

# Community Referral Program

## Overview, Results, Recommendations

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<b>Executive Summary</b>	<b>3</b>
<b>Introduction and Background</b>	<b>4</b>
<b>Community Referral Program: Phase Two</b>	<b>5</b>
Training	5
Program Set-up	6
<b>Program Process</b>	<b>6</b>
Assessments	6
Follow-ups	7
<b>Program Findings</b>	<b>7</b>
Total Clients Helped	7
Data Analysis	7
Program Barriers	8
Data Analysis	8
Demographics	9
Results	10
Income	10
Data Analysis	11
SNAP/LINK	11
Data Analysis	12
Resources Provided	13
Results	13
Housing Referrals	13
Ages vs. Housing Requests	14
Data Analysis	14
Housing Requests vs. Income	15
Data Collected	15
All Medical Referrals	16
Other Services Requested	17
<b>Program Recommendations</b>	<b>18</b>
Structure Recommendation	18
Frequency Recommendation	18
Coordinator Recommendations	19

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## **Executive Summary**

The Northwest Food Partners Network implemented the Community Referral Program to support its member food pantries and meal sites in providing community resource referrals to their clients, once it was identified that each program director did not have the capacity to address this on their own. Over the course of several months, a referral specialist conducted regular visits at four food pantry or free meal sites located in the Humboldt Park, Logan Square and Belmont Cragin communities. The referral specialist met individually with clients to assess and evaluate their immediate needs and provide warm referrals to services to address them. During these visits, the specialist tracked data about the demographics of the clients she served, as well as the type of requests that were made of her. This report serves to summarize the findings. After serving a total of 143 clients among the partner agencies, the referral specialist found that the most frequently requested services related to housing, food and employment. She highlighted certain demographic points in the client population she served, including income source and age. After analyzing results and feedback, she recommended that the program continue in future years. She provided specific recommendations for a referral specialist with the time capacity to assist clients in finding resources and who is knowledgeable of client needs and available community resources.

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## **Introduction and Background**

This report will summarize and evaluate the Community Referral Program of the Northwest Food Partners Network, during the time period from November 2016 to April 2017. The report will discuss the general process, findings and recommendations.

### **The Northwest Food Partners Network**

The Northwest Food Partners Network (NFPN) is an alliance of hunger-fighting organizations on Chicago's Northwest Side, with focus on the Humboldt Park, Logan Square, Hermosa, West Town, East Garfield Park and Belmont Cragin neighborhoods. The coalition's mission statement is: "The NFPN unites organizations in the mission to provide quality food, promote self sufficient and wellness, and build a bridge between emergency food providers and community issues."

The NFPN was founded by La Casa Norte in 2009 with the goal of supporting, and organizing the work of small emergency food providers in the same area. Since then, the NFPN has expanded and developed into a large network that included twelve member agencies in 2016, most of whom provide a food pantry or free hot meal to the community. Other local nonprofits, businesses, farmers' markets and health centers are more loosely involved in the network as associates. Since the network's founding, its lead agency has been La Casa Norte, a non-profit organization headquartered in Humboldt Park that serves youth and families confronting homelessness.

### **Community Referral Program: Phase One**

In early 2016, a NFPN member program director approached the network with a problem. During mealtime at the free hot meal site that she led, she was constantly being pulled aside by clients who wanted help and support with situations going on in their lives. In theory, she wanted to sit with them and hear their stories. However, she just did not have the time to talk to them during mealtime, as she was busy managing the food program's operations. She also had no background in mental health, which she felt might be needed to provide the clients socioemotional support.

After she brought up this concern, it became clear that many program directors in the network faced a similar challenge. The network leadership decided to pilot a solution. Over twelve weeks of the summer, a staff person visited the original program director's hot meal site every single week. She sat with clients and asked them about their lives and needs. She also interviewed some clients formally to ask what kind of additional support at a meal program they would find

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helpful. She ultimately found that clients sought her out for specific requests for information about services and navigating systems in the community. They rarely sought only socioemotional support. She recommended that in a program Phase Two, a person trained as a Referral Specialist visit food programs regularly to provide one-on-one needs assessments with clients, as well as referrals to a diverse array of free services available outside that program's walls.

## **Community Referral Program: Phase Two**

Based on the results and recommendations of Phase One, the purpose of Phase Two of the Community Referral Program was to connect the clients of the NFPN to outside resources within their communities. The network brought on and trained a Masters'-level clinical social work intern and trained her to act as a referral specialist within food pantries and free meal sites. Phase Two was completed between September 2016 and April 2017, by Crystal Vargas, Community Engagement Clinical Intern at La Casa Norte, and overseen by Rachel Bhagwat, La Casa Norte's Community Engagement Coordinator and the NFPN Chairperson.

### **Training**

Prior to visiting sites and providing referral services, the referral specialist completed training in order to help her build a knowledge of resources available in the community. The referral specialist shadowed La Casa Norte's Information and Referral Specialists for a month in order to gain an understanding of client needs in the community. As the information was received, the referral specialist researched available community resources through a combination of agency resources and internet searches.

The referral specialist also visited each site before providing clients with services in order to meet with the coordinators. She discussed topics such as the type of client population that the agency served, issues clients experience, and popular resources requested. This allowed the referral specialist to research available community resources for those specific issues to be ready for the first day of the Community Referrals program at the agency.

Before the first referral visit, the referral specialist would also tour the agency and plan with the coordinator how and where referrals would be provided. The referral specialist scheduled the meetings and tours while the program was operating. This allowed the referral specialist to see how the programs worked at each site, and to plan with the coordinator where the Community Referral table would be set-up. The referral specialist then implemented and set-up the program at each agency, as discussed in the next section.

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## **Program Set-up**

The program was implemented at four NFPN member agency sites: San Lucas United Church of Christ, Open Arms Ministries, Iglesia Evangelica Emanuel, and European American Association.

