


10.16.2025
Housing Action Illinois
Illinois Office to Prevent & End Homelessness (OPEH)

Agenda

- Introduction
- Illinois Homelessness Response Collaborative
- Illinois Homelessness Mortality and Morbidity Report Year 2
- Hunger Pains Report
- Conclusion

Home Illinois Foundation

2021: Illinois Governor JB Pritzker signed Executive Order to Fight Homelessness

- Creating Illinois Interagency Task Force on Homelessness
- Community Advisory Council on Homelessness
- Chief Homelessness Officer & IL Office to Prevent & End Homelessness
- 2022: First state plan to prevent and end homelessness, Home Illinois, released, covering State FY23-24

July 2023

- HB2831: Home Illinois Bill codifies the executive order that created the Interagency Task Force, Advisory Council and Office
- Home Illinois Program created with initial $200M annual general revenue investment

2024: Second State Home Illinois plan, covering State FY25-26

Who We Are

Vision

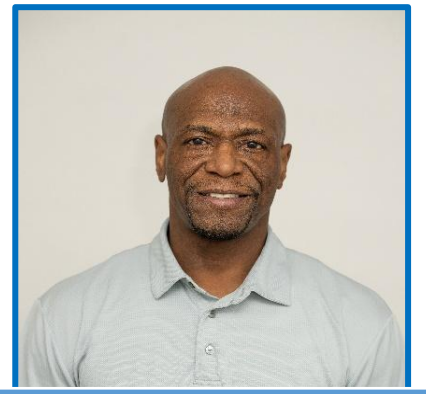
No resident in the State of Illinois lives on the street, in a shelter, or in overcrowded housing. Illinoisians earn a living wage that allows them to afford housing in their community, without fear of eviction. When a housing crisis occurs, safety net supports allow quick resolution to stabilize housing.

Mission

Coordinating State of Illinois agency strategies and investments and partnering with the community to build a strong safety net and permanent housing for Illinoisans facing homelessness and housing insecurity.

Office to Prevent and End Homelessness

OPEH Senior Leadership Team



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OPEH Roles

Drive state investments in scaling solutions to end homelessness

Build state agency and community capacity

Identify policy solutions to homelessness

Incubate program innovations

Advance research and data capacity

Engage community, government and elected officials in partnerships

Staff three legislatively mandated committees

Produce Ending Homelessness Plan and Annual Reporting

Illinois Homelessness Response Collaborative

Illinois Homeless Response Collaborative

- Build a Resilient, Coordinated Homeless Response System
- Demonstrate Outcomes: Invest in and Use Data
- Prevent Homelessness Before It Happens
- Stabilize and Sustain Resources

Goals of the Illinois Homelessness Response Collaborative

Build Resilient, Coordinated Homeless Response Systems

- Invest in system capacity building
- Implement Communities of Practice
- Train and support communities in system improvement

Demonstrate outcomes: Invest in and use data

- Support CoCs in reaching quality data
- Meet benchmarks for statewide quality data reporting
- Understand CoC level goals in ending homelessness for target populations

Prevent Homelessness before it happens.

- Adopt US Interagency Council on Homelessness Prevention Framework to improve coordination and impact of current programs
- Analyze HP, Shelter Diversion and Court Based Rental Assistance utilization data; Visualize data and access to resources

Stabilize and Sustain Resources

- Solidify feedback mechanism between CoCs and State to understand impact of federal shifts in funding/policy
- Counter local criminalization efforts
- Seek strategies and opportunities for PSH preservation; creation of new units of PSH and RRH

OPEH IS:

- Investing funding with the Continuums of Care to increase capacity for system and data work to reduce homelessness.
- Hosting cohort and leadership calls with CoCs and OPEH to advance a coordinated response to shifts at the federal level.
- Creating feedback loops that connect community data to state-level decisions and identify state-level actions to support local goals.
- Managing the technical assistance and coaching network to support IHRC goals

Local Homeless Systems (CoCs) are:

- Build a diverse, inclusive coalition of local stakeholders.
- Set local goals and aim statements to drive progress toward ending homelessness.
- Participate in training, convenings, and technical assistance.
- Prioritize building and maintaining high-quality data systems with metrics that are shared with the state.

Together, we are

- Responding to a changing, uncertain environment with clear communication and partnership.
- Leveraging proven tools to drive results and communicate the success of our collective efforts.
- Driving progress on the goals in Home Illinois: Illinois' Plan to Prevent and End Homelessness and move closer to our vision for Illinois.

Illinois Homelessness Mortality & Morbidity Report 2017-2023

State Collaboration and Innovation

- In 2023, IDPH was tasked with creating the first Homelessness Mortality and Morbidity Report for Illinois
- Intergovernmental collaboration between academic and governmental partners
  - Illinois Department of Public Health
  - University of Illinois Chicago School of Public Health and the Institute for Healthcare Delivery Design
  - Illinois Office to Prevent and End Homelessness
- Draws on a long history of local and community groups doing homeless mortality reporting as a systems change tool
- New Report to be released this month, October 2025.

2nd Report New & Expanded Elements

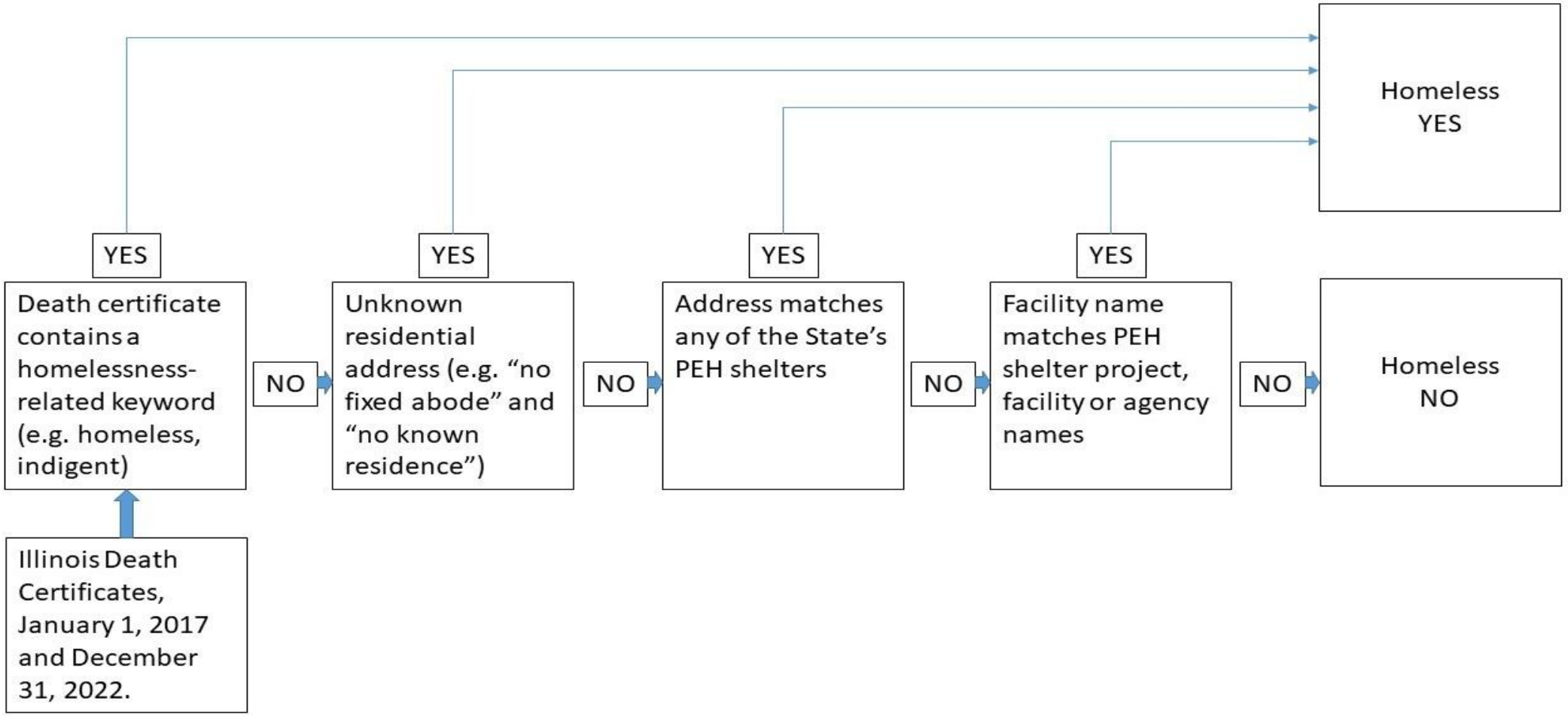
This report includes new elements developed with input from the community, including:

