TRAINING, EDUCATION
AND
MANPOWER, INC.

~ T E A M , I N C . ~

Assessment of Community Need & Agency Goals 2011-2012

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Service Delivery Area (SDA):
Ansonia, Beacon Falls, Bethany, Derby, Milford, Orange, Oxford, Seymour, Shelton, Woodbridge – New Haven and Fairfield County

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TABLE OF CONTENTS

Section I. AGENCY OVERVIEW

Mission: TEAM Inc. is a multi-service nonprofit corporation registered in the State of Connecticut since 1965. The mission of TEAM is to connect individuals and families with solutions that lead to well-being, self-sufficiency and full participation in the community.

TEAM achieves its mission by conducting activities that focus on the needs of economically disadvantaged individuals and families residing in the Naugatuck-Housatonic Valley region including resource mobilization, education, advocacy and service delivery.

The overreaching goals that TEAM strives for are:

- Low-income people become more self-sufficient
- Low-income people, especially vulnerable populations, achieve their potential by strengthening family and other supportive systems;
- The conditions in which low-income people live are improved;
- Low-income people own a stake in their community

TEAM implements a performance-based "Results Oriented Management and Accountability" (ROMA) system that uses outcomes and indicators to track the success of clients and results of programs.

The majority of administration and program service functions take place in the Derby office and the Ansonia Early Education facility. There are seven child development centers in the region. Social services, which are provided primarily in the ten contiguous communities of the Naugatuck Valley and suburban New Haven County, are designed to empower and support economically and socially disadvantaged individuals and families. Eighty percent of financial resources for programming stems from federal legislation, and the agency is a responsible steward of public funds. TEAM services currently are focused on;

- The social, cognitive and nutritional growth of preschool children
- The maintenance of the health and independence of the elderly
- The development of skills and assets in low-income families
- The promotion of housing stability and the avoidance of homelessness
- The understanding and utilization of public and private resources

The agency employs over one hundred staff, many of whom reside in the area, and injects over eight million dollars into the local economy annually.

Clients: TEAM administers over 20 effective, community-based programs and services that reached more than 10,000 people this year. TEAM's target population includes residents living in Ansonia, Beacon Falls, Bethany, Derby, Milford, Orange, Oxford, Seymour, Shelton and Woodbridge. Eligibility requirements for programs and services vary according to each program. TEAM's programs serve a wide variety of people ranging from preschool aged children from low-income families to senior citizens. Clients are of diverse racial and ethnic backgrounds with limited educational and economic successes, most often lack transportation as well as stable and affordable

housing. Individuals and families present at TEAM with ongoing, complex life situations as well as those confronted with a one-time crisis.

Overview of Programs:

***Community Services*:**

- Housing: Eviction/Foreclosure Mediation & Rent Bank, Housing Crisis Intervention, Beyond Shelter Transition Support, and Homelessness Prevention & Rapid Re-Housing
- Elderly: Meals on Wheels, Senior Community Cafés (includes the Griffin Hospital Senior Meal Choice Program), Homemaking Support, Medical Demand Transportation and Valley Interfaith Caregivers
- Economic: Financial Literacy, Individual Development Accounts, and Volunteer Income Tax Assistance
- Case Management: Pre-Assessment, Full Assessment, and Information/Referral Services
- Energy Assistance: CT Energy Assistance Program (CEAP), Federal Emergency Management Agency (FEMA), Operation Fuel, Utilities Matching Payments, Warm Hearts Fuel Bank, and Project Reach.
- Holiday Giving: Valley Toys for Tots
- Other Services: Diaper Bank (Distributive Partnership - New Haven Diaper Bank)

Early Education Services:

- Head Start: (160 slots) Preschool Child Development with *Around the World Literacy/Raising Readers*, and Fatherhood components
- Child Day Care: (75 slots) Preschool Care includes Derby Day Care Center Inc.
- School Readiness: (70 slots) Sites in Ansonia, Beacon Falls, Derby, Shelton, Seymour
- Child Food Care Program: A component of the Head Start, Child Daycare & School Readiness
- Family Resource Center: Free Play groups, Focus & Advisory Groups, Family Activities, Parenting Workshops, *Ages and Stages*, and Information/Resource referrals
- Child and Adult Food Care Program: Nutritional guidance & reimbursement for snacks & meals served by licensed care providers
- Note: NAEYC Accreditation applies to (6) eligible sites (237 slots)

Community Action Activities: TEAM collaborates with a wide variety of community providers to allow for a broad base of Community Action Activities. The agency spearheads, partners with, participates in, and holds memoranda of understanding with (and provides space and/or technical assistance for) a variety of community based coalitions and initiatives. Examples include but are not limited to:

- Convener of the Valley Dental Advisory Council, which monitors the C. Scott-Hill Health Center Richard O. Belden Dental Clinic activities
- Partnerships with Griffin Hospital, Derby/Ansonia Senior Centers, and Seymour's Norman Ray housing complex to locate, staff and support elderly nutrition sites
- Co-location agreement of the Valley Regional Adult Education Even Start program for Ansonia early education center clients
- On-going support and leadership to six local School Readiness Councils (Seymour, Shelton, Beacon Falls, Derby, Ansonia, and Milford)
- Partnership with the LNV Parent Child Resource Center to provide intervention services

- Collaborations with Birmingham Group Health Services (Umbrella Project), ACT & Beth El Homeless Shelters for funding to transition shelter clients
- Cooperative grant agreements with Columbus House and Community Mediation Inc. to provide community services
- Leadership in the Valley Council of Health & Human Services and its Senior and Early Education Task Forces
- Member of the board of the Workforce Investment Board

Who we serve: TEAM administers over 20 effective, community-based programs and services that reached more than 10,000 people during the year 2010. The following statistical data reflects the demographics of the population served by TEAM programs from October 1, 2009 through September 30, 2010.

TEAM offered services to 10,163 individuals over the 2010 program year. The majority were females 62% with the highest categorical age range represented being 24-44 (22%). Adults over the age of 55 were the second highest at 21%, children between the ages of 12-17 represented the third highest age group (12%). Less than 10% of the individuals served self-reported their ethnicity to be Hispanic, with 67% of the individuals served self-identified themselves as White, Black or African American 12% and 4% self-reporting their race as Other.

The education levels of the individuals served show that 26% are High School Graduate or earned their GED, 10% have acquired some Post Secondary Education. The majority of the individuals served (87%) self-reported having Health Insurance, and 12% of individuals served declared they were disabled.

A total of 4,395 families were served over the 2010 program year. Households receiving services were comprised primarily by a single person (40%), followed by single parent female (28%). Two parent household (16%) and two adults with no children (11%), 107 (2.5%) reporting as single parent male. The household size most common were families with four or less members (one 42%, two 22 %, three 16%, four 11%). The majority of the household living arrangements (65%) were reported as rentals with (33%) reporting home ownership, 1.5% reported their housing as other and 9 families reported themselves as homeless.

The majority of these families (81%) reported their household income below 200% FPL. Families gained their income from a variety of sources with the majority (30%) reporting income from Social Security and (24%) reporting income as other. In addition (12%) of families reported income from employment as their only source and 328 or (7%) reported income through TANF, SSI, or General Assistance.

Section II. DESCRIPTION OF THE SERVICE DELIVERY AREA (SDA)

The service area encompasses six towns/cities that compose the lower Naugatuck Valley area – Ansonia, Beacon Falls, Derby, Oxford, Seymour, and Shelton—and four towns/cities to the east and south periphery – Bethany, Milford, Orange, and Woodbridge. Nine cities and towns are located in New Haven County, and one – Shelton – is located in Fairfield County. Although there are no major Connecticut cities in the ten-town SDA, three major metropolitan areas border the region - Waterbury to the north, New Haven to the east, and Bridgeport to the south – and range between eight and fifteen miles away. Public transportation routes connect to New Haven and Bridgeport, which is also the location of State services.