San Lucas United Church of Christ, located in Humboldt Park, was the first site for the Community Referral Program. The referral specialist visited the site once a week for an average of two hours each visit during the hot meals program. The referral specialist had a table overlooking the hot meal program, as there was not a private space available at the site.

The next site visited was Open Arms Ministry, located in Logan Square. The referral specialist would visit the Drop-in Program once a week for an average of two hours. Since the Drop-in Program at Open Arms also did not have a private space available, the referral specialist had a table overlooking the program.

The referral specialist visited the third site, Iglesia Evangelica Emanuel, once a month for an average of two hours each visit during food pantry hours. The agency had a private room available for the referral specialist to complete assessments and referrals.

The last site, European American Association, also requested the referral program for their food pantry program. The referral specialist visited the agency once a month for an average of two hours. The agency also had a private room available for the referral specialist to complete the assessments and referrals.

## **Program Process**

### **Assessments**

Clients were notified prior to and during the visit that a referral specialist was available for community referrals. If clients requested the services, they would meet with the referral specialist to complete an assessment form. The assessment took approximately twenty minutes to complete, and was used to provide referrals catered specifically to the client. The referral specialist's ability to complete full intakes relied on the time availability of the specialist and the clients. If the either one did not have enough time for the full assessment, the referral specialist still answered questions as requested.

If the referral specialist was already with a client, other clients were instructed to write their name, contact information and requested services on a sign-up log. This allowed the clients to know when they would be called for the assessment. If they did not have time for the assessment, the referral specialist had their contact information to notify the client when the next referral visit

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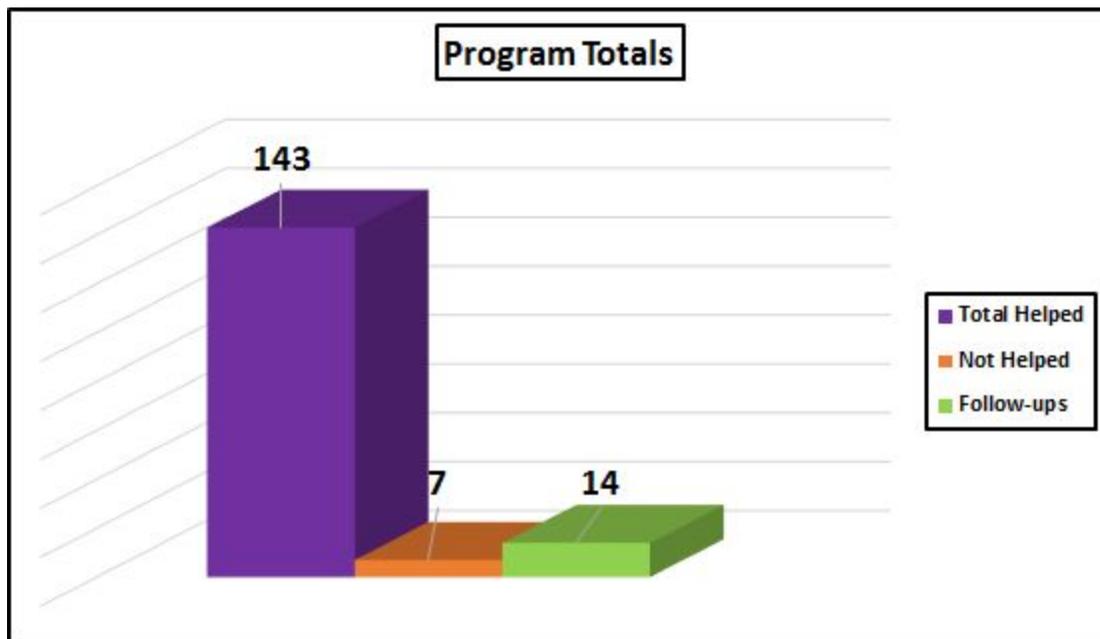
would be. Also, if the client needed an immediate referral, the referral specialist was able to mail the information the client requested using the contact information provided on the sign-in.

## Follow-ups

After each visit, the referral specialist would complete follow-ups with each client. After analyzing each assessment form, the referral specialist would gather the necessary resources for the referrals and mail the documents to the clients, or bring the documents to the referral site for the next visit. At the next visit, the referral specialist would follow-up with clients to confirm they received the referrals, inquire if they needed any further referrals, and answer any questions they may have about the resources. Follow-ups with clients about their progress with the referrals were sometimes difficult after the initial assessments because some clients did not always come to the programs regularly. Sometimes follow-ups were completed right after the initial meeting, sometimes a few weeks or months after the initial meeting.

