# Permanent Supportive Housing Assistance

## Annual Report – State Fiscal Year 2026

## July 2025 – June 2026

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# Program Overview

The Vermont Medicaid Permanent Supportive Housing Assistance (PSHA) program was established to reduce the incidence and duration of homelessness in Vermont. Permanent Supportive Housing (PSH) is an evidence-based intervention proven effective in reducing homelessness, improving quality of life, preventing emergency department use and hospitalization, and reducing overall healthcare costs for individuals with high needs.

In January 2023, PSHA was authorized by Vermont's Global Commitment to Health 1115 Demonstration Waiver to leverage Medicaid to expand permanent services that support Vermonters with complex health and social needs to successfully transition into and maintain residency in permanent housing through intensive, person-centered services and case management.

The Program leverages a Conflict-Free Case Management (CFCM) approach to ensure that the PSHA services for each Participant are grounded in an independent, "conflict-free," person-centered care plan addressing the Participant's whole-person needs, as required by federal regulations. The Office of Economic Opportunity (OEO) within the Department of Children and Families is responsible for verifying participant eligibility and providing this CFCM. Following this initial assessment, participants are enrolled into PSHA and receive intensive case-management provided by contracted service agencies while the CFCMs continue to ensure that whole-person needs are addressed.

Participants receive Housing Navigation Services to reduce barriers and access housing. When housing is identified, Community Transition Assistance (CTA) funds may be used to cover essential move-in activities and costs. Ongoing Tenancy Sustaining Services support Participants in maintaining stability through connections with community resources, enhancing independent living skills, assistance with maintaining benefits and/or employment, eviction prevention, and addressing other needs as identified in service plans.

In fall 2024, Vermont's Department for Children & Families (DCF), Office of Economic Opportunity (OEO) issued a Request for Proposals. OEO launched this project midway through State Fiscal Year 2025 (SFY25) in five communities throughout the state: Chittenden County, Franklin County, the Northeast Kingdom, Washington County, and Windham County, creating a regional capacity to serve 106 individuals. The chart below shows the contracted agencies, number of staff positions, and total allocated caseload.

| PSHA Community Partner | Staff Positions | Total PSHA caseload |
|---|---|---|
| Burlington Housing Authority | 2 Positions | 28 |
| Capstone Community Action | 1 Position | 14 |
| Champlain Calley Office of Economic Opportunity<br>Franklin County<br>Chittenden County | 1 Position<br>1 Position | 28 |
| Groundworks Collaborative | 2 Positions | 24 |
| Northeast Kingdom Community Action (NEKCA) | 1 Position | 12 |
| TOTALS | 8 Positions | 106 Participants |

# Program Report

During the first half of the fiscal year, OEO rapidly enrolled Participants into the program, and Conflict Free Case Managers were able to fill all available PSHA openings before the end of calendar year. A primary challenge in this phase was that many of the people prioritized for the program could not be easily located for assessment. Coordination among OEO, PSHA agencies, mental health and substance use providers, and local housing coalitions helped locate people, disseminate information about the program, and streamline referral processes.

CFCMs verified qualifying health needs through medical records when accessible and developed relationships with health care providers serving unhoused Vermonters to ensure timely access to assessments for physical, mental health, and substance use conditions.

Most Participants who were referred expressed enthusiasm about PSHA services, although some were frustrated that enrollment did not come with an immediate housing opportunity.  Many shared long-term housing-focused support was not something they

had previously received or been offered. Others noted that they had not been successful with available office-based support and were more open to the field-based, assertive engagement model of PSHA. Others had such complex needs that while they had other service providers, they could not focus their work on accessing and sustaining housing.

Consistent engagement in services is often difficult for people experiencing homelessness. This year highlighted the importance of persistent engagement practices, assertive outreach, and community partnerships to maintain services. While other services may discontinue when clients do not show up for appointments or lose their phones, PSHA providers displayed creativity and dedication to finding and reconnecting with Participants by physically going to locations where they know Participants stay at night or frequent during the day, collaborating with partners and intentionally building rapport with judgement-free, person-centered services.