The region has two distinct characteristics – a semi-urbanized, post-manufacturing core with dense zoning fostering a larger stock of older, multi-family dwellings and rental units, and a more affluent, residential suburban ring to the north, east and south. The urbanized core region was once a prosperous part of Connecticut's industrial base and includes Ansonia, Seymour, Beacon Falls, Derby and Shelton. The suburban zone reflects larger acre zoning, single family housing and includes Oxford, Bethany, Woodbridge, Orange and Milford. Residents of the latter zone tend have more commercial relationship with the cities of New Haven, Waterbury or Bridgeport than the core Naugatuck Valley communities.

Racially and economically, the region is diverse. Because of its large rental housing base, Ansonia and Derby house the largest number of lower income families as well as households on Temporary Assistance for Needy Families (welfare). The median income level is lowest here and in Seymour, Beacon Falls and Shelton. The decline of manufacturing since the mid-1970's saw the beginning of a trend of rising unemployment and increasing poverty in this sub-region. The suburban communities in the region – Oxford, Bethany, Orange and Woodbridge – have maintained higher median incomes and education, and lower levels of unemployment. The more affluent communities also have a richer spectrum of services managed by the municipality.

The region's governance structure is individual Boards of Aldermen and Selectmen. Regional planning is conducted by the Valley Council of Governments for Shelton, Derby, Ansonia and Seymour. Oxford and Beacon Falls belong to the Waterbury Council of Governments, while Orange and Woodbridge belong to New Haven's Council. Milford is affiliated with Bridgeport. Each community has its own Board of Education and school system, although Beacon Falls shares a regional high school with Prospect. Bethany, Woodbridge and Orange also share a regional high school.

Population: In 2000, the U.S. Census recorded a regional population of almost 185,000, a growth of about 7 percent since 1990. This migration increased the number of Spanish-speaking families in the region. An increase of 5% between 2000 and 2009 was reported for the six Valley communities (Source: *Valley CARES, 2010).*

Population Mix: Gender/Age: The population of region is approximately 5 percent of total state's population. There are approximately 42,200 children under the age of 19 in region, comprising of 23 percent of the population. Children under the age of 5 comprise 6 percent of the population.

TABLE 1: AGE AND GENDER (as a % of 2010 population)

Town		Pop.	Age Categories					
			0-4	5 -17	18-24	25-49	50-64	65+
Ansonia	*Male*	18,531	3	8	5	17	9	6
	Female		3	8	5	18	10	9
Beacon Falls	*Male*	5,708	4	9	4	19	10	5
	Female		4	8	4	19	10	5
Bethany	*Male*	5,573	3	10	3	17	12	6
	Female		3	9	3	18	11	7
Derby	*Male*	12,598	3	8	4	18	9	6
	Female		3	7	4	18	10	10
Milford	*Male*	54,377	3	8	4	18	10	6
	Female		3	8	3	18	11	8
Orange	*Male*	13,817	3	9	3	15	11	8
	Female		3	9	2	15	12	11
Oxford	*Male*	12,678	3	10	4	18	11	4
	Female		3	9	3	19	10	5
Seymour	*Male*	16,059	3	8	4	18	10	6
	Female		3	8	4	18	10	8
Shelton	*Male*	39,261	3	9	4	16	11	6
	Female		3	8	4	16	11	9
Woodbridge	*Male*	9,050	3	10	2	14	12	7
	Female		3	10	2	16	11	9

Source: CT Economic Research Center: Town Profiles, 2011

Married couples with children (18 yrs or less) households measured a low of 17.8% in Derby in 2000 and a high of 36% in Bethany, Oxford and Woodbridge. Ansonia had the highest percentage of households with single mothers (9.2%) and seniors with no children (12.3%). Derby had the highest percent of non-family households (38%). (*Source: US Census)*

Diversity: The SDA was 90% Caucasian in 2006. The minority population in the SDA varies from a high of 17% in Ansonia to a low of 5% in Oxford *(CT Economic Research Center: Town profiles, 2007)*. The Valley Regional Adult Education reported serving immigrants from 128 different countries in 2008. In 2010, a grant to the International Institute will result in the placement of 50 Nepalese families in Ansonia.

Household Income: Median household income for New Haven County and Connecticut are $59,640 and $65,969, respectively. Three communities - Ansonia, Derby, and Seymour - have median household income below the State average. Because of these and other data points, Ansonia and Derby are identified as "distressed communities" by state/federal agencies and therefore eligible for entitlement funding. Woodbridge, Orange, Oxford and Bethany have the highest median income levels in the region; and in the case of Woodbridge, it is twice the rate of Ansonia.

TABLE 2: Median Household Income 2007	
Ansonia	$52,790
Beacon Falls	$69,435
Bethany	$91,895
Derby	$56,034
Milford	$75,048
Orange	$97,375
Oxford	$94,628
Seymour	$64,301
Shelton	$82,753
Woodbridge	$125,296

Poverty

The 2000 Census indicates that 6.1% of area residents lived on incomes that fell below the Federal Poverty Level (FPL). The State of Connecticut average was 7.9%. The number of children living in poverty has increased, according to *CT Voices for Children*.

Table 3: Percent of Individuals & Children Living in Poverty and Relative Poverty (2000)

Town	Percent of Residents Below Federal Poverty Level (FPL) < 100%	Children Under 18 Below Federal Poverty Level (FPL) < 100%	Children Under 5 below FPL (<100%)	Children Under 18 below 200% of FPL
Ansonia	7.6%	13%	14%	33%
Beacon Falls	5.9%	10%	6%	16%
Bethany	2.6%	4%	1%	13%
Derby	8.3%	10%	6%	21%
Milford	3.7%	4%	3%	12%
Orange	2.5%	2%	0%	5%
Oxford	2.1%	3%	1%	9%
Seymour	3.7%	6%	10%	17%
Shelton	3.2%	3%	4%	11%
Woodbridge	2.3%	3%	1%	9%

Source Ct. Voices for Children

Ansonia had the highest number of food stamp recipients in 2008 (1702) and Bethany the fewest (27). Milford had the highest number of Medicaid clients (3306) followed by Ansonia (3276) and Shelton (2310). TANF recipients were 352 in Ansonia (highest), 158 in Milford and 156 in Derby in the same year according to CT Department of Social Services data.

The Elderly: Nationally, 9.9 percent of individuals 65 years of age and older live at or below the federal poverty level, while in the Valley 5.2 percent of those in that age group live at or below the poverty level. Most of these are women.

Employment: Connecticut's employment growth has consistently lagged behind the nation's since 1988. During the year ending May 2007, the U.S. employment growth averaged 0.12%, while Connecticut's employment growth averaged 0.09%. The decline of manufacturing has altered the employment mix in the Valley area; service industries now employ more workers than goods producing industries. The current recession has affected all communities, but the Valley towns have the highest unemployment

Table 4	TEAM Service Area Employment – 2007 and 2011			
TOWNS	2007 LABOR FORCE	2011 LABOR FORCE	2007 (Sept.) UNEMPLOYED Rate	2011 (May) UNEMPLOYED RATE
Ansonia	10,102	10,115	6.0	10.5
Beacon Falls	3,293	3,392	4.5	9.6
Bethany	3,104	3,161	3.7	7.1
Derby	6,954	7,005	5.4	10.5
Milford	32,073	33,017	3.2	8.1
Orange	7,405	7,264	3.3	7.0
Oxford	7,006	7,657	3.4	6.9
Seymour	9,330	9,459	4.7	9.0
Shelton	22,899	23,462	4.0	8.2
Woodbridge	4,995	4,861	3.3	5.7
Area Totals	*107,161*	*109,393*		

Southwestern Connecticut lost 13,000 jobs between 2008 and April 2010 and employment remains several thousand jobs below the 2007 mark. Real wages in many cases are actually *less* than they were prior to the downturn in the early years of the decade – making it even more difficult for families to deal with rising housing and energy costs. The average wage ($49,036) in the job sectors that are gaining jobs is lower than the average wage ($64,300) in the sectors that are losing jobs (*Connecticut Voices for Children)*. By March 2009, the State unemployment rate had risen to 7.5% and the Connecticut workforce shed 58,000 jobs since December 2007. In 2009-10, four major Valley businesses closed their doors.