- all deaths and hospital visits of PEH during the year 2023;
- a more detailed description of children, teens and youth experiencing homelessness;
- a more detailed description of hospital visits involving severe mental illness;
- risk of drug-related overdose and drug treatment provided;
- a more detailed analysis of non-fatal and fatal cold-related injuries;
- deaths occurring on public transportation;
- an evaluation of changes in contributing causes of death to attempt to explain trend in deaths observed over the past seven years.

NEW: CoC fact sheets will be available online soon and are intended as a local advocacy tool!

Mortality Key Findings

Inclusion Criteria: Death Records



Case Identification

2996 deaths were identified between 2017-2023

	Statewide (N=2,996)
Homeless Keywords[1]	314 (10.5%)
No Known Residential Address[2]	1284 (42.9%)
Shelter Street Address Match[3]	1464 (48.9%)
Shelter Name Keyword Match[4]	56 (1.9%)

Demographics

- Average age at time of death was **almost 20 years younger** among PEH compared to the general IL population
  - **55.5 years vs 74.2 years old**
- Despite non-Hispanic Whites comprising the largest proportion of PEH decedents, the proportion of PEH who were **non-Hispanic Black was more than double the proportion** observed in the general population
  - non-Hispanic White, 46.7% vs. 74.2%
  - **non-Hispanic Black, 40.0% vs. 16.9%**
- **10.4% (313)** of PEH decedents were identified as veterans on their death records
- Additionally, **30 decedents** had been employed in public sector jobs, of which seven were former police officers, two were paramedics, and one was a correctional officer.

Geographic Information

- **Nearly all** the decedents died in urban counties (n=2,840; 94.8% of all PEH decedents).
  - **83.6%** died in the DPH region which covers the greater Chicago metropolitan area
  - **59.9%** in the city of Chicago
  - By comparison, only **60.8% of general population** decedents died within the greater Chicago metropolitan area.
- There were **156 PEH (5.2% of all PEH decedents)** who died in rural counties.
  - Disproportionately female
  - Older
  - Died from chronic health conditions or traumatic injury
  - Less likely to die due to drug related overdoses

Place of Death

- Among PEH decedents,
  - **42.2%** died at a hospital
  - **24.7%** in an emergency shelter, hotel, motel, temporary residence or transitional housing
  - **19.6%** in the outdoors and other informal settings (any outdoor setting, vehicle, public buildings, abandoned buildings)
- By comparison, in the general population
  - **0.1%** died in a hotel, motel or temporary residence
  - **0.6%** died outdoors or in other informal settings

Notable Death Data

- There was a **marked increase** in the number of public transportation deaths in 2022 and 2023.
- **89 deaths** occurring on public transportation, most of which occurred on trains or in train stations.
- The trend in deaths of PEH **increased significantly** from 2017 to January of 2022 but began to **significantly decline** since May 2022.
- However, there was a **surge** in PEH deaths at the end of 2023, starting in November. It is unclear if the surge in deaths has persisted into 2024.
- Overall PEH mortality is **still above baseline levels** from prior to the COVID-19 pandemic.

Notable Death Data

- There was almost three times the proportion of PEH that were murdered compared to the general population **(3.1% vs 1.1%)**.
- Compared to all PEH deaths,
  - PEH who were murdered were disproportionately **44 years or younger**
  - **and non-Hispanic Black.**
- There were **56 suicides and 19,651 suicide attempts** involving PEH over seven years.
  - The proportion of deaths attributed to suicide is **marginally higher** than what was identified in the general population.

Contributing Cause of Death

- Coinciding with the younger age of death, a lower proportion of PEH died from chronic health conditions associated with the aging process, such as diseases of the circulatory, respiratory, and nervous systems, or cancer.
- However, compared to the general population, PEH disproportionately died from
  - drug-related overdoses **(39.3% vs 4.9%)**,
  - traumatic injuries **(11.3% vs 5.6%)**,
  - and excessive cold **(3.7% vs 0.1%)**.

Weather Related Death or Injury

- **112 PEH** had cold exposure identified as a contributing cause of death with an additional **6,930 cold injuries** treated in the hospital setting.
- The findings demonstrate that a proportion of cold injuries occurred at temperatures when many municipalities **do not have** expanded emergency shelter services for extreme cold weather (typically below 32°F).

Morbidity Key Findings

People Identified

- The **1,820,004 ED visits and hospital admissions** involved **75,145 unique persons** with a median of 14 hospital visits per person over 7 years (2017-2023)
- Only **12.0% (219,234)** of the visits coded with Z59 (the ICD-10 code for homelessness).
- Nearly all PEH **(93.6%)** in the hospital dataset visited an Illinois hospital **more than once** between 2017-2023
- **25% of PEH had 29 or more visits** over the seven years, comprising **66.3%** of total hospital visits
- **One person** had **1,470** hospital visits over the seven years

Morbidity Key Findings

- High utilizers of medical care in the hospital setting were disproportionately diagnosed with an array of **serious chronic cardiovascular, respiratory, neurologic, and renal disorders**.
  - Chronic conditions are exacerbated during periods of homelessness because of inadequate access to medical care necessary to manage these chronic conditions.
- The **most common comorbidities** noted for PEH hospital patients included **hypertension, chronic pulmonary disease, substance use disorders, psychoses, and depression.**
- There were **29,483 hospital visits to treat PEH for injuries** caused by assaults.

Injuries

- Most commonly **poisoning, falls, assault/homicide, temperature-related, and transportation-related** (pedestrian or bicyclist struck by motor vehicle)
- **37,208 visits from assaults** (more common in ED visits)
- **19,002 visits from suicide attempts** (more common in admissions)

Morbidity Findings

- The majority of PEH were discharged to home or self-care.
  - For PEH, this may be a discharge to a shelter or the streets, which may result in difficulty accessing continued care or treatment, as amenities available to adequately control chronic health conditions may not be available in these settings.
- The demographics and health issues in hospital cases are nearly identical to the decedents.
- PEH seeking hospital-based medical care and those who died were:
  - **predominantly middle-aged** (mean age 45 years during hospital visits and 56 at time of death),
  - **male, non-Hispanic White, and non-Hispanic Black**.

