



# Best Practices in Action

*Case studies on effective housing programs supporting individuals experiencing homelessness across North Carolina*



**NC COALITION** to end  
**HOMELESSNESS**



## Introduction

North Carolina Coalition to End Homelessness (NCCEH) works to uphold human dignity by pursuing justice and engaging in innovative partnerships to end homelessness in North Carolina. This is achieved through **capacity building** and **technical assistance** for service providers, **systems change** and **policy advocacy**, and **coordinating partnerships** across the state. As part of this work, NCCEH supports housing programs across the state that effectively support individuals experiencing homelessness access safe and stable housing and achieve long-term stability. Fundamental to this support is continuously learning from these organizations on the ground to inform our advocacy efforts.

This report is a compilation of four case studies on housing programs across the state that demonstrate the impact of **adapting evidence-based best practices to meet the needs of local communities**. These programs were selected through statewide outreach to NCCEH's partners to provide a snapshot of the geographic and programmatic diversity of North Carolina's homelessness response system. The four organizations highlighted in this report are **Allied Churches of Alamance County** in Burlington, **Rejuvenation Support Services** in Winston-Salem, **Shepherd's House** in Mount Airy, and **VOA - Chesapeake and Carolinas** which serves dozens of communities statewide.

The programs featured in this report address a range of community needs, unique populations, and geographic contexts, however they share many of the same key strategies that lead to their shared success: **holistic support and wrap-around services**, a **housing first approach**, **person-centered care**, and **innovative community partnerships**. They also share many of the same challenges: the **lack of affordable housing** and transportation, the **rising cost of living**, **insufficient mental health services**, and high **administrative burden**, all of which were unanimously reported as barriers to success in supporting those they served in achieving long-term stability.

Their shared experiences support NCCEH's ongoing call for funding and support for community-based response systems that provide data-driven, evidence-based care for North Carolinians experiencing and at risk of homelessness.

## About the author

Dorothy Goodwin is a candidate for a dual Masters in Social Work and Public Health at the University of North Carolina, Chapel Hill. Dorothy's internship at NCCEH focused on systems change, advocacy, and the intersection of health and housing. Any questions about this report can be directed to [admin@ncceh.org](mailto:admin@ncceh.org).



# ALLIED CHURCHES OF ALAMANCE COUNTY

BURLINGTON, NC – ALAMANCE COUNTY, BOS REGION 6

**Mission:** *Preventing and ending homelessness and food insecurity through direct service and leadership in collaborative community efforts*

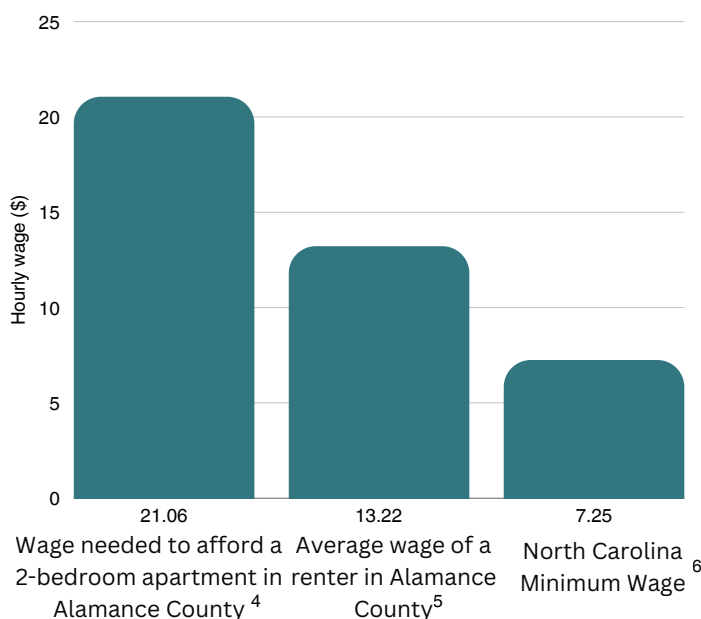
## ABOUT ALAMANCE COUNTY

Situated within Region 6 of the Balance of State Continuum of Care, Alamance County is a rapidly growing area within the Piedmont where poverty and homelessness remain salient issues:

- Alamance County's poverty rate: **13.8%**<sup>1</sup>
- North Carolina's poverty rate: **12.5%**<sup>2</sup>
- Alamance County residents without health insurance: **12%**<sup>1</sup>
- North Carolinians without health insurance: **8.6%**<sup>2</sup>
- **61** individuals experiencing homelessness<sup>3</sup>

### Rising Costs, Insufficient Wages

The wage needed to afford a 2-bedroom apartment in Alamance County compared to what the average renters earn



## ABOUT THE PROGRAM

As the regional lead agency for their Balance of State CoC region, Allied Churches of Alamance County (ACAC) sets the standard of care for the region. They coordinate with other community partners to provide their own full continuum of services to support clients in their return back to housing. These services include:

- **Emergency shelter:** dignified and safe temporary shelter including:
  - 40 beds for single men
  - 24 beds for single women
  - 3 private suites for families
- **Empowerment center:** offering support services for its shelter guests and community members in crisis, including:
  - housing navigation
  - utility and rental assistance
  - healthcare
  - employment readiness
  - benefits enrollment
- **Joe's Diner:** community kitchen serving hot lunch and dinner five days a week for anyone facing food insecurity in Alamance County.