Education: There is a significant correlation between household income and education levels in the region. Ansonia and Derby lag behind other communities in the number of college graduates, and have the lowest median incomes in the region.

Table 5	ADULT EDUCATIONAL ATTAINMENT - Highest Level (by percent of population: 25 years old or more)			
Town	High School or Less	High School Graduate	Some College	BA/BS or More
Ansonia	17.8	42.2	19.8	15
Beacon Falls	13.2	29.8	22	27.1
Bethany	4.2	23	16.8	48
Derby	21.4	34.9	19.9	17.8
Milford	11.5	31	20.9	29.3
Orange	7.4	21.4	18	45.6
Oxford	7.7	31.6	20.8	32.2
Seymour	15	34.3	23.3	19.5
Shelton	12.7	29.2	20.2	29.9
Woodbridge	5.6	15.9	12.9	60.9

The 2006 median wage of workers with a bachelor's degree or higher ($26.39 per hour) was more than double the wage paid to workers lacking a high school education ($9.79 per hour). In real dollars, the median wage of the highest educated since 1979 has grown from $20 per hour to around $27 per hour, but for the least educated, wages have fallen from $12.50 to about $10.00.

High School Drop-Out Rates: Ansonia (9.4%), Seymour (6.9%), Shelton (6.8%) and Milford (6.7%) had the highest drop-out rates in the region in 2007. All other communities did not have a rate over 3.8%. Many dropouts enroll in GED or high school equivalency examination classes at the Valley Regional Adult Learning Center in Shelton.

Health: Accessing medical and dental care eludes many of the region's poorest children and residents. Families lacking a medical home have a choice among several walk-in clinics: Griffin Hospital Convenient Care, St. Vincent's Immediate Care, and the Valley Health Connection – the latter operated by the New Haven-based Cornell Scott/Hill Health Center, which offers affordable pricing and payment options. Prescription costs have challenged lower-income people hoping to maintain their health. In a National Energy Assistance Survey Report, 25% of elderly who receive energy assistance, a low-income group by definition, say they go without medicine at some time to meet their energy bills. Over 36% of non-elderly receiving energy aid reported the same. (*NEADA, September 2005*). Connecticut ranks among the bottom five states providing significant levels of dental care to Medicaid eligible children (www.ctappleseed.org/projects/dental.org) as few dentists are willing to accept State's HUSKY medical insurance rates. For this reason, TEAM developed the Richard O. Belden Dental Clinic in 2008, which served 2,600 clients in its first year.

Child Abuse and Neglect: From 1990 to 2003, reported child abuse cases in Connecticut rose 130% (*Institute for Innovation in Social Policy, "Social State of Connecticut", 2005*). Last year, over 5% of all children in the state were referred for help because of abuse. The table below shows the number of total allegations received by the Connecticut Department of Children and Families ("DCF") in 2006 compared to the number of substantiated reports in several towns.

Data for towns with 10 or less children substantiated as abuse and/or neglect have not been reported, however the data is reflected in the overall state information. A majority of the allegations were due to claims regarding emotional neglect and physical neglect.

Table 6: Towns	2005 Allegations	Substantiated	Substantiated Rate
Ansonia	864	172	20%
Derby	285	46	16%
Seymour	288	20	7%
Shelton	462	70	15%
Milford	670	156	23%
Connecticut	**81,277**	**19,903**	**24%**

Number of Low Birth Weight Babies: Half of the communities in the region showed higher low-weight babies than the State percentage (7.8%) in 2004 – Oxford (9.8%), Ansonia (9.4%), Beacon Falls (8.6%), and Milford (8.2%).

Teen Pregnancy Rates: The teenage birth rate is highest in the cities of Ansonia (6%), Derby (5%), and Shelton (5%). The State average is 7%.

Immunization Levels Among School Children: Since immunization helps to stop the spread of diseases that are vaccine preventable, it is important to have a higher percentage of students vaccinated in the public school systems. The immunizations include DTP, IPV, Measles, Rubella,

and Mumps. All school systems showed a 100% immunization rate in 2008 with two exceptions (Shelton, Milford) which showed 99%.

Children with Disabilities: Children with a disability face special barriers to learning and development. The following table shows the number of children with disabilities between the ages of 5 to 15, and the type of disability.

Table 9:	Disability of Non-institutionalized Children Ages 5 to 15									
2000	**Ansonia**	**Beacon Falls**	**Bethany**	**Derby**	**Milford**	**Orange**	**Oxford**	**Seymour**	**Shelton**	**Woodbridge**
Non-institutionalized children ages 5 to 15	2,797	800	887	1,817	7,493	2,139	1,735	2,296	5,614	1,753
Children with no disability	2,484	743	837	1,736	7,156	2,075	1,625	2,161	5,391	1,688
Children with disability	277	46	37	63	263	64	110	127	203	40
Percentage of children with disability	**9.9%**	**5.8%**	**4.2%**	**3.5%**	**3.5%**	**3.0%**	**6.3%**	**5.5%**	**3.6%**	**2.3%**
Type of disability										
Sensory disability	6	0	0	0	31	7	17	10	31	0
Physical disability	0	0	0	0	16	17	0	27	9	8
Mental disability	266	46	37	63	216	40	93	90	163	32
Self-care disability	5	0	0	0	0	0	0	0	0	0

Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, 2000

Child Care: Up to 25% of the state's five year olds enter kindergarten without the language, cognitive, and behavioral skills for early learning success (*CT Voices for Children*, "*Investing in the Early Years"*). In the Valley-Milford region, the highest rates of children entering school without preschool exist in Ansonia and Derby. These deficits have been countered recently by increased School Readiness program funding. Several Discovery projects in the region, funded by the William C. Graustein Foundation, are attempting to increase parental awareness of the benefits of early education.

Early care costs for infants and toddlers range from $7,000 to $15,000 per child and preschool education can range from $6,800 to $10,000 per year (*CT Voices for Children*). Most subsidized programs maintain a waiting list. In the region, TEAM provides Head Start, State-subsidized Day Care and School Readiness programming (250 slots). Ansonia Public Schools operates a School Readiness program for approximately 90 children. In Milford, the Good Sheppard Day Care program provides State-subsidized, center-based child day care; and Derby Day Care offers forty-five such slots in that community. A need exists in the upper Valley area (Ansonia-Derby-Seymour) for infant-toddler care. CT Care4Kids subsidies remain the key to affordability for parents using private centers or home-based care.

Housing: Connecticut's housing costs have outstripped wage increases by 3 1/2 times during the past ten years. Between 2000 and 2005, housing prices rose approximately 64% percent statewide, while wages rose only 18.5%. Sixteen out of 20 occupations projected to grow the fastest in Connecticut through 2012 will not be able to afford a typical 2-bedroom apartment. Of 620

occupations in Connecticut, the median wage of 294 occupations is less than the state's $19.30 housing wage, the hourly pay needed to afford a 2-bedroom apartment (HOMEConnecticut.org).

Public (project) housing and Section 8 housing subsidies are the primary options for low-income families seeking to maintain a quality of life in the face of unaffordable rents. However, local housing authority have extensive wait lists (for non-elderly) for a subsidy, which can take years to be considered. TEAM's report, *Housing the Valley Workforce"* (2004) remains the definitive document on the lack of affordability in the region's housing stock.

The 200 Census showed that in local communities 1% to 4% of households in the region had relatives living in family and non-family households. Recent foreclosures have increased these numbers.