Part of the Conflict Free Case Management model is the continued engagement in care coordination between the CFCM and PSHA provider. Through December, these meetings occurred monthly to support program understanding and adherence, as well as to case-review. More recently, scheduled meetings turned to quarterly, revisiting initial whole-person care plans to ensure comprehensive care coordination. CFCMs remained accessible to Participants and providers to support with ongoing needs. In addition to these meetings, CFCMs offered to support or lead Team-Based-Care meetings to streamline services for individuals with complex care needs. Further support from the CFCMs came in the form of holding short monthly provider meetings as well as biannual full day Community of Practice meetings to reinforce training and peer learning.

Despite significant external barriers to accessing housing, PSHA providers and Participants worked diligently toward permanent housing. The program housed 31 households in FY26. With Housing Choice Vouchers unavailable statewide, households and providers had fewer options for sustainable housing. Most move-ins were into units with project-based vouchers that allowed the housing to be sustainable. Other households found success through extremely reducing expenses such as by committing to regular use of food shelves and navigating opportunities with private landlords. When moving in, households were able to access CTA funds to make their new units feel like home through purchases such as beds, tables and chairs, and kitchen items. These funds were also used to reduce barriers to accessing housing such as utility arrears and security deposits.

In addition to a dearth of housing subsidies, PSHA provider agencies faced challenges related to staffing. A couple of agencies had their PSHA providers leave their positions, leaving no staff available to serve their caseload. This was particularly challenging in those communities that are only contracted to have one PSHA staff member. In these cases, agencies worked to have supervisors or other agency staff provide support, but ensuring the intensive case-management proved challenging. Agencies, dedicated to hiring qualified, compassionate, and committed staff, often struggle to quickly fill vacancies.

In late FY26, CFCMs started annual service renewals. Documentation was formalized and all Participants who had been in the program for one year received reassessments and worked with their CFCM to create new care-plans for the year. These meetings allowed for CFCMs to hear more directly from Participants. Themes were that for those who were housed, continued services felt important to sustain security, and those that were not yet housed felt that PSHA services helped them feel hopeful and engaged.

Quarterly Data and biannual written reports from PSHA provider agencies to OEO demonstrated both successes and challenges. Narrative reports highlighted Participants surviving and improving unsafe living conditions, accessing community and residential treatment, rebuilding trust with providers, strengthening community connections, bolstered hope, and movement towards stability. One story from an annual report is included at the end of this document.

The next section focuses on data collected on PSHA services in FY26.

# Data

## Data for PSHA at AHS

### Enrollment Information

Number of individuals referred to OEO for PSHA - **200**

Number assessed for services by OEO - **167**

33 people that were referred for PSHA services through coordinated entry could not be located despite assertive outreach, had moved out of the service area, or did not meet categorical eligibility such as experiencing homelessness.

Number authorized for services by OEO - **150**

17 people who were assessed for services by OEO conflict-free case managers did not end up being authorized for services. Reasons included:

Ineligibility due to housing status

Ineligibility due to Medicaid eligibility

Ineligibility due to lacking a verified health need

Deciding they did not want the services

Not engaging to complete the assessment

Number enrolled with PSHA provider agencies - **134**

16 people who were authorized by OEO conflict-free case managers did not end up enrolling with provider agencies due to no longer having interest in the program or lack of engagement despite assertive outreach.