Demographics By Visit

66.0% of visits were for males

- Males also had a higher proportion of visits with the Z59 code (~74%)

Visits were predominantly for adults, aged 25-64 (83.8%)

- 26,450 visits for children under 18 years old (1.5%)
- 141,320 visits for youth aged 18-24 (7.7%)
- 126,924 for ages 65+ (7.0%)

96.0% of visits for IL residents

8.4% of visits designated as self-pay (no insurance coverage)

Demographics by visit

Majority non-Hispanic whites (41.7%) & Black/African Americans (44.1%), but the proportion varied by visit type and coding status

non-Hispanic whites accounted for 43.0% (versus 38.2%) of admissions coded with Z59

Black/African Americans accounted for 51.5% (versus 35.7%) of ED visits coded with Z59

Rates at which Black or African American Illinoisans experience homelessness, as well as rates of hospital visits by Black or African American PEH found in this study, are vastly disproportionate to their share of the Illinois population

Primary Diagnosis - Comorbidities

Top primary diagnosis	Other common primary diagnoses	The top six categories of comorbidities across visit groups include diagnoses related to
• Admissions: Mental Disorders • ED: Symptoms (non-specific)	• Substance Use Disorder • Musculoskeletal & Connective Tissue Disorders • Disorders of the Respiratory System • Disorders of the Circulatory System	• Substance Use • Hypertension • Alcohol use • Psychoses • Chronic Pulmonary Disease • Depression

Substances

Substance use disorders consistently appear as a top primary diagnosis, comorbidity, & cause of injury in the overall analysis

- Over half of visits (50.6%) note the patient suffered from SUD
- 11.3% are coded for intoxication at the time of the hospital visit
- The most common agents cited are nicotine, alcohol, stimulants, and opioids

This is far less common in visits for children, youth, & pregnant persons

- SUD: 25.4% visits for pregnant persons; 11.2% for children; 41.8% for youth
- Intoxication: 1.1% visits for pregnant persons; 1.4% for children; 5.1% for youth

IHMMR Goals, Recommendations & Response

Acknowledgement

- **Early access** to general health and psychiatric services, as well as housing programs, has been shown to be associated with **reduced morbidity and mortality** in people experiencing homelessness.
- **Improved surveillance data** of mortality and health care utilization patterns of PEH can **inform policies** that address unstable housing or homelessness, reemployment and healthy work, and the health care needs of PEH.

Report Top Lines

55.5 v 74.2
age of death

39.3% v 4.9%
Overdose
Cause of Death

38X more likely to die from cold exposure

3x more likely to die by homicide

Over 19,000 ED visits for suicide attempts

$22.3B in Healthcare billing

Goals for Enhancing the Annual Report

Link	Collaborate	Assess	Develop
Link hospital records with death records • Increase the number of PEH identified in the death records • Allow to assess the relationship between history of homelessness and mortality	Collaborate with CoCs to share and link HMIS data with vital records and hospital data • Improve denominator data • Allow to evaluate the relationship with homelessness, housing services, and health outcomes	Assess the impact of policies, such as city and county ordinances banning encampments, on mortality and morbidity	Develop an online dashboard to allow for more interactive and customized reports

Report Recommendations: Increase Data & Provider Engagement

Enhance	Integrate	Evaluate	Conduct	Explore	Develop
Work to enhance the identification and documentation of individuals experiencing homelessness within healthcare settings.	Integrate broader data sources to enrich understanding of homelessness demographics and service utilization.	Evaluate the feasibility of establishing a mortality review board for individuals experiencing homelessness.	Conduct a statewide warming center access assessment.	Explore opportunities to gather housing status at death.	Develop and implement a provider engagement strategy.

State Strategies to Support the Health of PEH

Increasing Medical Respite

Increasing Health Focused PSH

Creating New Funding Mechanisms through Medicaid 1115 Waiver

Launched SUD Focused Street Outreach Program

Hired OPEH Senior Policy Advisors at Medicaid & Public Health Agencies

Food Access fo Unhoused Individuals in IL

Research by the Institute for Research on Race and Public Policy (IRRPP) at the University of Illinois Chicago

In partnership with the Illinois Office to Prevent and End Homelessness

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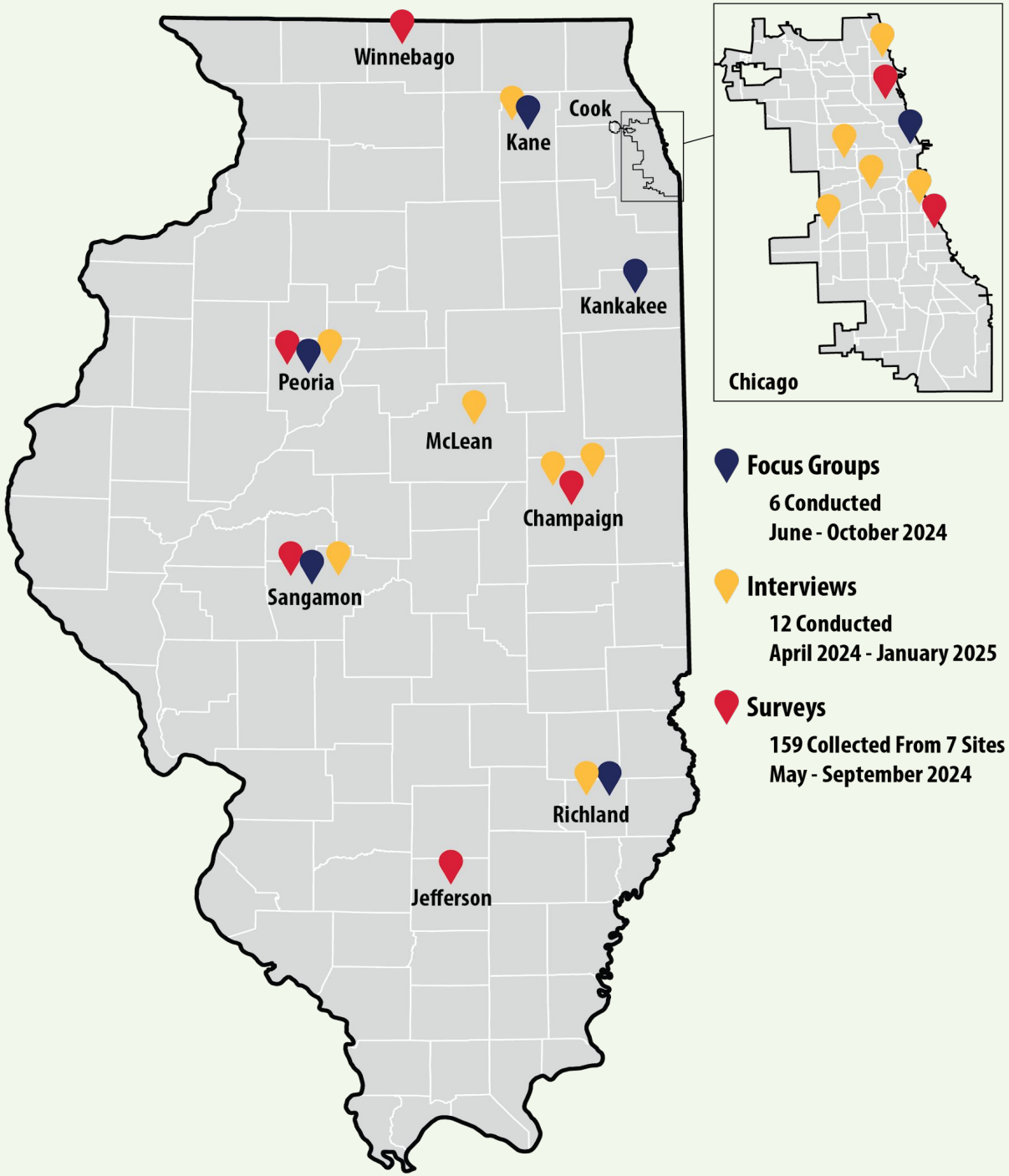
Research Questions