Transportation: Improvements have been made in past years through advocacy of nonprofits and the Valley Council of Governments, and bus service from Bridgeport to Derby was implemented in 2002 with the Derby train station acting as regional hub. Valley Transit continues to operate as a dial-a-ride service at affordable rates although timing and availability are cited as issues by clients, and Milford Transit operates a similar program in that community. Oxford, Seymour and Shelton Senior Centers operate senior vans to assist their customers. Currently there are two fixed route transit systems and one rail system in the region: The Greater Bridgeport Transit Authority and Connecticut Transit run fixed-route buses to/from Bridgeport and New Haven respectively. Conn-Rail runs limited service (four times daily) between Bridgeport and Waterbury (with stops in Derby, Ansonia, Seymour), and connects with Metro-North in Bridgeport (and the coastal NYC-Boston corridor.)

Public Services: People in the community use a variety of methods to seek assistance. The State-supported INFOLINE or #2-1-1 is a free phone service operated by the United Way of Connecticut and supported with State funds which connects people to community resources. It recorded 9,157 information requests from the region in 2008. www.infoline.org/professionals/Statistics/Default.asp)

Orange, Woodbridge and Milford each has a well-staffed Human Services Department. The remaining seven communities depend on regional agencies to assist their residents with social needs and connection to appropriate services. In the Valley area, the Valley Council of Health and Human Services – of which TEAM is a founding member – created an Electronic Valley website (www.electronicvally.org) in 1998 which provides a host of information about municipal and social services in addition to local events. The Valley Council is a network of forty nonprofits in the region, and their CEOs meet regularly to review area needs and conduct joint planning. In 2009 the Valley Independent Sentinel on-line news edition developed links to the websites of a majority of social service providers in the region.

TEAM implemented a Human Services Infrastructure initiative in 2003 to insure that all applicants for agency services receive a basic social assessment. Those found to have more than two critical social needs receive follow-up counseling and referrals. TEAM receives referrals from all towns and cities in the region and has had long-standing arrangements with four communities who accept applications for the Low Income Heating Assistance Program (LIHEAP) – know in Connecticut as the Connecticut Energy Assistance Program (CEAP) – on behalf of the agency.

TEAM's Early Education Department updates a Regional Services Guide annually, which is distributed to clients, and Northeast Utilities publishes an annual State-wide services guide, both of which are useful guides for professionals and the public. The Valley Council is planning to issue a new guide in 2011 and update it electronically on its website www.valleycouncil.org.

The State Department of Social Services (DSS) administers TFA and SNAP benefits from its regional office in New Haven, which is a forty-fifty minute bus trip from the Naugatuck Valley and thirty minutes from Milford. Through a contractual arrangement, TEAM staff is able to complete applications for assistance for those residents in the Naugatuck Valley who have transportation barriers, which are forwarded to DSS for processing. The CT Department of Children and Families maintains a sub-regional office in Milford, from which staff investigate and monitor cases of child neglect and abuse in the TEAM region.

Section III. COMMUNITY NEEDS

TEAM used existing externally available information (i.e. studies, reports, statistics) and internal data (preliminary needs assessment of applicants for agency services) to identify needs. Key resources were: Valley/Milford Region Needs Assessment (2007, Sacred Heart University Graduate School of Business), City of Milford needs assessment (2007, United Way), TEAM Poverty Data Report (2008, Gary Stokes, Mountain Consulting), Community Conversation on Child Poverty Report (2009, Valley Council). The latter discussion resulted in a compilation of short and long-term measures that the community could take to lessen the impact of poverty in the region. Both TEAM reports are available on its website (www.teaminc.org).

In 2010, the Valley Council of Health and Human Services (www.valleycouncil.org) produced the Valley CARES report in which four hundred respondents completed a survey on community needs and perceptions, and regional data was analyzed and compiled. TEAM concluded that six significant social needs in the region ranked as priorities.

Primary Community Needs in the Region (for Low-income Families)

Need	Ranking
Affordable Housing	1
Employment Opportunities	2
Transportation	3
Access to Health Care	4
Knowledge of Community Resources	5
Preschool Care	6

Following is a discussion of the steps that TEAM will take in 2011-12 to address the needs as well as a listing of the community and agency resources available.

1. *Housing (Affordability)*

Problem: 1) Many households are paying over sixty to seventy percent of their income for rent and the number of publicly operated housing units and Section 8 certificates in the region fall short of the number of families whose household income needs rental assistance, and 2) a housing purchase is beyond the financial ability of an increasingly significant percentage of the region's residents, who lack savings for downpayment.

Agency resources - Housing:
Asset Building - the Individual Development Account savings program match client savings for buying their first home, education or auto; financial literacy training and case management are included.
Energy Assistance - Staff assists 4,000 lower-income families in the region annually to pay winter heating bills with State/Federal aid. Median benefit in 2009-10 was $825 per unit.
Housing Intervention - Staff offers mediation to prevent homelessness and support for shelter clients seeking permanent housing. Rent bank and re-housing subsidies are available,
Tax Preparation Assistance - the Volunteer Income Tax Assistance (VITA) clinic assists lower-income residents to a complete a filing and obtain Earned Income Tax Credits, designed to help low income people to build assets.

Identified Need	***Action(s) to be Taken by the Agency in 2011-12***
Affordable Housing Community Need - 1	1. Maintain federal/state resources for eviction mediation, re-housing and other housing intervention resources to assist area residents avoid homelessness. 2. Publicize openings for Section 8, RAP and other subsidized housing programs, and assist area residents to complete Section 8 applications. 3. Instruct consumers in family budget development and management; connect them with utility forgiveness programs, and facilitate first-time homebuyer and credit reclamation seminars 4. Assist individuals to transition successfully from temporary, transitional shelters to permanent housing. 5. Administer the CT Energy Assistance Program and pay a portion of winter heating costs for needy families and individuals to supplement their financial resources. 6. Increase resources for Individual Development Account programming to assist first-time homebuyers to be successful. 7. Provide financial literacy classes for clients; and arrange credit reclamation seminars and foreclosure assistance seminars. 8. Provide information to municipalities on State funding and Smart Growth housing strategies that improve housing affordability and access in the region for first-time homebuyers. 9. Advocate for affordable housing, and connect local developers with opportunities for public funding and resources.

Community resources – Housing:
American Red Cross, Valley Chapter (Ansonia) provides temporary housing vouchers for disaster relief.
Ansonia Housing Authority (Ansonia) oversees 165 units of HUD low-income housing, 148 units of senior housing, and the Section 8 program for Ansonia, Seymour, and Shelton.
Area Congregations Together (Derby) runs homeless shelter and maintains food bank network.
Derby Housing Authority (Derby) oversees 106 senior housing units and Section 8.
FHLA offers low-interest loans through lending institutions and can provide grants for down-payments/closing costs.
Greater New Haven Community Loan Fund offers "rescue" programs for foreclosure victims and multi-family dwellers.
Milford Redevelopment & Housing Partnership (Milford) manages 400+ units of mixed development housing (i.e. elderly and non-elderly disabled residents) and 62 units of family housing and Section 8.

Mutual Housing Association of South Central CT, Inc. (New Haven) oversees an affordable home ownership projects and development.
New Samaritans (Shelton, Derby) developed 68 units of HUD "202" housing for low-income seniors in Shelton, Derby.
Shelton Housing Authority (Shelton) maintains 200+ units of senior housing.
Seymour Housing Authority (Seymour) maintains 100 units of senior housing; 86 units for low-to-moderate income families; and recently constructed a 56-bed assisted living facility.
United Methodist Homes – (Shelton) congregate senior living facility with 92 Section 8 units.
Valley YMCA (Ansonia) Fitness center, childcare, sports clinics, 32 single-room occupancy units.

2. *Employment Opportunities*

Problem: 1) A shrinking number of living wage jobs are available to adults and youth with limited education and training. The continued erosion of production opportunities, a tightening service and retail market, and exposure to a newly troubled financial sector are factors that contribute to the region's employment challenges.

