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SPRINGFIELD/GREENE, CHRISTIAN AND WEBSTER COUNTIES CONTINUUM OF CARE

Beyond the Myths

Part Two:

Older Adults and Homelessness in the Ozarks—Aging in Community Requires More Than a Roof

Springfield/Greene, Christian,
and Webster counties
Continuum of Care

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PART TWO:
Older Adults and Homelessness in the Ozarks—Aging in Community Requires More Than a Roof

The Promise of Aging Safely

A COMMUNITY'S COMMITMENT TO OLDER RESIDENTS is tested not only by the services available after a crisis, but also by whether those residents can maintain a secure home before a crisis occurs. Aging safely requires more than simply surviving another cold winter or reaching another birthday. It requires a place to sleep without fear of displacement, to store medication, to recover from illness, to receive visitors, and to maintain ordinary routines. For an older adult, housing is also the setting in which independence becomes possible by providing a bathroom that can be used safely, a kitchen that supports adequate nutrition, and an address through which benefits and services remain accessible.

Homelessness among older adults in the Ozarks should therefore be framed not simply as a lack of shelter, but as a threat to the security, health, independence, and community connections that make aging safely possible. Missouri's home- and community-based services system explicitly seeks to help eligible people receive support outside institutional settings, while social service organizations focused on older adults identify home safety and transportation as important supports for continued independence. These programs demonstrate that aging policy already depends on housing, even when housing and homelessness are administered through separate systems.

The local homelessness response has a foundation on which to build. The Ozarks Alliance to End Homelessness (OAEH) coordinates the federally designated Continuum of Care serving Springfield and Greene, Christian, and Webster Counties. The continuum helps to coordinate a community-wide effort involving nonprofit organizations, government, advocates, and people with lived experience to create opportunities to connect homelessness expertise with the aging-services network rather than treating older adult

homelessness as a separate, marginal concern.[1] OAEH's coordination of the regional Continuum of Care provides a foundation for connecting homelessness expertise with aging services. The sections that follow examine how existing resources could be organized around older residents' housing and support needs.[2]

The central argument advanced in this part of "Beyond the Myths" is that homelessness among older adults should be understood as both a housing problem and an aging-services problem. An effective response must prevent avoidable displacement, provide accessible emergency options, secure housing affordable at actual household incomes, and arrange the services necessary to sustain that housing. Public awareness matters when it helps residents recognize these needs without reducing older people to stereotypes of helplessness, personal failure, or inevitable decline.

Who Counts as Older?

The word *senior* appears straightforward, but in practice different systems use different age thresholds which tend to render the use of the word to accurately describe the population slippery at best. Research on homelessness often examines adults beginning at age fifty because people experiencing homelessness can develop substantial functional limitations well before what most would recognize as a conventional retirement age. Aging services commonly utilize eligibility guidelines that begin at sixty, while particular federally assisted elderly housing programs use sixty-two. Census descriptions push the age out even further frequently identify the population as those aged sixty-five and older. While these categories can overlap, they are not, in fact, interchangeable, which profoundly shapes the kinds of support that older adults confronting housing instability are able access.[3]

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[1]Missouri Department of Health and Senior Services (hereafter Missouri DHSS), "Apply for Home & Community-Based Services," accessed October 31, 2026, health.mo.gov/senior-disability-services/home-community-based-services/apply-home-community-based-services; SeniorAge, "Home Safety," accessed October 1, 2026, www.senioragemo.org/ home-safety; SeniorAge, "Transportation," accessed October 1, 2026, www.senioragemo.org/transportation; Ozarks Alliance to End Homelessness (hereafter, OAEH), *Annual Report: Fiscal Year 2025* (Springfield, MO: Community Partnership of the Ozarks, April 2026), 3–4, accessed September 29, 2026, cpozarks.org/wp-content/uploads/2021/01/OAEH-Annual-Report-FY25-Final.pdf.

[2] SeniorAge, "Home Safety"; SeniorAge, "Transportation."

[3]University of California, San Francisco, Benioff Homelessness and Housing Initiative (hereafter, UCSF Benioff), "UCSF Benioff Homelessness and Housing Initiative Releases Findings on Aging and Homelessness," May 23, 2024, accessed October 1, 2026, homelessness.ucsf.edu/sites/default/files/2024-05/Older%20Adults%20Report%20Press%20 Release%202024.05.23.pdf; U.S. Department of Housing and Urban Development (hereafter, HUD), "Chapter 3: Eligibility for Assistance and Occupancy," in *Occupancy Requirements of Subsidized Multifamily Housing Programs*, section addressing Section 202 PRAC eligibility, accessed October 1, 2026,

For the purposes of this paper, *older adults* will generally include people fifty and older when discussing homelessness research and prevention. Specific statistics and program rules, however, will retain the age restrictions used by their sources. This approach allows for the inclusion of people whose health and housing needs emerge before they become eligibility for certain senior programs without implying that every person over fifty necessarily requires specialized assistance.

The distinction has practical consequences locally. For instance, a fifty-eight-year-old with mobility limitations may need an accessible apartment and help maintaining a tenancy but may not qualify for an age-restricted property serving residents sixty-two and older. Or perhaps, a sixty-one-year-old may qualify for an aging-service referral while still being forced to navigate housing services that impose a different housing eligibility threshold. Missouri's disability-related home- and community-based services can serve some adults below traditional senior ages, but eligibility depends on other program-specific requirements rather than on age alone.[4]

Local data should therefore preserve useful age bands, as reporting only a combined "adult" category can conceal the age-related needs of older people who are between fifty and sixty-four. Reporting only those sixty-five and older can omit people who already find themselves experiencing age-associated functional challenges that make housing stability more difficult for them. A more practical local reporting framework would distinguish ages fifty to fifty-four, fifty-five to sixty-one, sixty-two to sixty-four, and sixty-five and older when sample sizes and privacy protections permit. These are proposed analytical categories that would provide researchers and policymakers a more granular portrait of the housing crisis among older residents allowing service providers to be more focused in the programs that they design and maintain. These categories would help distinguish age-related patterns without treating age alone as a measure of service need.

www.hud.gov/sites/documents /43503c3hsgh.pdf; U.S. Census Bureau, "QuickFacts: Greene County, Missouri," accessed October 1, 2026, www.census.gov/quickfacts/fact/table/greenecountymissouri/PST040223.

[4]Missouri DHSS, "3.25 Personal Care Assistance—State Plan (Consumer-Directed Service Model)," *Home and Community Based Services Manual*, accessed October 1, 2026, health.mo.gov/providers/manuals/home-and-community-based-services-manual/300-available-home-and-community-based-4; HUD, "Chapter 3," Section 202 PRAC eligibility; United Way of Greater Kansas City, "Senior Housing Information and Referral | Strafford Senior Center," accessed October 1, 2026, search.unitedwaygkc.org/search/2beb871a-1a7a-5589-8770-50fe775cbdfa.

What Local Evidence Shows

The clearest verified local homelessness snapshot available comes from OAEH's fiscal year 2025 annual report, which enumerated 588 individuals experiencing homelessness on the January 2025 Point-in-Time count night. Seventeen percent of those counted were unsheltered. Among the people experiencing unsheltered homelessness, 19 percent were adults fifty-five and older.[5] The last figure must be approached with particular care inasmuch as it does not signal that 19 percent of all people experiencing homelessness in Greene, Christian, and Webster counties were older adults. The figure describes the age composition of one subgroup on one night, not the overall prevalence of homelessness or housing instability among older residents.

Springfield's broader housing evidence helps explain why a more inclusive definition of housing instability must be applied to homelessness policy and diversion and prevention deserves attention in these discussions. According to the City of Springfield there is a deficit of 8,960 housing units affordable to households at 30 percent of area median income, using a 2018–2022 housing-data baseline. Planning and Development identifies 10,585 renter households paying at least half their income toward housing, using 2020–2024 American Community Survey data. These figures describe Springfield households generally, not older adults specifically or the entire three-county region. They nevertheless document substantial affordability pressures within the housing market that older residents must navigate.[6]

The two sets of date establish two separate facts that must be addressed. First, older adults are present in the local unsheltered population, and, second, Springfield has substantial housing affordability pressures that create an added barrier for many residents who are fifty and older. They do not, however, establish how many older adults will become homeless, which individual factor caused a particular episode, or the proportion of county residents currently at risk, as the cohort of older adults in the region are an infinitely diverse population that resist universal policy approaches. The appropriate response to these limitations in our understanding of older adults experience housing instability is neither

[5]OAEH, *Annual Report: Fiscal Year 2025*, 5.

[6]City of Springfield, Planning and Development Department, *LIHTC Incentivization & Project Scoring Framework*, Finance and Administration Committee presentation, Bob Atchley, principal planner, n.d., slide 3, accessed October 2, 2026, www.springfieldmo.gov/DocumentCenter/View/76870/Low-Income-Housing-Tax-Credit-Incentivization-Presentation?bidId.

silence nor extrapolation. It is to state what is known, identify what remains unknown, and make older adult housing stability a specific subject of local measurement.