1. Where, and how, do unhoused individuals in Illinois get their food?
2. What barriers to unhoused individuals in Illinois face when accessing food?
3. What can service providers in Illinois do to provide unhoused individuals with a sense of dignity and belonging while they access food?
4. How can the state better support the unhoused population in Illinois, specifically around food access?

Methodology



Data Collection Sites

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Unhoused Individuals' Food Access Experiences

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Relying on Social Networks for Information Sharing

"I'm thankful for people that would tell you, 'Hey there's a soup kitchen this way,' or you know, they show you other things to go and get your food. And if it wasn't for that, then, I mean, then I wouldn't know about it."

"That's the good thing that I found out, when I was here — that everybody knows like somewhere different."

Developing Networks of Care

“**INTERVIEWER**: [Notices Edith looking ill] You ok, Edith?

SERENITY: Edith’s sugar is acting up. Yep.

INTERVIEWER: Is there anything —

EDITH: Where are my sensors?

SERENITY: Where’s your insulin? Check your sugar. She just had that whole bread sandwich. Ain’t no telling what she ate this morning when she got up.

OLIVIA: You alright? I noticed, I just seen you, cause you — because your mouth was dry. So, I knew something was about to go down.

SERENITY: You can always tell.

PAM: Want some water?”

Dignity in Food Practices

Taste, quality, and content of food can act as a signal of care

The way that food is prepared and served can promote autonomy and foster dignity

Structural barriers limit providers' ability to fully honor the needs, preferences, and autonomy of those they serve

Expressing Care through Food Practices

"JABARI: You actually can taste the difference in the food when it's cooked — just cooked and not cooked from the heart...

KARLA: That's true.

JABARI: When it's gave to you [and] it ain't gave from the heart, it taste — it's a different taste to it. You might get full but you won't enjoy it.

ISAIAH: You definitely won't enjoy it [...]. I ate. I'm full, but I'm not happy."

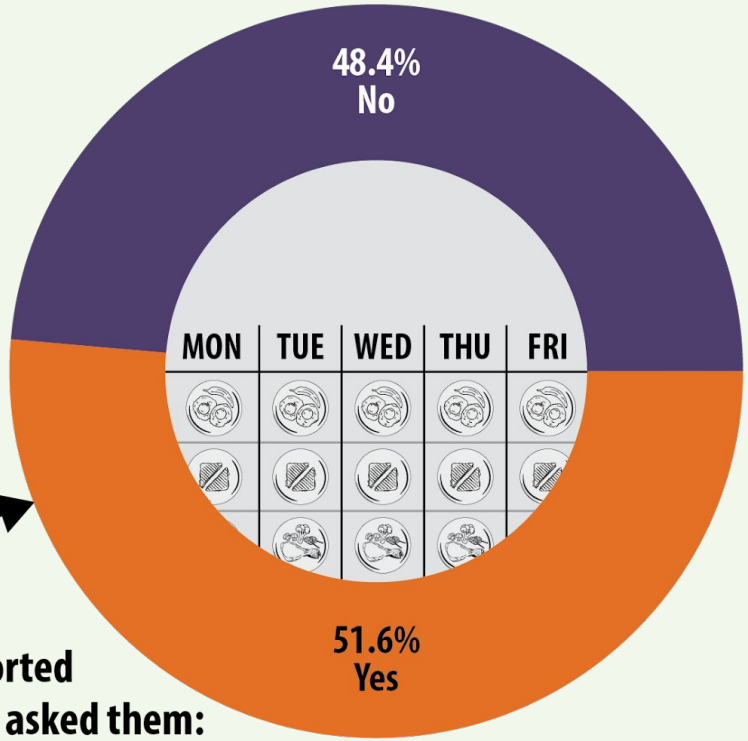
SNAP Experiences

- The application process as complicated and bureaucratic, making knowledge of the system and help from others very important
- Most unhoused people in Illinois feel that they do not get enough benefits
- The proportion of survey respondents receiving SNAP benefits was similar between sheltered vs. unsheltered respondents, but sheltered folks have access to more SNAP application support

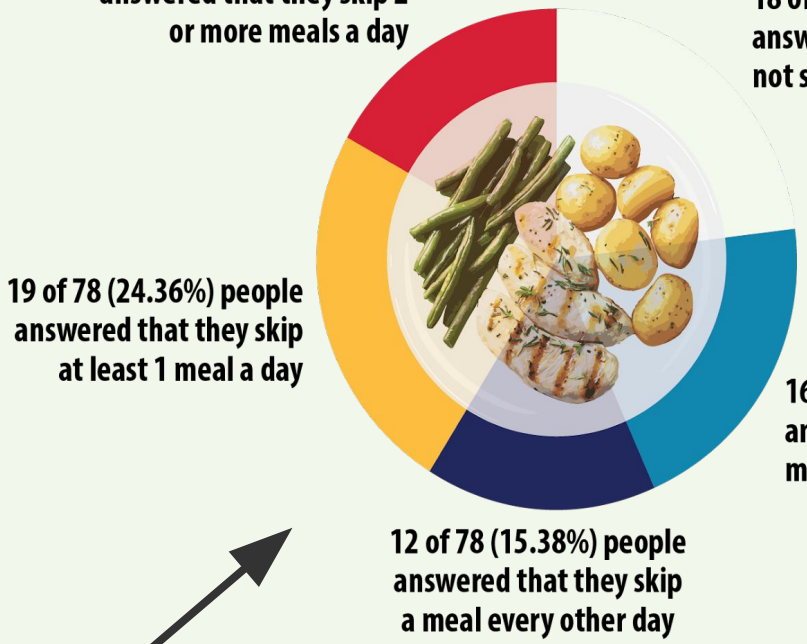
Food Access Barriers

Meals Skipped in an Average Week

Survey respondents were asked "Was there a time in the past month when you needed food but were not able to access it for any reason. 80 respondents (51.6%, n=155) answered "yes."



To learn more about the 80* unhoused individuals who reported having food access barriers, we asked them: "In an average week, how many meals do you skip because you do not have access to food?" Their responses are captured below.



*While 80 respondents were asked this question, only 78 provided an answer.

