PROVIDING PRIMARY HEALTH CARE TO RURAL HOMELESS POPULATIONS: A RESOURCE MANUAL FOR RURAL NURSE PRACTITIONERS

by

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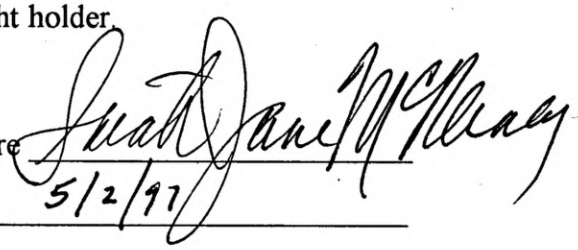
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ABSTRACT

Homelessness is a growing problem in rural America. Homeless populations in rural areas are at high-risk for a variety of problems including inadequate housing, lack of adequate income, mental and physical illness. Rural communities often lack the resources required to meet the needs of the homeless.

The role of the rural nurse practitioner (NP) is to provide primary health care to individuals, families and the community. The rural NP may be looked to for leadership and guidance in addressing local health and social issues such as homelessness. It is important for the rural NP to have adequate information available to assist the community in examining the extent of homelessness, and to assess the needs and concerns of the homeless residing in the community.

The purpose of this project was to compile a resource manual that can be utilized by rural nurse practitioners providing holistic care to homeless in their communities. This project was designed to create an awareness of the existence of homelessness in rural communities so that their needs can be addressed. Another purpose was to provide a framework for the rural nurse practitioner to build collaborative ties within the community to facilitate meeting the needs of all community members including the homeless. An extensive review of current literature and discussion with service providers led to the development of a resource manual for rural nurse practitioners providing primary health care to homeless in rural communities. The resource manual includes: (a) an example of integrating a homeless needs assessment into an initial interview, (b) guidelines for conducting a homeless needs assessment in the community, (c) a list of resources available to homeless in Ravalli County, Montana, to provide an example of resources available in a rural county, and (d) a brief list of State and Federal resources available to assist homeless in the community.

CHAPTER 1

INTRODUCTION

Homelessness is a reality for a growing number of individuals in rural communities. Homeless populations in rural areas have limited access to health promotion, disease prevention, and treatment services. Providing care to rural homeless individuals requires the nurse practitioner (NP) develop a broad scope of practice addressing all aspects of health. The NP's scope of practice involves caring for individuals, families and the community. The entire rural community is recognized as the client.

Nurse practitioners are advanced practice nurses providing primary health care to rural residents. The rural NP practicing within the primary health care model collaborates with the community to meet the needs of underserved homeless individuals.

Purpose

The purpose of this project was to provide a resource manual for rural NPs practicing primary health care in rural communities. The resource manual guides the rural NP in integrating an individual needs assessment for the homeless into a confidential initial history interview. It instructs the NP in initiating and conducting a community needs assessment for the homeless, and provides information on resources in Ravalli County, Montana as an example of resources available to homeless individuals in a rural community. Included in the manual is a brief list of State and Federal programs designed to assist communities addressing the needs of the homeless population.

Background and Significance

Homelessness is pervasive in American society. The prevalence of homelessness in America is largely unknown. It is estimated that there are between 500,000 to 600,000 homeless in the United States on any given night (Burt & Cohen, 1989). This was an estimate of urban homeless individuals without shelter. Urban homelessness was well documented in the literature. By contrast there was a dearth of research examining rural homelessness.

In the literature rural homeless persons were less conspicuous than their urban counterparts. Patton (1988) noted, rural traditions of self-help and reliance on relatives, friends, and neighbors versus utilizing taxpayer supported programs masks the dimension of the problem of rural homelessness. Perception was an issue in viewing rural homelessness. Community residents who lost their farms or homes were perceived as "locals who have fallen on hard times" whereas transients or outsiders were more readily identified as "homeless". Homelessness and rural poverty are on the rise (Fitchen, 1992; Flynt, 1996; National Rural Health Association, 1996; Patton, 1988).

Rural cultural values created obstacles to seeking assistance from social services. Obstacles have included concerns about the family's reputation in the community, a lack of understanding of services available and how they work, family socialization regarding seeking assistance from sources outside the family, feeling that one must bear one's own problems, fear of being seen as unable to care for oneself, pride and shame. Conversely, rural culture can provide a "protective" function. These protective qualities included work orientation, value placed on self-sufficiency and long-term relationships, bonds with extended family, friends and clergy (Gladden, 1991). Rural cultural qualities set rural homeless populations apart from urban populations and created a unique perspective for accessing resources for this underserved population.

Patton (1988) defined homelessness as housing situations that are both unstable and temporary, and a lack of sufficient resources to secure adequate housing. Patton's definition is utilized for this project. Having an awareness of what constitutes homelessness allows the rural nurse practitioner to provide holistic community-based primary health care. Several factors must be considered in a description of the rural homeless population: (a) the lack of housing, social support, and financial resources, (b) persons "doubling-up" with relatives or friends for extended periods of time, and (c) lack of inclusion of individuals paying minimal rent and living in substandard housing.

Problems of the Rural Homeless

Homeless individuals in rural areas represent a high risk population faced with a myriad of problems. The principal problem of rural homeless people was the lack of an adequate living space. An additional problem was lack of employment or sparse employment. Insufficient income or resources interfere with an individual's ability to meet the basic need for housing, food, clothing and a sanitary water source.

Another problem faced by rural homeless persons was access to health care. Patton (1988) reported several barriers to health care access. The first barrier was the lack of financial resources. Often homeless people have battled acute and chronic health problems that were left unattended due to lack of adequate funds, lack of insurance, and no public assistance. The second barrier was scarcity of adequate health services in rural areas. Rural communities often lacked a primary health care provider. Frequently, rural residents have traveled long distances to seek medical care.

Rural hospitals have faced a financial crunch in recent years due to the changing health care climate. Patton argued that this seriously limited their ability to provide

uncompensated care and further decreased resources available to rural homeless individuals who are ill.

The third barrier to health care access was lack of transportation. Homeless individuals have obtained public assistance that provided for health care expenses; however, they have been unable to seek treatment due to long distances to providers and lack of adequate transportation. Barrier four was the lack of anonymity experienced by rural residents. The rural homeless have been hesitant to access services in their community because they feared their plight would become public knowledge.

Role of the Nurse Practitioner

The NP in a rural community may be sought for leadership and direction in coordinating local health and social issues. Rural NPs often provide care in sparsely populated areas without formal resources. Developing relationships with formal and informal leaders in the rural community is the beginning of a comprehensive partnership. Leadership and problem solving skills can be utilized to identify issues and resource needs of rural homeless population.

In a rural community the NP may be the only health professional in the area. The rural NP utilizing a primary health care practice framework provides community oriented care. Rallying the community to use available resources, and striving to increase access to care within existing programs, the rural NP can play an integral role in assuring that homeless persons' needs are met.

The rural NP's contact with homeless individuals begins with presentation for health concerns. Unobtrusive questions in the intake interview or history form addressing the client's housing situation broaches the subject of housing needs or inadequacies. The intake interview creates an opportunity to inquire about other issues important to the

homeless client. These issues often include unemployment, lack of adequate financial resources, lack of transportation, and inadequate support systems (Albers & Paolini, 1993). The intake interview is a rudimentary begining towards assessing the needs of the homeless client in the rural community.

Homeless Needs Assessment

In order to provide effective services to rural homeless persons it is essential to determine the extent of the homelessness in the community. The NP can stimulate interest in performing a community needs assessment of the homeless population and guide the local community through the steps of the process. Dahl, Gustafson, and McCullagh (1993) wrote "comprehensive needs assessment helps the nursing leader create a strategy to assure health problems receive a fair share of the community's attention and resources" (p. 42). The NP can assist in identifying health promotion, education, and illness prevention needs of homeless individuals in the community. A community needs assessment of the homeless population should include information about basic needs such as food, clean water, and shelter as well as the need for education, income support and employment.

It is important to encourage community members interested in homeless individuals to participate in the assessment process. Community education is enhanced when a variety of community members are involved in the needs assessment process .

Formal Resources

In urban areas a well-defined social service system assists homeless individuals in meeting their needs. Larger rural communities with a broad economic base have more formalized social services networks than smaller rural communities. Formal resources available in larger rural communities might include: (a) county health and human service departments providing case management, Medicaid, WIC programs, food stamps, Families

Achieving Independence in Montana, and occasionally health care services, (b) shelters provided by volunteer organizations, (c) food banks or pantries that provide emergency food sources, (d) rural hospitals providing indigent care, (e) health clinics providing low-cost or free health care services, and (f) transportation services. County based services have been available to smaller communities within the county. Rural communities in sparsely populated counties seldom have formal social services available (Patton ,1988). Thus, these communities rely on their informal resources.

As an advocate for homeless individuals the rural NP can provide education regarding the existence of formal resources. The NP in a rural health practice can help identify specific resource needs of rural homeless persons and assist in linking individuals to formal resources in the community.

Informal Resources

Resources available in a small rural community may not be readily apparent. As previously noted, these resources often come from informal sources. As Webster (1984) described, informal resource systems are based on moral precepts of helping the less fortunate. Principal sources of informal helping are voluntary associations, relatives, friends, and neighbors. Informal resources available in rural communities often include: (a) church groups and clergy, (b) local service groups; i.e, Lions Club, and Future Farmers of America, 4-H, (c) friends, neighbors, and extended family members, (d) concerned citizens willing to volunteer their time, homes, and/or money.

Objectives

The major objective of this project was to compile a resource manual that nurse practitioners utilize in providing holistic care to homeless individuals in their communities. The manual includes: (a) an example of the integration of an individual homeless needs assessment into an initial history interview, (b) guidelines for conducting an effective community needs assessment of the homeless population, (c) a list of resources available to homeless persons in a rural county, and (d) a brief list of State and Federal resources available to assist homeless in the community.