What the Count Misses

The OAEH itself describes the Point-in-Time count as a snapshot rather than an annual measure of everyone who needs help. Its value lies in documenting a defined population at a particular moment, not in establishing the full extent of housing insecurity among older adults. A careful reading therefore distinguishes between those the count identifies and the broader population whose need for prevention or housing assistance that it does not measure.[7]

Temporary accommodation is one such circumstance. An older adult staying in a relative's spare room may have shelter without a dependable right or agreement to remain. Assessment should establish whether the arrangement is voluntary, safe, adequate, and reasonably sustainable, including whether expectations concerning money, caregiving, or other contributions are understood and acceptable. A shared home can provide genuine stability; an uncertain invitation or an arrangement maintained through pressure should not automatically be treated as a resolved housing need.

Homeownership likewise does not establish that continued residence is secure. An unsafe bathroom, failed heating system, inaccessible entrance, or deteriorating property may threaten an older adult's ability to remain at home even when no rent is due. These circumstances call for an assessment of the dwelling's usability and the feasibility of repairs, modifications, or additional assistance. The relevant question is whether the home can remain a safe and sustainable setting, not simply whether the resident owns it.

A proposed local assessment framework should distinguish three groups:

- People currently experiencing homelessness, who may require immediate access to safe shelter or housing.
- People facing a near-term loss of housing, who may require urgent prevention.
- People whose housing remains intact but is becoming financially or functionally unsustainable, who may require continuing stabilization.

These categories are intended to guide assessment rather than replace program-specific eligibility rules. Although they may overlap, they help distinguish the immediate threat from the conditions that must change for housing to remain viable.

[7]OAEH, *Annual Report: Fiscal Year 2025*, 5.

An older adult should not have to lose housing before the community recognizes a preventable crisis. A coordinated response can identify the need first and then determine which resources can lawfully and practically address it. This broader understanding also provides a foundation for examining the assumptions that shape public responses to older adult homelessness. Before turning to the pathways into instability and the services available locally, it is therefore necessary to challenge several prevailing myths that can obscure older adults' circumstances.

Challenging the Prevailing Myths

Public awareness efforts should challenge misconceptions about older adult homelessness through evidence, careful distinctions, and attention to individual circumstances. Replacing one generalization with an equally sweeping counterclaim does little to improve public understanding. A more credible approach distinguishes findings from other jurisdictions from verified local conditions and separates a person's need for assistance from the availability of an appropriate intervention. For Springfield and Greene, Christian, and Webster Counties, the objective should be to clarify how housing instability develops, why existing resources may not resolve it, and what a proportionate response would require.

Myth: Older Adults Experiencing Homelessness Have Always Been Homeless

Homelessness can begin at different stages of adulthood; it is not necessarily a lifelong condition. The California Statewide Study of People Experiencing Homelessness found that 41 percent of older adults experiencing homelessness reported their first episode after age fifty. Although this percentage should not be treated as an estimate for the Ozarks, it establishes that later-life onset is a substantial pathway within the study population.[8]

The distinction challenges the assumption that an older person without housing must have experienced decades of instability. The California research describes later-onset homelessness among people who had worked, formed households, and experienced

[8]UCSF Benioff, *Toward Dignity: Understanding Older Adult Homelessness: Executive Summary* (San Francisco: UCSF Benioff Homelessness and Housing Initiative, May 2024), 8, accessed October 4, 2026, homelessness.ucsf.edu/sites/default/files/2024-05/Older%20Adult%20Homelessness%20Executive%20Summary%2005.2024.pdf.

prolonged economic insecurity before losing housing. Local assessment should therefore consider what changed in a previously viable arrangement rather than infer a housing history from a person's present circumstances. Equally, an earlier or prolonged experience of homelessness should not be interpreted as evidence that stable housing is unattainable.[9]

Myth: A Benefit Check Guarantees Housing

A predictable income does not necessarily provide an adequate income. Retirement benefits, disability payments, and other assistance may offer continuity while remaining insufficient to cover suitable housing alongside food, utilities, transportation, and health-related expenses. These income sources also differ in their purposes, eligibility requirements, and payment amounts; they should not be treated as a uniform financial safety net.[10]

The relevant question is not simply whether a payment arrives, but whether the household's available resources can sustain an appropriate home. Springfield's affordability pressures, described in the preceding local evidence section, make that distinction particularly consequential. Assistance with benefits can improve a household's position, but it should not be assumed to eliminate a continuing gap between income and housing costs. The following section examines that gap in greater detail.[11]

Myth: Any Shelter Placement Resolves the Immediate Problem

An available shelter bed represents a potential resource, not confirmation that a placement is suitable for a particular person. The Home Safe evaluation documents circumstances in which older adults' functional and medical needs complicated access to appropriate shelter. The practical correction is therefore to distinguish availability from

[9]UCSF Benioff, *Toward Dignity*, 8.

[10]Social Security Administration, "2026 Cost-of-Living Adjustment (COLA) Fact Sheet," under "SSI Federal Payment Standard," accessed November 4, 2026, www.ssa.gov/news/en/cola/factsheets/2026.html; Social Security Administration, *Fact Sheet: Supplemental Security Income (SSI)*, publication no. 05-11002 (April 2026), www.ssa.gov/pubs/EN-05-11002.pdf.

[11]City of Springfield, Planning and Development Department, *LIHTC Incentivization & Project Scoring Framework*, presentation to the Springfield City Council Finance and Administration Committee, Bob Atchley, principal planner, n.d., slide 3, accessed October 4, 2026, www.springfieldmo.gov/DocumentCenter/View/76870/Low-Income-Housing-Tax-Credit-Incentivization-Presentation?bidId=.

suitability without assuming either that every offer will work or that shelters are generally inadequate.[12]

A declined placement should prompt inquiry into the reasons rather than an immediate judgment that assistance has been rejected. Some barriers may be resolved through an adjustment or additional support; others may require a different setting. The immediate responsibility is to identify a safe, workable response, while recognizing that temporary shelter and sustained housing serve different purposes. “Emergency Shelter Must Fit” develops the operational implications of this distinction.

Myth: Every Older Adult Experiencing Homelessness Needs Institutional Care

Neither age nor homelessness alone determines the appropriate level or setting of care. Missouri’s home- and community-based services framework provides options for eligible individuals to receive assistance while living outside an institution. The existence of these options challenges the assumption that the only alternatives are complete self-sufficiency or institutional placement.[13]

An appropriate response begins with the individual’s circumstances, preferences, and support needs. Some residents may require substantial personal assistance, while others primarily need an affordable unit, an accessible environment, or limited practical support. Community-based care should not be promised without verification, but institutional care should not be presumed necessary merely because housing has been lost. The eligibility and coordination questions governing these decisions are addressed in “Housing and Care Together.”

Myth: Giving Someone a Referral Completes the Task

Providing contact information can begin a connection, but it does not establish that assistance was received. Missouri’s published home- and community-based services process

[12]Margot Kushel et al., *Evaluation of the Home Safe Program: Homelessness Prevention for Older Adults & Adults with Disabilities, 2022–2025* (San Francisco: UCSF Benioff Homelessness and Housing Initiative, January 2026), 12, homelessness.ucsf.edu/sites/default/files/2026-01/Home%20Safe%20Evaluation%20Report%20Final.pdf.

[13]Missouri DHSS, “HCBS Eligibility, Process & Program Limits,” under “Minimum Eligibility Requirements,” “Process,” and “Program Limits,” accessed October 4, 2026, health.mo.gov/senior-disability-services/home-community-based-services/hcbs-eligibility-process-program-limits.

distinguishes referral from subsequent assessment and care planning, illustrating why these stages should not be treated as interchangeable. A resident may still face obstacles in communicating a concern, preparing documents, arranging transportation, or understanding what to do next.[14]

The proposed local standard is therefore to confirm whether a connection occurred and whether unresolved needs remain. This is a recommendation for coordinated practice, not a finding that regional providers routinely fail to follow through. Its purpose is to prevent responsibility from ending at the point of referral while an older adult remains in crisis. "Connecting Local Service Systems" explains how supported handoffs and assigned follow-up could make that responsibility operational.

From Myth-Challenging to Better Public Decisions

Challenging these myths does not require agreement on every policy choice; it requires a more accurate foundation for evaluating those choices.

These misconceptions obscure a central distinction: receiving income is not the same as being able to afford a safe and suitable home. For older adults in the Ozarks, the discussion must therefore move beyond whether a benefit check arrives to whether available resources can sustain housing alongside other essential expenses. To understand these challenges more fully, the next section examines the relationship between income, housing costs, and the assistance needed to close an enduring affordability gap.[15]

Fixed Income, Changing Costs

The phrase *fixed income* can obscure more than it explains. Some older adults receive retirement benefits, some receive Supplemental Security Income, some continue working, and some combine several sources. These arrangements differ substantially. Social Security retirement benefits reflect an individual's earnings record, whereas SSI is a needs-based program for eligible older adults and people with disabilities who have limited income and resources. Describing both as a "fixed income" can conceal important differences in the amount available, the financial reserves a household can draw upon, and its ability to absorb an unexpected

[14]Missouri DHSS, "HCBS Eligibility, Process & Program Limits."

