Naomi Hubert, Housing Coordinator, UCP Texas, interview, January 12, 2009.

[162] Ibid.

[163] Ibid.

[164] "Housing Opportunities," UCP Texas homepage, accessed January 12, 2009, from http://www.ucptexas.org/housing.html.

[165] Hubert, interview.

[166] Ibid.

[167] Ibid.

[168] Ibid.

[169] Ibid.

[170] Royal Walker, Co-Director, Institute for Disability Studies, University of Southern Mississippi, interview, January 12, 2009.

[171] Alma Ellis, Project Coordinator, Institute for Disability Studies, University of Southern Mississippi, email, January 13, 2009.

[172] Cassie Hicks, Coordinator for Housing Initiatives, Institute for Disability Studies, University of Southern Mississippi, interview, January 12, 2009.

[173] Hicks, interview.

[174] Walker, interview.

[175] IDS Housing Fact Sheets, accessed January 11, 2009, from http://www.usm.edu/ids/housing/housing_fact_sheets.pdf.

[176] Ellis, email.

[177] IDS Housing Fact Sheets.

[178] Ellis, email.

[179] Walker, interview.

[180] Ibid.

[181] Ellis, email.

[182] M. Morris, *Coordination and Leveraging Long-Term Supports with Affordable and Accessible Housing for Persons with Disabilities: Maryland Case Study,* February 2007, pp. 1–2. Rutgers Center for State Health Policy.

[183] Ibid., pp. 3–4.

[184] Ibid.

[185] Ibid.

[186] Ibid., p. 2.

[187] Ibid., pp. 1–2.

[188] Ibid., pp. 3–4.

[189] Ibid., p. 4.

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[388] Rents cannot exceed local markets, which in some cases then will be less than these maximum rent caps.

[389] According to HUD, "Certain rental assistance programs can be used to raise the total rent above the LIHTC rent limit. For example, project-based Section 8 contract rents can exceed the LIHTC limit, but tenant-based Section 8 contract rents cannot."

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[393] The categories are not necessarily mutually exclusive, since developers can target more than one population.

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[424] The evidence to support this concern is found in recent Voluntary Compliance Agreements including with the Boston Housing Authority and Chicago Housing Authority.

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[593] 28 C.F.R. 35, App. A, p. 450.

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[709] The different federal funding programs are outlined in NCD Topical Brief #1: "Federal Evaluation"; and examples of how private and nonprofit developers use these funds are provided in NCD Topical Brief #2: "Private and Nonprofit Sector Housing."

[710] The American Planning Association provides model zoning for commercial zoning that "permits" rather than requires housing in the mix, http://www.planning.org/research/smartgrowth/pdf/section41.pdf; Smart Growth codes developed in conjunction with the Environmental Protection Agency, http://www.planning.org/research/smartgrowth/.

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http://www.huduser.org/rbc/. Also see M. Luger and K. Temkin, *Red Tape and Housing Costs: How Regulation Affects New Residential Development* (New Brunswick, NJ: CUPR Press, 2000).

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[715] Consolidated Plan/CHAS 2000 Data, U.S. Department of Housing and Urban Development, http://www.huduser.org/datasets/cp.html. We compiled all State-level data to produce the data tables in Appendix A; these numbers reflect only the CHAS 2000 data that HUD makes available to State and local jurisdictions on the Internet.

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[717] See *Guidelines for Preparing Consolidated Plan and Performance Report Submissions for Local Jurisdictions*, U.S. Department of Housing and Urban Development Office of Community Planning and Development, http://www.hud.gov/offices/cpd/about/conplan/toolsandguidance/guidance/.

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[726] As cited in *Olmstead*: “States are required to place persons with mental disabilities in community settings rather than in institutions when the State’s treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the

placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."

[727] See W. Fox-Grage, B. Coleman, and D. Fleer, *The States' Response to the* Olmstead *Decision: A 2003 Update,* National Conference of State Legislatures (NCSL) and AARP Public Policy Institute, 2004; Mathis, "Community Integration of Individuals with Disabilities: An Update on *Olmstead* Implementation," *Journal of Poverty Law and Policy* (November–December 2001), http://www.bazelon.org/issues/disabilityrights/resources/olmstead.

[728] The New Freedom Initiative was announced by President George W. Bush on February 1, 2001, followed up by the Executive Order 13217 on June 18, 2001.

[729] See Fox-Grage et al., *The States' Response to the* Olmstead *Decision*.