## Program Findings

### Total Clients Helped



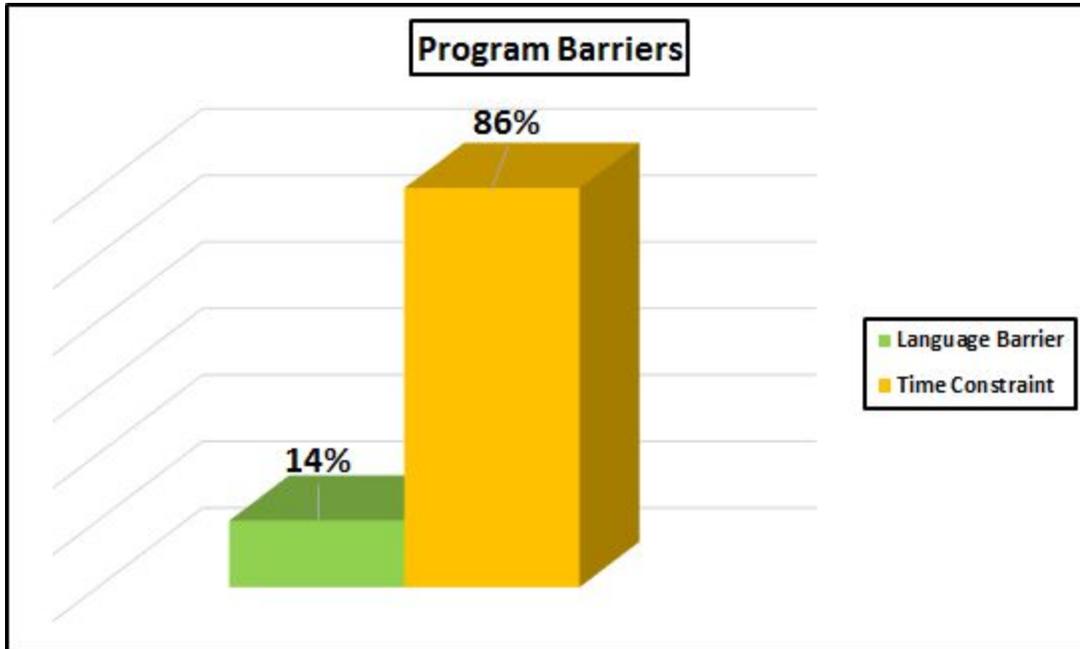
### Data Analysis

The graph above reflects the total number of clients served from November - April. Out of 150 total clients who requested services, 143 received referral services and 7 were not served due to program barriers. Furthermore, of the 143 clients that received referral services, 14 were follow-ups. In these follow-ups, clients received referral services and would return for additional

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resources. In these cases the follow-ups took place a few weeks or months after the initial intakes.

### Program Barriers



### **Data Analysis**

The referral specialist was unable to serve 7 of the 150 clients because of some barriers in the program design. Represented in the graph above, 86% of the clients not served was due to a language barrier. There were several clients that were unable to understand English, and there was not a translator immediately available.

The remaining 14% of clients not served was due to a time constraint. The referral specialist did assessments with clients to aid in the referral process. The assessment took an estimated 20-minutes to complete. This caused an issues for clients who were unable to stay for the assessments due to prior commitments. In these cases the referral specialist would have the clients sign their contact information and referral requests on a form to be contacted for a future assessment or to receive immediate referrals. Another reason for the time constraint with the assessments was when the referral specialist was helping a client and had a long list of clients signed up for services. Since the referral specialist was at the sites for an average of only 2-hours, they were limited to the number of clients that were helped each visit. Sometimes the referral specialist would have to leave before the list was finished, or the clients had to leave before their name was called.

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## Demographics

This section will describe what clients the program served by discussing demographics. This demographics analysis will serve to illuminate the type of clients accessing food pantries by highlighting some basic information such as age, income status, SNAP/Link resources, and health care coverage status. This information helps to determine the best interventions to provide in the future. This data was collected from sixty-three intake assessments which were completed by the referral specialist during the first contact session with each client.

The communities of Humboldt Park, Logan Square and Belmont Cragin (where the specialist provided these services) have varying demographics in relation to race and average community income. Humboldt Park<sup>1</sup> and Logan Square<sup>2</sup> have roughly 50% Hispanics, however Humboldt Park has roughly 40% of Blacks, and under 10% are White, while in Logan Square those numbers are reversed. Belmont Cragin<sup>3</sup> has an even large population of Hispanics at nearly 75%, while 15% are White and only 5% are Black, with the remaining 5% were other races such as Asian, Mixed or Other. The annual median incomes for Humboldt Park<sup>4</sup>, Logan Square<sup>5</sup> and Belmont Cragin<sup>6</sup> are roughly \$30,000, \$40,000 and \$50,000, respectively.

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<sup>1</sup> <http://statisticalatlas.com/neighborhood/Illinois/Chicago/Humboldt-Park/Race-and-Ethnicity>

<sup>2</sup> <http://statisticalatlas.com/neighborhood/Illinois/Chicago/Logan-Square/Race-and-Ethnicity>

<sup>3</sup> <http://statisticalatlas.com/neighborhood/Illinois/Chicago/Belmont-Cragin/Race-and-Ethnicity>

<sup>4</sup> <http://www.cmap.illinois.gov/documents/10180/126764/Humboldt+Park.pdf>

<sup>5</sup> <http://www.cmap.illinois.gov/documents/10180/126764/Logan+Square.pdf>