A secondary objective was to create awareness of the existence of homeless people in rural communities so that their problems can be addressed. To be able to provide community-based primary health care rural NPs should be aware of members of the community that do not have ready access to their services, namely homeless individuals. This project provides a framework for rural nurse practitioners building collaborative ties within the community in order to meet the needs of all community members including the homeless.

CHAPTER 2

LITERATURE REVIEW

Conceptual Framework

Homelessness is the consequence of a variety of mutually interacting economic, political, social, and medical factors (Gladden, 1991). Homelessness exists in rural communities as well as in urban communities. Providing care to rural homeless populations requires the NP develop a broad scope of practice addressing all aspects of health. The primary health care model was used in this project to conceptualize health care for homeless persons in rural communities.

The World Health Organization (WHO) (1978) set forth the basic premise of primary health care: essential health care that is accessible to individuals and families in the community through their participation and at a cost the community can afford. Four concepts are fundamental to the provision of primary health care: (a) essential health care, (b)accessibility, (c) collaboration and participation within the community, and (d) advocacy.

WHO (1978) specified services considered essential. Primary health care includes: education regarding existing health problems, promotion of food supply and nutrition, adequate supply of potable water, basic sanitation, maternal and child health care, prevention and control of locally endemic disease, treatment of common diseases and injuries, promotion of mental health and the provision of essential medications. Essential health care involves viewing health not merely as the absence of disease but as a state of physical, mental and social well-being (WHO, 1947). Essential health care extends beyond the provision of traditional health care services to include issues of housing, environment,

and economic, political and social opportunity (Barnes, Eribes, Juarbe, Nelson, Proctor, Sawyer, Shaul, & Meleis, 1995). Essential health care incorporates all aspects of the human condition.

Accessibility referred to whether a person has the means to obtain and afford needed services (Bushy, 1994). For the rural homeless population, accessibility to services is dependent upon financial resources (including Families Achieving Independence, Medicaid, Food Stamps, etc. . .), distance to services and transportation available, physical disability, literacy, and socialization, and health providers willingness to provide uncompensated or partially compensated care.

Access to health care was an important element in nursing's health care reform agenda. Barnes et al. (1995) noted that defining access to health care from a primary health care perspective implies a focus on the community served. It implies continual community participation and involvement in identifying essential services and resources, culturally and socially accessible health care services, and affordable health care services.

Advocacy is an ethical imperative for practitioners interested in providing primary health care in a rural community. Advocacy is based on the tenet that everyone has a right to receive just, equal and humane treatment (Spradley & Allender, 1996). Inevitably the rural NP will care for a homeless community member. Incorporating advocacy into her/his practice, the practitioner can form partnerships with community members to link individuals to resources. The belief that the NP, as a client advocate, promotes health by enabling informed self care by the client is found within the standards of practice for the primary health care nurse practitioner (American Nurses Association, 1987). Spradley and Allender promote two underlying goals of advocacy: (a) to assist clients in gaining greater independence or self-determination, and (b) make the system more responsive and relevant to the needs of the client.

Collaboration and participation within the community would entail cooperation and involvement of persons and agencies from a variety of sectors: housing, employment, education, safety and transportation, health and welfare (Anderson & McFarlane,1996). Building trusting relationships with homeless clients and forming collaborative partnerships with a variety of community service providers gives the NP insight into the diverse resource needs of the rural homeless population. Goeppinger (1993) wrote, "Partnership is important because health care is not given by health care providers to the community, but promoted through collaborative working relationships or interaction among researchers, professional and indigenous health care providers, policy makers, and residents" (p. 3).

The role of the rural NP is to provide primary health care to individuals, families, and the community. Nurse practitioners use a primary health care approach to engage with a community as a partner rather than as a separate entity and can act on the belief that expertise resides in the community itself (Anderson & McFarlane, 1996). Providing primary health care involves informing homeless clients of resources, acquainting them with services they are entitled to, and assistance in obtaining services available. Within the scope of primary health care the rural NP participates in a variety of community leadership activities, such as encouraging program funding, assistance with community needs assessment, and influencing changes in services offered. Rural nurse practitioners are uniquely suited to provide primary health care to rural homeless clients within the community. The NP-patient relationship is rooted in the profession's moral and ethical foundations and its commitment to people in need (Hickey, Ouimette & Venegoni, 1996).

In order to provide comprehensive primary health care to this population. It is important for the rural NP to understand what constitutes rural homelessness, and be able

to identify the problems and needs of homeless individuals. To achieve this understanding the literature review includes a section on the enumeration of the homeless population, the needs and problems of homeless people. Information about needs assessment was included to establish the theoretical basis for conducting a needs assessment.

Defining Rural

To discuss rural homelessness it was important to define rural. In the literature there were a variety of definitions of *rural*. The U.S. Bureau of Census (1987) defined rural as individuals living in towns with a population less than 2,500 or in open country. Elison (1986) proposed a definition of rural that includes a frontier designation as a realistic method for sparsely populated states like Montana. Elison defined a rural county as more than six, but less than 100 persons per square mile. Frontier is defined as less than six persons per square mile. Frontier areas often lack formal resources for rural homeless individuals.

Another method of defining rural is the use of the metropolitan statistical area (MSA). Office of Management and Budget (1983) described an urban county as encompassing at least 50,000 population, or an urbanized area of at least 50,000 with a total metropolitan population of at least 100,000. Counties that had not been designated MSAs were classified as rural. The Office of Management and Budget definition of rural was chosen for use in this project because it has been utilized by a wide variety of authors and it defined *rural* in a broad sense, including larger or smaller rural counties

Defining the Homeless Population

Homelessness is a complex, multidimensional problem. Attempts at defining of homelessness fall short of characterizing the extent of the problem.

In this section of the literature review a variety of definitions have been used to capture the essence of homelessness. "Homeless" or homeless individual defined by the PL100-77 Stewart B. McKinney Homeless Assistance Act (1987) as:

> 1. an individual who lacks a fixed, regular, and adequate nighttime residence; and
> 2. an individual who has a primary nighttime residence that is-
> (A) a supervised publicly or privately operated shelter to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
> (B) an institution that provides a temporary residence for individuals intended to be institutionalized; or
> (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (p 485).

This definition referred to individuals but could easily be adapted to families who find themselves homeless. Patton (1988) provided a method of defining homelessness as housing situations that are both unstable and temporary, and insufficient resources to secure adequate housing. Patton's definition was chosen for use in this project because it allows for inclusion of individuals on the verge of homelessness such as persons at risk of eviction, and battered woman staying in shelters temporarily.

The rural homeless population have not been easily defined. Fitchen (1991) reported that often rural people were not literally homeless in the sense of no roof over their head, but the roof might be a car, a dilapidated shed, a tent, deserted farmhouse, or isolated shack. It may mean temporarily living with relatives, friends, or in a camper trailer parked off the road or in a public campground. Homeless individuals often "double up" with family members and friends. First, Rife and Toomey (1994) found that nearly half of the 919 interviewees in their rural homeless study resided with friends and family. Fitchen (1992) reported that the rural homeless population were more likely to be widely dispersed rather than found in shelters, because small towns were less likely to have shelters, and rural people utilized informal social networks more often than formal

agencies for housing. Another group of homeless people were described as "living in cars along country roads or staying in public campgrounds beyond the normal season" (Momeni, 1989, p. 95).

Debate centered around inclusion of those at high risk for homelessness in the definition, such as persons living in inadequate or substandard housing. These "invisible or hidden " homeless could be one paycheck or one domestic argument from the streets (Baum & Burnes, 1993). Homelessness is a continuum of housing adequacy or housing stability (Wright, 1989). Lack of housing was one feature of defining the homeless population. To equate homelessness merely with the lack of a permanent living space is a very narrow view of the essential deficit of the homeless. Erickson and Wilhelm (1986) believed that focusing on inadequate housing diverts attention from the issue of lack of a stable base of caring and supportive individuals who help buffer the homeless individuals against the ups and downs of life. It was obvious that a variety of definitions of homelessness existed. There seemed to be a common thread among the definitions, temporary or unstable housing situations.

Enumerating the Homeless Population

Enumerating the rural homeless was a difficult task. The magnitude of the rural homeless problem was disguised by a long tradition of self-reliance, and assistance from family and friends rather than public assistance (Dahl, Gustafson, & McCullagh, 1993). No comprehensive studies were conducted to count the rural homeless population. The 1990 census made no special counts for rural homeless (Fitchen, 1991).

To date there are no national estimates on the number of rural homeless. Two states, California and Maryland, have published estimates of rural homeless populations based on those served by social service providers. Patton (1988) reported both states

developed identical estimates that 18 % of the homeless are rural residents. Patton argued that service provider estimates are often biased as a result of counting the same person or family twice when they are served by the same provider. The Housing Assistance Council, a Washington advocacy group, has suggested a figure of 12.5 % of homeless reside in rural areas (National Rural Health Association [NRHA], 1996).

Members of rural communities often do not perceive that homelessness exists in their community. Homeless friends and family members are not considered homeless. Homelessness is attributed to transients or outsiders (Institute of Medicine [IOM],1988). The few homeless research studies conducted support the notion that rural areas are not exempt from homelessness (First et al. 1994; Fitchen, 1991; Roth, Bean, Lust, & Savaenu, 1985).

The numbers of rural homeless individuals were not as important as whether the rural community was able to meet the burden of the homeless without outside assistance from the State or Federal government. A large population of rural homeless individuals may place a strain on already sparse resources in rural communities. Rural communities, already economically stressed, are reluctant to offer benefits for fear of becoming magnets for the homeless (NRHA, 1996).

Comparison of Rural-Urban Demographics

The homeless population is a diverse group of people, single men and women, runaway youth, and families with children, usually single-parent families headed by women. No single defining characteristic exists other than the lack of adequate housing. It is an injustice to "classify" all homeless based on the characteristics of the relatively few homeless interviewed.

To a limited extent, noting demographic generalizations was helpful to create a vision of the homeless population. Demographic data were presented here to dispel any myths about the homeless population and provide a perspective on the rural homelessness.