## Average Time for Outreach and Enrollment

Average number of days between referral to OEO and initial outreach - **.4**

Average number of days from referral to OEO and service authorization – **11.7**

## Whole-Person Assessments and Care Plans Completed

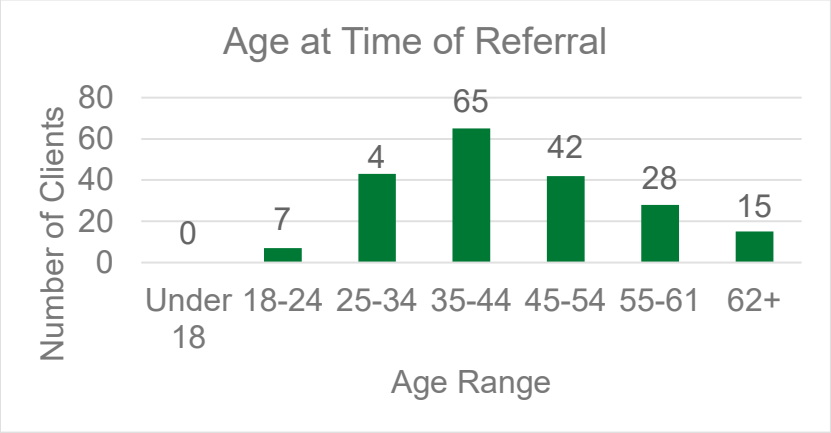
Percentage of Participants who completed assessments and care plans prior to receiving services - **100%**

Most Participants who shared feedback indicated that the assessment and care planning process felt easy and comfortable. Some shared that it added to confusion about who would be providing long term services and the ongoing role of the CFCMs. This confusion was lessened when Participants had pre-existing relationships with the PSHA provider agency. Care planning often showed that Participants were either

engaged with services outside of housing, or knew how to access them, although many indicated need to reconnect with primary care. Notably, two individuals were identified as eligible for VA services, referred, and gained access to VASH subsidies braided with PSHA services.

### Age at time of referral

The majority of participants fell within the 35-44 age range at time of referral.

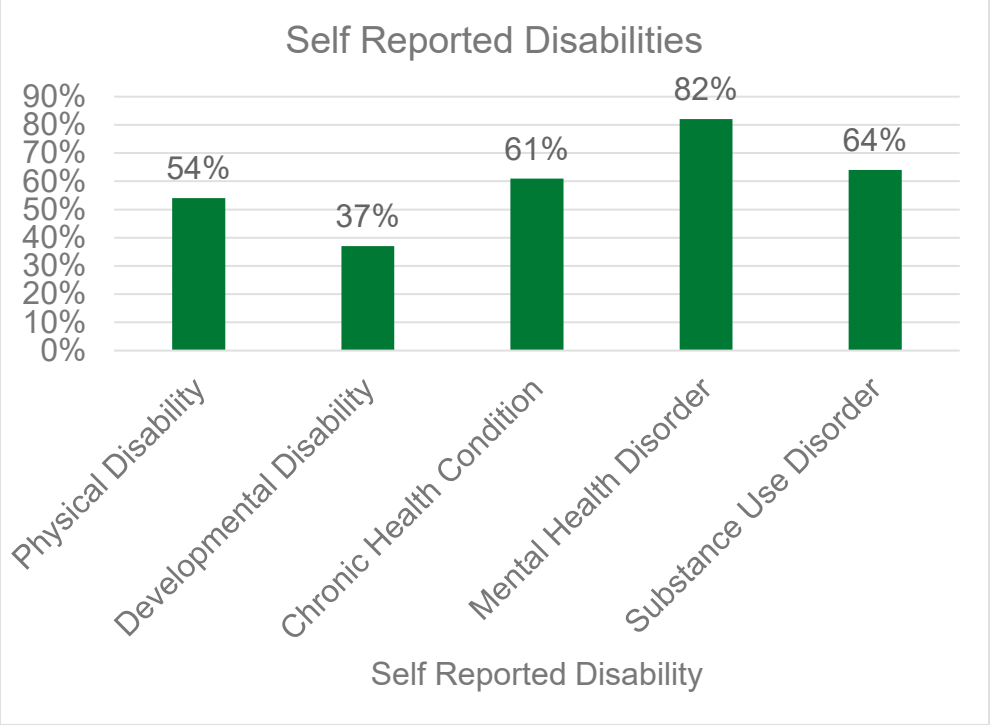



## Health Conditions Identified by Individuals enrolled in PSHA services

- Self-reported disabilities in **HMIS** [1]upon initial assessment by CFCM
  - 54% identified living with a Physical Disability
  - 37% identified living with a Developmental Disability or Brain Injury
  - 61% identified living with a Chronic Health Condition
  - 82% identified living with a Mental Health Disorder

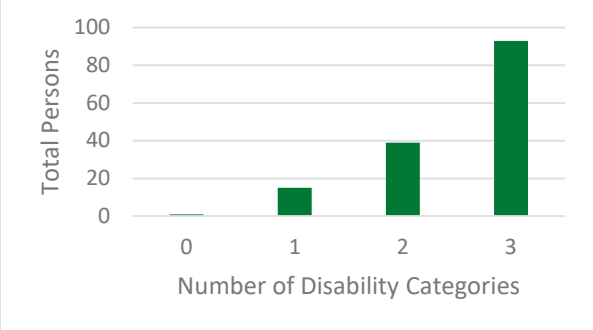
[1] Homeless Management Information System – a HUD-mandated secure, web-based database used by homeless service providers to collect client level data and coordinate care.