# ACAC'S 2025 IMPACT

## Emergency Shelter:

- **160** shelter guests secured safe housing and accessed support services through ACAC's offerings

## Empowerment Center:

- **1,100+** individuals supported through employment, eviction mediation, rental and utility assistance, and housing navigation services
- **86%** of clients gained employment within 5 days of connecting with ACAC
- **230** clients obtained stable housing with year leases

## Joe's Diner:

- **28,000 meals** served
- **500 lbs** of fresh fruits and vegetables served weekly



Hot meals ready for guests at ACAC's Joe's Diner

## PROGRAM SPOTLIGHT:

### COMMUNITY INTEGRATED LIVING PROGRAM

ACAC's programs go far beyond their emergency shelter services, demonstrating their commitment to their client's long term health and housing stability. One example of this commitment is the **Community Integrated Living Program (CILP)** which is designed to help individuals and families move from homelessness into **safe, stable, long-term housing while increasing self-sufficiency and community integration**. Through partnerships with local landlords, **ACAC leases 1- and 2-bedroom apartments to their clients at stable rental rates**, with 1-bedroom units ranging from \$750-800 and 2-bedroom units ranging from \$850-\$900. These partnerships provide an affordable rental and reduce barriers to housing that may prevent clients from accessing the traditional rental market. As part of the agreement with local landlords, **all CILP participants are employed at lease up and continue to receive case management services throughout their lease term**. This not only supports clients in increasing their self-sufficiency and maintaining stability, but also helps ensure that the program remains viable for participating landlords. ACAC has demonstrated ongoing success with CILP, with **23 partnership units and 42 clients in permanent housing in 2025 alone**.

**\$1,095/  
MONTH**

*Average cost of a  
2-bedroom apartment in  
Alamance County <sup>4</sup>*



**\$850/  
MONTH**

*Average cost of a  
2-bedroom apartment  
through CILP*

# ACAC'S KEY STRATEGIES

*Founded in 1982 as an interdenominational partnership of local churches to meet the needs of those facing food insecurity and homelessness, the agency has evolved over time to meet the growing needs of their community.*

## ADAPTING EVIDENCE-BASED BEST PRACTICES TO THEIR LOCAL CULTURE AND COMMUNITY CONTEXT

Alamance County's rural setting and limited resources in surrounding counties have shaped ACAC's programmatic delivery methods to fit the population they serve. ACAC draws from principles such as Permanent Supportive Housing models, landlord engagement, and wrap-around case management, and has adapted them to meet their own region's capacity, culture, and unique needs.

- *Learn more about Permanent Supportive Housing, wrap-around services, and landlord engagement as best practices.*

## FOCUS ON PREVENTION AND DIVERSION

In addition to providing emergency shelter, ACAC provides households in crisis with timely referrals to resources and community connections to prevent the loss of housing and emergency shelter entry. This not only prevents homelessness, but also ensures that those who stay in their emergency shelter are in the most need of temporary shelter.

- *Learn more about prevention and diversion intervention.*

## PROVIDING BOTH IMMEDIATE AND LONG-TERM SUPPORT

ACAC assesses client needs upon arrival and focuses on their future rather than their past. When a client enters the shelter, ACAC provides immediate and effective wrap-around case management support. Within 48 hours, they ensure that the client has met with a case manager, established goals around housing, health, and income, and applied for federal benefits if eligible. Within a week, 86% of their clients find full-time employment, making them eligible for more housing opportunities in the area. Most clients spend only 30-45 days in the emergency shelter due to this efficient system. After leaving the shelter, ACAC's team continues to provide ongoing support to their clients to help ensure long-term success and housing stability. For example, they have supported an individual client with finding new employment numerous different times when their previous roles were not a good fit for their scheduling or income needs.

- *Learn more about supportive service integration in homelessness services.*

## CREATIVE PROBLEM SOLVING AND SCALING

Being in a rural area with limited resources makes creativity a necessity for the success of ACAC. For example, when delays in HUD inspections created delays in returning clients to housing, ACAC became HUD-certified inspectors themselves to expedite the process. ACAC also started using the HUD unit checklist as the guidelines for their own properties to ensure high quality housing placements.