From January to October 1996 preliminary data were compiled by Opportunities Inc., (1996) a comprehensive community action agency located in Great Falls, Montana. Demographic data were obtained from seven Montana counties served; of 237 homeless individuals or those at risk of eviction 55.7% were women and 44.3% were men. Data from two other rural studies (First et al.1994; Roth et al.1985) showed a smaller percentage (48.5%) of homeless males in rural areas. Research studies have shown a larger proportion of homeless women in rural areas than in urban areas (Roth & Bean, 1986).

Marital status appeared to differ between urban and non-urban areas. A larger percentage of urban homeless had never been married (Roth et al.1985). In the same study a variance was noted in the number of married non-urban homeless (23.3%) versus married urban homeless (8.5%). These numbers were similar to those reported by First et al. (1994). Preliminary data from Opportunities Inc. showed that of 237 homeless individuals or those at risk for eviction, 65 were female single parent head of household, 113 were single individuals, 26 had two parents in the home, 22 were two adults with no children, six were single parent fathers, two households were multiple adults with children and three were unspecified.

Other demographic differences were noted among urban and non-urban homeless. Rural homeless tended to be younger than their urban counterparts. First et al. (1994) and Roth et al. (1985) found that the median age of rural homeless was 30-31 years, whereas the median age of urban homeless was 37 years (Shlay & Rossi, 1992). Opportunities

Inc.1996 data showed the average age of homeless persons or those at risk of eviction they served was 34.6 years.

It has been suggested that rural dwellers "take care of their own", utilizing informal networks of friends, neighbors, and relatives. Roth et al. (1985) found rural respondents tended to have more resources than their urban counterparts. In the study 23.8% non-urban homeless resided with friends and 16.9% resided with family. This was consistent with Opportunities Inc. data which showed that 20.6 % of the 237 homeless persons or those at risk of eviction were residing with friends or relatives.

Urban-rural differences were noted in the use of social services. Roth et al. (1985) indicated that rural interviewees were less likely to use community kitchens and shelters, but received welfare and general relief payments more often than urban homeless individuals. It is possible that the difference in social service usage was related to limited availability of social services in rural areas.

Similarities among urban and rural homeless populations have been reported. Educational level does not seem to vary in rural and urban homeless populations (Roth and Bean, 1986). The Ohio study (Roth et al. 1985) revealed that approximately 30% of urban and rural respondents had graduated from high school. In First et al. (1994) 56.7 % of rural respondents interviewed had high school diplomas.

Another area in which urban and rural homeless populations parallel is the proportion of those who have previously been incarcerated (Roth et al. 1985). It is difficult to tell from data collected whether incarceration was the result of their homelessness (vagrancy charges) or convictions from other crimes.

Comparisons noted in this literature review were based on the few rural homeless research studies available. It was difficult to characterize the rural homeless population

based on small samples of individuals in these studies. It was questionable whether generalizations should be made about the larger population of rural homeless.

Needs of the Homeless

In providing primary health care to the rural homeless population, the rural NP must be aware of their multiple needs. Needs expressed by the homeless population are basic human needs we all share: shelter, clothing, employment, food and clean water, social support, and health care.

Housing

The need for shelter is the most basic of human needs. It springs from the desire to be safe, secure, and grounded. The homeless are denied this most essential necessity by virtue of poverty, illness, or disability. There was a direct relationship between a decrease in availability of low-cost housing and increasing numbers of homeless. Since 1980 through 1988 the supply of low income housing has decreased by 2.5 million units (IOM, 1988).

Lack of housing may be an episodic circumstance or a lifelong condition. In the Ohio study conducted by Roth et al. (1985), 72.3 % of urban respondents and 76.1% of non-urban respondents had been homeless one year or less. First et al. (1994) reported that of those interviewed nearly 89.2 % had been homeless one year or less. The implication was that homelessness in rural areas was predominantly a short-term condition. Further research is needed to determine the duration of rural homelessness. Roth et al. (1985) found a difference in where urban homeless individuals and non-urban homeless individuals slept. Roth et al. noted that 37.1% urban respondents depended on shelters, whereas 20.4 % of non-urban homeless respondents utilized shelters. This may

have been a function of lack of the availability of shelters in non-urban areas. Non-urban homeless (40.7%) were more likely to reside with friends or relatives than urban homeless (10.7%) (Roth et al.1985). Nearly half of rural poor live in substandard housing (NRHA, 1996). By many definitions individuals living in substandard housing were not considered homeless, but were at high risk for homelessness.

Employment and Income

A survey of both urban and rural homeless males in Utah revealed that the need for a job ranked second after shelter among the stated needs of homeless individuals (Momeni, 1989). One of the causes of homelessness frequently cited was unemployment and long-term joblessness (First et al. 1994; Johnson and Cnaan,1995; Roth et al. 1985; Shlay and Rossi,1992). Wright (1989) suggested that job histories of homeless individuals showed that they were among the extremely poor and were unemployed for years. Roth et al.(1985) cited the major reason for lack of employment was the inability to find a job. A portion of the employment problem for rural homeless persons was explained by the lack of job opportunities in rural areas. As Flynt (1996) noted, rural areas are faced with declining agricultural and low wage industrial jobs.

Blau (1992) reported 24 % of the homeless population were involved in either full or part-time work. In a Utah study of the homeless individuals only 19.9% of men and 14% of women responded they were currently working; however 73% of men and 62% of women were looking for work (Momeni,1989). When asked if they had worked during the last month 22.2% urban homeless reported having worked, as compared to 35.4% individuals from non-urban areas (Roth et al.1985). First et al. (1994) noted 31.2% rural homeless persons had worked for pay in the last month, of those 43.2% had permanent full-time positions, and 20.2% had worked in permanent part-time jobs.

Homeless individuals have limited economic resources. According to Shlay and Rossi (1992) a relatively small percentage of the homeless population (20%) received General Assistance (GA) and even fewer homeless (10%) received social security benefits. This was not true of the homeless individuals sampled by Roth et al. (1985), of which 61.4% of non-urban and 40.4% of urban respondents received welfare and general relief payments. The Interagency Council on the Homeless (1991a) reported an average income per person (including government benefits) of approximately $130 per month among homeless persons with half of the homeless population receiving less than $60 per month. It was not difficult to understand how individuals with such extremely low incomes were unable to find adequate housing or afford food for themselves or their families.

Sustenance

In most cities a variety of programs offer free meals or food that can be prepared. Often homeless shelters provide meals along with a place to sleep. Soup kitchens were a source of meals for other homeless individuals. Food banks and food pantries make available uncooked perishable and nonperishable foodstuffs for poor and homeless individuals. Johnson and Cnaan (1995) noted that obtaining food was a daily challenge for homeless individuals and the extremely poor. Methods homeless people used for acquiring food seemed to vary. Roth et al. (1985) reported that urban residents (51%) were more likely to utilize soup kitchens than were non-urban respondents (11.6%). Roth et al. suggested that this was due to the availability of soup kitchens in urban areas. Alternatives were available in non-urban areas, non-urban respondents purchased food from grocery stores for their own preparation and obtained handouts more often (22.2%) than urban homeless respondents (9.5%). The number of non-urban homeless purchasing food may have been suggestive of increased numbers of non-urban homeless individuals

"doubling up" with friends and relatives, or was reflective of the increased reliance on GA of rural homeless persons.

Often homeless people do without meals, or eat out of dumpsters. The parents of homeless families must find food for their children as well as themselves and often do without meals to provide enough for their growing children. Lack of adequate nutrition can lead to serious health problems and developmental problems for children (Shlay & Rossi, 1992).

Social Support

The need for social contact is a fundamental need of the human organism. As Maslow (1954) reasoned, the need for intimacy and close personal contact is linked to higher order needs such as self-esteem and self-actualization. For many homeless individuals the need for social support is not met. Homelessness may produce feelings of isolation and minimization of social attachments. Goodman, Sax, and Harvey (1991) noted that a lack of a social network to rely on in times of crisis places the homeless at a greater risk of repeated episodes of homelessness. According to Shlay and Rossi (1992), research showed the homeless population in general lacked strong social ties to social networks; on average 36% reported having no friends and 31% reported no contact with families. Roth et al. (1985) reported more non-urban homeless respondents (43.4%) had relatives they counted on. In the same study Roth et al. found that rural homeless people had more frequent contact with relatives than urban homeless. First et al. (1994) reported that more than half of those interviewed stated they could count on relatives for assistance.
It was clear that social support was important to rural homeless people. The nature and extent of that support was only briefly discussed in the literature.

Medical Problems

Medical problems of homeless persons commonly include malnutrition, psychiatric disorders, alcohol and drug abuse, and chronic disabling disease. The interaction between health and homelessness is complex. The IOM (1988) found that there were different types of interactions between health and homelessness. Some of those interactions included health problems that precede and contribute to homelessness, that are consequences of homelessness, and illnesses complicated by homelessness.

Health services received by homeless individuals were usually episodic and focused on acute, often emergent problems. By the time homeless individuals obtained services it was often late in the course of the illness (Hickey, Ouimette, & Venegoni, 1996). Health status and health needs of rural homeless populations were 2 areas lacking data in the literature. Research studies of rural homeless populations did not provide specific information about rural homeless peoples health needs. Roth et al. (1985) described health problems but did not separate urban from non-urban homeless populations.

Some general statements can be made regarding the health of homeless people. Until adequate research is undertaken it is unclear whether there are similarities or differences in urban and rural homeless populations related to specific health needs. Homeless persons by virtue of their vulnerability are at increased risk of physiologic disease. Living in open spaces, exposed to infestation, extremes of temperature, illness due to poor nutrition, lack of cleanliness, and potential trauma, the homeless as a group are most at-risk and least able to achieve health maintenance. This was supported in data from the Robert Wood Johnson Foundation; the death rate for homeless males was about five times that of the non-homeless males (Interagency Council on the Homeless, 1991a). Many of the homeless had no subsidization for even the most rudimentary health care.