[15]Kushel et al., *Evaluation of the Home Safe Program*, 5–6.

expense.[16]

Nor does *fixed* necessarily mean that the payment never changes. Social Security and federal SSI benefits receive cost-of-living adjustments tied to a national price index, but those adjustments are not calculated to match an individual household's rent increase or other particular expenses. The more useful distinction is between income that is predictable and income that is adequate. Knowing when the payment will arrive does not establish that it will cover rent, utilities, food, transportation, and health-related needs. For the discussion of older adult homelessness, the relevant question is therefore not simply whether someone receives a regular check, but whether recurring income and available resources can sustain safe, usable housing without repeatedly sacrificing other necessities.[17]

For instance, the federal Supplemental Security Income payment standard for an eligible individual is $994 per month in 2026, while the standard for an eligible couple is $1,491. These are maximum federal standards that must not be confused with a universal Social Security retirement benefit.[18] For a person receiving $994 per month, keeping housing costs within the conventional affordability benchmark of 30 percent of income would mean spending no more than $298.20 per month on housing, illustrating how little someone relying solely on that income could spend on housing while remaining within the benchmark.[19]

The policy implication is straightforward. Careful budgeting cannot resolve a persistent mismatch between income and essential expenses. Financial counseling may improve benefits access or identify avoidable costs, but it cannot create an affordable unit where none is available. Treating arrears solely as a budgeting failure therefore confuses a resource deficit with an individual shortcoming. A more useful discussion asks whether the household has sufficient resources to maintain housing without repeatedly sacrificing food, medication, utilities, or other necessities.

Prevention assessments should therefore distinguish a temporary interruption in

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[16]Social Security Administration, *Supplemental Security Income and Other Benefits: Information for People with Limited Earnings*, publication no. 05-10710 (April 2022), 1, accessed October 4, 2026, www.ssa.gov /myaccount/assets/materials/limited-earner.pdf.

[17]Social Security Administration, "Cost-of-Living Adjustment (COLA)," accessed October 4, 2026, www.ssa.gov/OACT/COLA/colasummary.html.

[18]Social Security Administration, "2026 Cost-of-Living Adjustment (COLA) Fact Sheet."

[19]City of Springfield, *Springfield Housing Study*, City Council presentation, December 5, 2023, slide addressing housing affordability, accessed October 4, 2026, www.springfieldmo.gov/DocumentCenter/View/64866 /Housing-Study-Update-Presentation; Social Security Administration, "2026 Social Security Changes"; City of Springfield, *LIHTC Incentivization*, slide 3.

otherwise sustainable finances from an ongoing affordability gap. A delayed payment, a one-time moving expense, or an isolated emergency may be resolved with short-term assistance. In those circumstances, a limited intervention can restore stability because the household can reasonably meet its housing costs once the immediate disruption is addressed. A continuing gap between rent and recurring income requires a different plan: a deeper subsidy, a more affordable unit, a sustainable shared arrangement chosen freely, or another durable intervention. Paying arrears without addressing that gap may prevent an immediate displacement while leaving the household exposed to the same crisis again. The assessment should therefore consider not only what is needed to preserve housing today, but also whether the household can sustain it in the months ahead.

The same distinction should guide rapid rehousing. Temporary assistance can provide an essential bridge, but the exit plan must explain what happens when that assistance ends. For an older household unlikely to increase earnings substantially, a plan that depends on unspecified future income is not yet a sustainable housing plan. Before assistance expires, the plan should identify how ongoing housing costs will be covered and what alternative will be pursued if the anticipated resources do not materialize. Success should mean more than securing a lease or completing a period of assistance; it should mean establishing a credible path to continued housing stability.

How Housing is Lost

Older adult homelessness should not be understood as a single life story. Some people grow older while experiencing repeated or prolonged homelessness. Others lose stable housing for the first time later in life. These pathways can involve different histories, service relationships, health needs, and opportunities for prevention. A useful assessment must therefore ask not only whether someone has experienced homelessness before, but also what changed to make the current housing situation untenable.

The California Statewide Study of People Experiencing Homelessness provides evidence that later-life first episodes deserve attention. The distinction between earlier- and later-onset homelessness directs attention to the events that destabilize a previously viable housing arrangement. Though the study focuses on California research, it does challenges the assumption that all older people experiencing homelessness have been homeless throughout adulthood.[20] A first episode later in life should immediately trigger questions about the loss of income, relationships, or practical support that previously made secure housing possible, rather than an

[20]UCSF Benioff, “Releases Findings on Aging and Homelessness.”

assumption of persistent, longstanding instability.

A local prevention framework should consider several possible transitions: the death of a spouse or other household member; separation from a partner; loss of work; the end of an informal caregiving arrangement; an unaffordable rent increase; deterioration of an owned home; or discharge from a setting without an adequate housing plan. Assessment domains should also consider whether several changes have coincided, since addressing one immediate expense may leave other threats to housing unresolved.

Each domain raises different questions. After a household member dies, can the survivor maintain the lease or mortgage? When a person has lived with relatives, is there an enforceable tenancy or only an informal understanding? After a health event, is the former home still usable? If a person loses employment, is a benefit application pending, or is there no replacement income available? The answers should help distinguish a temporary disruption that can be resolved with limited assistance from a lasting change that requires an entirely different housing arrangement or continuing support.

The aim is not to medicalize or bureaucratize ordinary life changes, but, rather, to recognize moments when housing can become unstable before a person identifies as homeless. Senior centers, legal services, health providers, and trusted community organizations may be useful referral points precisely because residents can approach them for help with a specific problem that might metastasize into a housing crisis, rather forcing the adoption of a stigmatized label. For instance, SeniorAge's existing connection to Legal Services of Southern Missouri offers one practical starting point for linking older residents' legal concerns with a broader assessment of housing stability.[21]

Health Changes the Stakes

Housing loss becomes especially dangerous when an individual already has difficulty walking, bathing, dressing, remembering appointments, or managing medication. These are practical concerns about daily functioning, not simply diagnostic labels. Missouri's consumer-directed personal care guidance explicitly connects assistance with daily activities to the ability to live independently in the community.[22] The relevant distinction is between having a health condition and having the environment and assistance needed to manage that condition safely.

Research can illustrate the intensity of these needs without establishing local prevalence.

[21]SeniorAge, "Legal Services," accessed November 1, 2026, www.senioragemo.org/legal-services.

[22]Missouri DHSS, "3.25 Personal Care Assistance."

In the California older adult homelessness analysis, 53 percent of respondents described their health as fair or poor, and 43 percent reported at least one limitation in activities of daily living. Those figures apply to the study population; they should not be transferred to the OAEH population.[23] Their significance for the Ozarks is not that they establish how many residents need assistance, but that they identify functional needs local assessments should be prepared to recognize.

Placement assessment should consider functional usability alongside affordability and availability, including access to bathrooms, mobility equipment, and necessary assistance. A nominally available bed or apartment may not resolve the problem if the person cannot use it. In Springfield and Greene, Christian, and Webster Counties, a placement decision should therefore consider the usability of the setting alongside its affordability and availability.

Assessment should distinguish medical need from housing need while recognizing their interaction. A person may need both an apartment and personal assistance, but a medical diagnosis alone does not identify the appropriate housing arrangement. Conversely, a housing referral does not eliminate the need for clinical assessment when an acute medical problem is present. A coordinated plan should specify who will address each need, when assistance is expected to begin, and what will happen if the proposed support cannot be arranged.

This paper does not assume that every older adult experiencing homelessness needs institutional care. Missouri's home- and community-based services system exists to support eligible people outside institutions, subject to functional, financial, and program requirements. That framework supports an individualized approach rather than a choice between unsupported independence and unnecessary institutional placement.[24] Eligibility, however, should not be confused with confirmation that an appropriate provider and sufficient assistance are available for a particular placement. Because Missouri's framework includes reassessment and changes to person-centered care plans, local housing partners should also establish a way to revisit support arrangements when a resident's abilities or circumstances change.[25]

[23]UCSF Benioff Homelessness and Housing Initiative, "Releases Findings on Aging and Homelessness."

[24]Missouri DHSS, "2.00 Medicaid Eligibility," *Home and Community Based Services Manual*, accessed October 10, 2026, health.mo.gov/providers/manuals/home-and-community-based-services-manual/200-medicaid-eligibility; Missouri DHSS, "HCBS Eligibility, Process & Program Limits."

[25]Missouri DHSS, "HCBS Eligibility, Process & Program Limits."

Emergency Shelter Must Fit

Emergency shelter remains an essential part of a homelessness response, but an available bed is not necessarily an accessible or clinically appropriate placement. The distinction matters when a person cannot climb into a bunk, requires help with daily activities, or uses equipment that depends on reliable electricity. An assessment should therefore distinguish between the existence of an opening and the person's ability to use that opening safely. The objective is not to require every shelter to provide every level of care, but to identify the conditions and assistance necessary for a particular placement to work.