## CENTERING RELATIONSHIPS AND BUILDING INNOVATIVE PARTNERSHIPS

ACAC's successes are rooted in their ability to leverage other local resources and establish meaningful relationships in the community. Examples include partnering with Elon University's agriculture program to provide fresh produce at their community kitchen; networking with community landlords to house clients with barriers to traditional rentals; and building lasting local businesses and foundations to 70% of their annual funding

- *Learn more about effective community engagement strategies for addressing homelessness.*

## LOOKING TOWARD THE FUTURE

ACAC plans to expand their existing services with plans to build their own apartment complex next to their location in downtown Burlington. This complex will create:

- **9** rent-controlled 1- and 2- bedroom units
- long-term **supportive and stable housing** for ACAC clients
- **sustainable income revenue** for ACAC

### To learn more and connect, contact:

Jai Baker, Executive Director  
jbaker@alliedchurches.org  
[alliedchurches.org](http://alliedchurches.org)



ACAC's main office in downtown Burlington, NC

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# REJUVENATION SUPPORT SERVICES

WINSTON-SALEM, NC – FORSYTH COUNTY

***Mission:*** A comprehensive and holistic approach that fosters lasting empowerment and community reintegration

## HOMELESSNESS IN WINSTON-SALEM

Rejuvenation Support Services participates in the Winston-Salem/Forsyth Continuum of Care, which coordinates regional planning and federal funding for work that supports individuals experiencing or at risk of homelessness in Forsyth County.

### ***Poverty and Homelessness:***

- Winston-Salem's poverty rate: **17.7%**
- North Carolina's poverty rate: **12.5%**
- **478** individuals experiencing homelessness in the 2025 PIT Count
- **58% increase in homelessness** from 2023 to 2024, the largest increase in the state

### ***Rising Costs and Limited Housing Stock:***

- Average rent for a 2-bedroom apartment: **\$1,232/month**
- Wage needed to afford a 2-bedroom apartment: **\$23.69/hour**
- **49% of renters** face challenges in affording their housing
- over **10,000 families** faced an eviction in the last year

## ABOUT THE PROGRAM

Fully licensed in 2023, Rejuvenation Support Services (RSS) is already making a big impact. Their mission is to provide safe transitional housing and supportive services for adults experiencing homelessness including those in recovery from substance use disorder, veterans, and adults returning from incarceration.

RSS was started after Barbara Stowe and Charles W. Moore III witnessed an increase in homelessness in their community and wanted to help. When other local providers shared that their patients in substance use treatment had no place to go following discharge, they jumped in to fill this gap. As a result, they now run a transitional housing program where clients get a second chance and can work towards their own goals of self-sufficiency and independence.



# SERVICES

**Transitional Housing** - Rejuvenation Support Services transitional housing properties provide a clean and safe environment for residents to sleep, heal, and work towards their goals.

- 3 homes
- 13 beds
- Average stay: 4-12 months

**Wrap-around support services** - In addition to providing shelter, all members of Rejuvenation Support Services receives case management support to reach their goals towards long-term self-sufficiency. This includes support in:

- Education and employment
- Healthcare
- Transportation
- Obtaining vital documents
- Benefits enrollment
- Budgeting and life skills
- Permanent housing placements

**Recovery Support** - Many members at Rejuvenation Support Services are in active recovery from substance use disorder. To support them, RSS:

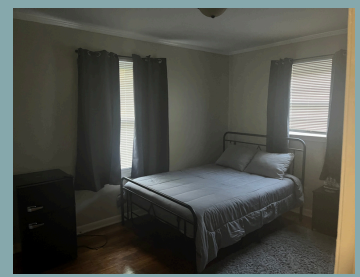
- **Coordinates care** with treatment providers such as Winston-Salem Comprehensive
- Connects members with **peer support** and **mental health counseling**
- Host **Alcoholics Anonymous** and **Narcotics Anonymous** meetings on-site

**Community Service Placements** - Through a partnership with the local court, Rejuvenation Support Services connects community members with court-mandated community service opportunities in the area. Beyond this placement they also:

- Connect community members with **job opportunities**
- Support **successful reentry** through connections with local resources

***“THE MOST IMPACTFUL PART OF MY WORK IS SEEING INDIVIDUALS REGAIN HOPE AFTER BELIEVING THEY HAD NONE.”***

**- BARBARA STOWE, FOUNDER & EXECUTIVE DIRECTOR**



AN RSS  
TRANSITIONAL HOME

# RSS'S KEY STRATEGIES

*Rejuvenation Support Services' offerings are grounded in their belief that everyone deserves a second chance and that housing is the first step to long-term stability, empowerment, and community reintegration. They deliver their services through a combination of key strategies:*

## HOUSING FIRST APPROACH

Rejuvenation Support Services' approach to supporting individuals embodies a Housing First approach. Recognizing that people are better able to address other challenges once they have a secure place to live, RSS prioritizes providing safe and stable housing and a welcoming environment for members before working with them on other long-term goals.

- [Learn more about Housing First models.](#)

## STRONG COMMUNITY PARTNERSHIPS

As a small nonprofit, RSS relies on local partnerships to provide the comprehensive support their members need. These partnerships include local employers, faith-based organizations, food pantries, healthcare providers, and veteran organizations that help them support their members.