Health care needs of the homeless population ranged from simple colds to problems that result from lack of adequate shelter, such as pneumonia, and cellulitis (Johnson and Cnaan, 1995). One of the leading causes of death and disability among the homeless persons was trauma (Brickner, Scharer, Conanan, Elvy, and Savarese, 1985). Trauma included simple contusions, lacerations, sprains, bruises, burns and fractures. Brickner et al. (1985) reported that approximately 30 % of 524 homeless people treated in San Francisco over a six month period were seeking treatment for traumatic injuries.

Dermatologic disorders were among another group of conditions common to the homeless population. Homeless persons had an increased incidence of bacterial cellulitis and pustular skin lesions (IOM, 1988). Infestations of body lice and scabies were frequently seen in the homeless population. Brickner et al. (1985) noted that homeless individuals spread body lice and scabies via exchanging clothing, picking up clothing off the streets, or sleeping next to one another on park benches, on sidewalks, or in hallways.

Another commonly cited disorder in the homeless population was venous stasis and its sequelae. Venous stasis was often the result of prolonged sitting, standing or sleeping with the legs down which led to cellulitis and skin ulcers (IOM, 1988).

Exposure was a constant problem for those living out in the elements. Hypothermia and frostbite were not uncommon afflictions among the homeless population. Brickner et al. (1985) found that heat stroke was a major risk for homeless people during hot and humid weather. Environmental exposure was associated with increased mortality from hyperthermia, hypothermia, and frostbite (IOM, 1988).

Crowded, cramped living arrangements were the backdrop for communicable disease among urban homeless populations. The most disconcerting of communicable diseases was tuberculosis (TB). Wright (1989) mentioned that the rate of TB among the homeless population in the U.S. was at least 25 times higher than the rate among the

population as a whole. Brickner et al. (1985) used the term "double jeopardy" to note two phenomena: (1) homeless in America are at high risk for developing TB, and (2) once they contracted the disease, poor nutrition, crowded living spaces, and stressful lifestyle make it unlikely they will receive the medication and environmental conditions needed to cure the disease. There was no data available for rates of TB in rural homeless populations.

A proportion of the homeless suffer from chronic illnesses. Hypertension, arteriosclerotic cardiovascular disease, chronic obstructive pulmonary disease, and diabetes were among just a few of the chronic illnesses afflicting homeless persons. These chronic illnesses required follow-up and consistent monitoring to provide the best outcome. However, homeless individuals were often unable to afford medications prescribed to them, and had inadequate storage capabilities, or lack transportation to seek medical treatment (Brickner et al. 1985).

Mental illness

Psychiatric disorders can be antecedents to homelessness. Often the mentally ill were unable to find or retain community resources such as housing, a stable source of income, or mental health treatment or rehabilitative services (Erickson & Wilhelm, 1986). A stereotypic perception exists that the homeless are mentally ill individuals who are unable to secure adequate housing. A portion of the homeless population were individuals with psychiatric disorders; however, Shlay and Rossi (1992) noted there was a wide variation in estimations of prevalence of mental illness among homeless populations. There were no universally accepted definition of mental illness or common methods of measuring mental illness. Several authors (Interagency Council on the Homeless,1991a; Kondratas, 1991; Roth et al.1985; & Shlay and Rossi, 1992) found that approximately

30% of homeless persons suffer from one form of mental illness. This meant that most of the homeless population were not mentally ill.

It has been suggested that homelessness creates psychiatric disorders due to psychological trauma. Goodman et al. (1991) argued that homelessness itself was a risk factor for emotional disorders. It is difficult to separate the association of mental illness to homelessness.

Deinstitutionalization has been blamed for creating a subgroup of the homeless population that are mentally ill. However, Kiesler (1991) argued that deinstitutionalization is not a major factor in the prevalence of homelessness. Roth et al.(1985) reported that nearly 3 in 10 homeless respondents in the Ohio study had been hospitalized for a mental illness. In the same study Roth et al. found 30.6% of urban homeless respondents and 27% of non-urban homeless respondents had been hospitalized for mental health problems.

Homeless persons may be dually diagnosed. Meaning, they may be mentally ill and substance abusers. Drake, Osher and Wallach (1991) observed that the designation of "dually diagnosed" homeless was a misnomer. In reality these individuals were multiply impaired, many had medical illnesses, legal problems, histories of trauma, and behavioral problems.

Substance Abuse

Substance abuse was viewed as a cause and an effect of homelessness. Substance abusers had difficulty keeping a job; their dependence on drugs often alienated them from support systems, setting up a scenario for homelessness. Again it would be easy to fall back on the view of homeless as "skid row alcoholics" and drunken "Bowery bums." As with much data regarding the homeless population, a disparity existed in the numbers quoted on substance abuse. Data on the number of homeless substance abusers vary

greatly. Blau (1992) found that one-third of the homeless population had substance abuse problems. Kondratas (1991) also noted that one-third or more of the homeless population have serious substance abuse problems. Caton (1990) argued that more studies using standardized instruments were needed to assess the extent of substance abuse among the homeless population.

Some very interesting data reported by Roth et al. (1985) separated alcohol use from drug use. Roth et al. noted that 45 % of the respondents sampled stated they had been drinking some, 19.2% drinking a lot, and 35.2% were not drinking at all. With regard to drug use, 32.2 % of respondents had used drugs in the past month; but when they were asked if the drugs had been prescribed by a doctor 22.6 % answered yes. This was self-reported data with inherent potential for reporting bias.

Homeless Needs Assessment and Resource Inventory

The United Way (1982) defined needs assessment as:

> a systematic process of data collection and analysis as inputs into resource allocation decisions with a view to discovering and identifying goods and services the community is lacking in relation to the generally accepted standards, and for which there exists some consensus as to the community's responsibility for their provision (p.10).

In addition, a community needs assessment identifies at-risk groups in the community requiring services. A needs assessment provides demographic information about the at-risk groups in the community.

Conducting a community needs assessment of the homeless population can be achieved through collaboration between the rural NP and the community. Information gleaned from the needs assessment directs the NP in providing primary health care to rural homeless clients and provides data for the community to utilize in designing services for the homeless population. It is important to conduct a thorough community needs

assessment to identify specific needs of the rural homeless population and to identify at-risk populations. Needs must be enumerated before efficacious assistance can be offered. The community needs assessment of the homeless population enhances community involvement in service delivery planning, and allows for decision making about setting priorities for service delivery. A community needs assessment of the homeless population also creates a database for evaluation of current and future programs (Neuber, 1980).

The principle of community responsibility is essential. This principle has two elements. First, there is a responsibility and accountability of individuals, and organizations to the whole community. Second, there is the responsibility of the community to promote the well-being of its individuals (United Way of America, 1982). Both elements are congruent with the primary health care model.

A resource inventory is an integral part of a needs assessment. The resource inventory is a detailed account of community resources. The inventory should include the program title, capacity of the program, eligibility criteria, the extent to which the homeless are currently being served, and barriers to participation in the program (United Way of America,1982). All the programs that would benefit the homeless should be included in the resource inventory (Interagency Council on Homeless, 1991b). A community needs assessment of the homeless population and resource inventory provides rural counties with the information required to address the problem of homelessness in their communities. Furthermore, it provides data for establishing an appropriate referral network.

Formal and Informal Resources

The homeless population has diverse needs and may require assistance from a variety of resources. Urban areas often have a wide array of formal resources to assist the homeless in meeting their needs. Services available to the homeless vary immensely with location. The size of the community often dictates the number and extent of services

available to the homeless. When reviewing formal resources in rural communities it is important to keep in mind the size of the community.

Formal resources available to the rural homeless population was a neglected area in the literature. Authors (First et al. 1994; Frank & Streeter, 1985; Roth et al. 1985) referred to the lack of social service resources for rural homeless, but no research studies were available to substantiate that claim. In rural areas formal resources were often provided out of population centers, the county seat, or nearby cities (Webster, 1984).

Social services such as food stamps, Women Infants and Children program (WIC), Families Achieving Independence in Montana (FAIM), and Medicaid were available to rural homeless. These programs required the applicant to fill out forms which was problematic for homeless individuals or families who had poor reading or writing skills. Programs require an initial interview, which was difficult for rural homeless individuals living long distances from the population center, and who had no form of transportation.

Housing is a resource all homeless require. Urban areas frequently had formal programs working to assure adequate temporary shelter for homeless persons. Emergency shelters and missions were usually located in these communities. Shelter facilities were virtually unknown in rural areas because building and maintaining them had not been cost effective on a per capita basis (NRHA, 1996). Local and county governments were attempting to develop temporary housing strategies. First et al. (1994) reported hotel and motel rooms were rented on a nightly basis to provide temporary shelter.

It was difficult to distinguish formal resources from informal resources. Webster (1984) noted authors used different terminology to describe informal systems in rural communities. Often friends, neighbors and family were considered part of the rural informal resource system. Some authors included service clubs and churches as part of the

informal system. Webster argued that formal resources are professional individuals or organizations with formal purpose to provide health or social services.

Informal networks in rural communities are the ties that bind the community together. Information, support, and shelter are received from friends, family, and colleagues. Informal networks are an integral part of informal resources in the rural community. In order to create comprehensive services for rural populations, it is important to have an awareness of informal networks operating within a community. An understanding of informal networks is essential for holistic primary health care of rural homeless clients.

One informal resource utilized by the homeless persons was housing. Housing often consisted of "doubling up" with family or friends for an indefinite period of time (First et al. 1994; Fitchen, 1991; Roth et al. 1985). While not considered literally homeless, individuals were "doubling up" which was usually temporary and often an unstable situation. For other rural homeless individuals temporary shelter was set up in a church or meeting hall. It was not uncommon for congregation members to agree to informally house homeless who were members of their congregation (NRHA 1996). Social support was another informal resource utilized in rural communities. Martinez-Brawley (1993) noted the importance of a variety of informal networks to help people cope with problems of living.