A 2026 evaluation of California's Home Safe program documented staff difficulties locating shelter for participants with complex functional needs, including problems involving bunk beds and supplemental oxygen. It also described the use of emergency hotel stays when suitable shelter could not be located, illustrating how a mismatch between needs and available accommodations can require an alternative interim response. For the Ozarks, the lesson is that the community needs to plan for these situations rather than assume that a standard referral will resolve them.[26]

An older adult accessibility review should examine the entire shelter experience: entry, bathrooms, sleeping arrangements, medication practices, daytime access, transportation, and emergency evacuation. It should also identify which needs a facility is staffed and, where applicable, licensed to address. Written policies matter, but actual usability should be assessed with people who have relevant lived experience. A person may be able to enter a building yet remain unable to use its bathroom, reach the assigned bed, or manage an essential daily routine. A thoughtful assessment that recognizes the challenges faced by some older adults should therefore distinguish barriers that can be addressed through equipment or changes in practice from needs that require additional personnel or a different setting.

Public discussion must avoid interpreting every declined placement as a rejection of help. Before making that judgment, the system should determine whether the offer was safe, usable, and compatible with the individual's essential needs. On the other hand, recognizing legitimate barriers does not require assuming that every proposed placement is unsuitable. The appropriate response is documentation and problem-solving. Staff should ask what specifically makes the placement difficult and whether an adjustment could make it workable, rather than treating acceptance or refusal as a complete assessment. Recording an unresolved accessibility or support need separately from a general refusal would also provide a clearer account of where the response system needs additional options.

[26]Margot Kushel et al., *Evaluation of the Home Safe Program*, 12.

Shelter providers also need realistic expectations. A facility designed for emergency lodging should not be expected to provide skilled nursing or continuous personal care without the necessary personnel and arrangements. When a person's needs exceed a shelter's capacity, the problem requires a coordinated response rather than blame directed at either the person or the shelter. Missouri's home- and community-based services framework offers a potential route to assistance for eligible individuals, but it requires assessment, Medicaid eligibility, and compliance with program limits; it should not be treated as an automatic source of immediate care in any proposed shelter setting.[27] Any placement that depends on outside assistance should therefore confirm that the service can lawfully and practically be delivered there, rather than assume that a referral guarantees coverage.

A practical local goal is an agreed escalation pathway by which staff can connect an older adult with appropriate assistance when a standard placement has been deemed unsafe. The pathway should provide interim options that can be considered, and outline who will be the responsible party until an appropriate plan is confirmed. Such a pathway should distinguish an acute medical emergency from a nonemergency need for accessible accommodation or personal assistance, with clearly identified contacts for each situation. It should also specify how partners will confirm that the person reached the agreed destination and that essential supports are in place, so that an unsuccessful referral does not become the end of the response.

Geography Shapes Access

The OAEH Continuum of Care encompasses Springfield and Greene, Christian, and Webster Counties, while One Door and New Day and the O'Reilly Center for Hope provides a Springfield-based hub for coordinated intake and multiple partner services.[28] A locally grounded response must therefore evaluate not only the availability of services but also their accessibility from residents' actual locations. Regional coverage should not be equated with equivalent access across the service area. For older adults, the practical value of a resource depends on whether the journey, scheduling requirements, and means of communication are compatible with their circumstances.

SeniorAge identifies transportation as an important determinant of independence and

[27]Missouri DHSS, "HCBS Eligibility, Process & Program Limits."

[28]OAEH, *Annual Report: Fiscal Year 2025*, 3, 7-10; Community Partnership of the Ozarks, "New Day," Community Partnership of the Ozarks, accessed October 14, 2026, www.cpozarks.org/new-day/; Community Partnership of the Ozarks, "One Door," Community Partnership of the Ozarks, accessed October 14, 2026, www.cpozarks.org/one-door/.

notes that older residents in rural and suburban areas may have limited options for medical appointments, grocery shopping, and other essential trips. Its transportation assistance relies on partner organizations, local tax boards, and grants.[29] A referral should consequently be verified against actual service availability rather than interpreted as a guarantee of transportation. Assessment should establish whether a provider serves the relevant location, can accommodate the individual's mobility needs, and operates at the time required.

For a person facing housing loss, transportation has implications extending well beyond access to medical care. It can determine whether an individual attends a housing interview, views an apartment, obtains documents, reaches a court hearing, or completes a benefits appointment. These are planning implications of the relationship between transportation and service access, not estimates of unmet demand in any particular county. A referral process should therefore identify the travel required at each stage rather than assume that transportation can be arranged after an appointment is scheduled. Where travel presents a barrier, partners should consider whether the task can be completed remotely or through assistance closer to the resident's location.

A three-county response should combine the benefits of centralized expertise with opportunities for access outside the Springfield locations. Co-location of relevant supportive services at New Day and the O'Reilly Center for Hope is a means of reducing transportation and other access barriers, but that benefit should be considered alongside the journey required to reach the hub itself.[30] Potential complementary strategies include scheduled outreach at trusted community sites, telephone appointments where appropriate, accessible document assistance, and coordination between housing navigators and transportation providers. Each strategy should be evaluated for usability rather than selected solely for administrative efficiency. Remote access, for example, should remain an option rather than a presumption, with an alternative available when a resident cannot complete the process by telephone or online.

Relocation should likewise be evaluated through its practical consequences and the older adult's informed preferences. An apartment farther from existing services may offer a lower rent while introducing transportation expenses, separating the resident from familiar support, or complicating access to care. These considerations do not preclude relocation, but should be necessary components of any assessment as to whether a proposed placement is sustainable. Housing navigation should compare the costs and support arrangements associated with the new location against those of other feasible options. It should also distinguish between a move the

[29]SeniorAge, "Transportation."

[30]OAEH, *Annual Report: Fiscal Year 2025*, 10, 16.

resident considers acceptable and one accepted only because no workable alternative has been identified. Housing navigation should therefore compare the full costs and practical consequences of location, not rent alone.[31]

Independence Is Not Isolation

Public discourse sometimes equates independence with the absence of assistance, overlooking the distinction between performing every task without help and exercising meaningful control over one's life. A more appropriate standard is whether an older adult retains authority over daily routines, living arrangements, and care preferences while receiving necessary support. Transportation assistance, legal counsel, meal services, or help with bathing need not diminish that authority. Independence should therefore be understood in terms of self-determination rather than complete self-sufficiency. This interpretation accords with federal home- and community-based services regulations that emphasize individual choice, autonomy, and participation in community life.[32]

Missouri's person-centered services framework is consistent with this distinction: assistance should support the resident's choices rather than make complete self-sufficiency the measure of independence. For housing and homelessness practitioners in the Springfield region, the relevant question is not whether an older adult requires help, but whether an appropriate combination of housing and support can sustain the person's chosen living arrangement.[33]

The same principle should inform the involvement of relatives and other informal caregivers. Although family members may provide substantial assistance, practitioners should not presume that every older adult has a safe, willing, and financially capable support network. The National Academies emphasizes the diversity of caregiving relationships, responsibilities, and circumstances, including differences in geographic proximity and the intensity of assistance provided. The existence of an adult child or another relative should therefore prompt an assessment of actual support rather than serve as evidence that a suitable housing option is available. Assessments need to distinguish emotional connection from the practical capacity to

[31]SeniorAge, "Transportation."

[32]"Contents of Request for a Waiver," 42 C.F.R. § 441.301(c)(4)(i), (iii)–(v), accessed October 11, 2026, www.ecfr.gov/current/title-42/section-441.301.

[33]Missouri DHSS, "HCBS Eligibility, Process & Program Limits."

provide accommodation, financial assistance, or continuing personal care.[34]

When relatives or friends participate in housing and care planning, their involvement should reflect the older adult's preferences and informed consent, with appropriate attention to any authorized representative's role. Federal requirements for Medicaid home- and community-based waiver services place the individual at the center of planning and describe unpaid natural supports as voluntarily provided. Practitioners should accordingly clarify the assistance being offered, its anticipated duration, the feasibility of caregiving responsibilities, and whether either party experiences pressure to accept the arrangement. Shared expectations should be documented, particularly when a proposed housing placement depends on continuing informal assistance. Planning should also identify an alternative response if the arrangement becomes unavailable, unsafe, or unsustainable.[35]

Housing assistance must not make social isolation an implicit condition of deserving support. An older adult may maintain meaningful relationships without those relationships supplying all necessary income, accommodation, or personal care. Similarly, an intervention can strengthen family connections without treating relatives as substitutes for affordable housing and adequately resourced services. The National Academies situates family caregiving within a broader debate about the responsibilities of individuals, families, and public institutions, rather than treating it exclusively as a private obligation. Local policy should therefore recognize informal support as a potential contribution to housing stability, not presume that its existence resolves an otherwise unmet housing need.[36]

The practical objective is supported autonomy that delivers access to sufficient assistance to sustain housing, meaningful choice over how that assistance is delivered, and continuing attention to changing circumstances. In Springfield and Greene, Christian, and Webster Counties, this objective should guide coordination among housing navigators, aging-service providers, health professionals, and the individuals whom older residents choose to involve. Consistent with person-centered planning principles, success should be evaluated not by the elimination of assistance, but by whether the resulting arrangement remains responsive to the person's needs, preferences, and desired participation in community life.[37]

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[34]National Academies of Sciences, Engineering, and Medicine, *Families Caring for an Aging America* (Washington, DC: National Academies Press, 2016), 20–21, accessed October 4, 2026, doi.org/10.17226/23606.