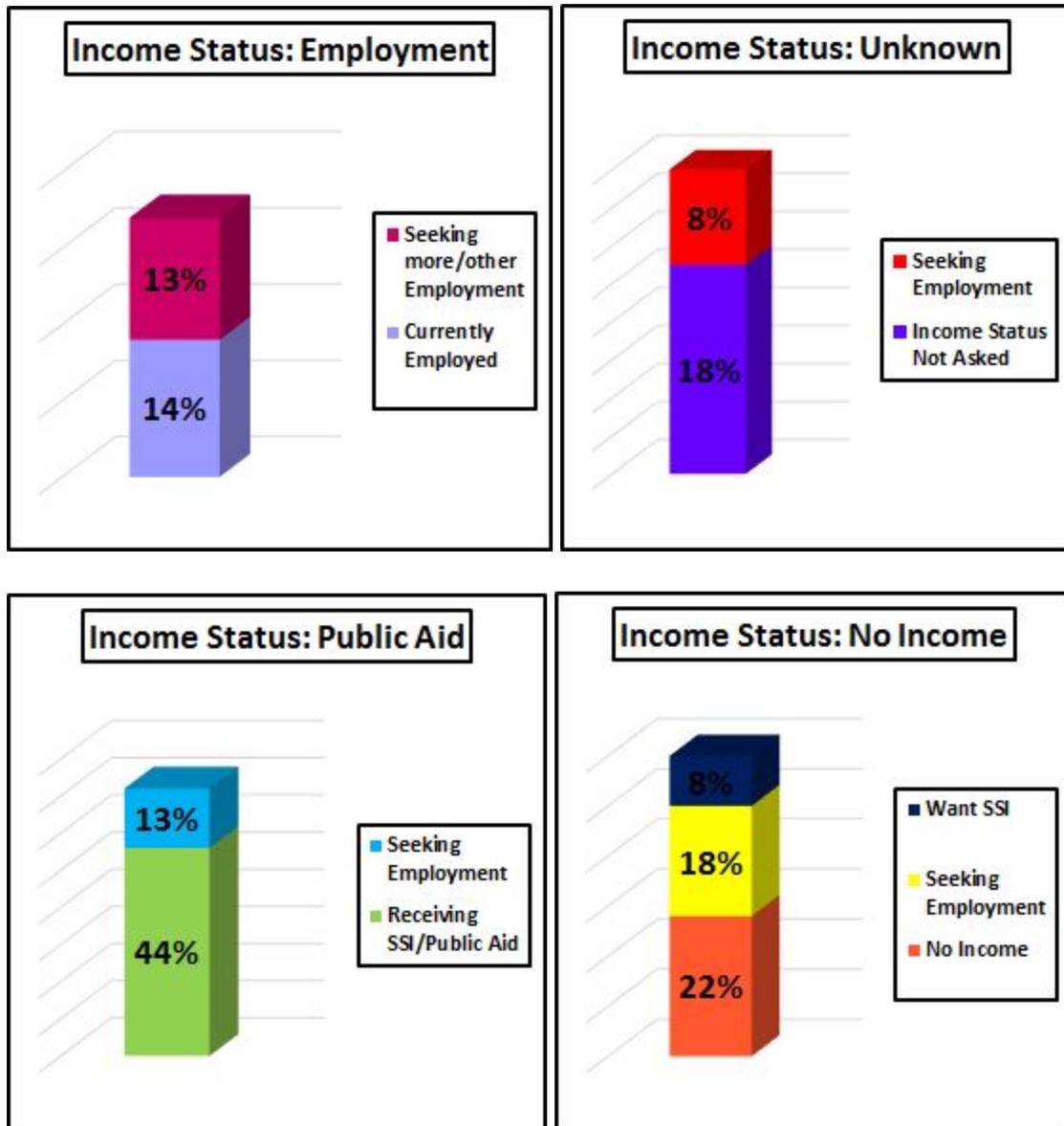
<sup>6</sup> <http://www.cmap.illinois.gov/documents/10180/126764/Belmont+Cragin.pdf>

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## Results

### Income

This section discusses the income status of the clients that were provided referrals. The income status includes the type of income the clients were receiving, and if they requested employment services or assistance in applying for public aid.



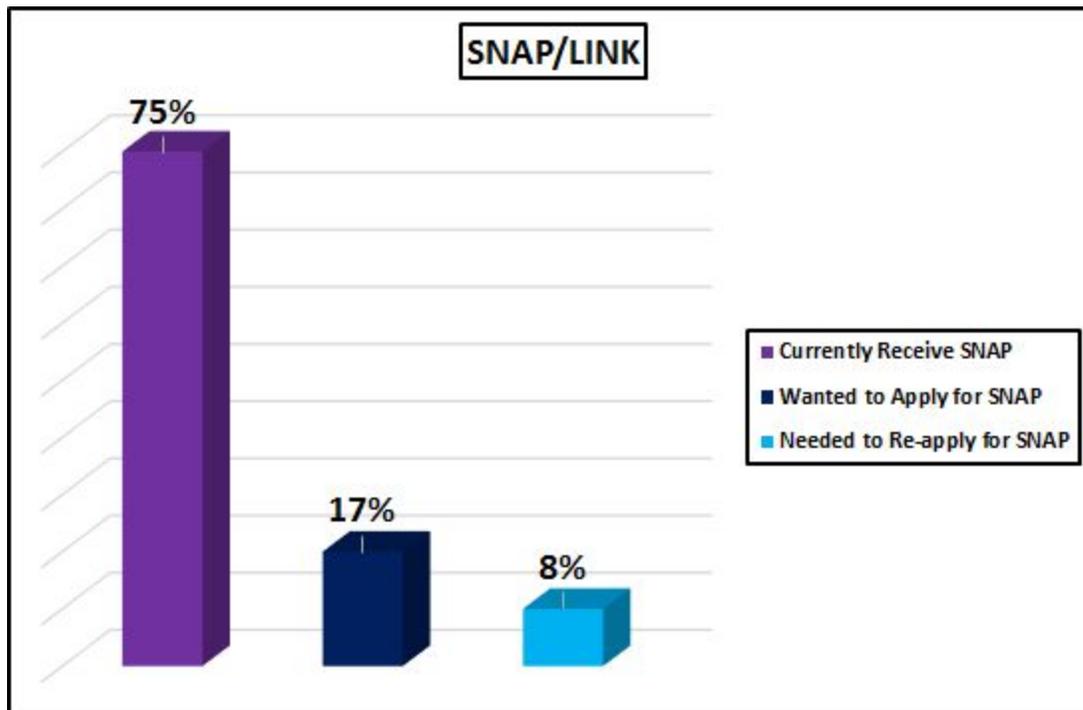
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## Data Analysis

In summary, out of the 63 who completed intakes, 52% were seeking employment referrals. Not reflected in the graph, out of 143 total served, 29% were seeking employment referrals. The 63 participants seeking employment referrals is included in the total number of requested employment referrals.

According to the results, over half of the participants from the intakes were seeking some type of employment. This data shows an overwhelming amount of requests for employment in the communities served. This brings into question the unemployment rate and available jobs in the community. Humboldt Park is one of the communities that had the referral program as well as where the majority of the clients served were living. According to Illinois Department of Employment Security, Humboldt Park has one of the highest unemployment rates.<sup>7</sup> Furthermore the rate of public cash assistance for households in these communities<sup>8</sup> is low, just over 3% for Belmont Cragin and Logan Square, and just under 6% for Logan Square.