## RECIPROCAL RELATIONSHIPS WITH CLIENTS

RSS prioritizes building reciprocal relationships with their members, meaning that they ensure each of their members is an active participant in goal setting around program requirements. This approach creates an environment that is both supportive and accountable, empowering members to take ownership over their own path towards self-sufficiency.

## HOLISTIC SUPPORT

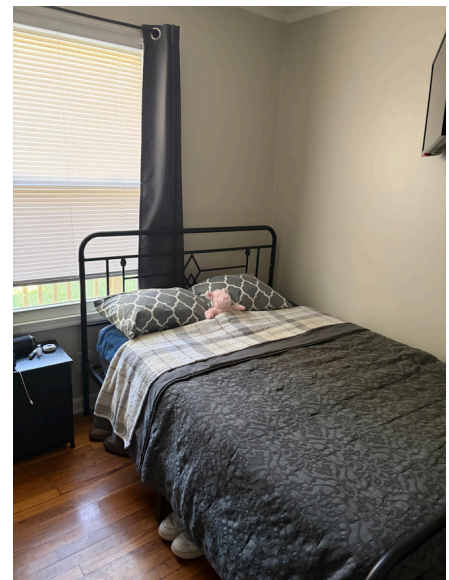
Rejuvenation Support Services' model focuses on supporting the "whole person," including their socioemotional needs as well as their physical ones. They work one-on-one with members to create a personalized plan to reach their goals and provide client-centered, tailored support for reaching them. This support includes things such as developing healthy daily routines as well as budgeting, time management, and household responsibilities. They encourage socioemotional growth through support with building communication and conflict resolution skills. This approach recognizes the complex intersecting issues that cause and perpetuate homelessness and sets members up for long-term success.

- [Learn more about wrap-around supportive services.](#)

# CLIENT SUCCESS STORIES

## BILLY

Winston Salem Comprehensive referred Billy to Rejuvenation Support Services after he was in and out of the hospital due to the deleterious health effects of his struggles with substance use. The day before leaving for RSS, he struggled with thoughts of suicide, but after he came to RSS he said he “saw the light.” Through RSS, Billy was connected with consistent and appropriate healthcare services, regained healthy eating patterns, received a long-overdue surgery, and maintained his sobriety. Through it all, he has had the constant support of RSS leadership and his assigned case manager. Since Billy is a Veteran, RSS also connected him with his disability benefits, helping him access the income he earned serving our country. Most importantly, Billy now has a safe and supportive environment to continue to recover from his medical issues and works towards long-term stability until he is able to move onto independent housing.



TOP: HOME SWEET HOME FOR RSS'S CLIENTS  
BOTTOM: A SAFE PLACE TO LAND AFTER A LONG DAY

## TOM

Tom came to Rejuvenation Support Services after serving 15 years in prison. He was in need of stable housing and employment in order to reconnect with his family. Within 6 months, the RSS team supported Tom in finding a third shift job that matched his preferred work schedule. Through this connection, he was able to save up enough money to find independent housing. Now, Tom is a valued community member, has maintained his employment, and is rebuilding his life alongside his family and children.

## ONGOING CHALLENGES

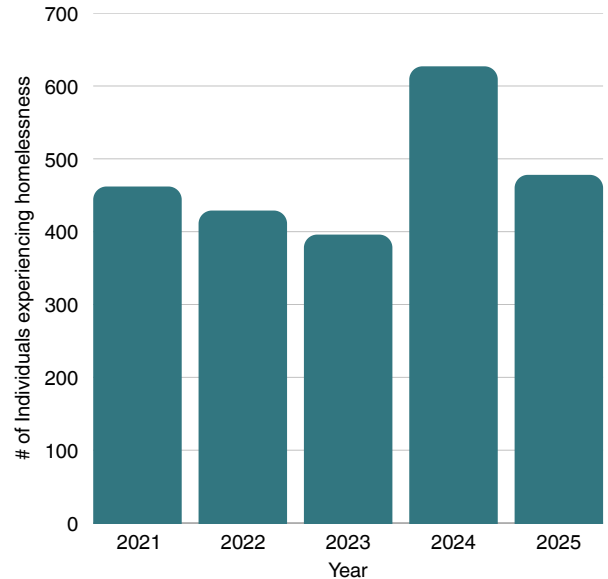
As a new, small nonprofit, Rejuvenation Support Services faces ongoing challenges in sustaining and growing their work, such as:

- Limited available federal funding
- High administrative burden
- Barriers in meeting funding and grant requirements, such as costly independent financial audits
- Growing rates of homelessness in the area
- Shortage of affordable housing
- Complex web of barriers facing clients as they work to achieve long-term stability

## LOOKING TO THE FUTURE

Rejuvenation Support Services plans to expand their services in the future to support more individuals in their community. They have plans to renovate the basement of currently owned property to add three more beds for individuals to stay in. They are also actively seeking an apartment complex or multi-family property that would allow them to expand housing opportunities for veterans, individuals in recovery and reentry, and others experiencing homelessness.