- 64% identified living with a Substance Use Disorder




Of these,

- 1 did not self-identify with a long-term disability[2]
- 15 identified with one category of long-term disability
- 39 identified with two categories of long-term disability
- 93 identified with three or more categories of long-term disability




[2] Health need was verified upon assessment

## Data for PSHA participants enrolled with provider agencies

This section shows data provided by the PSHA provider agencies as listed above.

### Enrollment Information

126 households enrolled at end of reporting period

156 individuals enrolled at end of reporting period

164 households were enrolled in services throughout the year

195 individuals enrolled in services throughout the year

### Housing Status

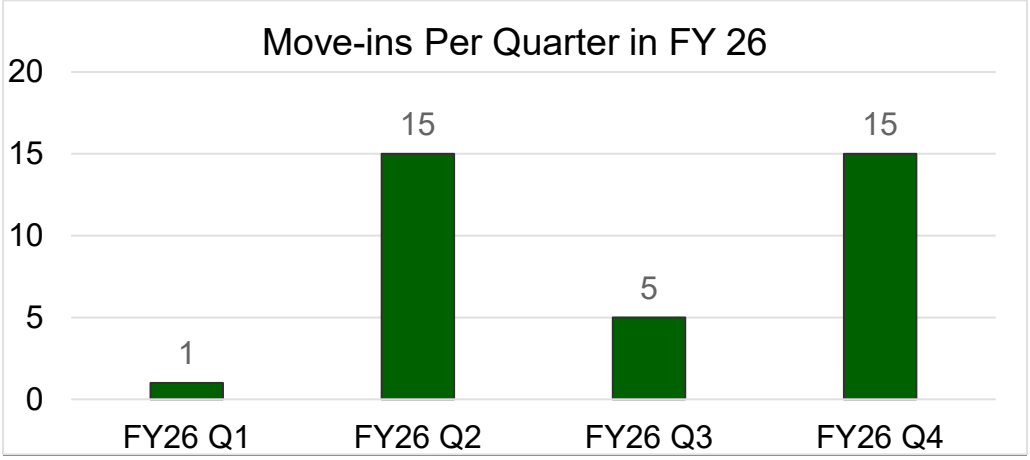
At the close of the fiscal year:

- 36 households stably housed (28%)
- 92 households accessing housing navigation services (72%)

### Housing Move-Ins

31 PSHA households moved into permanent housing during this fiscal year;

1 in Q1, 15 in Q2, 5 in Q3, and 15 in Q4.



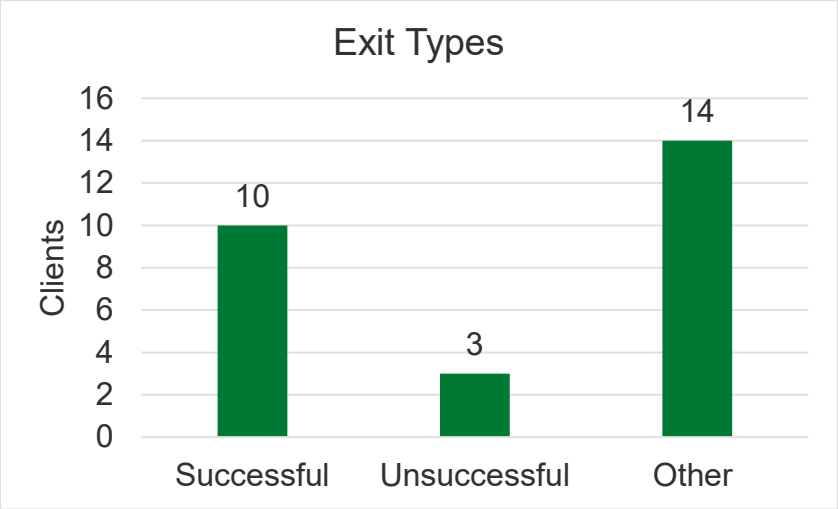
To support these households moving into housing, **$35,053** of Community Transition Assistance funds were used. These expenses went to paying security and utility deposits and utility arrears as well as to purchase home-making items such as beds, kitchen supplies, and basic furniture.