## SNAP/LINK



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<sup>7</sup> [http://www.ides.illinois.gov/LMI/Pages/Targeted\\_Employment\\_Areas.aspx](http://www.ides.illinois.gov/LMI/Pages/Targeted_Employment_Areas.aspx)

<sup>8</sup> [http://www.ilpovertyreport.org/sites/default/files/uploads/Chicago\\_Neighborhood\\_Indicators\\_00-11\\_130109.pdf](http://www.ilpovertyreport.org/sites/default/files/uploads/Chicago_Neighborhood_Indicators_00-11_130109.pdf)

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## Data Analysis

Out of 63 completed intakes, 24 clients were able to give their SNAP status. The data in the chart above reflects the percentage of the 24 participant intakes which had client requests for SNAP/Link referrals. Not reflected in the graph is the 3% of 143 total participants assisted that were seeking SNAP/Link referrals, specifically resources related to SNAP appeal and redetermination.

The data showed a low rate of participants who receive SNAP. This was initially surprising because all participants served were currently accessing a food pantry or hot meal program. Their use of these emergency food services suggests that food is a need for 100% of these clients. However, this is discordant with their low usage of SNAP resources, especially given that in addition to low SNAP usage rates, only 6% of clients were interested in applying. This brings into question the percentage of clients who are able to qualify for SNAP benefits.

One hypothesis is that the percentage of undocumented participants at the sites could have contributed to a low SNAP enrollment. Food pantries and free hot meal sites do not track data about their client's' immigration status, but according to rough estimates given by each program director, roughly 20% of participants at San Lucas, 60% at Iglesia Evangelica Emanuel, 20% at European American Association, and 50 % at Open Arms Ministries are believed to be undocumented or are permanent residents who have not met the 5 year requirement for public benefits. Undocumented immigrants are unable to qualify for SNAP benefits, and moreover immigrants do not qualify for SNAP benefits unless they have been a permanent resident for at least 5 years. Since they do not qualify for other public benefits as well, this demographic data hypothesis could have affected the results around income.

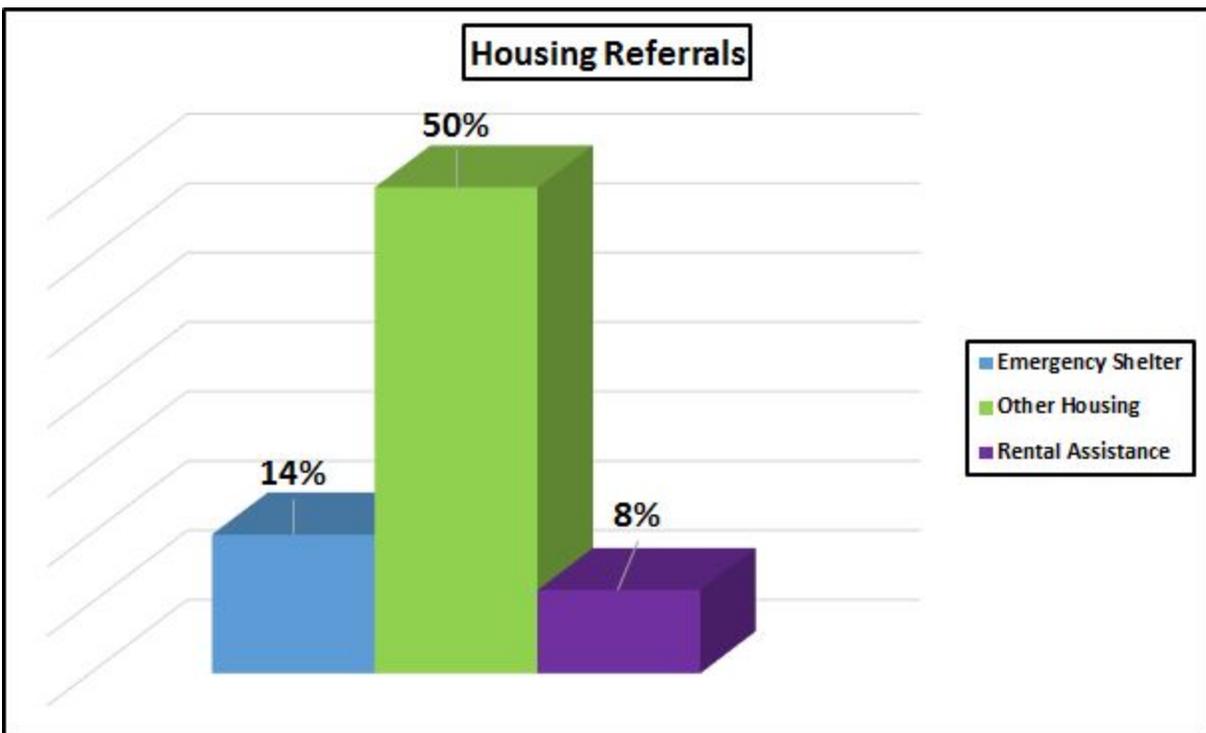
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## Resources Provided

This section will describe the type of services and resources that clients requested. This data was collected from a combination of one-time contacts and intake assessments. Each graph in the sections below show the percentage of the total 143 clients served and who requested referrals for each type of service.

### Results

#### Housing Referrals



As shown in the chart above, among all 143 clients, 14% were seeking emergency shelter referrals, 8% were seeking referrals for rental assistance, and 50% were seeking other housing referrals. In this chart “other housing referrals” refers to transitional housing programs and permanent housing. Some clients requested multiple types of housing referrals, and as such are double-counted in the chart above.

Housing was by far the type of referral most requested by the clients in this program. This highlights housing as an overarching need in the target communities, which may be explained by the unemployment rates, the rising cost of living<sup>9</sup>, and other factors within the served areas.