**Number of Individuals Experiencing Homelessness In Winston-Salem/Forsyth**  
**Continuum of Care 2021-2025**  
Based on Point-In-Time Count Data



HUD Exchange - CoC Homeless Populations and Subpopulations Reports

### To learn more and connect, contact:

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[barbarastowe@rejuvenationsupportservices.org](mailto:barbarastowe@rejuvenationsupportservices.org)

[rejuvenationsupportservices.org](https://rejuvenationsupportservices.org)



**NC COALITION to end  
HOMELESSNESS**

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# THE SHEPHERD'S HOUSE

MOUNT AIRY, NC – SURRY COUNTY

***Mission:*** Restoring hope and rebuilding lives in support of a future where homelessness and hunger do not exist

## HOMELESSNESS IN MOUNT AIRY AND SURRY COUNTY

Situated within Region 4 of the Balance of State Continuum of Care, Mount Airy is the largest town in Surry County. Known for its tourism, the area has experienced an increase in homelessness and wealth disparity in recent years:

### **Poverty**

- Mount Airy's poverty rate: **26.7%**
- North Carolina's poverty rate: **12.5%**

### **Growing Population, Decreasing Housing**

- Surry County population grew by **7%** in 2023
- Surry County housing stock decreased by **1%**
- **25%** of Surry County residents are cost-burdened by housing costs
- **47%** of renters faced difficulty in affording rent

This creates conditions for increased rates of homelessness and housing instability:

- **217 evictions** were filed in Surry County in 2026
- Over **7,000** individuals experiencing homelessness in 2025 in their five-county CoC Region, compared to just under 5,000 in 2024

## ABOUT THE PROGRAM

The Shepherd's House has been a pillar of support to individuals experiencing homelessness in the Mount Airy community for over 20 years. Founded in 2003, the Shepherd's House envisions a community where homelessness and hunger do not exist. They pursue their mission by providing a comprehensive continuum of services including emergency shelter, transitional housing, case management services, and a newly launched street outreach program.

Shepherd's House works closely in partnership with the Balance of State Continuum of Care and its member organizations, collaborating on annual funding opportunities, technical assistance, and systems improvements locally and across their region.

# SERVICES

**Emergency Shelter** - Shepherd's House offers:

- **64** beds for women and families
- A safe and supportive environment for clients to heal and work towards their goals

**Transitional Housing** - for individuals who are ready to live independently but face barriers in accessing the private rental market

- Income-based rental program
- Opportunity to build rental and credit history
- Up to **2** year stay before moving on to permanent housing

**Case management** - Shepherd's House case managers work with residents to establish and achieve goals through individualized plans for success. This includes connecting them to:

- Education and employment opportunities
- Benefits and vital documents
- Financial literacy courses
- Physical and mental healthcare

**Street outreach** - Shepherd's House meets clients experiencing unsheltered homelessness throughout the region, offering:

- On-location case management services
- Meals and nonperishable food
- Access to laundry and showers
- Connection to other local resources



TOP: SHEPHERD'S HOUSE SHELTER AND MAIN FACILITY IN DOWNTOWN MT. AIRY

MIDDLE: "MOMENTS WITH MOM" STATUE OUTSIDE OF SHEPHERD'S HOUSE

BOTTOM: SHEPHERD'S HOUSE MOBILE OUTREACH VAN

**"Sometimes you need a helping hand. Like, if I wouldn't have ever met Jessica...I don't know where I would be."**

*- a Shepherd's House client sharing her experience working with Shelter and Facilities Manager Jessica Stevens*

# SHEPHERD'S HOUSE KEY STRATEGIES

*Over the past five years, the leadership of Executive Director Jana Elliott has transformed Shepherd's House's impact. Their organization has grown and adapted to meet the evolving needs of the area through strategies based on local trends and data, client feedback, and industry best practices.*

## RESPONDING TO GROWING NEED

Witnessing the rise in homelessness in their area in recent years, Shepherd's House has continuously expanded their services and programs to meet the needs of the community. In 2023, they expanded their shelter from 18 to 64 beds, more than tripling their capacity to support women and children. In addition, they also began a Transitional Housing program for clients who may need interim long-term housing to reestablish credit and build savings before going out into the private rental market. In the same year, they also started a street outreach program where they meet with unsheltered adults across Surry, Stokes, and Yadkin Counties, providing support and resource connections. With a long shelter waitlist, this program has enabled them to expand the number of individuals they are able to support at a given time. By continuously monitoring community trends and soliciting feedback from clients served, Shepherd's House is able to ensure that their services remain responsive to the local need.

## PRIORITIZING MENTAL HEALTH SERVICES

For many years, Shepherd's House focused its services solely on shelter and housing programs. Ongoing evaluation determined that more robust mental health support was essential to their clients' long-term success

and housing stability. By providing both a safe and stable residence as well as layered on mental health and recovery supports, Shepherd's House ensures that each individual client has the tools they need to remain successfully housed, regardless of what challenges they may face.