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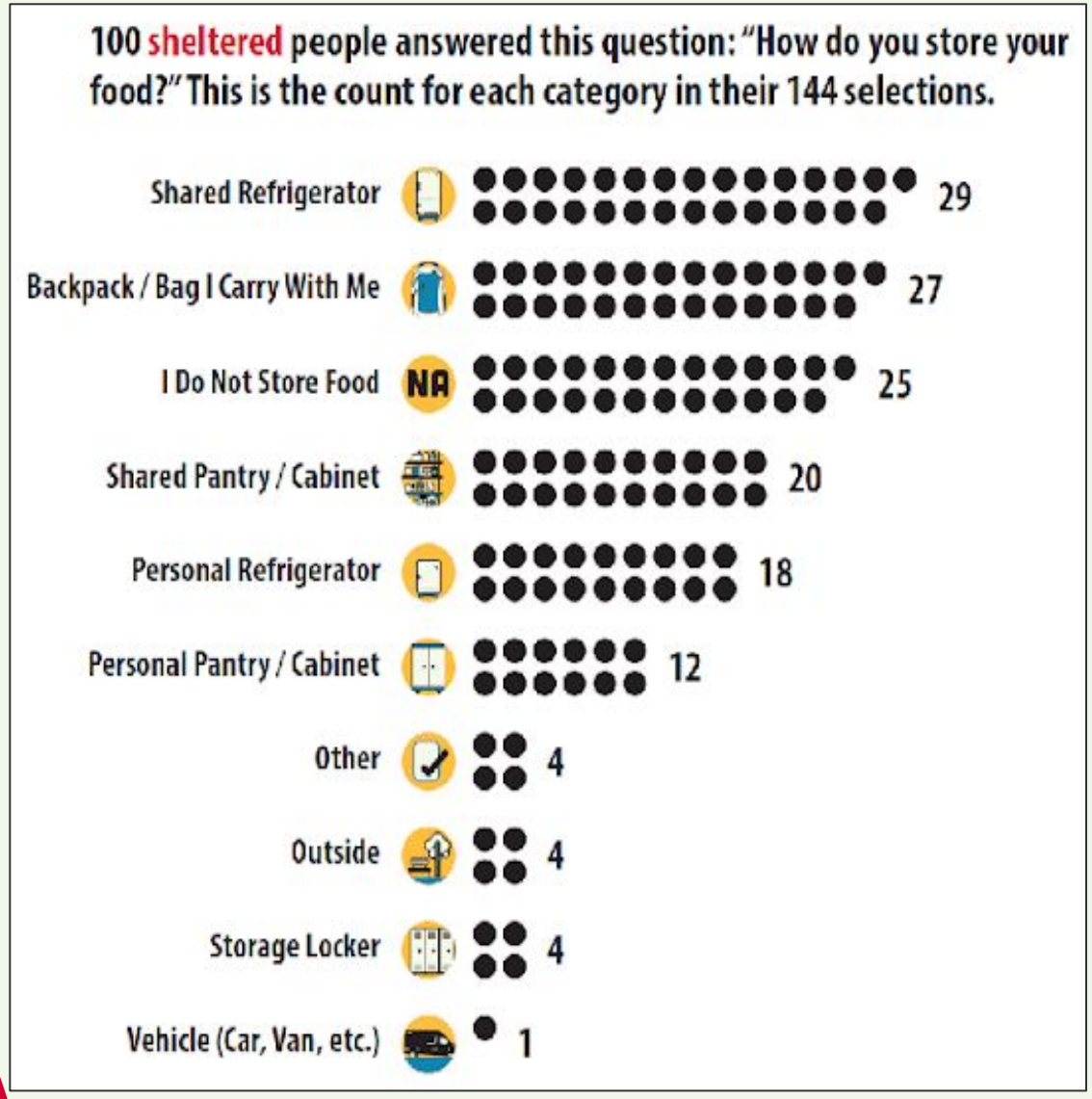
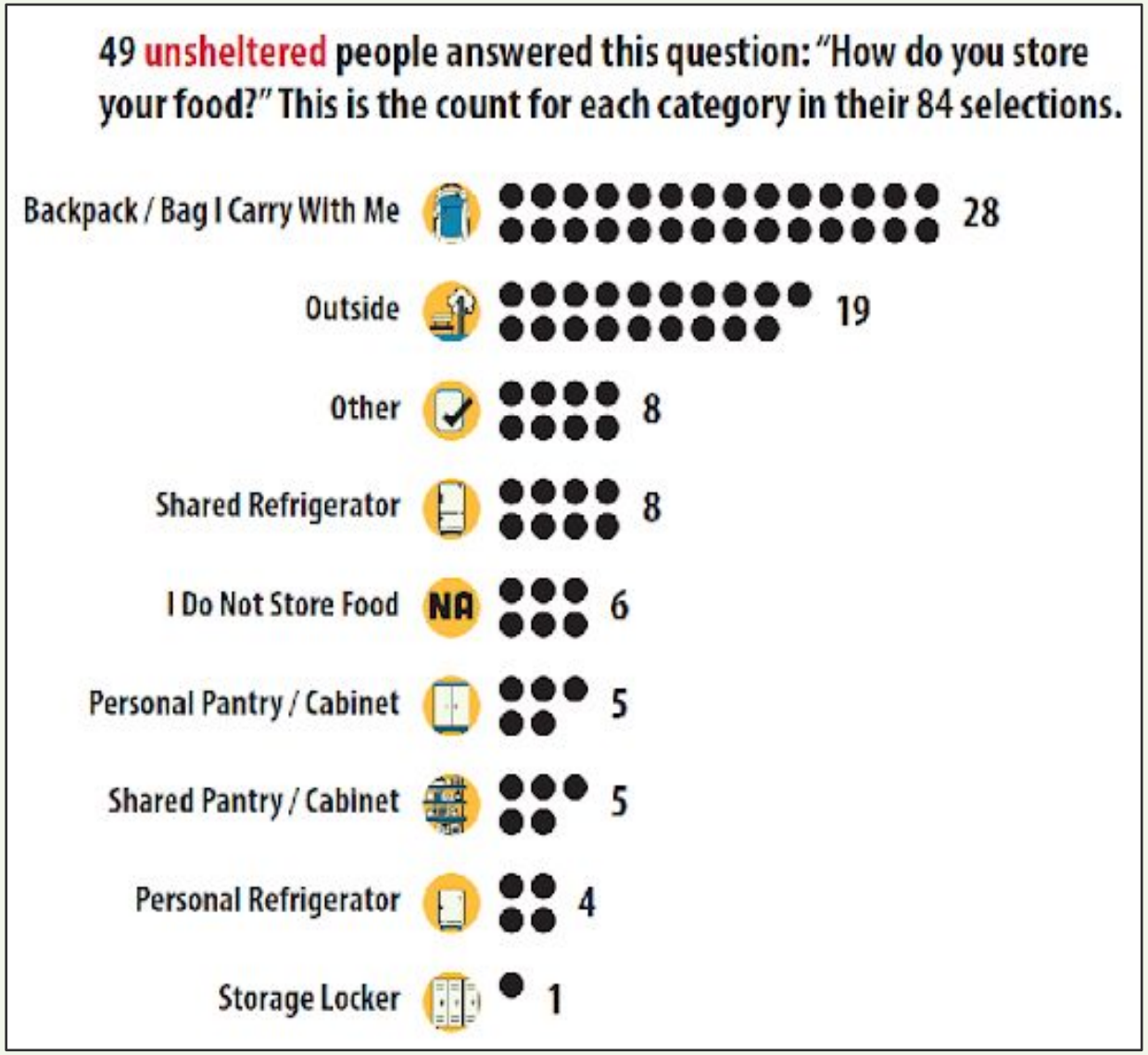
Food Storage and Tools

