



Ending homelessness
Rebuilding lives

FY26 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, including children
- Goal 3: Support NFF households in connecting families to community resources and supports as well as obtaining and maintaining sources of income

INPUTS/RESOURCES	ACTIVITIES	OUTPUTS	SHORT TERM OUTCOMES	INTERMEDIATE OUTCOMES	LONG TERM OUTCOMES
<p>People</p> <ul style="list-style-type: none"> • 15 FTE Case Managers • 3 FTE Managers • 1 PTE Licensed Clinician • Up to 204 families, and up to 59 additional unit-based referrals, referred by DHS <p>Financial</p> <ul style="list-style-type: none"> • Government Funding from DHS and Medicaid • In-Kind donations & private donors • Professional development funds • Brex cards <p>Partnerships</p> <ul style="list-style-type: none"> • DC government partners (DHS, DCHA, CFSA, etc.) • Community Partners, such as CSA/ACT teams, landlords, share packages, etc. • Collaboration with other external community partners/agencies <p>Infrastructure</p> <ul style="list-style-type: none"> • 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, CRISP • On-site notary <p>Training</p> <ul style="list-style-type: none"> • External: TCP, DHS, and other required and recommended trainings • Internal: created and implemented as needed 	<p>Comprehensive case management services, including but not limited to:</p> <ul style="list-style-type: none"> • 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 (e.g., school verifications, landlord verifications, family, etc.) • Community visits (e.g., shelters, schools, rehab, hospitals, etc.) • Collaborating with school liaisons/truancy officers, school counselors, 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, Emergency, and other Financial Assistance as possible • 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 • Assistance with budgeting and financial planning • Assistance with DHS Annual Intake Assessments • Referrals for Emergency Shelter Placement if needed • 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 and emergent needs • Emergency on-call <p>Documentation (e.g., DAP notes, UIR reports, home visit/community forms, internal risk assessment forms, fatality reports, check requests, income verification, LRSR/RFTA, etc.)</p> <p>Communication and collaboration with DHS, DBH, DCHA as well as attendance at all leasing, 1:1 with monitoring team, and monthly provider meetings</p> <p>Billing and quality assurance practices</p>	<p>Number of families served (up to 204 families, and up to 59 additional unit-based, at a time)</p> <p>Number of families achieving or maintaining stable housing</p> <p>Number of families in the Navigation phase meeting contractual engagement requirements</p> <p>Number of families in the Stabilization phase meeting contractual engagement requirements</p> <p>Number of children attend school regularly, per district standards</p> <p>Number of families maintaining stable health (including Head of Household and all children)</p> <p>Number of Heads of Households with substance use disorder referred to treatment/ACT; Number seeking treatment</p> <p>Number of Heads of Households with mental health disorders referred to treatment; Number engaged with CSA</p> <p>Number of Heads of Household receiving some form of income (e.g., employment, benefits, etc.)</p> <p>Number of Heads of Household progressing towards their ISP goals</p>	<p>At least 85% of participants will maintain housing stability as evidenced by not receiving an eviction judgment against them</p> <p>At least 85% of children attend school regularly, per district standards</p> <p>At least 75% of Heads of Households and children see their primary care physician annually and receive immunizations and exams as needed</p> <p>At least 75% of participants will be referred to substance abuse treatment when there is known substance use</p> <p>At least 75% of participants will be referred to mental health services when there is known mental health issues</p> <p>At least 75% of households will use scheduled medical appointments or urgent care, when appropriate, instead of emergency services</p> <p>At least 75% of households will have at least one source of income</p> <p>At least 80% of households have a completed and comprehensive Individualized Service Plan</p> <p>82% of monthly Medicaid and DHS billing requirements met</p>	<p>At least 90% of participants will maintain housing stability as evidenced by not receiving an eviction judgment against them</p> <p>At least 90% of children will be seen on a monthly basis</p> <p>At least 95% of children attend school regularly, per district standards</p> <p>At least 80% Households will support physical and mental health of all members</p> <p>At least 80% Households will establish and maintain sources of income</p> <p>At least 90% of families are making progress towards their identified Individualized Service Plan goals</p> <p>86% of monthly Medicaid and DHS billing requirements met</p>	<p>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</p> <p>Families achieve and maintain stable housing</p> <p>Families achieve their service plan goals</p> <p>Families are connected to community resources to help them maintain stable health and seek support with substance use and/or mental health disorders</p> <p>Continued partnership with DC government partners and other key community partners</p>