Identified Need	*Action(s) to be Taken by the Agency in 2011-12*
Employment Opportunities Community Need – 2	1. Refer clients to employment opportunities that can assist them to meet their goals and improve self-sufficiency. 2. Refer clients to the regional One Stop Center efforts to promote access to employment, training opportunities, and Job Readiness classes, such as resume writing, interviewing, and job retention skills. 3. Assist clients to save and acquire financial resources – through the Individual Development Accounts (IDA) – as well as acquire post-secondary education. 5. Participate in area Youth Services Bureau advisory councils and promote work-study programming for youth. 6. Seek resources to implement employment exploration programs for lower-income youth.

Community Resources – Employment:
Birmingham Group Health Services (Ansonia) offers job placement and case management for clients with chronic mental illness.
Bureau of Rehabilitation Services (Ansonia) aids residents with significant physical or mental disabilities to prepare for, find, or keep a job.
CT Works (Derby) operates the summer youth employment and makes grants for job development.
Career Resources (Bridgeport) – offers job seekers career counseling, job search assistance and referrals, training vouchers, and manages the One-Stop center in the region.
Shelton High School Career Center offer opportunities for mentoring, job shadowing and work experience for high school youth in Shelton.
The Workplace, Inc. (Bridgeport) coordinates job training and education programs in SW CT.
Valley Association for Retarded Children and Adults (Derby) offers workshop for mentally retarded adults.

3. *Transportation*

The problem: 1) Public transportation systems are restricted to the New Haven/Bridgeport corridor, and limited during off-peak hours; the local Transit District concentrates service (85%) on senior citizen needs.

Agency Resources – Transportation:
Volunteer Interfaith Caregivers at TEAM – connects volunteers to needy persons, often to provide transportation.
Medical Ride program (for seniors) – funded by the Agency on Aging of South Central CT, it subsidizes the cost of rides for needy seniors to medical appointments.

Identified Need	*Action(s) to be Taken by the Agency in 2011-12*
Transportation Community Need – 3	1. Advocate for expansion of public transportation routes. 2. Maintain information on vanpool networks (i.e. Rideshare) for client use. 3. Assist clients to acquire the financial resources – through Individual Development Account (IDA) program – to purchase an automobile. 4. Provide subsidized medical rides for elderly clients. 5. Recruit and employ volunteers to transport needy residents. 6. Partner with Lutheran Family Services *Good News Garage* program for affordable auto purchasing.

Community Resources – Transportation *:*
The Greater Bridgeport Transit Authority (GBTA): Regular service connects the Bridgeport hub to Shelton and Derby; a Coastal Link (CL) bus operates along Route 1 from Guilford to Stamford.
Connecticut Transit (CT Transit): Regular service connects New Haven to Derby, Shelton, Ansonia and Seymour; service connections are possible to Meriden, Wallingford, Milford, and the Shore Line; a hub is maintained at the Derby train station.
ConnRail provides commuter rail service between Bridgeport and Waterbury with stops in Seymour, Ansonia and Derby – currently four to six trips daily.
Metro-North Railroad operates its New Haven Commuter Line from Union Station, to Grand Central Terminal in New York City with stops in Milford, Bridgeport, etc.
Towns of Oxford, Seymour, and Shelton maintain senior vans.
Valley Transit and Milford Transit – Para-transit services offering Dial-A-Ride. Valley Transit operates from 6:15 a.m. to 5:50 p.m. Monday through Friday.

4. Access to Health Care

Problem: 1) The lack of and high cost of health care reduces the preventive health measures taken by area residents.; and 2) the high cost of prescriptions forces residents with limited insurance coverage to forego medications.

Agency Resources – Health:
Cornell Scott Hill Health Center R. O. Belden dental clinic provides affordable dental care.
Early Education program provides health screenings for all enrolled preschool children and helps parents to arrange follow-up treatments.
Medical rides provided by VTD are underwritten by an agency grant.
Senior Nutrition programming provides home-delivered meals to the homebound and affordable Café meals for the mobile senior.
Valley Dental Advisory Committee monitors dental care capacity and service in the region.

Identified Need	*Action(s) to be Taken by the Agency in 2011-12*
Health Care Access Community Need – 4	1. Participate in the Valley Council Health Indicators Project to promote analysis and awareness of the region's health profile. 2. Promote the use of affordable health care options through referrals to the Griffin Hospital Community Access Network and the local Federal Qualified Health Clinics (the Community Health Connection and Belden Dental Clinic.) 3. Link residents in need to public benefits and entitlement programs such as HUSKY, Medicare, ConnPace, SAGA, Food Stamps (SNAP), and Medicare Part D for prescription drug assistance, and provide assistance with application processes. 4. Conduct outreach and provide presumptive eligibility services for the HUSKY

	program; advocate for improvements in HUSKY health benefits and the participation of more area physicians in the program. 5. Advise residents of affordability initiatives such as the "Family-Wize" prescription discount card, and Project Serve food purchasing program. 6. Maintain operational oversight of the Belden Dental Clinic and convene the Valley Dental Advisory Council regularly to assess regional dental care issues.

Community Resources – Health :

C. Scott-Hill Health/Community Health Connection (Ansonia) is the Valley region's federal qualified walk-in clinic and offers affordable geriatric, ob/gyn care and general medical care.
CHOICES – AASCC program offers counseling on medical benefits for seniors and trains benefits counselors.
Community Crisis Team (Valley-wide) is a coalition of health & human service agencies on call to respond to a crisis which is coordinated by Birmingham Group Health Services
ConnPace & Medicare Part D – publicly subsidized state and federal programs offering prescription assistance.
Griffin Hospital (Derby) - 160 bed, acute care hospital that runs on a patient-centered model of care.
Liberty Center (Ansonia) offers substance abuse & mental health services through outpatient and case management.
Milford Health District provides programs in community health and environmental health.
Parent Child Resource Center – Psychiatric counselors evaluate children, proscribe medication, and offer parent training and support.
Rape Crisis Center of Milford (Milford) - Counseling for sex assault victims and their families, and prevention.
Salvation Army (Ansonia) - Food collections, clothing.
Valley Health Departments offers community health programming and WIC program.
Valley Parish Nurses (Derby) - Nurses educate their church parishes on health issues, give health screenings, lead discussion groups, partner in the Safe Kids Coalition
Valley United Way offers FamilyWize prescription discount cards.
Valley Women's Health Access (Derby) connects uninsured/underinsured women in Valley with free or low cost healthcare and human services.
VNA of South Central CT (New Haven) - Home health care in 35 towns including the Valley/Milford.
Yale-Griffin Prevention Research Center (Derby) conducts health research studies and projects.

5. Information on Community Resources

Problem: 1) The public is not fully aware of sources of assistance in times of need, and 2) are often unclear of the public benefits for which they may be eligible.

Agency Resources – Information:

Human Services Infrastructure system ensures all clients are screened for social needs and appropriate referrals are made within the agency and the community.

Identified Need	***Action(s) to be Taken by the Agency in 2011-12***
Information Referral Community Need – 5	1. Complete social assessments of all agency clients. 2. Refer clients to community and public service resources in the region. 3. Provide space for organizations who compliment the agency's mission. 4. Maintain an information rich website. 5. Participate in community fairs, events and forums. 6. Distribute print brochures of agency programs. 7. Publish information in local media to inform the public of agency programs. 8. Assist area residents to identify aid and submit applications for public assistance.