[35]"Contents of Request for a Waiver," 42 C.F.R. § 441.301(c)(1)(i)–(ii), (c)(2)(v)–(vi), (ix).

[36]National Academies of Sciences, Engineering, and Medicine, *Families Caring for an Aging America*, 20.

[37]Missouri DHSS, "HCBS Eligibility, Process & Program Limits"; "Contents of Request for a Waiver," 42 C.F.R. § 441.301(c)(2)(i)–(iv), (c)(3)(i).

Differences Within Older Adulthood

Older adults experiencing housing instability should not be treated as a homogeneous population. The interactions between age and disability, race, gender, household composition, veteran status, economic circumstances, and exposure to violence or exploitation should inform inquiry without becoming substitutes for an assessment of individual circumstances. Guidance available through HUD Exchange similarly cautions against inferring a person's needs or vulnerabilities solely from protected characteristics and instead emphasizes attention to lived experience. For Springfield and Greene, Christian, and Webster Counties, this approach requires locally grounded analysis rather than the uncritical application of national or out-of-state findings.[38]

Research from California illustrates the importance of examining racial disproportionality while preserving geographic and methodological distinctions. The UCSF Benioff Homelessness and Housing Initiative reported that Black adults constituted 31 percent of Californians age fifty and older experiencing homelessness, compared with 6 percent of California's overall population in that age group. Thought disparity identified in the study points to a substantial equity concern in the California context that does not speak to the racial distribution of older adult homelessness in the Ozarks, it, nevertheless, should raise questions about potential unequal exposure to housing instability and access to assistance.[39]

Local evaluation should therefore examine potential disparities at successive stages of the housing-assistance process: requesting help, completing documentation, undergoing assessment, receiving referrals, securing a lease, and maintaining housing. HUD Exchange guidance supports examining equitable access, experiences within the response system, and outcomes after participants leave it. Reporting only final placement totals may obscure barriers encountered earlier, including the experiences of residents who never complete an application or reach the referral stage. Where local samples are small, analysis should acknowledge statistical uncertainty and use reporting practices that protect individuals from identification. These limitations warrant methodological care, not the exclusion of older adults' experiences from evaluation; confidential interviews and voluntary feedback can complement aggregate measures.[40]

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[38] HUD Exchange, *Coordinated Entry as a Tool for Equity: Do's and Don'ts*, accessed October 11, 2026, files.hudexchange.info/resources/documents/Coordinated-Entry-as-a%20Tool-for-Equity-Dos-and-Donts.pdf.

[39] UCSF Benioff Homelessness and Housing Initiative, "Releases Findings on Aging and Homelessness."

[40] HUD Exchange, *Coordinated Entry as a Tool for Equity*.

Household composition likewise warrants explicit attention in assessment and placement planning. A couple may require accommodation for both partners even when their functional abilities and support needs differ substantially. An older adult who provides care for a spouse, adult child, or another household member may require arrangements that cannot be understood through an assessment focused exclusively on that individual. Such circumstances should be considered before a referral is made, rather than addressed only after a proposed placement proves unsuitable. Assessment should clarify whom the resident wishes to live with, what assistance each household member requires, and whether the proposed setting can accommodate those preferences within applicable program requirements. Although federal Medicaid waiver regulations govern a distinct service system, their emphasis on individual preferences, assessed needs, and voluntary supports offers a relevant planning principle: household relationships should be examined rather than assumed.[41]

Survivors of domestic violence, dating violence, sexual assault, or stalking may require additional safeguards when seeking or maintaining housing. OACAC's published notice explains that the Violence Against Women Act provides protections within covered housing programs, including protections against certain denials or terminations of assistance, confidentiality requirements, and procedures for requesting emergency transfers. These protections are program-specific, and a request for an emergency transfer does not guarantee that an appropriate unit will be available. Local practice should therefore combine individualized safety planning with assistance from qualified housing and survivor-service advocates, rather than presume that age or an existing household relationship establishes safety. Consistent with HUD guidance on coordinated entry and victim services, assessment and referral procedures should protect privacy and avoid unnecessary disclosures that could compromise a survivor's safety.[42]

Connecting Local Service Systems

An effective response to older adult housing instability in Springfield and Greene, Christian, and Webster Counties need not begin with the creation of an entirely new service infrastructure. Rather, it should strengthen connections among existing resources while identifying the limits of their eligibility criteria, capacity, and scope of practice. OAEH has an

[41]"Contents of Request for a Waiver," 42 C.F.R. § 441.301(c)(2)(i)–(vi).

[42]Ozarks Area Community Action Corporation, *Notice of Occupancy Rights under the Violence Against Women Act*, HUD-5380, accessed October 11, 2026, oac.ac/wp-content/uploads/2025/09/VAWA-NOTICE-5380-2028.pdf; HUD, *Coordinated Entry and Victim Service Providers: FAQs*, accessed October 11, 2026, files.hudexchange.info/resources/documents/Coordinated-Entry-and-Victim-Service-Providers-FAQs.pdf.

established network of housing programs, coordinated entry, partner agencies, and cross-sector committees. The existence of this infrastructure provides a foundation for collaboration, but it should not be interpreted as evidence that every older resident can obtain the particular combination of assistance required.[43]

The OAEH provides the region's Continuum of Care framework, while New Day and the O'Reilly Center for Hope brings multiple partner agencies together to support housing access and financial stability. One Door serves as a central point for coordinated intake, assessment, prioritization, and housing referrals. SeniorAge contributes aging-related resources through transportation partnerships, home-safety assistance, and connections to legal services. Legal Services of Southern Missouri provides assistance with eligible civil legal matters, including certain housing disputes and public-benefit proceedings. These organizations constitute complementary points of access, although work may remain in establishing a formal, comprehensive pathway specifically for older adults experiencing housing instability.[44] Effective coordination would preserve these professional distinctions while establishing clear procedures for consultation and referral. A shared response should therefore specify not only which organization receives a referral, but also which professional responsibility that referral is intended to address.[45]

A referral, however, should not be equated with a completed connection to assistance. An older resident may receive accurate contact information yet remain unable to explain the problem, assemble documentation, arrange transportation, or navigate multiple application processes. A proposed local practice standard should distinguish an informational referral from a warm handoff and from confirmed service access. HUD guidance concerning coordinated entry and victim-service providers illustrates the more active approach: it describes warm handoffs that may include a telephone call, transportation, or other assistance with the transition between providers. Applied to older adult housing practice, this principle would require a designated staff member to confirm whether the receiving organization established contact and to identify an alternative when the initial referral cannot be completed.[46]

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[43]OAEH, *Annual Report: Fiscal Year 2025*, 3, 7, 10, 12–14.

[44]OAEH, *Annual Report: Fiscal Year 2025*, 3, 10; SeniorAge, "Home Safety"; SeniorAge, "Transportation"; SeniorAge, "Legal Services"; Legal Services of Southern Missouri (hereafter LSOSM), "Legal Services of Southern Missouri," accessed October 11, 2026, www.lsosm.org/.

[45]OAEH, *Annual Report*, 7, 10; SeniorAge, "Transportation"; SeniorAge, "Home Safety"; LSOSM, "Legal Services of Southern Missouri."

[46]HUD, *Coordinated Entry and Victim Service Providers: FAQs*, question 4, accessed October 11, 2026, files.hudexchange.info/resources/documents/Coordinated-Entry-and-Victim-Service-Providers-FAQs.pdf.

Greater coordination should not entail indiscriminate information sharing. Participating organizations should establish consent procedures, clarify the purpose of each disclosure, and limit information exchange to what is necessary and permitted under applicable requirements. HUD's coordinated-entry guidance distinguishes information needed to determine eligibility from permission to share that information among providers, emphasizing that participation in a coordinated system does not eliminate confidentiality protections. One agency's familiarity with a resident should therefore not be treated as authorization for unrestricted disclosure of medical, legal, financial, or personal histories. Interagency protocols should explain what may be shared, with whom, and under what authority, while enabling residents to understand how their information will be used.[47]

A workable local structure would designate a lead navigator for each participating household, assign specific responsibilities across agencies, and establish a documented follow-up point. The lead role need not belong to the same organization in every case; it should reflect the resident's preferences, the principal barrier to housing stability, and the participating organizations' capacity. The proposed arrangement could build upon OAEH's existing coordinated-entry and case-conferencing structures without presuming that those structures currently provide comprehensive older adult navigation. Its central objective would be to prevent the resident from becoming the sole coordinator of a complex response at the moment housing is most precarious. Accountability would rest not merely on whether a referral was issued, but on whether an appropriate connection occurred and unresolved needs were recognized.[48]

Prevention Before Displacement

Homelessness prevention should begin with an individualized assessment of the conditions necessary for an older adult to remain safely and sustainably housed. Depending on the circumstances, an appropriate intervention may involve financial assistance, legal advocacy, essential repairs, personal assistance, resolution of a benefits problem, or a planned transition to alternative housing. This emphasis on individualized stabilization is consistent with federal Emergency Solutions Grants provisions addressing housing assessment, benefits coordination, and the development of a housing and service plan. No single intervention should be presumed sufficient across all cases. For Springfield and Greene, Christian, and Webster Counties, the proposed approach should distinguish preserving a viable housing arrangement from prolonging

[47]HUD, *Coordinated Entry and Victim Service Providers*, questions 3 and 5–6.