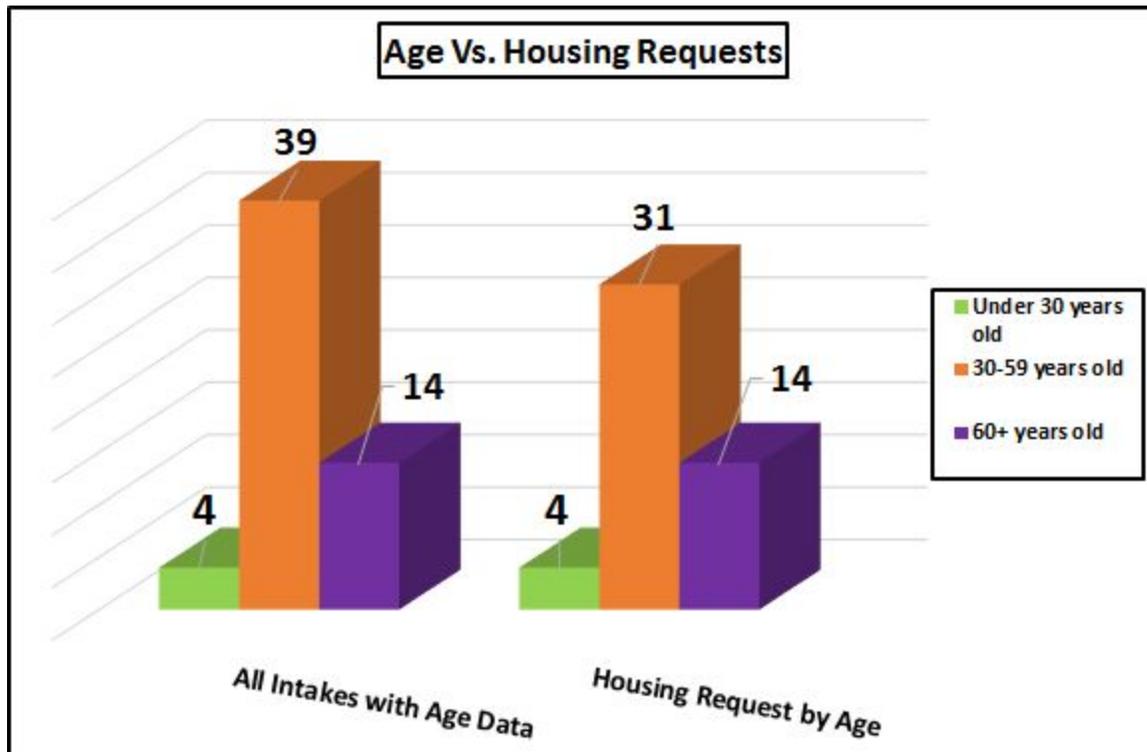
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<sup>9</sup> <http://www.domu.com/blog/crunching-domu%E2%80%99s-data-for-a-look-at-rising-rents-in-chicago>

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## Ages vs. Housing Requests

This section discusses the relationship between the ages of those who were served versus requests for housing referrals.



### **Data Analysis**

Of 63 completed intakes, 57 contained age data, which is represented in the chart above. All participants under the age of 30 and over the age of 60 were seeking housing referrals. Housing referrals in this chart includes emergency shelter referrals as well as transitional and permanent housing.

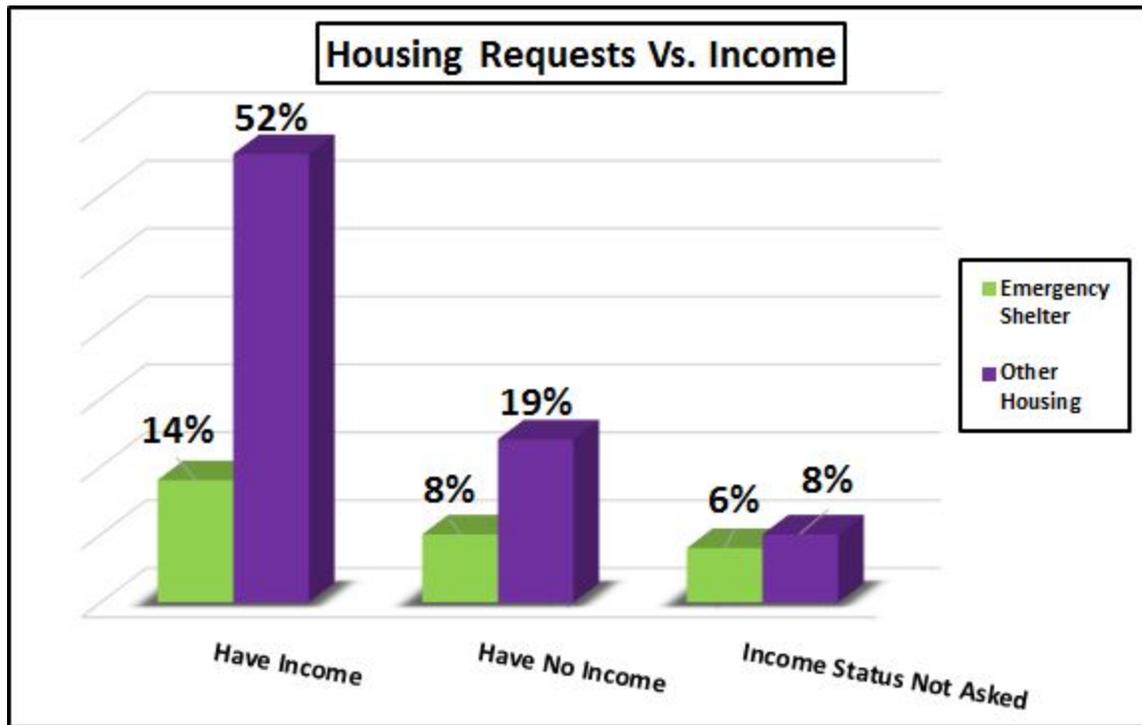
The results show a need for more housing resources for those 60 years old and older. As discussed in the data analysis, all 14 participants over the age of 60 were seeking housing referrals. These results show that housing referrals were one of the most requested resources for the age group. Senior housing is different than other housing, because majority of the programs only require tenants to pay 30% of their income in rent. Senior citizens are on a fixed income and are unable to afford most housing options. However, since the programs are also age restricted, some of the clients that were requesting services, did not qualify for senior housing. The age restriction could relate to why the 31 of 39 clients between the ages of 30 and 59 were requesting housing referrals. Those who are toward the end of the age bracket do not qualify for senior

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housing programs. There are also long waiting lists for most senior housing programs, which could relate to the high requests for senior housing among those over the age of 60.