Community Resources – Information :
Community Response Team (Valley-wide) is a coalition of health & human service agencies on call to respond to an event (such as a major employment downsizing) with information (coordinated by Valley United Way)
Infoline/United Way of Connecticut offers free help-by-phone for service referral and crisis intervention from anywhere in Connecticut by dialing 2-1-1.
New Haven Legal Assistance (New Haven) - Free legal aid for those unable to obtain it commercially because of limited income, disability, discrimination.
Public libraries in the region provide information for residents about area services.
Valley Council of Health & Human Services- A coalition of forty regional service providers which meets regular to plan strategy and review area needs.
Valley United Way (Ansonia) – Provides referrals and financial assistance to local community agencies, and community leadership; oversees Corporate Volunteer Council, and Volunteer Action Council.

6. Preschool Care & Education

Problem: 1) There is a lack of infant-toddler care in the upper Valley area; 2) the capacity of child care in general – particularly affordable care – is insufficient when compared to the number of preschool children of working parents living in the region; 3) many young parents lack a social support network on which to rely for guidance with regard to understanding of their children's developmental; and 4) high school drop-out rates exceed the state average in Derby and Ansonia.

Agency Resources – Child Care:
School Readiness: full-day preschool for 70 children in Ansonia, Derby, Shelton, Seymour and Beacon Falls; sliding fee scale sets affordable payments.
Head Start: part day/year free, quality child development preschool program; opportunities for parent involvement; 160 slots in a center-based program. Centers are located in Ansonia, Seymour, and Milford.
Day Care: subsidized, full day, quality preschool development program in Ansonia and Derby; capacity = 75 children.
Child and Adult Care Food Program: encourages healthy meals in the region's licensed home day cares through monitoring and reimbursement of food expenses; 75 providers in a 19- town/city region participate.
Even Start: a program of the VRAE Center offering GED, ESL and parenting classes on site for agency clients.
Family Resource Center: learning center and educational resources for young parents; and play groups for children.
Valley Toys for Tot: an annual appeal to the Valley community generates multiple toys for over 1400 children in 600 economically disadvantaged families each holiday season.

Identified Need	***Action(s) to be Taken by the Agency in 2011-12***
Child Care Community Need -6	1. Manage and/or support subsidized School Readiness preschool development programs in Ansonia, Beacon Falls, Derby, Seymour and Shelton. 2. Co-locate VRAE Even Start program at agency site to promote parental life skills, learning, and GED and ESL course completion. 3. Provide quality subsidized day care and Head Start pre-school programming. 4. Provide wrap-around (full-day) preschool education services for 36 Head Start children. 5. Provide CAFCP nutritional support, guidance and reimbursement to licensed home daycare providers and provide nutritious meals to enrolled children. 6. Collaborate with Prevention by Early Intervention program to assist preschool children identified as having significant social and emotional needs. 7. Participate in local early education planning/development partnerships (e.g. School Readiness Councils, Discovery Committees, Valley Council for Health & Human Service's Early Child Care Committee, Systems of Care, and the Milford Social Services Council) as well as state-wide associations 8. Maintain affordable, long-term facility commitments from Milford, Seymour, Beacon

	Falls, Derby and Shelton to support program stability and match requirements. 9. Ensure program monitoring systems are in place to measure the quantitative and qualitative improvements in children's socialization and cognitive skill levels. 10. Maintain private resources for *Raising Readers* and *Computer Tots* literacy programming. 11. Implement infant/toddler capacity to increase care options for clients. 12. Act as fiduciary and convener of Graustein Memorial Foundation Derby Discovery Project to promote pre-school systems in the City. 13. Advocate for the CARE 4 Kids subsidy program as a means to make child care affordable. 14. Insure parent participation in the governance of agency programs and the learning of their children. 15. Solicit resources to maintain a Family Resource Center program to assist parents to understand and participate positively in their child's development. 16. Recruit parents for PETS, PLTI and related leadership trainings. 17. Use Early Education program meetings to impart skills to parents for interfacing with educational systems relative to their child's needs. 18. Develop a community support work group to design strategies to improve educational outcomes for youth.

Community Resources – Child Care (and Family Support):

Ansonia, Derby, Shelton Discovery Projects convene early education providers, develop systems planning and author a web-based newsletter for parents.

Ansonia Community Action Center provides after-school program in Ansonia.

Big Brothers, Big Sisters (Bridgeport) matches children from single parent families and children with special needs with trained volunteers who foster children's healthy development.

Boy Scouts—Housatonic Council (Derby) prepares young men to make ethical choices over their lifetime.

Boys and Girls Village (Milford) – provides programming and shelter for children from abusive homes.

Birmingham Group Health Services (Ansonia) offers mental health care, HIV/AIDS outreach and education, domestic violence services, substance abuse prevention and education.

Christian Counseling and Family Life Center (Shelton) offers family and anger management counseling

Catholic Family Services (branch offices in Ansonia and Shelton) provides affordable personal counseling, adoption and pregnancy services, Hispanic outreach, and employment assistance.

Derby Day Care Center (Derby) offers affordable child day care program for 50 preschoolers.

Derby Youth Services assists students to succeed in high school through specialized programming.

Girls Scouts—CT Trails Council (Waterbury offices) - Largest voluntary organization for girls.

International Institute of Connecticut (Bridgeport) aids immigrants, refugees, and their families through counseling, advocacy, and translation.

Julia Day Nursery (Ansonia) – A non-profit preschool and kindergarten program for ages 3-8.

Junior Achievement of Western CT (Bridgeport) – Volunteers from area businesses teach youth about free enterprise system, financial literacy, promote workforce readiness.

Planned Parenthood (branch office in Shelton) offers birth control education.

Parent Child Resource Center (Derby) treats children with emotional and behavioral problems

Public (and private) libraries offer a variety of free learning programs and classes, and web access.

Seymour-Oxford Nursery & Child Care Association (Seymour and Oxford) provides affordable before and after school child care in six locations and during summer recess.

Shelton Youth Service Bureau (Shelton) offers after-school programs, community service projects and peer support groups for youth in Shelton

Valley Boys & Girls' Club (Shelton) provides after school care, recreation, and educational programs to Valley children ages 6 to 18.

Valley Council Early Childhood Committee coordinates regional strategies, and early learning fairs.

Valley Recreation Camp offers a summer program for area children

Valley Regional Adult Education (Shelton) offers high school, basic adult education, GED and ESL classes, and workforce and technology training.

Valley YMCA – summer and year-round recreation programs for youth; after-school programs in Derby and Ansonia

V. HUMAN SERVICES INFRASTRUCTURE (HSI)

Procedures for Intake Process/Case Management/ Client Tracking

Human Services Infrastructure (HSI) Philosophy and Overview

The Human Services Infrastructure (HSI) program is a partnership between the Community Action Agencies of Connecticut, Connecticut's Department of Social Services, and 2-1-1 in order to foster a more effective coordination of services to needy, low-income, and vulnerable Connecticut populations. At TEAM, Inc., the Community Action Agency for the Naugatuck Valley and suburban New Haven County region, HSI exists to harness the available human service capital on behalf of the vulnerable populations served by TEAM Inc, removing barriers to services, ameliorating family and personal crises, and moving them toward self-sufficiency.
HSI intake procedures; pre-assessment, full assessment and case management services enable TEAM Inc. to:

- harness everything TEAM does to serve more efficiently the at-risk and vulnerable populations of the greater Valley region
- enable team to build the human service capital needed to serve the at-risk and vulnerable populations of the greater Valley region
- assess more efficiently the needs of the at-risk and vulnerable populations in the greater Valley region
- coordinate more efficiently the services available to the at-risk and vulnerable populations through TEAM and DSS services and programs
- give capacity for a more efficient case coordination of all at-risk and vulnerable populations in the greater Valley region

HSI enhances TEAM's capacity to coordinate more efficiently the services needed to remove social, family, and employment barriers for area residents, move at-risk and vulnerable people and families toward self-sufficiency, and thus fulfill its mission to alleviate the causes of poverty one person, one family at a time.