[730] See M. Kitchener, M. Willmott, M. Alameida, A. Wong, and C. Harrington, *Introduction to* Olmstead *Lawsuits and Olmstead Plans,* 2008, http://pascenter.org/olmstead/index.php; S. Rosenbaum, J. Teitelbaum, and A. Stewart, *An Analysis of* Olmstead *Complaints: Implications for Policy and Long-Term Planning* (Washington, DC: Center for Health Care Strategies, Inc., 2001), http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/olmsteadcomplaints.pdf

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[732] CMS definition, http://www.ssa.gov/disability/professionals/bluebook/general-info.htm. For further information on how medical necessity can impact a person with disabilities trying to receive medical services (e.g., CMS-funded), see "Medical Necessity Determination in the Medicare Program: Are the Interests of Beneficiaries with Chronic Conditions Being Met?" http://www.partnershipforsolutions.org/DMS/files/MedNec1202.pdf.

[733] http://www.ucp.org/ucp_channeldoc.cfm/1/13/12632/12632-12632/6184.

[734] Ibid.

[735] P.L. 101–336.

[736] Seven broad architectural guidelines: 1) accessible entrance on an accessible route; 2) accessible public and common use areas; 3) usable doors; 4) accessible routes into and through a dwelling unit; 5) reinforced bathroom walls; 6) useable kitchens and bathrooms; and 7) accessible light switches, electrical outlets, and environmental controls. For further information, see http://www.hud.gov/offices/fheo/disabilities/fhguidelines/fhefha5.cfm#sect5.

[737] For further information, see http://www.iccsafe.org/cs/codes/

[738] See NCD Topical Brief #2 for more information.

[739] Before the ACS, HUD would produce annually adjusted estimates of the decennial census.

[740] NSP requires targeting for assistance a proportion (at least 25 percent) of individuals at or below 50 percent of AMI.

[741] See NCD Topical Brief #1 for more details and data on this point.

[742] See NCD Topical Brief #1 for an overview.

[743] See T. Reuters, *Medicaid Long-Term Care Expenditures in FY 2007 and Medicaid HCBS Waiver Expenditures FY 2002 through FY 2006,* 2008, at the Clearinghouse for Home- and Community-Based Services, http://www.hcbs.org/.

[744] See, for example, www.socialserve.com, a nonprofit organization that has developed housing locator Web sites for more than half the States (number is in flux as some are in development and not yet active), most of which have search features that include some level of accessibility and affordability.

[745] Rutgers Center for State Health Policy/NASHP, Community Living Exchange Collaborative, *Single Entry Point Systems: State Survey Results,* August 2003, http://www.nashp.org/Files/SEPReport11.7.03.pdf.

[746] See http://www.cms.hhs.gov/NewFreedomInitiative/01_Overview.asp#TopOfPage for overview and State profiles featured in CMS Promising Practice resources.

[747] See http://www.cms.hhs.gov/PromisingPractices/HCBSPPR/list.asp?intNumPerPage=all&submit=Go for specific State examples.

[748] See summary overview of effective policy and strategies: O'Keeffe, Crisp, Doty, Flanagan, Smith, et al., *Developing and Implementing Self-Direction Programs and Policies: A Handbook,* National Resource Center for Participant-Directed Services and Robert Wood Johnson Foundation, 2009, http://www.cashandcounseling.org/resources/handbook.

[749] See, for example, New Hampshire's infrastructure to track participants and monitor provision of services and supports over time. The system is designed to improve funding and service coordination, as well as to provide check-in points for consumers so risks of community living can be proactively identified and managed to prevent future institutionalization.

[750] See http://www.hpm.umn.edu/ltcresourcecenter/research/rebalancing/Rebalancing_state_ltc_systems.htm for long-term research of systems change initiatives.

[751] A. O'Hara, "Using Mainstream Affordable Housing and Service Systems Resources to Create Permanent Supportive Housing for Cross-Disability Homeless and At-Risk Populations," in *A New PSH Approach: The Louisiana and North Carolina PSA Initiatives* (Boston: Technical Assistance Collaborative, Inc., 2009).

[752] Access Living was contracted to assist in writing this report. As one of the oldest Centers for Independent Living in the country, Access Living is a recognized leader in developing innovative programs aimed at improving system change and coordination.

[753] Few States have included housing locator information in their Consolidated Plans, while some States have housing locator services available. States that are implementing Money Follows the Person are using such services.

[754] Only cities that have 30 or more units listed on Socialserve.com receive a housing filter component, particularly regarding accessible features.

[755] See http://www.massaccesshousingregistry.org/.

[756] See http://www.accessva.org/.

[757] See http://www.accessibleapartments.org.

[758] See http://www.housingconnections.org.

[759] See http://dail.vermont.gov/dail-programs for additional information and reports.

[760] See http://dail.vermont.gov/dail-publications; See also NCD Topical Brief #1 for overview of new 811 legislation, H.R. 1675.