- *Learn more about the [intersection of mental health and homelessness](#)*

## BUILDING AUTHENTIC CLIENT RELATIONSHIPS

The case managers at Shepherd's House recognize the diverse and complex circumstances that can lead to homelessness and that what works for one client may not work for another. To respond to this, they prioritize building authentic relationships and person-centered plans with each client. By investing the time to truly understand each client's background, beliefs, and hopes for the future, Shepherd's House services are more effective in meeting the individual, unique needs of their clients and setting them up for a successful programmatic experience.

**"I would talk to them individually. I would cry with them. You know, I learned about their lives and what caused them to be where they were."**

*- Robin, Lead Case Manager*

## FOCUSING ON FINANCIAL LITERACY

Shepherd's House prepares clients for life after the shelter by teaching them financial literacy and budgeting skills. Once a shelter resident is employed, they set aside 50% of their income into a personal account for each client that the Shepherd's House deposits for them at a local bank. A local banking team also teaches financial literacy classes to residents and works one-on-one with them to repair credit and create individual budgets. Upon graduation, clients have all of the savings they have accrued while at the shelter, helping them towards long-term financial and housing stability.

- *Learn more about [financial literacy](#) and [economic empowerment models](#)*

## EXPANDING COMMUNITY PARTNERSHIPS

Shepherd's House has expanded their partnerships with other agencies that interact with the local homeless population to ensure they all work together to best support their clients. This has included expanding their partnerships with DSS, the school system, law enforcement, emergency responders, and local mental health agencies such as Easter Seals and Phoenix Counseling Collaborative. In a rural area with limited resources, ensuring that community partners are working collaboratively is vital to their success. Through this collaboration, they are both able to ensure effective support and referrals for their clients and learn from other agencies' best practices for continuous improvement of the local network of services.

**"You can't know everything, but if you can tap into what everybody knows the most, and start building those connections with folks, that's been the biggest thing we can do."**

*- Polly, Case Manager and Community Liaison*

## COMMUNITY EDUCATION AND AWARENESS

Since rural homelessness often looks different than the common perception, many residents of Mount Airy and Surry County lack awareness of what their local crisis really looks like. This lack of understanding, combined with political trends that stigmatize homelessness, have generated some pushback on Shepherd's House services. In response, Shepherd's House has worked to educate the community about the realities of homelessness and the many different ways it can occur, as well as the solutions they implement through their programs. They have leveraged partnerships with local law enforcement and the school system, shared statistics on the clients they serve, published client success stories, and dispelled common myths about homelessness. They have also created volunteer opportunities so that community members can get involved and witness the positive impact of their work. These efforts have helped many in the community gain a better understanding of homelessness in their area and the importance of Shepherd's House services.

# IMPACT

- **3,798 clients** supported in shelter
- **586 clients** connected with through street outreach
- **51 clients** provided with Transitional Housing
- **352,887 meals** provided to hungry community members
- **1,030 clients** connected with mental health, recovery, and other wrap around services
- **67,016+ casework hours** logged in support of men, women, and children experiencing a crisis

## CLIENT SUCCESS STORIES

### BRIANNA

Brianna came to Shepherd's House after surviving emotional and financial abuse as both a child and as an adult. When she first arrived, she was very closed off to services and slow to trust others due to her traumatic past. However, Robin, Shepherd House's lead case manager, **met Brianna with empathy** and validated the trauma she had experienced. Over time, Robin worked patiently with her to slowly gain her trust, and the two built a strong relationship. Brianna was connected to mental health services provided by Easter Seals, where she received intensive psychotherapy and was diagnosed with a disability, enabling both providers to better understand and support her. Shepherd's House staff helped Brianna get awarded a Housing Choice Voucher, and after a year-long stay at Shepherd's House, **Brianna was able to move into permanent housing** with her child. She is now stably housed, works a part-time job, has been connected to other helpful benefits, and is continuing on her therapy journey. She is also enrolled in a local college and is **pursuing her Bachelor's degree**. Brianna is **on the path to break the cycles of abuse and trauma** and create a better future for herself and her child thanks to the support Shepherd's House provided.

# AMY

Growing up around substance abuse and domestic violence, Amy was born into a cycle of poverty and trauma that followed her from a young age. At 15, her father passed away, which led to a string of placements in juvenile detention and group homes where she endured more abuse. She had her first child in her teens, and Amy worked hard to be a responsible and caring mother. With no family support to lean on, cycles of domestic violence and substance use continuously pulled her back from achieving long-term stability for herself and her kids, even losing custody of her children at one point due to an abusive ex-partner.