### Housing Requests vs. Income

#### Data Collected



#### Data Analysis

The chart above shows the percentage of clients who requested emergency shelter and housing services in the 63 intakes, and how that relates with whether they have income. Income in this graph includes employment or other types of income such as SSI, public aid or retirement funds. It is important to note that some of the data in the chart is duplicated because some clients had requested referrals for both emergency shelters and other housing, such as transitional housing and apartments.

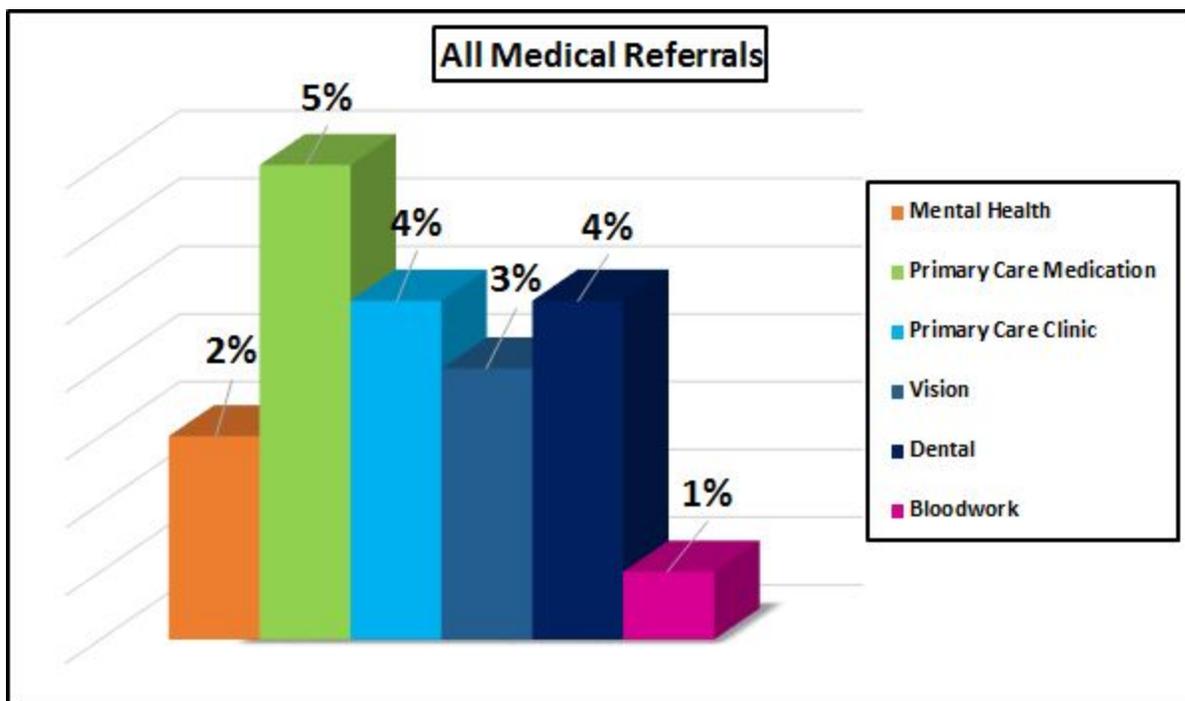
According to the data above, a large portion of clients requested referrals to transitional housing programs and apartments. Most clients with an income who sought housing referrals were asking specifically for these types of housing, however it is relevant to note that 14% of those with an income were looking for emergency shelters. This brings into question the amount of affordable housing that is available in the communities served. One theory is that clients have a significantly low income in comparison to the rising living costs in their communities. As a result, this is

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creating a barrier for clients in regards to affordable housing, leaving them searching for emergency shelter instead.

Furthermore, of those who have no income, only 8% were seeking emergency shelters versus 19% of the participants that were seeking other housing, such as transitional and permanent housing. Most housing programs and apartments require clients to have some type of income, so these clients would likely have not qualified for the type of housing they sought. This data point likely also relates to the data point showing that 18% of clients who were currently without income were seeking employment.