INTAKE PROCESS

1. **Client Entry**

Clients may access TEAM services through direct appointment, walk-in, referral and telephone inquiry. When a client enters the building, site or center, they need to register with the receptionist before proceeding any further. If the site does not have a receptionist, the client must enter the main office at the site and register with the designated program staff. The receptionist or designated program staff will refer clients in the following manner;

- Clients that have a direct appointment will be referred to that Program Service for intake

- Clients that walk in will be provided with the Universal Intake Form by the receptionist or designated program staff and then referred to the respective program.
- Clients that make telephone inquiries will be directed to the appropriate intake staff person.

At no time should any client have to wait for an initial contact from TEAM staff. Initial contact can be as small as, "Please have a seat we will be right with you".

2. Intake Process

It is important to uncover the clients' need when they enter the building, site or center. This will help ensure that the client's needs are met and that clients are referred to the appropriate program(s) and services(s) within TEAM. TEAM has many different programs and services, some have open enrollment and others require a referral from a funding source or funder approved referral agency.

The receptionist or designated program staff person will ask the client basic questions, such as "How can we help you today? or "What can we do for you?" Once the client's need has been uncovered, the receptionist, or designated program staff will provide the client with the Universal Intake Form and then will direct the client to the appropriate program(s) and/or service(s).

For those client's entering an Early Education site or center the client will complete the Early Education Enrollment Application and then be directed to the appropriate program(s) and/or service(s).

If you have any questions about a program's enrollment and/or entry guidelines, please ask your Supervisor.

Every client who enters TEAM's doors at any building, site or center must be entered into the Client Tracking system. **TEAM will be using the *Keyware* system to track all of our clients and the services they receive.** This client tracking system is an internet based computer software program that allows TEAM management, staff and funding sources to see and track the progress of each client TEAM serves.

During the intake process, TEAM staff will use the Keyware system to do the computerized portion of the intake. This software system *does not* replace your method of intake as required by a program's funding source. Program staff should still complete the intake paperwork (or additional computer software entry) as instructed to do so by each funding source.

****Should you have any questions about the funding sources requirements for intake processes, please see your Supervisor. ****

ALL client demographic and additional information needs to be filled out completely no sections are to be left blank. The entire Keyware intake is to be completed while the client is in your office and is not to be done at a later date or after the client leaves. This is to ensure that all information is filled out completely and accurately. There is NO exception.

Please remember to print out a copy of the intake form and obtain the necessary client and staff signatures

Note: A copy of the intake form needs to be printed out and filed for every TEAM program that the client is enrolled in, and/or when information is changed or updated.

3. Pre-Assessment and Full Assessment

The pre-assessment process is designed to help TEAM staff look holistically at the client's needs and determine if and what referrals should be made to help the client achieve their desired

level of self-sufficiency. The pre-assessment screening tool asks clients the questions necessary to determine if they are in need of immediate and/or additional services.
A pre-assessment screening tool is to be completed for each client to determine their needs and self sufficiency baseline. The pre-assessment screening tool is to be completed when the client is in front of you for their initial intake, not when they come back, or bring back an application. The pre-assessment tool is a list of questions to be asked by the TEAM staff member and to be answered by the client. The answers to the questions will help the Community Resource Specialist and/or TEAM staff to determine what types of referrals are warranted to address the clients' needs. Should a client answer no in two (2) of the specified questions in the pre-assessment tool then that client will be referred to The Community Resource Specialist for a full assessment and for Case Management Services in their primary area of need.
If a need for additional services is identified, then the TEAM Community Resource Specialist or TEAM staff person would make an appropriate referral for the client.
Example: A client coming into the energy program may be in need of additional services. The client comes in for energy, after completion of the intake and assessment, you learn that the client was recently laid off from work and was unable to pay the rent last month. The Community Resource Specialist or TEAM staff person would put the client in contact with TEAM's Eviction Foreclosure Prevention Program (EFPP). Therefore, all of the client's needs are being addressed.

4. Referrals

There are two (2) types of referrals that can be made for TEAM clients. There are internal referrals and external referrals. An internal referral is a referral made to a program, service or resource within TEAM. An external referral is a referral made to an agency, program or service outside of TEAM. It is important to familiarize yourself with the internal and external programs within the greater Valley region.
Examples of internal referrals are: TEAM's Child Care Programs, Energy Assistance, Eviction Prevention, etc…
Examples of external referrals are: The Department of Social Services, ACT Food Bank, My Sister's Place, Birmingham Group Health Services, Spooner House, etc.
It is up to the Community Resource Specialist or TEAM staff person to identify the areas of need for client referrals and it is the pre-assessment and assessment tools that will assist you with this process. After a pre-assessment and/or a full assessment has been conducted, a review of the answers will allow the TEAM staff person(s) to evaluate and determine what programs, services and referrals can be made. It is important to remember that referrals can be both internal (made within the agency) and external (made to an agency outside of TEAM).
When making a referral, it is the responsibility of the Community Resource Specialist or TEAM staff person to ensure that referrals are made properly. To determine the most effective method of referring clients, it is best to contact the referral source and find out how the program, services or agency accepts referrals. It is important to remember that not all programs, services and agencies accept referrals in the same manner. Referrals can be made to both internal and external sources using the following methods, but is not limited to these two options: Calling the program with the client present, providing the client with program information so they may contact the program or service when they leave TEAM.
However, if a client takes information to call a program or service after they have left your site, you must document this in the goals and follow-up with the client (within a reasonable amount

of time) to ensure that contact has been made and that no additional services or assistance are needed at that time.
A client may need a referral to a program or service you are not familiar with. If this happens, it is important to try and locate the service within our area for that client. There are many different ways to locate services. Here are examples of a few of the methods available:

- **2-1-1** (this is CT's information line and has a list of most of the services and program eligibility requirements within the state of Connecticut). 2-1-1 is accessible through the internet or by dialing 2-1-1 on your phone.
- **Valley Council of Health and Human Services Listing -** This listing is put together by the Valley Council of Health and Human Services organizations serving the Lower Naugatuck Valley and can be obtained by accessing the Councils website (www.valleycouncil.org)
- **Your Co-Workers** – Co-workers can be a great resource when locating programs and services in the local area.
- **Agency List** – Resources for external referrals to programs and/or services most often utilized by the Agency are listed on the last page of this document.

All internal and external referrals to programs and/or services are to be logged into the ***CAPS client*** tracking software. The Keyware data program recognizes a referral as a goal and there are goals and services options available to choose from within the system. Goals and services must come from the available lists and ***may not*** be written in a free format option. The goals and services assigned to a client are tracked by the software which allows TEAM to track the Agency goals .

5. Follow-up

Follow-up is extremely important in the HSI process. There are many reasons to follow-up with clients. The first is to ensure that the client was able to receive the needed assistance; second, to see that the client's needs are taken care of and/or if there is any additional assistance that is needed to help the client reach their desired level of self-sufficiency, third, to be able to report the positive outcomes achieved by TEAM clients. TEAM serves many clients throughout the year and assists them to receive the necessary services to help them on the road to self-sufficiency.
Follow-up needs to happen on a regular and consistent basis. It can happen as often as needed, daily, weekly, bi-weekly or even monthly. The amount of follow-up needed depends on the referrals and services made for each client. Once a client receives a referral, the information is entered into the client tracking software. The outcomes of those referrals are tracked during the follow-up process and progress is outlined utilizing the Keyware Software. All TEAM staff and the Community Resource Specialists will be responsible for updating the goals section of the *Keyware* software as the client progresses through the program and/or services. It is especially important to ensure that all goals are "achieved" or "exited" and not left in the "progressing" status. The Keyware data program cannot credit the Agency with completed goals unless this final step is taken.
All staff must understand that correctly tracking client goals using the ***CAPS system*** is how TEAM can meet the **Federal Mandate** to report on TEAMs agency goals via the Result-Oriented Management and Accountability **(ROMA**) tool which directly impacts TEAMs ability to produce an accurate annual Community Service Block Grant **(CSBG IS**) report.