Lack of transportation was another need that had been fulfilled by informal sources. Tangible resources provided by informal networks included food, clothing, and transportation (Patterson, Memmott, Brennan, & Germain, 1993).

Summary

The extent of homelessness in rural areas is largely unknown. However, it was clear from research and anecdotal information from service providers that homelessness existed in rural communities. The rural homeless were not easily defined or located. Their needs were assumed to be similar to the urban homeless population however, scant qualitative research had been conducted to assess the specific needs of rural homeless persons. Research relating to resources available to rural homeless was lacking. It was evident that further qualitative and quantitative research was required to, clarify the extent of the problems of rural homeless populations, and identify specific needs of the rural homeless to develop resources to assist them in meeting those needs.

Utilizing the primary health care model assists rural nurse practitioners in developing a practice sensitive to the needs of all community members including homeless individuals. Primary health care gives direction for collaboration with a variety of formal and informal resources in the rural community to provide effective care to homeless individuals in the community.

CHAPTER 3

METHODOLOGY

The process of designing the resource manual for this project included a general review of literature and contact with formal and informal service providers. The resource manual was designed to be utilized by rural nurse practitioners in providing holistic primary health care to homeless individuals in their communities.

Literature Review

Development of the resource manual began with an extensive review of literature about the rural homeless population. Particular attention was paid to research studies with sample populations of rural homeless individuals. Other topics identified for literature review included: health status and health needs of homeless, community collaboration, primary health care, and community needs assessment.

An extensive interview was conducted with Sherry James B.A., B.S., M.H.S., planner and program developer, and Geoff Wrigg, B.S., M.A.S., computer programmer at Opportunities Inc., a community action agency in Great Falls, Montana. From January through October preliminary homeless demographic data was gathered by Opportunities Inc. using the Agency Client Profile Form. The data included households reporting homelessness or an eviction concern. This reporting was congruent with the definition of homelessness utilized for this project. This data was chosen to augment information in the literature review because it provided insight into a homeless population in Montana.

Resource Manual

Section I of the resource manual includes an example of the individual needs assessment survey to be included in an initial office interview. The individual needs assessment form was adapted from the Agency Client Profile Form with the written consent of Ms. James. The Agency Client Profile Form was chosen as a model because it assists rural NPs in identifying homeless clients or those at risk for homelessness within their practices. In addition, it provided a comprehensive assessment of clients needs and concerns. The form was concise, easy to read, and supplied a wide variety information.

Section II of the resource manual provides the rural NP with guidelines for conducting a community needs assessment of the homeless population. These guidelines were compiled after a review of literature and discussions with social service providers. As a community leader the NP can initiate a community needs assessment of the homeless population, and identify needs and concerns of homeless individuals in the community.

Section III includes an inventory of resources available to homeless populations in Ravalli County, Montana. The inventory of resources was conducted between September, 1996 and February, 1997. A list of community resources was obtained from Ravalli Tele-Link, a telephone information and referral service. From the list formal service providers were interviewed in person or by telephone. Those interviewed were:

(a) director of Ravalli County Health and Human Services,

(b) program director Human Resources Council,

(c) Ravalli County Public Health Nurse,

(d) Hamilton Job Service Center,

(e) Marcus Daly Memorial Hospital social worker,

(f) Crossroads, addiction treatment and family counseling service,

(g) River Front Counseling, a community mental health center,

(h) Supporters of an Abuse Free Enviroment (SAFE), an emergency shelter for women fleeing domestic abuse,

(i) Ravalli County Sheriff's Department,

(j) a local taxi service

(k) Birthright,

(l) Ravalli Council on Aging,

(m) Ravalli County Attorney's office,

(n) director of Healthy Families program,

(o) Commodity Center,

(p) Stevensville Clothes Closet,

(q) Child and Family Services, and

(r) Ravalli Services, a thrift store.

Informal resource providers were surveyed. Those providing resources included pastors, the Ministerial Association, members of the Stevensville Civic Club, Ravalli Literacy, and Haven House a volunteer food bank. Information requested included: the program title, the capacity of the program, services provided, eligibility requirements, and extent to which the homeless are being served. Further information regarding resources was obtained from bulletin board postings at local establishments in Hamilton, Montana, Stevensville, Montana and Florence, Montana. Webster (1984) set forth definitions for formal and informal systems, these definitions were utilized to differentiate formal service providers from informal service providers.

Section IV of the manual provides a brief list of State and Federal programs designed to assist the homeless. Program information was acquired from a search of the internet, government publications, and other literature.

CHAPTER 4

DISCUSSION

Results

In order to provide primary health care rural NPs should increase their awareness of the complex health needs of rural homeless individuals. Section one of the resource manual assists the rural NP in providing primary health care to homeless individuals or those at risk for homelessness in the rural community. An example of how to incorporate an individual homeless needs assessment into an initial health history interview is included in the manual. The individual needs assessment gives the NP information about specific resource requirements of the client. Understanding the needs of the rural homeless client allows the NP to tailor treatment plans and interventions to meet those needs. While developing this project the author acquired a keen understanding of the variety of unmet needs of the rural homeless client.

The second section of the resource manual directs the NP in a collaborative effort with the community in conducting a community needs assessment of the homeless population. Collaboration provides community members with knowledge of community based resources. The community feels an ownership of the assessment process when they participate. Assessment outcomes become important to community members participating in the assessment process. In order for an assessment to be successful the community must be involved (World Health Organization, 1978).

A community needs assessment of the homeless population serves several purposes: (a) educating the local population about the existence of homelessness in the community, (b) quantifying the extent of homelessness in the rural community, and (c)

ascertaining the needs and concerns of the homeless in the community. This manual assists the rural NPs in broadening their scope of practice to include the larger population of the community.

A resource inventory of Ravalli County, Montana was conducted to provide an example of resources that may be available to rural homeless people within their communities. Resources available in Ravalli County are listed with descriptions of the programs, eligibility requirements and the addresses and phone numbers of resources. The information is not generalizable to all rural areas. The manual includes guidelines for compiling a resource inventory. It was designed to give direction to rural NPs seeking resources for homeless clients in their communities. Knowledge of available resources in the community is essential to providing comprehensive, holistic primary health care to clients.

Ravalli County is located in western Montana. It has a population of 25,010 (Census Data, 1990). Census Data reported 4,022 residents whose incomes were determined to be below poverty status in 1989. Individuals below the poverty level are at highest risk for homelessness (Johnson & Cnaan, 1995). There was no data available about the number of homeless people in Ravalli County.

Ravalli County is an example of a rural county in which a variety of sectors cooperate to meet the needs of its residents. The author observed this phenomena while conducting the resource inventory of Ravalli County. It was gratifying to observe formal and informal providers working together to provide emergency housing and rent assistance, clothing, food and counseling services for residents who lack financial resources. This demonstration of the number and scope of resources available might offer encouragement to the rural NP to replicate the resource inventory in his/her own

community. Many residents had donated time, money, food, clothing and facilities to assist in meeting the diverse needs of individuals in the community.

Some service providers in Ravalli County lacked complete knowledge of the resources available in the county. The resource inventory helps bridge this gap in knowledge about resources in the community and saves service providers time in locating available resources.

The fourth section of the manual provides a list of State and Federal programs designed to assist the homeless. A variety of programs provide financial assistance, resource materials, direction for implementing services, and funding for new services for the homeless population. According to the National Rural Health Association (1996) officials in rural communities were often unaware of state and federal aid available. Knowledge of resources available is valuable for community leaders in order to strategically plan services that effectively meet the needs of rural homeless populations.

Limitations

One limitation of the resource manual concerns the demographic data compiled by Opportunities Inc. A portion of the data was collected in urban Cascade County. Because of this, data were skewed toward urban homeless populations. However, the data were used to provide an example of homeless demographic data from Montana and included individuals residing in rural counties. Demographic data specific to the rural counties served by Opportunities Inc. were unavailable to the author.

A second limitation was that the inventory of resources was conducted in only one rural Montana county. The resource inventory information was specific for Ravalli County and not generalizable to other counties in Montana. Conducting a resource inventory over

a wider geographic area would increase data about resources available to rural Montana homeless populations, and identify their resource needs.

The third limitation was that the information included in the resource inventory was obtained from September 1996 to February 1997 and subject to change on a regular basis. The information may become dated. The purpose of the resource inventory information is to provide an example of potential resources available in a rural community, not as an ongoing resource for services available in Ravalli County.

A final limitation, was the author's lack of residency in Ravalli County, which may have created a barrier to collection of information about informal resources in the county. As Long and Weinert (1989) noted the insider-outsider distinction that occurs in rural areas limits the acceptance of a health care provider who is not living in the rural community.

Implications for Nursing Practice

The manual created as part of this project is a valuable resource for NPs providing primary health care to homeless persons in their communities. Integrating an assessment of individual needs and concerns into the initial history taking interview allows the NP to identify the homeless individuals in his/her practice and to assist homeless clients in identifying their resource needs. Once the needs and concerns are identified, the NP can collaborate with the homeless client and community resources to assist them in meeting their complex needs.

Advocacy is a concept within the primary health care framework. NPs should become actively involved not only in the NP-client relationship but also in social-political relationships in order to be a client advocate. One advocacy activity carried out by rural NPs is providing appropriate referrals and linking the homeless clients to available

resources. It is important for the rural NP to become aware of the formal and informal resources in the rural community. The manual's resource inventory provides an example of resources that may be available in a rural community.

The manual assists the rural NP in assuming a leadership role by providing them with information about initiating and conducting a community needs assessment of the homeless population. The community needs assessment targets the high-risk homeless population, and can illuminate their needs and concerns. The rural NP can collaborate with community members in designing resources that improve accessibility and comprehensiveness of services available to rural homeless persons.

