FY25 Neighbors First Families (NFF) Logic Model

Agency Strategic Goals:

1. Goal #1: Strengthen and expand our services and housing programs to help end homelessness in the D.C. metro region (Goal #1 on SP)
2. Goal #3: Steward and strengthen our relationships with our government partners to ensure effective service delivery, improve the services experience, and support our system's collective efforts to end homelessness

Division/Program Goals:

- Goal 1**:** Support NFF households with navigating and maintaining housing stability
- Goal 2: Support NFF households in promoting child well-being as well as physical and mental health of all members
- Goal 3: Support NFF households in obtaining and maintaining sources of income

INPUTS/RESOURCES	ACTIVITIES	OUTPUTS	SHORT TERM OUTCOMES	INTERMEDIETE OUTCOMES	LONG TERM OUTCOMES
People • 14 FTE Case Managers • 3 FTE Managers • Up to 188 families referred by DHS Financial • Government Funding • In-Kind donations & Private Donors • Professional Development Funds • Brex cards Partnerships • DC government partners • Community Partners, such as CSA/ACT teams • Collaboration with other external community partners agencies Infrastructure • Computers/tablets • Cell phones • Adobe Pro licenses • Microsoft Office software • SharePoint site • Agency vehicles for staff to transport participants, if needed • Office space • HTH, Credible, HMIS • On-site notary Training • External: TCP, DHS and other required and recommended trainings • Internal: created and implemented as needed	Comprehensive case management services, including but not limited to: • Warm handoffs with transferring participants • Face-to-Face engagements (e.g., home visits, visits in the community, office visits) • Non-Face-to-Face engagements (e.g., telephone calls, texts, emails, letters, video conferencing, etc.) • Collateral contacts and outreach engagements • Community visits (e.g., shelters, schools, rehab, hospitals, etc.) • LSRP/RFTA housing application assistance • Biopsychosocial (BPS) assessments with Heads of Household, including child needs • Individual Service Plan (ISP) development and implementation with Heads of Household • Attendance at voucher briefings • Accompaniment at Unit Viewing/Lease Signing • Delivery of Share Packages and other food items to families • Utility Assistance, Emergency Fund payments, and other Financial Assistance • Referrals to Access help line and other translation services, when needed • Advocating/supporting participants with landlords, agencies, etc. • Monitoring mental health and substance use symptoms, conducting appropriate referrals as needed • Mediating client crises, engaging emergency providers as necessary • Referring families to community resources and supports, as needed • Supporting households with Medicaid recertification • Assistance with budgeting and financial planning • Assistance with DHS Annual Intake Assessments • Referrals for Emergency Shelter Placement • Assistance with Medicaid, DCHA and Local recertification • Assistance with unit inspections, as needed • Referrals to behavioral health services, collaborate as needed • Attendance at family support meetings • Addressing general participant concerns • Emergency on-call Documentation (e.g., DAP notes, UIR reports, home visit community forms, internal risk assessment forms, mortality reports, check requests, zero-income reports, etc.) Communication and collaboration with DHS, DBH, DCHA as well as attendance at all leasing, 1:1 with monitoring team, and monthly provider meetings	Number of families served (up to 188 families at a time) Number of families achieving or maintaining stable housing Number of families maintaining stable health (including Head of Household and all children) Number of families in the Navigation phase meeting contractual engagement requirements Number of families in the Stabilization phase meeting contractual engagement requirements Number of Heads of Households with substance use disorder referred to treatment/ACT; Number seeking treatment Number of Heads of Households with mental health disorders referred to treatment; Number engaged with CSA Number of Heads of Household receiving some form of income (e.g., employment, benefits, etc.) Number of Heads of Household progressing towards their ISP goals	At least 80% of participants will maintain housing stability as evidenced by not receiving an eviction judgment against them At least 75% of Heads of Households and children see their primary care physician annually and receive immunizations and exams as needed At least 75% of participants will be referred to substance abuse treatment when there is known substance use At least 75% of participants will be referred to mental health services when there is known mental health issues At least 75% of households will use scheduled medical appointments or urgent care, when appropriate, instead of emergency services At least 80% of households will have at least one source of income 82% of monthly Medicaid and DHS billing requirements met	At least 90% of families will achieve their identified Service Plan goals At least 80% of Households will support child well-being At least 80% Households will demonstrate housing stability At least 80% Households will support physical and mental health of all members At least 75% Households will establish and maintain sources of income 86% of monthly Medicaid and DHS billing requirements met	Decreased homelessness and increased quality of life for high-risk families in DC who are assigned to Friendship Place as their PSH services provide; identified by self-report and demonstrated by paying rent/utility bills on time, recertifying independently, and meeting all child-related needs Families achieve and maintain stable housing Families achieve their service plan goals Families are connected to community resources to help them maintain stable health and seek support with substance use and/or mental health disorders Continued partnership with DC government partners