- Access to tools and storage impacts participant autonomy
- Shelter rules often restrict food tools and storage options due to cleanliness and storage space concerns or limitations
- Navigating food tools and storage barriers can be especially difficult for unsheltered individuals
  - 72.3% of ***sheltered*** individuals had access to a microwave versus 49% of ***unsheltered*** individuals
  - For refrigerators, 44.6% of ***sheltered*** individuals versus 22.4% of ***unsheltered*** individuals

Food Storage Methods of the Sheltered & Unsheltered





Food Service Rules and Disparate Experiences

- Rules related to food access, including mealtimes and distribution procedures, frequently create inequality and stratified experiences
- Limited operating hours create challenges for unhoused individuals, disrupting their ability to meet basic nutritional needs
- Working individuals face particularly acute challenges
- Some rules seemed arbitrary or discriminatory while others were unequally enforced or altered without notifying residents

Restrictive Rules as a Barrier for Employed Individuals

"I was working at a place and I wasn't able to eat while I was there, you know, and I'd like feel weaker and stuff like that. So like, I kinda wish there was a program here for people that only worked while they're getting like their first paychecks. If they could hook us up with lunch [...] because that's kinda like a hard hurdle to cross."

"Work schedule, sometime, conflict because I'm typically not off work until 1 in the afternoon, and I'm not making it back to the facility 'til, like, 1:30, 1:45. So, by then, breakfast and lunch has been served. And, if staff hasn't put aside any late plates, you know, I don't get any food."

Other Barriers to Food Access

- Transportation and weather challenges can significantly limit individuals' ability to receive consistent, nutritious meals, especially for those with disabilities
- Unhoused folks often have difficulty maintaining their health and managing their specific dietary needs due to lack of autonomy
  - This leaves many to make the difficult choice between risking their health or going hungry
- The stress and potential danger associated with accessing food in certain places forced individuals to choose between their emotional/physical well-being and accessing their next meal
  - Especially for women and those without a reliable support system

Safety Concerns Restrict Food Access

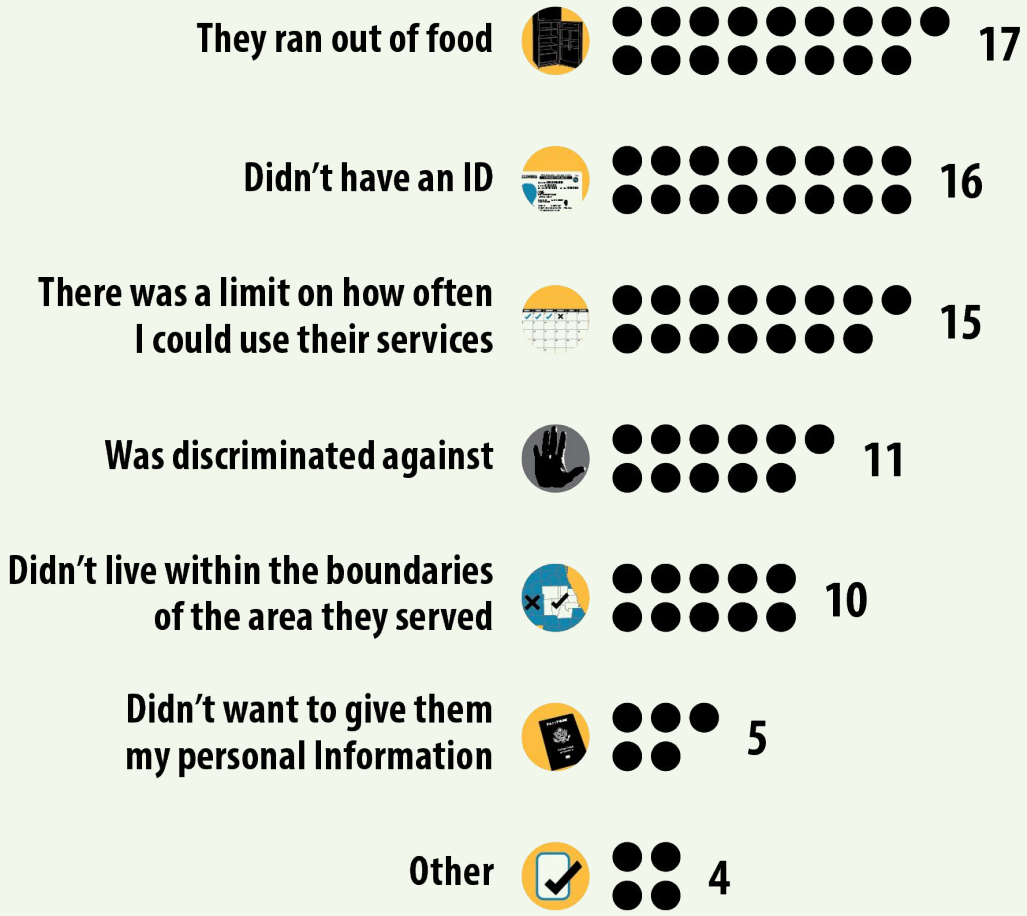
"It's just — it's crazy, it's like a — almost like a zoo, you know. Everybody's off, their defenses are up so high because of the situations that they're already in, and I just walk past. You know, I'd be like all right, it's not worth eating today, so then just go. 'Cause I'm not trying to get jumped over food or making a look at some guy, or maybe I looked at somebody for too long, you know."

"There's couple guys that had something stupid to say. As soon as I walked up, you know, and it's just […] it puts you out of the mindset of like getting out here. It puts you into like a crazy survival mode."

Service Providers

REASONS SURVEY RESPONDENTS WERE TURNED AWAY FROM A FOOD SERVICE PROVIDER

40 people responded to this prompt: "Select all of the reasons you've been turned away from a food service provider." This is the count for each category in their 78 selections.



Service Provider Barriers

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Food Supply Challenges

"They ran out of food" was most common reason respondents were turned away from food service provider

Donation-dependent model characterized by:

- Limited choice
- Questionable food quality
- Nutritional compromise
- Unpredictability in quality, amount, timing, nutritional value, etc.

Examples of Food Supply Challenges

"We get a lot of the canned vegetables that they don't want. We get a lot of starchy pastas [...]. If you're diabetic and you shouldn't be having starches, you know, that doesn't help. And we rarely get meat or frozen foods. And so folks get frustrated that they don't have meat to actually get protein and to be able to have a more rounded meal."

"We aren't always necessarily guaranteed to have certain foods. So our menu making has to be based off of what we might get on the truck that week [...]. If we got 200 cans of salmon, now we are looking up recipes with salmon."