[48]OAEH, *Annual Report*, 10, 18.

one that remains unsafe or financially unsustainable.[49]

Legal Services of Southern Missouri (LSSM) identifies lease disputes, landlord lockouts, inadequate living conditions, and public housing matters among the issues for which its attorneys may provide advice or representation; SeniorAge identifies LSSM as the organization through which it provides legal services. These resources offer an institutional foundation for incorporating early legal screening into a local homelessness-prevention strategy. Nevertheless, a referral should not be equated with an accepted case or a guarantee of representation. Practitioners should confirm eligibility, case acceptance, and the provider's ability to respond within the relevant timeframe. Where feasible, the referral process should include assistance assembling documents and communicating the urgency of the housing threat.[50]

The timing of intervention should be treated as a substantive component of prevention rather than an administrative detail. A household should not be required to approach unavoidable displacement before a housing-related legal concern receives attention. At intake, staff should identify notices, scheduled hearings, subsidy actions, and other potentially consequential deadlines, then promptly seek qualified legal assistance. LSSM describes an application and screening process before case acceptance, underscoring the importance of distinguishing an initial request for assistance from an established attorney-client relationship. Case managers should facilitate access, document referral efforts, and coordinate follow-up without attempting to substitute informal guidance for professional legal advice.[51]

Prevention assistance should follow the affordability assessment developed earlier: arrears payments are appropriate when they restore a sustainable tenancy, while continuing shortfalls require a longer-term plan. Federal homelessness-prevention regulations emphasize restoring stability in existing housing or facilitating a move to other permanent housing, rather than treating payment alone as the intervention's endpoint. Emergency assistance should therefore be linked to an assessment of recurring income, benefits access, ongoing expenses, and the availability of more affordable housing. This approach preserves the immediate value of crisis assistance while recognizing that a one-time payment cannot be presumed to resolve a

[49]"Housing Relocation and Stabilization Services," 24 C.F.R. § 576.105(b)(1)(i)–(ii), (b)(2)(D)–(H), accessed October 14, 2026, www.law.cornell.edu/cfr/text/24/576.105.

[50]LSOSM, "Housing"; SeniorAge, "Legal Services."

[51]LSOSM, "Applicants," accessed October 14, 2026, www.lsosm.org/applicants/.

continuing affordability deficit.[52]

Prevention strategies should encompass older homeowners as well as renters. SeniorAge's home-safety program describes assistance identifying modifications and resources, potentially including assistive technology, that can improve safety and reduce fall risks. Assessment should therefore consider whether an owned home remains usable and safe, rather than treating ownership as sufficient evidence of housing security. A proposed local protocol should distinguish relatively modest accessibility or safety needs from more extensive repair problems requiring other expertise and funding. Referrals should also clarify whether the identified intervention is actually available, affordable, and capable of addressing the condition that threatens continued residence.[53]

A proposed local prevention fund should permit a reasonable range of individualized interventions while remaining accountable to its legal authority, funding restrictions, and written standards. Federal Emergency Solutions Grants regulations illustrate that prevention can include specified financial assistance, housing-stability case management, mediation, and legal services, although those provisions do not authorize every potentially useful expenditure. Where a documented need falls outside one funding source's permissible uses, the proposed local model should identify complementary resources rather than assume that a single fund can finance the entire response. The central accountability question should be whether an authorized expenditure addressed an identified threat to safe housing and contributed to a credible stabilization plan—not whether every household received an identical service.[54]

Diversion Without Coercion

Homelessness diversion seeks to identify a safe and acceptable alternative to emergency shelter or unsheltered homelessness through individualized housing problem-solving. Potential interventions include mediation, flexible financial assistance, housing navigation, and reconnection with family, friends, or other community supports. The 2026 Home Safe evaluation distinguishes diversion from prevention by describing it as an approach that helps people who have recently become homeless resolve their circumstances rapidly, using many of the same practical interventions employed in prevention. This distinction is analytically important because

[52]"Homelessness Prevention Component," 24 C.F.R. § 576.103, accessed October 14, 2026, www.law.cornell.edu/cfr/text/24/576.103; "Housing Relocation and Stabilization Services," 24 C.F.R. § 576.105(b)(2).

[53]SeniorAge, "Home Safety."

[54]"Homeless Prevention Components," 24 C.F.R. §§ 576.103, 576.105(a)–(c).

maintaining an existing tenancy and restoring housing after its loss involve different starting conditions. For older adults, the appropriateness of a diversion arrangement should depend on its safety, accessibility, and compatibility with the individual's preferences and support needs.[55]

Diversion must not become an administrative justification for returning an older adult to an unsafe household. A proposed arrangement should specify where the individual will reside, whether participation is voluntary, its anticipated duration, and the contingency plan if the arrangement ends. Professional guidance emphasizes that people without a safe alternative should not be diverted away from shelter. Assessment should therefore consider more than the immediate availability of a bed: it should examine whether the person can use the accommodation safely and remain there without unacceptable conditions. A discharge destination should not be classified as successful merely because it is outside the emergency shelter system.[56]

Comparable safeguards should govern mediation between an older adult and a landlord, relative, caregiver, or prospective host. A negotiated agreement may be appropriate when the parties can participate voluntarily and communicate without intimidation. It should not require an individual to relinquish safety, accept exploitation, or assume obligations that cannot reasonably be sustained in order to avoid homelessness. Where abuse, neglect, or exploitation is suspected, the response should include appropriate professional assessment and compliance with applicable reporting obligations. Missouri's Adult Protective Services framework provides a relevant pathway for concerns involving eligible adults. Under such circumstances, mediation should not be presumed an appropriate substitute for protective intervention, legal assistance, or an alternative housing placement.[57]

Any local pilot should incorporate the eligibility, consent, escalation, and follow-up standards specified in the implementation agenda. A local design should also assign responsibility for unresolved cases so that an unsuccessful diversion attempt does not interrupt access to other assistance.[58] Diversion outcomes should be assessed through subsequent housing stability, not shelter avoidance alone. The Home Safe evaluation explicitly distinguishes temporary

[55]Kushel et al., *Evaluation of the Home Safe Program*, 7–8.

[56]National Alliance to End Homelessness, "Key Takeaways: The Role of Emergency Shelter in Diversion," March 10, 2025, accessed October 14, 2026, endhomelessness.org/resources/toolkits-and-training-materials/role-emergency-shelter-diversion/.

[57] Missouri DHSS, "8.00 Abuse, Neglect and Exploitation," *Home and Community Based Services Manual*, accessed October 14, 2026, health.mo.gov/providers/manuals/home-and-community-based-services-manual/800-abuse-neglect-and-exploitation

[58]Kushel et al., *Evaluation of the Home Safe Program*, 3–6, 8–9.

accommodation from permanent housing in its outcome definitions, illustrating why an indoor destination cannot automatically be treated as a permanent resolution. Local reporting should also identify unknown outcomes and avoid presenting short-term shelter avoidance as proof that continuing assistance is unnecessary.[59]

Diversion is most appropriately understood as an additional housing pathway, not as a mechanism for denying access to emergency shelter or other housing assistance. Its value lies in expanding safe choices through collaborative problem-solving rather than narrowing the options available to someone in crisis. National Alliance to End Homelessness guidance explicitly states that diversion should not function as a barrier to available shelter. Accordingly, declining an unsuitable arrangement should prompt further assessment and consideration of alternatives rather than an assumption that the person has rejected assistance. The governing principle should be choice: a diversion outcome is defensible only when it offers an acceptable response to the individual's housing crisis without making safety contingent on compliance.[60]

Housing First, With Support

Debates concerning Housing First can become detached from the circumstances and preferences of individual older adults. Housing First treats stable housing as a foundation for addressing other needs rather than a reward for demonstrating "housing readiness." The Home Safe evaluation emphasizes prompt connection to housing or housing supports, voluntary services, and participant choice. For older adults, implementation must combine these principles with attention to affordability, functional suitability, and the assistance required to sustain the placement. For Springfield and Greene, Christian, and Webster Counties, the proposed analytical focus should therefore be the suitability and sustainability of each housing arrangement, rather than an abstract choice between housing and services.[61]

For an older adult experiencing a persistent affordability gap, the housing component should provide a credible means of maintaining affordability beyond the initial placement. For an individual requiring assistance with personal care, the service component should be sufficient, accessible, and confirmed rather than merely anticipated. Conversely, a person who requires neither intensive assistance nor a specialized setting should not be presumed to need a more complex intervention solely because of age or a history of homelessness. Missouri's home- and

[59]Kushel et al., *Evaluation of the Home Safe Program*, 10–11.