As a Participant moved into housing, they said they felt more hopeful than before. They had previously been placed in an apartment that was not successful and the Participant believes that was because they were left in an unfurnished apartment without support. Now, with ongoing support to help them furnish and settle into their new home, they feel confident.

Another Participant told OEO how much more secure they and their partner felt in their new apartment that felt like a home. The participant was hopeful to engage more consistently in necessary mental health services, and their partner was able to start working full time due to access to a secure place to sleep well and shower.

## Exit information

Most households who were disenrolled from services did so after successfully attaining and stabilizing housing, or for other reasons such as moving out of state, losing Medicaid eligibility, or passing away.  There were a few instances when individuals were enrolled with pre-existing legal issues and were sentenced to long-term incarceration. Three individuals were disenrolled due to disengagement from services.




# Looking Forward

As FY27 begins with agencies carrying full PSHA caseloads, OEO anticipates a full year of quality services. Access to Federal Housing Choice Vouchers is expected to resume, and the program will leverage Vermont's new rental assistance program under Act 143. Agencies will continue expanding their capacity to provide long-term tenancy-sustaining services, including lease adherence, eviction prevention, treatment access, employment and community integration, and benefits stabilization.

# A PSHA Story That Says it All

One participant in our Permanent Supportive Housing Assistance (PSHA) program entered services while experiencing unsheltered homelessness, living outdoors and camping during the height of winter. The referral came at a time when the ground was covered in snow and temperatures posed a serious risk to her health and safety. Her chosen PSHA Specialist (PSHAS) immediately focused on meeting her most urgent needs. Together, they identified a safer place to camp… while longer-term solutions were pursued. The specialist secured a new tent, tarp, warm socks, and hand warmers to help protect her from the elements, while simultaneously working to obtain emergency motel accommodations for the remainder of the winter.

The PSHAS quickly helped her fill out subsidy and housing applications. Once submitted, it was only weeks until hearing that her name had come up on a waiting list

and she had a chance of moving into permanent housing. The participant was initially denied by the landlord, though with some support from her PSHAS, she appealed the decision and asked for a hearing to try and overturn the denial. The denial was overturned and she successfully secured an apartment. Working with her PSHAS, she moved into stable housing and furnished her new home, marking an important milestone in her housing journey.

Shortly after moving in, however, it became apparent that the participant was experiencing significant mental health symptoms and subsequent behaviors that created challenges for both her and the surrounding community. Ultimately, the landlord determined that the tenancy could not continue. Rather than allowing the situation to escalate into an eviction, the landlord and participant reached a mutual agreement that allowed her to voluntarily vacate the apartment, receive financial assistance to support her transition, and, importantly, retain her Section 8 Housing Choice Voucher.

Throughout this transition, the PSHAS remained a consistent source of support. They coordinated the move from the apartment, ensured the participant's personal belongings and furniture were stored, and helped secure a safe temporary place to stay. Rather than viewing the end of the tenancy as the end of the intervention, the PSHAS continued working alongside the participant to identify and secure another apartment where she could successfully utilize her voucher, where she remains stably housed today.

This experience demonstrates the value of intensive, relationship-based case management during periods of crisis. While the participant was unable to remain in her initial apartment, the continuity of services prevented the loss of her housing subsidy, preserved her personal belongings, avoided a more traumatic housing disruption, and positioned her for another opportunity at stable permanent housing.

This success highlights that success is not always defined by a linear path but by the ability to maintain support, preserve critical resources, and continue moving toward long-term housing stability despite significant setbacks.