ID & Documentation Requirements

- Of the service providers with whom we spoke, none required individuals to provide physical documentation in order to receive food services
- The Emergency Food Assistance Program (TEFAP), a USDA program that provides funding to all regional food banks in IL, allows flexibility in verifying the identity of someone seeking services
- So service providers who turned away service seekers for lack of ID were likely private providers that:
  - Have ID requirements that do not align with state or federal rules governing food distribution OR
  - Are unaware of the flexible documentation requirements as put forth by IDHS and the USDA

Resource Limitations

"Unfortunately, we're at capacity often. So, we do need to turn some young people away, which is devastating."

"If we receive donations or grants specifically meant for our meal service, we just can't give it out. As much as I have a giant stockpile of pinto beans downstairs, I could have ten million, and because they're not specifically allotted to go out to people who need it, we can't give it out, which, you know, it sucks."

Personnel Constraints & an Unsustainable Workforce

Many service providers reported a lack of workforce sustainability characterized by:

- Underpaid staff
- High turnover rates
- Heavy reliance on volunteer labor

“Sometimes, the groups call off, and they don’t come in […]. So then they put together some leftovers, and they pretty much give it to us. So, in the winter — and it doesn’t have to be the winter. It can happen right now, you know […]— You expect a group to come, and they might call off. And then they give us either sack lunches or somethin’ they just put together for us to have.”

Service Providers' Negative Treatment of Service Seekers

"Sometimes it feels like they come across on you in a disrespectful way […]. I mean look at how you're talking to us. We ain't dogs. We're human like you are."

"I don't want nothin' that you don't wanna give me. […] If I'm in a situation where I'm hungry and I need food and I have to come here to eat, and y'all acting like you don't wanna feed me, cool — don't, you know what I'm saying? I'll go somewhere else, I'll figure somethin' else out. I don't ever wanna really come to mentally think that I'm a burden.

Service Providers' Positive Treatment of Service Seekers

- On the flip side, many unhoused individuals spoke positively of staff interactions
- When asked if the staff at their primary food provider treats them with dignity and respect, the top two responses among survey respondents were "Strongly Agree," (37.2%) and "Agree" (29%).

"Before I got in this situation, I ignored a lot of those stuff," Jabari said in reference to receiving a service that made him feel respected, "but it means so much now. You know, like you said, a smile here, a thank you, this and that — and that is priceless."

Innovative Approaches to Navigating Food Access Barriers

- Bartering food with other providers
- Delivering food to clients
- Tailoring services to the needs of a specific population (recognition of context and cultural factors)
- Shopping style pantries to promote client autonomy
- Providing opportunities for clients to provide feedback
- Prioritizing dignity in meal experiences through radical hospitality

Policy Recommendations

1) Expand Infrastructure for Food Storage and Distribution
2) Leverage the 1115 Demonstration Health-Related Social Needs (HRSN) Infrastructure
3) Advocate for Food Waste Diversion and Recovery Programs
4) Expand SNAP Access and Flexibility
5) Ensure Oversight and Accountability for Food Service Providers
6) Increase Awareness of Food Assistance Programs
7) Expand Access to Basic Utilities
8) Maximize Existing Federal Funding Opportunities
9) Strengthen Local Food Systems
10) Enhance Food Access Initiatives within State-Funded Outreach Programs

Upcoming opportunities to connect with us

Low barrier shelter listening sessions

Please join OPEH and the Illinois Department of Human Services Office of Housing Stability for a listening session on shelters in our State. We want to hear your thoughts about:

- What are the strengths and challenges of our current shelter system?
- What is needed to strengthen our shelter system?
- What is needed to make our shelters accessible to Illinoisans with barriers to shelter, such as but not limited to active serious mental illness, substance use disorder, pets, storage needs, and couples?

Seven identical listening sessions are being held throughout the state to gather community feedback. Remaining sessions:

- 10/29, 2-3 pm, Virtual Session (Webex)
- 10/30, 10-11 am, Virtual Session (Webex)

State of Illinois - Shelter Community Listening Session Registration

Shifting federal landscape

- The State of Illinois remains committed to solutions to prevent and end homelessness rooted in dignity, housing, and care, not punishment. We understand that homelessness is a housing systems problem and are committed to data-driven best practices including housing first and harm reduction. We will continue to monitor federal developments and work with state and local partners to promote a homelessness response system focused on safety, dignity, and long-term solutions.
- We want to hear from you. Please let us know of any federal changes affecting your organization, such as changes to grant terms, incentives, or any other requirements, by emailing us at homeless.office@illinois.gov.
- For Continuum of Care leads, continue to stay engaged in the Illinois Homelessness Response Collaborative to support coordination as the federal environment shifts.
- SNAP changes including work requirement rule changes are coming as a result of federal H.R. 1. See “SNAP Rules are Changing” and other guidance here: dhs.state.il.us/?item=174038.
- Input opportunities to shape the next Home Illinois Plan (FY 27-28) are coming up this fall and winter. Sign up for our newsletter to stay connected.

Thank you

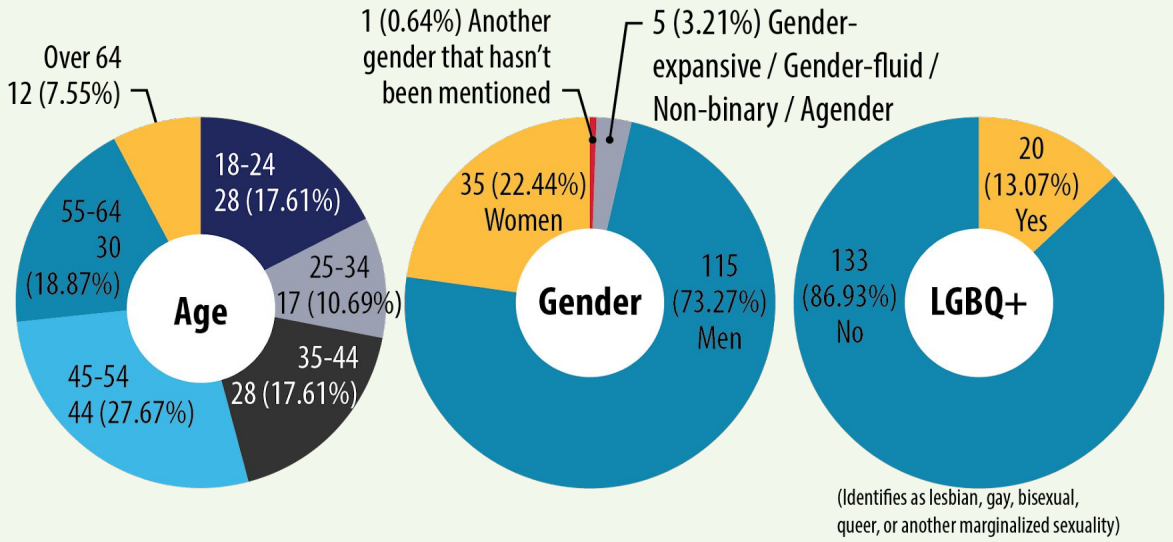
Stay in touch at:

- Email us at homeless.office@illinois.gov
- Visit us at Endhomelessness.illinois.gov
- Sign up for our newsletter at https://mailchi.mp/illinois/opeh-comms-signup