[60]National Alliance to End Homelessness, "Diversion," accessed October 14, 2026, endhomelessness.org/resources/toolkits-and-training-materials/diversionexplainer/

[61]Kushel et al., *Evaluation of the Home Safe Program*, 8.

community-based services process reinforces the importance of individualized assessment, participant-centered planning, and subsequent adjustments when needs or supports change. Local planning should consequently distinguish the need for financial assistance from the need for personal care, while recognizing that some residents require both.[62]

This approach avoids two misleading alternatives: requiring complete self-sufficiency before housing is offered and assuming that placement in a unit completes the intervention regardless of its suitability. The first makes the resolution of other difficulties a prerequisite for housing, whereas the second treats an address as sufficient evidence of stability. The Home Safe evaluation describes participants whose housing needs were inseparable from mobility limitations, medical needs, and inadequate financial resources, illustrating why placement and support must be considered together. A more defensible local standard would assess whether the resident can afford, safely use, and maintain the housing arrangement over time. Under this standard, continuing assistance is not necessarily evidence of program failure; it may be an appropriate component of sustained housing stability.[63]

Program planning should distinguish several related questions: What housing costs can the household sustain? Which physical features or accommodations are necessary? What assistance, if any, does the resident require? Which services can be funded and delivered? Who will respond if circumstances change? These questions support individualized decisions without presuming that a single housing model is appropriate for all older adults. Missouri's published guidance identifies eligibility assessment, individualized care planning, changes to care plans, annual reassessment, and service cost limits as distinct elements of its home- and community-based services framework. A proposed local housing plan should similarly distinguish an identified need, eligibility for assistance, and the confirmed availability of a provider or funding source.[64]

Age-restricted subsidized housing represents one potential resource within this broader continuum. HUD's occupancy guidance describes Section 202 housing with Project Rental Assistance Contracts as requiring at least one household member to be sixty-two or older at initial occupancy. Meeting that age criterion does not, by itself, establish full eligibility, suitability of a particular unit, or immediate access to a vacancy. HUD's handbook distinguishes eligibility determinations from waiting-list administration and selection for available units. Local practitioners should therefore verify property-specific requirements, accessibility, application

[62]Missouri DHSS, "HCBS Eligibility, Process & Program Limits."

[63]Kushel et al., *Evaluation of the Home Safe Program*, 12–13.

[64]Missouri DHSS, "HCBS Eligibility, Process & Program Limits."

procedures, and availability before incorporating a particular property into a housing plan. This discussion does not establish current vacancies or waiting-list lengths in the Springfield region.[65]

Housing and Care Together

Housing assistance and personal care operate within distinct administrative structures, often involving different eligibility criteria, agencies, and funding sources. Missouri's guidance, for example, assigns Medicaid eligibility determinations to the Department of Social Services' Family Support Division and authorization of the home- and community-based services discussed here to the Department of Health and Senior Services' Division of Senior and Disability Services. Coordination therefore requires more than issuing separate referrals for housing and care. For Springfield and Greene, Christian, and Webster Counties, a proposed integrated approach should identify how each component will be secured and how the components will function together. A housing arrangement that depends on personal assistance should not be considered fully planned until responsibility for arranging that assistance has been established.[66]

Missouri's home- and community-based services guidance identifies several requirements, including Medicaid coverage that reimburses for the requested services, an appropriate eligibility category, participation in assessment and person-centered planning, nursing-facility level of care, and assessed unmet needs that authorized services can address. The state also describes program-specific requirements and cost limits that constrain the services available to an eligible participant. Consequently, an older adult's demonstrated need for assistance does not, by itself, establish eligibility for a particular service package. Assessment should distinguish the existence of a need from the legal and administrative conditions governing the response. This distinction is especially important when a housing plan would be unsafe or impracticable without a specified level of continuing assistance.[67]

Navigators should confirm the setting, scope, provider, and anticipated start of personal assistance before relying on it in a housing plan.[68]

For eligible residents leaving institutional settings, Missouri's Show-Me Home program

[65]HUD, "Chapter 3: Eligibility for Assistance and Occupancy," in *Occupancy Requirements of Subsidized Multifamily Housing Programs*, HUD Handbook 4350.3 REV-1, section 2, provisions concerning Section 202 Project Rental Assistance Contracts, accessed October 14, 2026, www.hud.gov/sites/documents/43503c3hsgh.pdf; HUD, "Chapter 3," para. 3-1(A)(1).

[66]Missouri DHSS, "2.00 Medicaid Eligibility."

[67]Missouri DHSS, "2.00 Medicaid Eligibility"; Missouri DHSS, "HCBS Eligibility, Process & Program Limits."

[68]Missouri DHSS, "HCBS Eligibility, Process & Program Limits"; Missouri DHSS, "2.00 Medicaid Eligibility," under "Spenddown and HCB Medicaid—Referrals."

provides a specialized transition pathway. The state describes Show-Me Home as a Money Follows the Person initiative supporting older adults and adults with disabilities who move from qualifying institutional residence to specified community settings. Its published criteria include at least sixty consecutive days in a skilled nursing facility, applicable MO HealthNet coverage before and after transition, and a move to qualified housing in which the participant's health and welfare can be assured. These conditions distinguish the program from a general housing entitlement for older adults experiencing homelessness. The guidance also distinguishes Show-Me Home participation from authorization of home- and community-based services: a nursing-facility level-of-care score is required when those services are to be authorized, but not for Show-Me Home participation alone.[69]

The local implication is that assistance should follow the individual's circumstances rather than require every older resident to complete an identical sequence of referrals. A person needing a modest accessibility modification, a person requiring continuing rental assistance, and a person transitioning from a skilled nursing facility may require different professional teams, funding sources, and timelines. Show-Me Home illustrates a structured transition model in which a coordinator assists eligible participants with identifying needs, locating appropriate housing, verifying safety and accessibility, and developing a transition plan. Its relevance to broader local practice lies in the deliberate allocation of coordination responsibilities, not in an assumption that every older adult qualifies for the program. A differentiated approach should preserve a clear point of contact while allowing the composition of the service team to reflect the actual housing and care needs.[70]

A proposed housing-and-care conference should produce a resident-informed plan specifying the intended setting, the resident's preferences, responsible parties, payment sources, unresolved questions, target dates, and responsibility for confirming that services have begun. It should also establish a contingency if the arrangement cannot be implemented, an emergency backup strategy, and follow-up after placement. These are proposed local planning standards informed by Show-Me Home's procedures, not requirements governing every housing program.[71]

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[69]Missouri DHSS, "7.00 Show-Me Home," in *Home and Community Based Services Manual*, under "Introduction," "Eligibility Criteria," and "Procedures," accessed October 11, 2026, health.mo.gov/providers/manuals/home-and-community-based-services-manual/700-show-me-home.

[70]Missouri DHSS, "7.00 Show-Me Home," under "Procedures."

[71]Missouri DHSS, "7.00 Show-Me Home," under "Procedures" and "Participation."

Lessons From Home Safe

California's Home Safe program provides a useful external example of integrating adult protection, housing assistance, and homelessness prevention. Administered by the California Department of Social Services and implemented through county Adult Protective Services agencies and their partners, the program offers financial assistance, housing navigation, landlord mediation, and enhanced case management. Its institutional significance lies in connecting expertise in aging and disability with the practical resources of the homelessness-response system. For Springfield and Greene, Christian, and Webster Counties, this structure offers a potential planning reference rather than an immediately transferable program model. Home Safe is not a Missouri program, and its eligibility rules, funding arrangements, and administrative authority should not be presumed to apply locally.[72]

A UCSF evaluation published in January 2026 included 6,709 cases in its principal analytical dataset, with 3,887 observations available for the relevant entry-to-exit housing analysis. Among participants included in that analysis who were housed at entry, 1,744 of 1,858 remained housed at exit, or 93.9 percent; among those experiencing homelessness at entry, 1,184 of 2,029 were housed at exit, or 58.4 percent. These percentages describe different starting populations and should not be combined into a single program "success rate." They also concern housing status at case closure rather than a uniform period of sustained housing after assistance ended. Interpretation therefore requires attention to the denominator, the evaluation's housing definitions, and the point at which outcomes were measured.[73]

These findings document observed outcomes, not a demonstrated causal effect. Although the evaluation included comparisons with other administrative homelessness data, it did not establish an equivalent untreated comparison group showing what would have occurred without Home Safe assistance. Missing outcome information and incomplete longer-term follow-up further limit interpretation; the proportion remaining housed cannot be equated with the proportion whose homelessness the program prevented. Nor do the findings establish a guaranteed success rate for a local initiative. Practical implementation lessons nevertheless remain useful: the evaluation identifies flexible funding, housing navigation, and collaboration between Adult Protective Services and homelessness providers as important features worth considering in the Ozarks. Any adaptation should examine how local housing availability, partner

[72]Kushel et al., *Evaluation of the Home Safe Program*, 3–9.