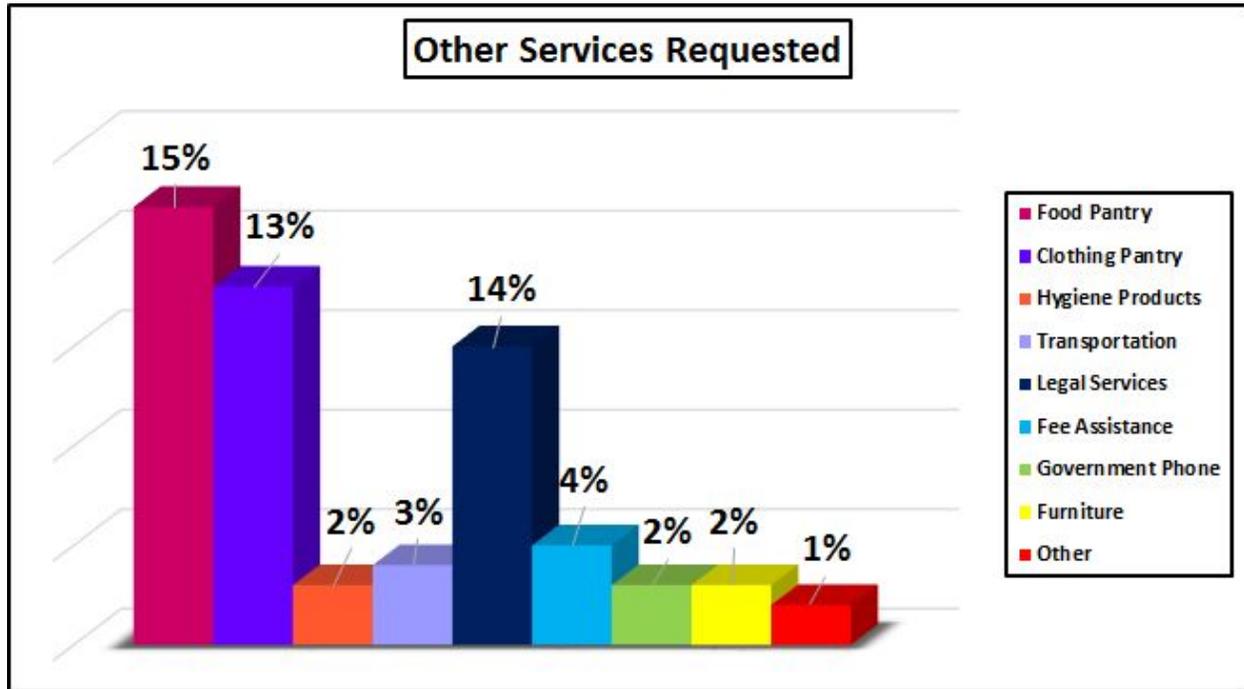
### All Medical Referrals



The number of referral requests for medical services was somewhat low, but still significant. Humboldt Park, Logan Square and Belmont Cragin have an abundance of low-cost and free medical services available at local clinics, schools and churches. Most referrals were for clients who were either unaware of their local clinics, or who were unaware of all the services the clinics offered.

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## Other Services Requested



The chart above shows the referral requests out of 143 total clients, but some clients requested multiple resources and were therefore duplicated. The most common requests were for food and clothing pantries, 15% and 13% respectively. The “fee assistance” category included requests for funeral expenses, children’s school fees and other emergency expenses. The “other” category includes referrals for GED classes and Veteran Resources.

It is interesting to note that clients were requesting food pantry referrals while currently accessing food pantries and free meal sites. This sometimes occurred because food pantries only accept clients who live within certain geographic boundaries, so some of these clients were currently accessing the incorrect food resource and needed a referral to the correct location. These referral requests could also be related to low SNAP enrollment rates and limited available resources at certain pantries, which could lead clients to inquire about additional food resources available.

Many of the other basic needs referral requests were also related to the limited available resources at programs. Many of the programs receive their resources outside of food from donations, and therefore are only able to provide other basic needs such as clothing and transportation assistance as it becomes available to their program. Furthermore, many of the coordinators did not have the time capacity to sit down with every client during programs in order to assess their needs, or did not have the knowledge of all the community resources available.

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## **Program Recommendations**

Once Phase Two of the program was completed, the referral specialist reached out to each site's program coordinators for thoughts on the program and any recommendations if it is to continue in the future. The coordinators unanimously agreed that the program was a high need in their own programs. Without the time availability to sit down with clients or knowledge of the resources available for clients in the community, coordinators felt the Community Referral Program was a success because it was able to provide those services.

### **Structure Recommendation**

In the 2016-2017 referral cycle, some sites did not have a private room available for the referral specialist, which sometimes caused a barrier with noise as it was in the middle of programs and it made it difficult to hear clients during the assessment process. However, in sites where a private room was available, this was sometimes a barrier as well because it prevented other clients from being aware that the services were being offered, which limited the number of clients who accessed referral resources.

In reaction to these barriers, the recommendation for future program structure is that program sites should have a private room, or separate and quiet room, available for the referral specialist to complete assessments. However, two referral specialists should be present at each visit. One specialist would walk around the site to inform clients about the referral program and sign them up for services if requested. The other specialist would complete assessments and give referrals as needed. It is also recommended for the specialist to have information packets on hand to give to clients for the referrals. This allows the client to have immediate access to the resources they need, and allowing more time for follow-ups.

### **Frequency Recommendation**

In the 2016-2017 referral cycle, the referral specialist visited certain sites every week, and certain sites only once per month. Both of these visit frequencies presented barriers. At once-per-week sites, many clients were repeat visitors to the programs, so after some time the specialist lacked new clients to serve. The frequency at once-per-month sites became a barrier as well because the clients would be different each visit, and many times were unaware of the services, even with prior advertisement.

In response to these observations, the recommendation is that referral specialists should visit each program site once every two weeks, for an average of two hours each site. This allows the clients more time to receive referrals and more time to access the resources before following up with the referral specialist. This also allows the referral specialist to see clients on a more

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frequent basis, without risking the issue of seeing the same clients who have already requested the services.

### Coordinator Recommendations

The coordinators also agreed that the structure and frequency of the program should follow the referral specialist's recommendations, as seen on the previous page. The coordinators also recommended the program have a referral specialist that is aware of the community resources. As discussed in the training section on page 6, the referral specialist went through training to research resources available in the community.

It was further recommended by the coordinators to have a referral specialist to not only know the resources but also what other programs the agencies offer. They felt this would help lessen the need for third-party referrals if the agency being visited already offers the needed services.

In conclusion, the final recommendation is to continue the Community Referral Program. As shown with the data provided in this report, the services of community referrals are needed and are requested often in the communities served. If the program is to continue, however, it is recommended to have some alterations to the structure and frequency of the program.