State and federal welfare reform programs threaten to increase the population of homeless and those at risk for homelessness by decreasing or limiting entitlements. It is important for rural communities to identify individuals in the community who are homeless and through collaboration and participation provide support for individuals affected by changing social service policies. Social service programs must become more responsive to the needs of homeless populations in rural areas in order to provide cost effective, responsive, and relevant services. This resource manual encourages the NP to develop a collaborative community oriented primary health care practice. It provides information about community activities the rural NP can initiate and participate in, to help provide a needed support for rural homeless clients.

Recommendations for Future Research

Few research studies examining the complex needs and concerns of the rural homeless were available. Two notable studies, First et al. (1994) and Roth et al. (1985) examined a variety of problems experienced by rural homeless in Ohio. Further research is required to clarify the extent of rural homelessness. Research should be conducted in a

variety of rural settings to obtain a comprehensive picture of what constitutes homelessness in different rural areas.

There is a need for additional qualitative research assessing the medical, psychosocial, and emotional needs of the rural homeless. The rural homeless are vulnerable to poor health due to exposure to the elements and problems in obtaining access to a regular source of health care. Further research on health status and health care utilization would enable program planners to target specific needed services (Roth, & Fox, 1990).

Another area for future research is the analysis of resource utilization by rural homeless persons. Examining the extent of service utilization would provide insight into services that are lacking, as well as those services that are effective in meeting the needs of the homeless population in the community. The IOM, (1988) encouraged research about the dynamics of homelessness, the health problems of homeless people, and effective service provision strategies. Clearly there is an immense need for more information about rural homeless populations in order to provide comprehensive community based health care to this vulnerable population.

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APPENDICES

APPENDIX A

PROVIDING PRIMARY HEALTH CARE TO RURAL HOMELESS POPULATIONS: A RESOURCE MANUAL FOR RURAL NURSE PRACTITIONERS

PROVIDING PRIMARY HEALTH CARE TO RURAL HOMELESS POPULATIONS

by

Sarah J. McNerney, BSN

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Introduction

This resource manual is designed to be utilized by nurse practitioners caring for homeless clients in rural communities. The manual provides an example of the integration of an individual homeless needs assessment into an initial interview. This provides the practitioner with insight into specific needs and concerns of the individual client or family seeking medical care. Guidelines for conducting a community needs assessment of the homeless population are provided. These guidelines foster collaboration with community members to identify the extent of the homeless population, and enumerate their needs and concerns. A resource inventory is included in the manual to provide an example of resources that may be available in other rural communities throughout the state of Montana. Finally, there is a brief listing of state and federal resources available to assist communities in addressing the problems of the homeless population.

Section I

Integrating an individual homeless needs assessment into an initial interview.

In the following section an example of assessment questions are provided. These questions can be incorporated into an initial client interview. The goal of the assessment is to identify specific resource needs of the client. After identification of clients needs, assistance can be offered in accessing available resources. The assessment helps to identify homeless clients or those at risk for homelessness. This knowledge is important in developing interventions and treatment plans tailored to meet the needs of the homeless client.

Integrating an individual homeless needs assessment into an initial interview

In order to provide the best health care possible, we are interested in all aspects of your health including your current needs and concerns. It is our hope that we can assist you and your family in obtaining available resources to meet your needs. We guarantee all information given will remain confidential. You have the right to refuse to answer any of the following questions.

Client Profile:

Name:_____ **Age:**_____

Current address:_____ **Date of birth:**_____

City, State:_____ **Sex: __male __female**

Marital Status:__Married **Employed:__yes __no**

__Single **If yes type of employment**

__Seperated _____

__Divorced

Phone:_____

Message phone:_____

Who is currently living in your household ?

List:_____

Is your housing adequate for you?_____
If no, why?_____

Describe problems you have with housing_____

Do you have any emergency necessities? Example: No money to buy groceries; homelessness or danger of eviction; and/or no money for medical care.
__food
__shelter
__Medical

Do you have unmet needs or concerns? Please check items which you feel are needed by or are of concern to you and/ or your family.

School

__obtaining funding
__difficulty reading
__difficulty with basic math
__child's attendance problems
__child's homework issues
__child's behavior problems

Child care

__funding child care
__accessibility of child care
__ availability of appropriate care

Transportation

__auto repair
__gas
__no transportation
__child safety seats

Indicate items that you would like assistance for yourself or your family:

Counseling

__ Personal problems
__Alcohol or drug counseling
__Stress management/ problem solving
__Family conflict
__Parenting classes
Other_____

Finances

__Budgeting
__Health insurance
__Affordable day care
__Food stamps
__Trouble paying bills
Other_____

Support system

__Lack of support from friends
__Lack of support from relatives
__Conflict with others
__Family conflicts
Other_____

Housing

__Housing assistance
__Need of major repairs
__Eviction
__Affordability
__Discrimination
Other_____

Employment

__Job training programs
__Job search strategies
__Career information
Other_____

Nutritional

__Hunger, skipping meals
__Food stamps
__Food buying tips
Other_____

Health and medical

__Medical exams
__Assistance with prescriptions
__Dental care
__Eye care
__AIDS/HIV testing, training
__Well child care
__Depression
Other_____

Adapted from the Agency Client Profile, Opportunities, Incorporated

SECTION II

Guidelines for conducting a community needs assessment of the homeless population

This section of the resource manual is designed to provide guidelines for collaboration with other community members in conducting a community needs assessment of the homeless population. As a leader in the rural community a nurse practitioner (NP) can play an integral role in initiating a community needs assessment of the of homeless population. Data gathered from the community needs assessment can be utilized to identify high-risk populations, demonstrate a need for services that are lacking, improve services that are available, and obtain funding for additional services in the rural community. An understanding of homeless demographics, their needs and concerns allows the nurse practitioner to provide essential accessible and collaborative primary health care.

Step 1: Developing an awareness of homelessness in the community

Initially, the rural NP may identify the existence of homeless individuals in the community through contact with individuals in his/her practice. Utilizing an individual homeless needs assessment incorporated into the initial interview provides data to support the existence of a homeless individuals in the rural community. An awareness of a potential problem stimulates the NP to initiate a grass roots effort to identify the number of homeless individuals, and identify needs and concerns of the homeless population residing in the community.

Step 2: Collaboration: building a community coalition

After identifying homeless individuals in the community, the NP can initiate a meeting of concerned citizens and service providers. One goal of the community meeting is to develop interest in conducting an assessment of the extent of the homelessness in the community. Another goal is to establish a community coalition that could assist in the

development of a community needs assessment of the homeless population. The NP stimulates interest by providing education and information about rural homelessness to local service groups or groups of concerned citizens with an interest in the problems of homeless individuals. The rural NP enlists assistance from members of these service groups to invite members of volunteer organizations, advocacy groups, social service and health providers, local government officials, homeless persons and citizens interested in assessing the problems of the homeless to attend a community meeting. Information about the meeting can be accomplished through a public service announcement in the local newspaper, notices on bulletin boards at local establishments, personal contact with individuals, or contact by telephone.

Individuals interested in contributing to the needs assessment process would organize the coalition and schedule future meetings to plan the assessment process. The community coalition should represent all segments of the community.

Step 3: **Developing goals**

The community coalition identifies the purpose for conducting a community needs assessment of the homeless population i.e., identifying the magnitude of the homeless problem, evaluating effectiveness of current services, need for additional services, or funding for new services. Next the goals and objectives of the assessment should be identified. From the goals and objectives a mission or vision statement can be developed to give direction to the project.

Then the coalition develops questions that need to be answered. This is driven by the overall goal that is developed by the coalition. Questions include information that is required such as:

1 Are there homeless in the community?

2 How many?

3 How do we identify the homeless in our community?

4 Where are the homeless living?

5 Who are the homeless? (demographic information)

6 What are the goods and services they require?

7 Are the homeless utilizing available resources?

8 What services already exist?

9 What are the services needed?

Step 4: **Planning data gathering activities**

Community needs assessment is a data collection process. The extent of data collection is dictated by the resources available to conduct the community needs assessment of the homeless population. The quality of the information about the community is only as good as the technique used to obtain it. Each community must decide what method(s) they will use to conduct a community needs assessment of the homeless population. The decision involves examining resources available to carry-out the assessment including available funding , the desired level of sophistication of information, and community acceptance of the method chosen. Prior to gathering data the coalition must identify specific data to be collected and the sources of data collection (records, people). The community may enlist the assistance of experts at colleges or universities to assist in survey design, and data collection.

There are a variety of methods for assessing the needs of a community. It is important to note that utilizing multiple data collection methods ensures a broad perspective and improves the reliability of the assessment. The coalition must decide upon the method(s) to be used for data collection.

Several methods can be employed by the coalition to collect data about the homeless individuals in the community. There are two effective methods for gathering data

on homeless persons utilizing services; surveying service recipients, and surveying service providers.

Surveys: A survey is an assessment method in which a series of questions are used to collect data that can be analyzed. Using the survey of service recipients involves surveying individuals who are or have been recipients of services. This method provides information about characteristics of the service population, problems in service delivery and access, and the effectiveness of the service. The disadvantages are the lack of information about those not using services, and issues of privacy and confidentiality.

Surveying service providers involves surveying information related to community needs from individuals in contact with service recipients, or those planning or managing service programs i.e., health and human service agency staff. This method is valuable for providing information about where homeless people can be found in a geographical area and how best to approach them for interview. The disadvantages of this method are that it reflects only the needs of individuals utilizing services.

Another method of gathering data is a target-group survey of homeless individuals. This is a challenge in a rural community. Rural homeless people often do not consider themselves homeless, or are hesitant to identify themselves as homeless. To survey the rural homeless population they must first be identified. This can be accomplished by: (a) utilizing key informants in locating potential subjects, (b) interviewing women at battered women's shelters, (c) locating settings where homeless persons might be found such as parks, public buildings, abandoned farmhouses, (d) posting notices about the homeless needs assessment in strategic locations, i.e., food bank, library, local newspaper, employment office, and on bulletin boards.