Losing and regaining custody of her children made Amy realize she needed a helping hand, so she made a call to the Shepherd's House. Amy had stayed at the Shepherd's House once previously, but had left the program before graduating. Thanks to recent program changes, she was allowed her to re-enter the program. Amy shared that the support she received from the staff was transformative. Instead of just focusing on employment and housing, Amy was also provided with support in processing all that she had been through and defining what she wanted in the future for herself and her children. Having this type of holistic support motivated Amy to stay committed to her goals and break the cycles she was born into. Amy graduated from the Shepherd's House in January and now lives in a 3-bedroom apartment with her children. She has a home to call her own, has held a steady job for over two years, and owns two cars. She continues to push herself to be the best version of herself, support her children's development, and grows everyday, knowing she has support down the road at Shepherd's House if she ever needs it.

## ONGOING CHALLENGES

Providing homeless services in a rural area presents many challenges for Shepherd's House staff, including:

- **Local resources often do not meet the needs of their clients**, especially in regards to ongoing mental health services.
- **A lack of affordable housing options and housing support programs**, exacerbated by recent funding cuts and a changing housing market, has made it more difficult for residents to find permanent housing following their shelter stay.
- **Ongoing stigmatization of homelessness**, which can impact their ability to expand services and work effectively with necessary community partners and resources.

## LOOKING TO THE FUTURE

The Shepherd's House plans to continue to act as a central resource for individuals and families experiencing homelessness in Mount Airy and continuously evolve their services to meet their community's needs. Their next step is to **open a men's shelter** to provide program-based housing and comprehensive case management services to single adult men experiencing homelessness. Further in the future, they plan to open a **daycare center** to fill the gap of childcare for single parents that has been a constant barrier for their clients.



*Helping Hands Foundation in Mount Airy, part of which will soon house a men's shelter operated by Shepherd's House.*

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**NC COALITION** to end  
**HOMELESSNESS**

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# VOA CHESAPEAKE & CAROLINAS - SUPPORT SERVICES FOR VETERAN FAMILIES

ACROSS NORTH CAROLINA

**Mission:** *Ensuring that those who served our country can live their lives with the dignity and independence they deserve*

## VETERAN HOMELESSNESS IN NORTH CAROLINA

Across North Carolina, veterans experience higher rates of housing instability and homelessness compared to the general population. This is due to many intersecting risk factors, including:

- High prevalence of PTSD, substance use disorder, and other mental illness
- Inaccessible healthcare options
- Isolation from social support and stigmatization
- Affordable housing shortages and insufficient wages

**In 2024, 5.9% (688) of all North Carolinians experiencing homelessness were veterans.**

- Veterans of color and women experienced disproportionate rates of homelessness
- Veterans who experienced homelessness were most often:
  - below 35
  - enlisted with lower pay grades
  - diagnosed with a mental illness

The number of veterans experiencing homelessness has **decreased by 36.5% in NC** in recent years, due to **substantial investment** from the U.S. Department of Veterans Affairs to address homelessness with housing resources.

## ABOUT THE PROGRAM

### VOA CHESAPEAKE & CAROLINAS

One of the organizations contributing to the decline of veteran homelessness in North Carolina is Volunteers of America - Chesapeake and Carolinas (VOACC). VOACC works across the state to expand access to safe housing and essential healthcare by delivering integrated, community-based services that meet people where they are. They increase access to housing through a continuum of supportive housing programs that prevent and end homelessness.

### SUPPORTIVE SERVICES FOR VETERAN FAMILIES

The Supportive Services for Veteran Families (SSVF) program was created by the Department of Veterans Affairs in 2012 as a part of their response to high rates of homelessness among veterans. VOACC decided to participate in the program due to the state's large veteran population. VOACC's SSVF program now covers 62 counties with five regional offices across the state, providing homelessness prevention, Rapid Rehousing, case management, housing navigation, and temporary financial assistance to veterans in need.



## THE SSVF PROCESS FOR CLIENTS

1. Receive a referral from the VA, coordinated entry, a partner agency, or through direct outreach
2. Visit an SSVF office and complete an initial eligibility screening with an SSVF staff member
3. Meet with staff to develop an individualized housing stability plan
4. Work with SSVF housing navigators to locate and coordinate both emergency and long-term housing
5. Connect with healthcare, income supports, benefits enrollment, and other community resources through support from SSVF case managers

“When a veteran is experiencing homelessness, there are often comorbidities that need to be managed, chronic medical conditions, mental health concerns, substance use, medication adherence, preventative care... Homelessness, in my experience, does not occur in a vacuum. I have never experienced a case where a veteran was experiencing homelessness and that was the only problem that we were facing. So stable housing obviously allows for the ability to engage in treatment, attend appointments, have somewhere to store your medication, to feel safe.”

- **Michele Bennett, SSVF Program Director**



# SSVF'S KEY STRATEGIES

*VOACC's programs are grounded in their belief that every veteran deserves dignity and respect and are designed to fill the gap in supportive services for veterans and their families.*

## HOUSING FIRST MODEL

SSVF is a Housing First program, meaning that they prioritize removing barriers and quickly connecting veterans to permanent housing in order to provide a stable foundation for them to achieve their other goals towards self-sufficiency, such as healthcare and employment.