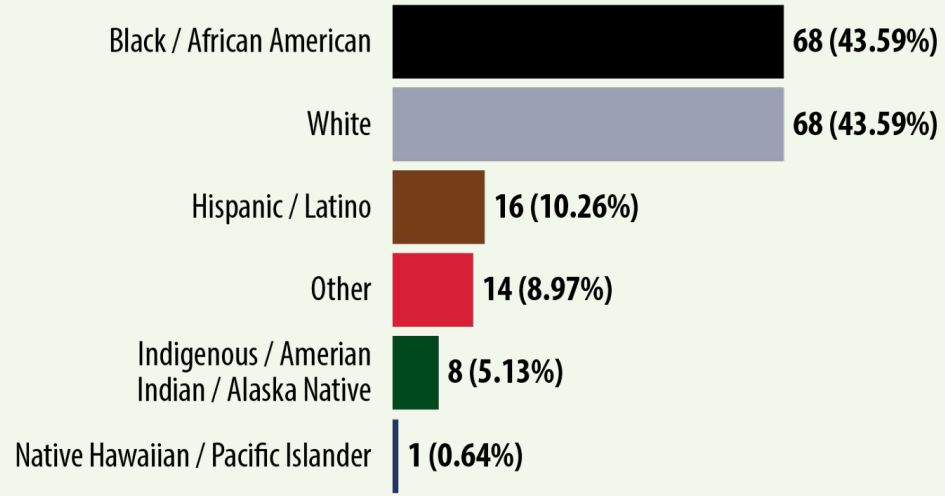
Q&A

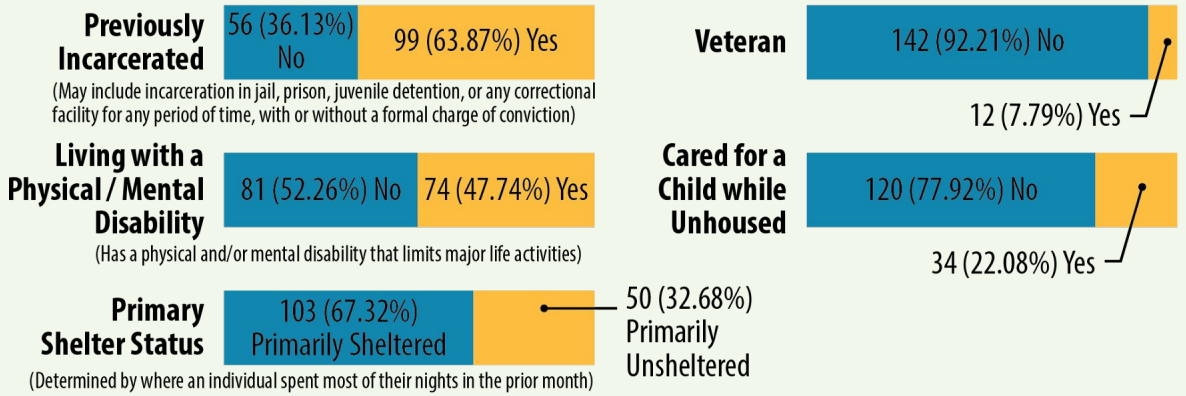
Appendix

Demographics: Survey



156 people gave 175 responses to identify their race. The prevalence of their responses is reported below.





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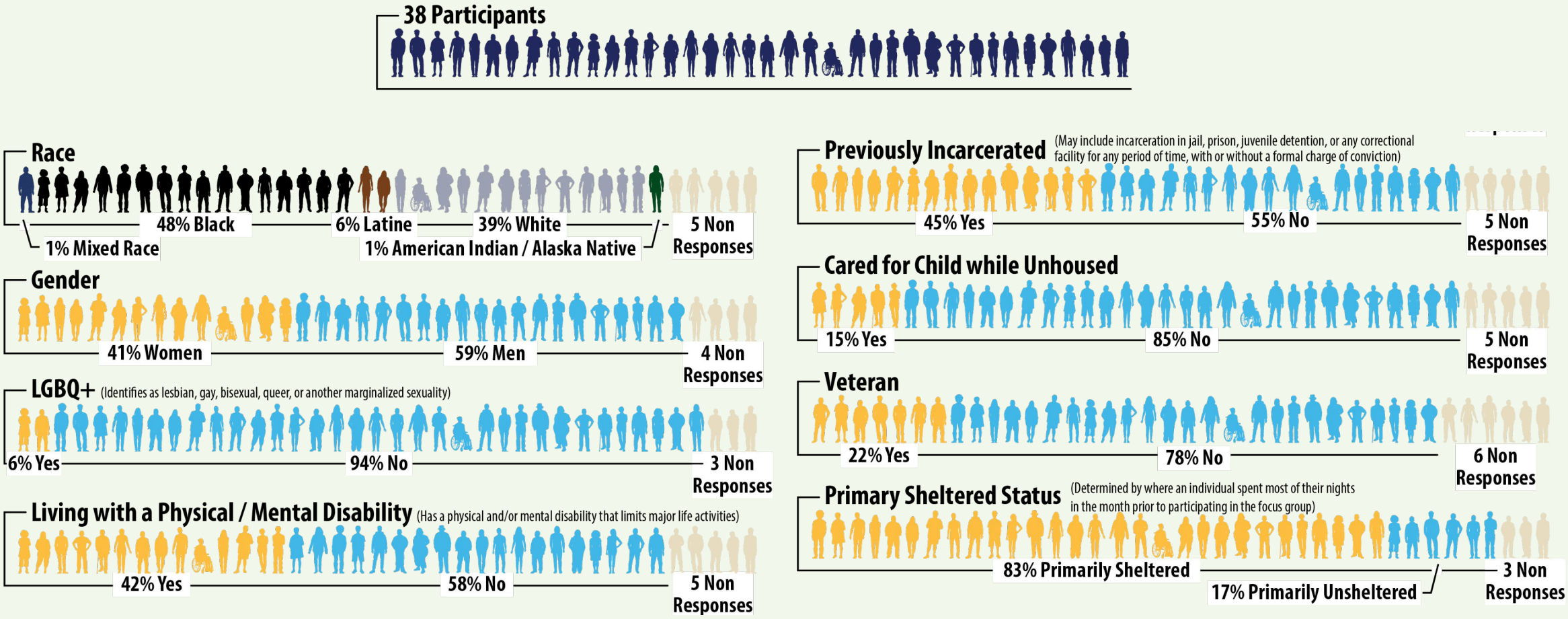
Demographics: Focus Groups



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Food Storage Rules Limit Autonomy

"I mean it costs more cash too though, 'cause like, we can't store food, so you can't buy in bulk, so you can't spend wisely, it's — it makes it a longer process to get outta here because of that, you know. It's actually annoying to have to eat every day."

"Yeah, you carry food from [the grocery store] and you get here and you gotta dump it, you know, no matter how much you got."

Health Conditions Restrict Food Access

"Mostly, I go to [a local soup kitchen] to eat breakfast sometimes in the mornin'. Because I'm a diabetic, and where I live at, they don't really too much serve diabetic food and everything. But some meals at [the shelter] is perfect. Some is just — it — hey, I don't eat it [laughter], to make a long story short. But it seem like they have good intention to feed you the right way and everything. But certain people just can't eat some of the things, like myself."