If a survey method is chosen the survey instrument must be developed. It is important to design an instrument that provides the information needed. A good rule of

thumb in designing the instrument is to *keep it simple*, ask questions that supply the desired data and that can be analyzed using expertise available to the coalition.

The survey instrument questions should include:

1. Demographic information- race, sex, age, marital status, education, length of residence in the community.

2. Housing information- Where are you currently living? Length of time in this living situation? Is your housing situation adequate? If no, why? Are you currently living with friends or relatives? Explain your living situation. Are you currently in danger of eviction?

3. Needs and concerns- questions related to employment, food, shelter, health, counseling, transportation and social support.

4. Services utilized- food bank, subsidized housing, shelters, medicaid, food stamps, income subsidies, WIC, counseling services.

A resource inventory should be included in the needs assessment. The resource inventory is a detailed account of community resources. The resource inventory can be accomplished by interviewing service providers. Interview questions include: (a) title of program, (b) how many individuals the program can serve, (c) eligibility requirements, d) extent to which homeless are being served, and (e) barriers to participation in the program.

Often interviews with service providers reveal other resources available in the community. It is important to read the local newspaper, bulletin boards and postings for information about services available. Interviews with local church and civic groups often yields resource information.

The coalition decides on a survey method and develops the survey instrument. The next step is data collection

Step5: **Collection of data**

The next step in the community needs assessment process is to organize and conduct the survey. The coalition must identify the method to be used to contact individuals to be surveyed. This contact can be achieved through personal interviews, telephone interviews, or mailed questionnaires. The preferred method to use in reaching rural homeless residents is to conduct a personal interviews, homeless individuals may lack a mailing address or telephone.

Volunteers could conduct interviews, mail questionnaires, and organize data collected. Volunteers must be trained to collect data. This assures continuity in data collection. The coalition may decide to supervise individuals collecting data to ensure proper interviewing techniques are employed.

It is important to maintain the confidentiality of survey participants. Consent to participate in the survey should be obtained from the individuals surveyed. Surveys may be individually numbered to assure confidentiality.

Step 6: **Analyzing data**

The analysis of survey data can take many forms from simple percentages and comparisons to complex statistical methods. The coalition can enlist the services of a data analyst, or contact individuals at colleges or universities to assist in the data analysis. The coalition must decide on the level of sophistication of data analysis required.

Survey responses can be manually tabulated, or data may be entered into a computer. Once the data has been organized a wide variety of analysis can be conducted. Frequency counts of responses can be made. A frequency is calculated by counting how often a particular response occurred. Graphs or charts can be developed to assist in illustrating frequency numbers. Responses can be grouped according to similarities and

frequency distributions, and a descriptive analysis of means, modes and percentages can be done.

Comparison of responses to sets of items can be made within a group of respondents. There are a variety of computer packages which are adequate to conduct these types of analysis.

Step 7: **Reporting results**

For clarity, findings should be reported in narrative and graphic form. The report includes a thorough discussion of implementation and participation in the assessment process.

Communication of the assessment data and analysis can be accomplished through formal presentations to government officials, private and public service providers, community leaders, and interested citizens. Implications of the assessment should be presented and recommendations developed by the coalition should be included in the presentation. If funding for services is being sought presentations may be made to funding groups, and state organizations.

Section III

Inventory of Resources in Ravalli County, Montana

This section includes an inventory of resources available in Ravalli County, Montana. The resource inventory provides a guide for examining location of resources in a rural community. Resource information was gathered from September, 1996 through February, 1997. Services often change; therefore this information may not be valid beyond publication date.

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Housing resources

Ravalli Welfare Office
310 N Third street,
Hamilton, MT.
363-1961
Hours: 8:00 am to 5:00 pm Monday-Friday

Offers vouchers for up to 3 days emergency housing, can be longer if in dire need and funds are available. Also offers 1 month rent assistance for those in imminent danger of eviction. Income eligibility requirements, must have eviction notice from landlord, and rent must be in arrears. See also Food and Financial Assistance.

Human Resource Council
316 North Third Street
Hamilton, MT
Hours: 8:30 am-5:00 pm Monday-Friday

Offers rent assistance through the section 8 housing subsidy program. Requires placement on State of Montana waiting list. Waiting list is currently closed. Eligibility requirement: Income eligibility. Application to Human Resource Council. See also

Haven House
115 State Street
Hamilton, MT
363-2450
Hours: 10:00 am-2:00 pm Monday, Wednesday, and Friday

Offers vouchers for up to three days emergency housing, can be longer if in dire need and funds are available. Provides one month rent assistance for those in imminent danger of eviction. Individuals are required to go to the Office of Health and Human Services for intake interview. Eligibility: Income eligibility requirement, or must have eviction notice from landlord, and rent must be in arrears. See also Food.

Pantry Partners
300 Main Street (rear of the building)
Stevensville, MT
no phone, access through the Stevensville Civic Club Peg Whitesitt 777-5514
or Eickert Realty, Lloyd Eickert 777-3696
Hours: 1:00 pm-3:00 pm Monday, Wednesday and Friday

Offers vouchers for up to three days emergency housing, can be longer if in dire need. Work with Haven House to access emergency housing funds. The same eligibility requirements apply. See also Food and Gasoline Assistance and Transportation.

Supporters of an Abuse Free Enviroment (SAFE)
P.O. Box 534
Hamilton, MT
363-4600 24 hour crisis line

Offers emergency shelter for women fleeing domestic violence. Women can utilize the service until adequate alternative housing is found. Can provide food, case management, assistance with legal services as needed. Eligibility: women seeking shelter from domestic violence.

Ravalli County Sheriff Department
205 Bedford
Hamilton, MT.
363-3033
Hours: 24 hours 7 days a week

Offers vouchers for emergency housing up to three days. Distributes emergency housing funds when Haven House or County Office of Human Services is closed. Can also provide funds for a hot meal. Eligibility: Income eligibility requirements. See also Food, Gasoline Assistance and Transportation.

Food

Haven House
115 State Street
Hamilton, MT
363-2450
Hours: 10:00 am-2:00 pm Monday, Wednesday, and Friday
Offers perishable and non-perishable foods to individuals and families, once per month. Eligibility requirements: None.

Pantry Partners
300 Main street (in the rear of the building)
Stevensville, MT.
No phone, Access through the Stevensville Civic Club, Peg Whitesitt 777-5514 or Lloyd Eickert 777-3696
Hours: 1:00 pm-3:00 pm Monday, Wednesday, and Friday.

Offers perishable and non-perishable foods to individuals and families, once per month. Eligibility requirements: None.

Ravalli County Sheriff Department
205 Bedford
Hamilton, MT.
363-3033
Hours: 24 hours per day 7 days a week

Emergency assistance funds for a hot meal. Distributes funds for Ministerial Association. Eligibility requirements: Pastor determines need for services.

Ministerial Association
171 Lewis Lane
Hamilton, MT.
375-6282 after hours 363-3033 (Sheriffs Department)
Hours: variable

Offers funds for 1 night in motel, a hot meal, funds for gasoline and if needed referral to other resources. Entails interview with a pastor who determines a need for services, then the individual obtains a voucher. The voucher is taken to the Sheriff's Department where funds are dispersed. Eligibility requirements: Pastor determines need for services. See also Gas Assistance and Transportation.

Ravalli Welfare Office
310 North Third Street
Hamilton, MT.
363-1961
Hours: 8:00 am- 5:00 pm Monday - Friday

Offers assistance through the Thrifty Food Plan (Food Stamps) entitlement program. Eligibility requirements: Income eligibility.

Healthy Families Program
Bedford
Hamilton, MT
363-4161
Hours: 8:00 am-5:00 pm Monday-Friday

Offers vouchers for nutritious foods for pregnant women and families with children under age 5 years. Eligibility: income eligibility requirements.

Clothing Resources

Commodity Center
215 North sixth Street
Hamilton, MT.
363-2134
Hours: 10:00 am-4:00 pm Tuesday -Friday

Offers clothing, bedding, blankets, and household goods at no cost. May also provide up to $45.00 one time emergency assistance with utilities, and when funds are available financial assistance for prescription medications. Eligibility requirement: Written referral from a social service agency.

Stevensville Clothes Closet
316 1/2 Main Street
Stevensville, MT.
No phone, access through VFW auxiliary Lois and Don Steaves 777-2671 or Walt Scherr 777-3851
Hours: 1:00 pm-4:00 pm Wednesday- Saturday
Offers clothing, bedding and household appliances at no cost. Eligibility requirement: None.

Ravalli Service Corporation
NE 111 Old Corvallis Road
Hamilton, MT
363-5400
Hours: 9:00 am-4:00 pm Monday-Saturday
Offers clothing, furniture, and bedding at no cost, as a one time emergency service. Eligibility: Letter from service organization, church or sheriff.

Thrift Store II
232 Main Street
Stevensville, MT.
777-2356
Hours: 9:00 am-4:00 pm Monday-Friday

Offers clothing, furniture, and bedding at no cost, as a one time emergency service. Initial inquiries should be made to Ravalli County Service Corporation. Eligibility requirement: Letter from service organization, church, or sheriff.

Employment assistance

Human Resource Council
316 North Third Street
Hamilton, MT
363-6101
Hours: 8:00 am-5:00 pm Monday, Tuesday, Thursday, Friday

Offers programs directed toward job training. JTPA a program that provides nine week summer jobs with on the job training for 14-21 year olds. Families Achieving Independence in Montana Jobs Program Eligibility requirement: One or two parent families with children up to 15 years of age. Must meet basic income requirement.

Job Service
333 Main Street
Hamilton, MT
363-1822
Hours: 9:00 am-4:00 pm Monday, Tuesday, Thursday, Friday

Offers Green Thumb an on the job training program. Eligibility requirements: 55 years old or older, 125 % of poverty level and a resident of Montana. Provide casual daily labor jobs when available. Eligibility requirement: None

Trapper Creek Job Corps
Darby, MT
821-3286

Hours: 9:00 am-5:00 pm Monday through Friday

Vocational training program. Eligibility requirement: 16-24 years old, income eligibility.