- Learn more about [Housing First Models](#).

## VETERAN-CENTERED SUPPORT

SSVF's case management and housing navigation supports are deeply centered in each veteran's unique and individual needs. They focus on building trust with their clients and tailoring their programs to be responsive to the unique challenges veterans face after leaving the military. SSVF recognizes that complex systems create a wide range of barriers, so support can look like providing medication management, scheduling appointments, or financially supporting transportation needs to ensure client success.

- Learn more about [Veteran-Centered Support](#).

## STRONG COMMUNITY PARTNERSHIPS

SSVF's effective care coordination relies on strong partnerships with other agencies across the state. VA healthcare centers are key partners, as well as six other healthcare systems across the state. Other veteran organizations such as Tunnel to Towers and Veterans Bridge Home provide essential wrap around support, as well as regional Continuums of Care and coordinated entry systems that assist with housing navigation and placements.

## INCORPORATING CLIENT FEEDBACK

VOACC programs are always looking to learn where there may be gaps in their services or in their understanding of veterans' needs. They do this by listening to the experiences of the veterans they serve and prioritizing lived experience in their hiring process. They have staff who have lived experience of both homelessness and military service who are able to provide a grounded perspective on what their clients are really experiencing day-to-day. Upon graduating from the program, they also send out a survey to veterans where they can provide feedback on the program, which they actively use to inform program improvements. For example, through feedback from clients on the timeliness of processes, VOACC created two new positions to improve their workflow and to better meet unsheltered veterans where they are.

- Learn more about [centering lived experience](#).

***"We really do believe that the veterans that we serve are the experts in their own experience, and we need to support their goals with dignity and respect."***

# CLIENT SUCCESS STORIES

## WILLIAM



When William entered VOACC's program he was unsheltered and struggling with unmanaged diabetes. An SSVF case manager supported William in coordinating with the VA to get him connected to primary care and behavioral health resources. After receiving these needed services, William's health stabilized and he was able to meaningfully and consistently engage in the housing search process with SSVF housing navigators. William now has stable employment and has been able to maintain permanent housing, better health, and an improved quality of life.

## BETH

Beth came to SSVF after receiving an eviction notice five days away from her scheduled induced labor. SSVF case managers and housing navigators swiftly connected with Beth before she gave birth so that by the time she got out of the hospital with her newborn, she once again had stable, permanent housing.

Eddie came to SSVF after a medical crisis impacted his income and left him, his wife, and two children with a pending eviction. SSVF provided Eddie and his family with temporary financial assistance and connected them to bridge healthcare services. They also worked with Eddie's landlord to preserve their housing, allowing them to avoid homelessness and destabilization.

## EDDIE

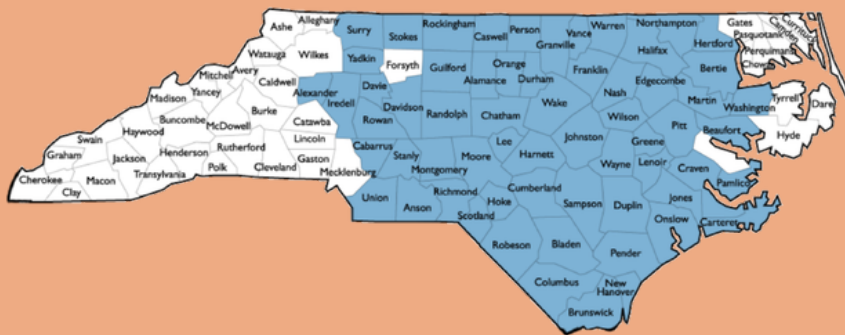
## ONGOING CHALLENGES

VOACC's SSVF program experiences many of the same ongoing challenges as other homeless service providers across the state in effectively supporting their clients in reaching long-term stability:

- **Lack of affordable housing and rising costs of living** - Rising rental costs, limited housing supply, and stagnating wages make it difficult to both secure and maintain housing for clients, especially in rural areas.
- **Limited transportation** - Limited transportation options create challenges for clients being able to attend appointments, maintain employment, and access services. As a result, SSVF has had to allocate funds towards bus passes and creative solutions like electric bikes in rural areas where public transportation is not available.
- **Landlord recruitment and retention** - Many clients have evictions, justice system interactions, and other barriers that cause many landlords to be unwilling to work with the SSVF program. Forming and sustaining relationships with participating landlords across such a large service area and within an increasingly competitive rental market is an ongoing challenge for SSVF housing navigators.

## LOOKING TO THE FUTURE

VOACC plans to continue supporting veterans experiencing homelessness and housing instability across the state with specific goals to expand their service area to Western North Carolina and South Carolina.



*VOACC's service area in North Carolina (highlighted in blue), which they hope to continue to expand in the future.*

### To learn more and connect, contact:

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