6. Software

TEAM will be utilizing several software data systems for intake purposes. Each program will have a required data system to utilize per the program funding source. For example the Housing program will use the Service Point data program, Early Education programs will use the Child Plus data program and Energy will use the Fuel Ware data program.

The Keyware data program is the only data program Team will use to track the outcomes of all the clients served and the services they receive through TEAM. Therefore, it is important to address what to do if a question or concern develops regarding these data programs.

What to do if:

- *Action Plans or Goal Sheets are not formatting properly, pages aren't printing properly or there is another problem with the system?*
- *The system fails/freezes/or just stops working?*
- *You cannot access a data program*

It is important to determine if the problem is coming from the PC itself or the data program. Also, it is important to provide as much detail as possible when describing what the problem with the system is, as this information can be crucial to solving the problem.

It is always best to shut down your computer and restart it if the system freezes. If this does not work and the data program does not begin to operate normally, please see your Supervisor or on to contact.

External Referrals for Programs and Services

211
DSS
Social Security Administration
DCF
WIC
DPUC
Care 4 Kids
One Stop
Griffin Hospital
Hill Health Center
VNA Services
Belden Dental Clinic
Husky Plan
Valley Women's Health Access
Community Health Connection
Valley Regional Adult Education
Charter Oak Program

Shelton Town Hall
Derby Town Hall
Seymour Town Hall
Milford Town Hall
Ansonia City Hall
Legal Aid
YMCA
Boys & Girls Club
Food Bank
Angel Food Ministries
Spooner House
Parent Child Resource Center
Yale Child Guidance
Planned Parenthood
Junta for Program Action
Dress for Success
My Sisters Place

VI. OUTCOMES AND MEASURES:

3. TEAM subscribes to the Results Oriented Management Accountability (ROMA) System adopted by USHHS Office of Community Services and undertakes its work in the context of six national goals, which are outlined below. In addition to the goal statements are measures (i.e. indicators) which determine how the agency will attain its goals. The period measured is October 1, 2011 to September 30, 2012.

OUTCOMES	MEASURES
Family Goals	
i. **Low-income customers become more self-sufficient.**	a. At least 10 out of the total 50 customers obtained part-time employment (less than 25 hours per week) at minimum wage or above without health insurance and benefits. b. At least 15 of the total 50 customers obtained part-time employment (equal to or greater than 25 hours per week), at a minimum wage or above without health insurance and benefits. c. At least 15 out of the total 50 customers obtained full-time employment (number of hours as defined by employer); at least minimum wage, without benefits. d. At least 5 out of the total 50 customers obtained full-time employment (number of hours defined by employer), above minimum wage and could include benefits. e. At least 120 out of the total 120 customers obtained a Federal Earned Income Tax Credit. f. At least 150 out of the total 150 customers obtained a Federal Child Tax Credit. g. At least 100 out of the total 150 customers demonstrated the ability to complete and maintain a budget for over 90 days. h. At least 10 out of the total 10customers opened an Individual Development Account (IDA) savings account and increased savings. i. At least 1 out of the total 10 customers began post-secondary education due to accumulated savings. j. At least 1 out of the total 10 customers purchased a home, mobile home, or condominium. k. At least 15 out of the total 50 housing customers obtained or maintained permanent rental housing of choice. l. At least 130 out of the total 130 customers obtained care for child or other dependent, in order to acquire and/or maintain employment. m. At least 60 out of the total 80 customers completed goals on their case management plan in order to move toward

	self-sufficiency
ii. **Low income people, especially vulnerable populations, achieve their potential by strengthening family and other supportive systems**	a. At least 5 out of the total 10 customers (adults) obtain their ABE/GED certificate or diploma. b. At least 15out of the total 20 customers (parents/caregivers) improved family functioning as a result of classes or supportive services. c. At least 350out of the total 350 customers maintained family stability by accessing affordable care of a minor child or other dependent. d. At least 20 out of the total 35customers demonstrated increased knowledge of positive parenting skills and techniques. e. At least 150 out of the total 200 customers demonstrated an increased knowledge of skills to manage income and increase savings. f. At least 450 out of the total 750 customers completed a payment plan for a matching payment program. g. At least 25 out of the total 25 customers completed a payment plan for the NUSTART Program. h. At least 30 of the total 35 total customers in temporary or transitional housing arrangements obtained safe, stable housing. i. At least 30 out of the total 35customers (households/individuals) maintained safe/stable housing for at least 90 days. j. At least 5 out of the total 10 customers (households) completed steps toward their first home purchase. k. At least 25 out of the total 35customers (households) obtained safe, stable housing through the payment of a Security Deposit. l. At least 6 of the total 25 customers obtained a rental subsidy. m. At least 200 out of the total 200 customer households received emergency supplemental food from a food pantry. n. At least 3800 of the total 5000 customers avoided utility termination or deliverable fuel crisis through agency payment. o. At least 40 of the total 50 customers avoided eviction or foreclosure through mediation for at least 120 days. p. At least 100 out of the total 100customers obtained the resolution of a problem with a fuel vendor. q. At least 52 out of the total 75 customers avoided eviction or foreclosure through the payment of delinquent rent or

mortgage.

r. At least 150 of the total 150 customers participated in senior congregate meal program.

s. At least 5350of the total 350 participated in Meals on Wheels.

t. At least 150 of the total 150 customers (children) participated in congregate meal programs.

u. At least 900 of the total 900 customers participated in the program's meal service.

v. At least 300 of the total 400 customers obtained or maintained necessary services with assistance.

w. At least 2500 out of the total 2500customers received referrals to necessary services.

x. At least 100 out of the total 100 customers were denied services.

y. At least 40out of the total 145 customers obtained access to needed health care.

z. At least 100 out of the total 100 customers maintained health, independence and self-sufficiency by utilizing shared-ride transportation.

aa. At least 235 out of the 238 total customers (children) ages 0 – 5 obtained age appropriate immunization, medical and dental care.

bb. At least 235of the total 235 customers (children) ages 0 – 5 participated in preschool activities to develop school readiness skills.

cc. At least 235of the total 235 customers (children) ages 0 – 5 who participate in preschool activities demonstrated improvement in school readiness skills.

dd. At least 10of the total 10 customers (children) ages 0 – 5 who participated in pre-school activities and were diagnosed as needing special education or remedial services, received appropriate services.

ee. At least 300 out of the 300 customers (seniors) maintained independent living status for 90 days through support services.

ff. At least 350 out of the total 350 customers (Senior Nutrition Program / Meals on Wheel recipients) received a daily check .to ensure their well-being upon delivery of their meal..

Agency Goals

i. **Agency among supporters and providers of services to low-**

a. The Contractor has entered into or renewed at least 60 formal or informal cooperative agreements or

	income people are achieved.	partnerships with other agencies or organizations to mobilize and leverage resources to provide for customers, a 'continuum-of-services' social services delivery system that is considerate of ethnic, cultural, and other special needs of the community.
ii.	**The Agency provides appropriate social services to the 'Target Population' designed to facilitate strengthened family and other support systems.**	a. The Contractor administered at least 17 social services programs or activities designed specifically to promote strengthened family and other support systems.
iii.	**The Agency increases their capacity to achieve results.**	a. The Contractor applied for at least 3 new sources of funding for social services programs or activities designed to promote strengthened family and other support systems.

Community Goals

i. **The conditions in which low-income people live are improved.**	a. At least 6 of the 7 early childhood and childcare centers that are available to low-income customers receive accreditation. b. The Contractor expanded the capacity of other agencies to serve low-income people by contributing in-kind services, space, and other resources amounting to the value of at least $100,000.
ii. **Low-income people own a stake in their community.**	a. At least 15 of 200 low-income customers participate in formal community organizations, government boards, or councils that provide input to decision making and policy setting through efforts of the Contractor. b. At least 25 of 100 low-income customers participate in social or volunteer activities through the efforts of the Contractor.