Mental Health and Counseling

Riverfront Counseling
1205 West Main Street
Hamilton, MT
363-1051
Hours: 8:00 am-5 pm, Monday-Friday

Offers adult case management of chronically mentally ill. Services available include outpatient treatment and medication clinics. Based on a sliding fee scale, state funds and grants offset cost of indigent care. Eligibility requirement: Eligibility is determined on a case by case basis.

Crossroads
214 Pinckney Street
Hamilton, MT
363-3060
Hours: 8:00 am-12:00 and 1:00 pm-5:00 pm Monday-Friday

Offers addiction treatment and family counseling services. Based on sliding fee scale, may have funds for indigent care through the Montana Department of Health and Human Services. Eligibility requirement: determined on a case by case basis.

Ravalli County Chemical Dependency Services, Inc.
824 First Avenue South
Hamilton, MT.
363-3060
Hours: 8:00 am-12:00 am and 1:00 pm-5:00 pm

Offers outpatient addiction treatment, counseling for families with members with chemical abuse problems and a parenting effectiveness discussion group. Based on sliding fee scale.

Health Care

Ravalli County Public Health Nurses Office
205 Bedford
Hamilton, MT
375-6259
Hours: 8:00 am-12:00 pm and 1:00 pm-5:00 pm Monday- Saturday

Offers Well Child Clinics, immunizations, and free HIV testing. Eligibility requirements: Income eligibility. Also offers services to special needs children 0-18 years old, are 200 % of poverty level and do not meet Medicaid requirements.

Access Links of Ravalli County
Marcus Daly Memorial Hospital
1200 Westwood Drive
Hamilton, MT
363-2211 ext 4460, 4436
Hours: 8:00 am-5:00 pm Monday-Friday

Offers early prenatal care, nutritional information, childbirth education classes, referral to and coordination with financial and other community resources. Eligibility: Income eligibility requirement.

Birthright
102 South seventh
Hamilton, MT
363-6710
Hours: Monday 11:00am-1:00pm, Wednesday 9:00am-11:00pm, Friday 4:00pm-6:00 pm.

Offers free pregnancy testing, counseling for women with pregnancy concerns, referral to community resources, referral to shelter home for pregnant mothers in need (when space is available).

Financial Assistance

Ravalli Welfare Office
310 North Third Street
Hamilton, MT
363-1944
Hours: 8:00 am-5:00 pm Monday-Friday

Offers financial assistance to families through the Families Achieving Independence in Montana (FAIM) program. Eligibility Requirement: One or two parent families with children up to 15 years old, income eligibility requirement.

Associated Veterans Relief Board
333 West Main
Hamilton, MT
363-1822 Job Service access through Walt Sherr in Stevensville 777-3851
Hours: Variable

Offers financial assistance to veterans depending on need and funds available. This is a source of last resort, emergency situations only. Eligibility: Honorable discharge required.

Gasoline assistance and Transportation

Valley Taxi
Hamilton, MT
961-4400
Hours: 6:00am-2:00pm Monday-Friday

Offers transportation within Hamilton to appointments. No cost rides from Haven House with voucher. Eligibility: Income eligibility requirements.

Ministerial Association
171 Lewis Lane
Hamilton, MT
375-6282 After hours Ravalli County Sheriff Department 363-3033.
Hours: variable

Offers funds for gasoline, one time service only. Interview with the pastor, the pastor determines a need for services. Individual receives a voucher that is taken to the sheriffs office where funds are distributed. Eligibility: Pastor determines service need.

Pantry Partners
300 Main Street
Stevensville, MT (rear of the building)
No phone access through the Stevensville Civic Club, call Peg Whitesitt 777-5514 or Lloyd Eickert 777-3696
Hours: 1:00 pm-3:00 pm Monday, Wednesday and Friday

Offers $5.00 for gasoline as funds are available. Eligibility: established need.

Legal Assistance

Ravalli County Attorney
205 Bedford
Hamilton, MT
375-6222
Hours: 8:00 am-12:00 and 1:00 pm-5:00 pm Monday through Friday

Provides criminal defense and information related to landlord tenant rights. Eligibility: None.

Montana Legal services
1-800-666-6899 or (406) 543-8343
Hours: 10:00 am-5:00 pm Monday, Tuesday. Thursday, and Friday

Offers assistance with problems concerning utilities, welfare eligibility, Social Security Insurance Disability, Divorce involving spousal abuse, Landlord/tenant disputes. Eligibility: Income eligibility, 150 % of poverty level.

Literacy

Literacy Volunteers of America Bitterroot
306 State Street
Hamilton, MT
363-2900
Hours: 11:00 am-4:00 pm Tuesdays and Thursdays, otherwise leave message

Offers free confidential one-on-one tutoring to any adult who wants to learn to read. Eligibility: None.

Section IV

State and Federal Resources

The final section of the manual provides information about State and Federal resources available to communities. These are resources that are available to provide funding, information and guidance for communities working on homeless issues.

State Resources:

Montana Department of Public Health and Human Services
Helena, MT.
(406) 444-5622

Mental Health- Department of Public Health and Human Services
Helena, MT.
(406) 444-3964

Health Services- Department of Public Health and Human Services
Helena, MT.
(406) 444-4473

Office of Community Development- Department of Commerce
Local Government Assistance Division
Newell Anderson
PO Box 200523
Helena, MT. 59620-0523
(406) 444-3757

Community Development Block Grant Public Facility (housing)
Dale Cole or Gus Byron
PO Box 200523
Helena, MT 59620-0523
(406) 444-3757

Home Program
Tim Burton
PO Box 200528
Helena, Mt. 59620-0528
(406) 444-0094

Office of Housing Assistance- Department of Commerce
Helena, MT.
(406) 444-2804

Economic Development- Department of Commerce
Helena, MT.
(406) 444-3814

Department of Housing and Urban Development Field Contacts
Montana (303)844-3811

US Department of Agriculture-Farmers Home Administration
Rural Housing Preservation Grants
Rural Self-Help Housing Technical Assistance
Very-low and Low-income Housing Loans
James Holzer
Farmers Home Administration
PO Box 850
Bozeman, MT 59771
(406) 585-2515

Rural Development Grants
Mitchell Copp
Farmers Home Administration
PO Box 850
Bozeman, MT 59771
(406) 585-2520

Local Government Center
Kenneth Weaver
Montana State University
Bozeman, MT 59717
(406) 994-6694

Montana Low Income Coalition
PO Box 1029
Helena, MT 59624-1029
(406) 449-9801

Montana People's Action
208 E. Main Street
Missoula, MT 59802-4418
(406) 728-5297

Federal Resources:

Office of Community Planning and Development
Comprehensive Homeless Assistance Program (CHAP),Community Development Block Grant Program
Phone: (202) 755-5977
Emergency Shelter Grants Program (ESGP) Phone: (202) 755-6322

Office of Housing
Transitional Housing
Permanent housing for handicapped homeless
Phone: (202) 755-9075
Property Disposition Program
Phone: (202) 755-5740

Office of Policy Development and Research
Supplemental assistance for facilities to assist the homeless (SAFAH)
Phone: (202) 426-1520

Department of Agriculture
Farmers Home Administration
Homes for the homeless
S. Agriculture Building
Washington, DC 20250
Phone:(202) 447-6903

Extension Service
Basic Living Skills Programs
S. Agriculture Bldg.
Washington, DC 20250
Phone: (202)477-3029

Department of Defense
Homeless Support Initiatives
Defense Logistics Agency Cameron Station
Alexandria, VA 22304-6100
Phone: (703) 274-6361

Department of Education
Adult Education for the Homeless Program
400 Maryland Ave.
Washington, DC 20202-7240
Phone: (202) 732-2399

Federal Emergency Management Agency
Emergency Food and Shelter Program
Room 710, 500 C street SW
Washington, DC. 20472
Phone: (202)646-3652

Department of Health and Human Services
Public Health Service
Health Care for the Homeless Grant Program
Parklawn Bldg., Room 7A22
5600
Fishers Lane
Rockville, MS 20857
Phone: (301)443-2512

Community Support Program
National Institute of Mental Health
Parklawn Bldg., Room 7c-06
5600 Fishers Lane
Rockville, MD 20857
Phone: (301)443-3706

Department of Housing and Urban Development
Emergency Shelter Grants Program
Shelter Care Plus Program
451 Seventh Street SW
Washington, DC 20410
Phone: (202)708-2140 or (202)708-1150

National Rural Housing Coalition
Robert Rapoza, Executive Secretary
601 Pennsylvania Avenue NW #850
Washington, DC 20004-2612
(202) 393-5229

Interagency Council on the Homeless
Fred Karnas Jr., Acting Director
451 seventh Street SW STE 7274
Washington, DC 20410
(202) 708-1480

National Alliance to End Homelessness
Nan Roman, Vice President of Policy and Program
1518 K street NW #206
Washington, DC 20005
(202) 638-1526

National Coalition for the Homeless
Mary Ann Gleason Executive Director
1612 K street NW #1004
Washington, DC 20006
(202) 775-1322

Health Care for the Homeless Information Resource Center
C/O Policy and Research Association
262 Delaware Avenue
Delmar, NY 12054-1123
(888) 439-3300 ext.246

Appendix B

REQUEST TO REPRODUCE DATA AND MODIFIED AGENCY CLIENT PROFILE

Sherry James
905 First Avenue North
Great Falls, MT 59403

Sarah McNerney RN
908 Sherwood
Missoula, MT 59802

Dear Ms. McNerney:

This is a letter granting formal permission to utilize preliminary demographic information from data collected through the Opportunities, Inc., Agency Profile Form, in your professional project. In addition, you have permission to use the modified version of the Agency Client Profile in your Resource Manual for Rural Nurse Practitioners. I agree to the modifications to the Agency Client Profile.

I would request that you furnish me with a copy of your project when it is complete. If you have questions, please feel free to call me.

Sincerely,