[73]Kushel et al., *Evaluation of the Home Safe Program*, 9–11, 19–20.

capacity, eligibility, and service delivery differ from the California setting.[74]

The evaluation also demonstrates why reported expenditures require careful interpretation. It identifies a median recorded expenditure of $1,326 per case while acknowledging variation in accounting practices and incomplete inclusion of personnel and administrative costs. This figure should not be treated as a standardized estimate of the full resources required to operate the program. A proposed local budget would need to identify direct household assistance separately from navigation, supervision, administration, data collection, and follow-up. Without that distinction, borrowing the California median as a projected cost per household could substantially understate the resources necessary to deliver a comparable intervention.[75]

These findings provide a basis for a local implementation agenda that tests promising practices while setting explicit responsibilities, realistic resource requirements, and measurable outcomes.[76]

A Local Implementation Agenda

For Springfield and Greene, Christian, and Webster Counties, OAEH and interested housing, aging-service, legal, and care partners should define the population to be served, participating organizations, decision-making responsibilities, and a manageable initial scope. A written implementation framework should assign responsibility for each action below and establish criteria for reviewing progress.[77]

Establish an older adult pathway.

Develop a shared initial assessment addressing displacement risk, continuing affordability, mobility, daily functioning, safety, consent, and access to essential services. Participating organizations should distinguish initial screening from later program-specific eligibility requirements and assign a lead contact for unresolved needs. The deliverable should be a documented pathway identifying the next action, responsible organization, and follow-up date.[78]

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[74]Kushel et al., *Evaluation of the Home Safe Program*, 5-6, 23-28.

[75]Kushel et al., *Evaluation of the Home Safe Program*, 5, 28–30, 37.

[76]Kushel et al., *Evaluation of the Home Safe Program*, 5–6, 36–37.

[77]Kushel et al., *Evaluation of the Home Safe Program*, 3-6.

[78]"Housing Relocation and Stabilization Services," 24 C.F.R. § 576.105(b)(1)(i)–(ii), (b)(2).

Create a flexible prevention mechanism.

Establish a fund with written eligibility rules, permissible expenditures, decision-making authority, and timely review procedures. Its administrator should distinguish temporary financial disruptions from continuing affordability gaps and identify complementary resources for needs outside the fund's authority. Each approval should document how the expenditure supports a credible housing-stability plan, not simply the amount disbursed.[79]

Formalize legal escalation.

Establish a protocol for identifying housing-related notices and deadlines, making prompt legal referrals, and confirming the outcome. Assign responsibility for follow-up while recognizing that representation depends on eligibility and provider capacity. The protocol should specify what happens when legal assistance cannot be secured before an urgent deadline.[80]

Audit accessibility.

Emergency and permanent housing partners should review actual usability, including entrances, bathrooms, sleeping arrangements, circulation routes, equipment, communication, and necessary assistance. Designated reviewers should identify barriers and produce a corrective-action list with responsible parties, priorities, and funding needs. Applicable legal obligations should be evaluated separately for each program and property.[81]

Connect housing and aging services.

Designate organizational contacts and adopt shared procedures for supported handoffs, consent-based information exchange, functional assessment, and follow-up. Assigned navigators should distinguish identified needs from service authorization and confirmed delivery, verifying the setting, scope, provider, and anticipated start of assistance before relying on it. The resulting protocol should identify who remains responsible when a requested service is unavailable.[82]

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[79]"Housing Relocation and Stabilization Services," 24 C.F.R. § 576.105(a)–(c); "Short-Term and Medium-Term Rental Assistance," 24 C.F.R. § 576.106, accessed October 14, 2026, www.law.cornell.edu/cfr/text/24/576.106.

[80]LSOSM, "Housing," accessed November 4, 2026, www.lsosm.org/lssm-services/housing/; LSOSM, "Applicants," accessed October 14, 2026, www.lsosm.org/applicants/; LSOSM, "Online Intake System," accessed October 14, 2026, application.lsosm.org/Application.

[81]U.S. Department of Justice, "Emergency Shelters: Access to All," in *ADA Best Practices Tool Kit for State and Local Governments*, chap. 7, addendum 2, accessed October 14, 2026, archive.ada.gov/pcatoolkit/chap7shelterprog.htm; U.S. Department of Justice, *ADA Checklist for Emergency Shelters*, accessed October 14, 2026, archive.ada.gov/pcatoolkit/chap7shelterchk.pdf.

[82]SeniorAge, "Transportation"; SeniorAge, "Home Safety"; SeniorAge, "Legal Services"; Missouri DHSS, "2.00 Medicaid Eligibility."

Include older adults in design.

Invite older adults with lived experience to review the proposed process through voluntary, accessible participation that does not affect eligibility for assistance. Before consultation begins, participating organizations should establish participation supports, decide on compensation for time and expenses, and explain how feedback will influence decisions. A written summary should document recommendations received, changes made, and reasons for decisions not to adopt particular suggestions.[83]

Define the pilot's boundaries.

The implementation framework should identify exclusions, unresolved funding needs, and procedures for seeking alternative assistance. Partners should state clearly that a limited prevention initiative cannot guarantee continuing rental subsidies, unfunded clinical services, or immediately available housing. Assign responsibility for documenting needs beyond the pilot's capacity and reporting them separately from its implementation results.[84]

Measuring What Matters

A local older adult housing strategy should count program activity, access to assistance, housing placement, and housing retention separately. Payments and referrals document actions taken; they do not, by themselves, establish that assistance began, a household moved into housing, or an existing arrangement became sustainable. For Springfield and Greene, Christian, and Webster Counties, partners should establish shared definitions and follow-up intervals before implementation, distinguishing immediate intervention from subsequent housing stability. The proposed dashboard below would organize these measures without combining different stages of assistance into a single "success" total.[85]

Proposed measure	Question it addresses	Recommended reporting distinction
Older adult households requesting assistance	Who is reaching the pathway?	Distinguish unique households from repeat contacts and identify the age threshold used.
Households facing	What proportion of	Record the identified housing threat

[83]Kushel et al., *Evaluation of the Home Safe Program*, 6-8.

[84]Kushel et al., *Evaluation of the Home Safe Program*, 5–6.

[85]Kushel et al., *Evaluation of the Home Safe Program*, 3, 6, 9-11, 19-21.

imminent displacement	demand concerns prevention?	and relevant deadline separately from general housing concerns.
Completed housing-needs and functional-support reviews	Have accessibility and assistance needs been identified?	Distinguish initial screening from any formal assessment requiring a qualified professional.
Time from request to substantive assistance	Is help arriving while it can still affect the outcome?	Distinguish acknowledgment, assessment, approval, and actual delivery of assistance.
Confirmed housing placements	Did a household move into housing?	Count move-ins separately from applications, referrals, and approvals.
Housing status at follow-up	Is the arrangement continuing?	Distinguish permanent housing, temporary accommodation, homelessness, and unknown status.
Initiation of necessary supports	Did assistance begin as planned?	Record confirmed service delivery separately from referral or authorization.
Unresolved cases and documented reasons	Where does the response lack an appropriate option?	Separate ineligibility, unavailable resources, unsuccessful contact, and arrangements declined as unsuitable.
Outcomes by age and other relevant characteristics	Are access and outcomes uneven?	Use consistent categories, protect confidentiality, and acknowledge small sample sizes.
Expenditures and operating resources	What resources were required?	Separate direct household assistance from staffing, administration, and follow-up costs.

Public reporting should make completeness visible. Each percentage should include its numerator and denominator, identify exclusions, and report unknown outcomes separately rather than implicitly treating them as successes. At each follow-up interval, reports should state how many households were due for review and how many had known outcomes. Changes in follow-up completeness should be considered when interpreting apparent improvement or deterioration over time.[86]

[86]Kushel et al., *Evaluation of the Home Safe Program*, 19–21, 36–37.

Evaluation should not create incentives to avoid residents with the greatest housing and support needs. Unadjusted comparisons may be misleading when providers serve populations with different starting circumstances, and the Home Safe evaluation identifies limitations in comparisons across programs and administrative datasets. Provider-level results should therefore be interpreted alongside participant characteristics, service availability, local housing constraints, and the resources available to each intervention. The objective is accountability through learning: determining what was delivered, what outcomes were observed, for whom, under what conditions, and at what full cost. Consistent with the evaluation's recommendation for standardized accounting, local cost reporting should include personnel and operating resources rather than rely exclusively on direct payments to households.[87]

Turning Awareness into Action

Homelessness Awareness Month can strengthen the local response when public engagement connects people with specific, verified opportunities to help. An older adult awareness initiative should build on existing community education efforts, respect partner organizations' capacity, and identify what participants should learn, how they can contribute, and who will coordinate their involvement.[88]

Learn the local connections.

Residents, employers, congregations, and community groups can learn where older adults may seek housing assistance, legal advice, transportation information, and related support. Campaign materials should distinguish these functions rather than imply that every organization provides the same assistance. Contact information, access procedures, eligibility requirements, and advertised availability should be verified before publication.[89]

Support an identified need.

Before organizing a collection or volunteer activity, ask a participating organization which contributions would address its current priorities. Confirm whether requested goods can be stored and distributed, whether financial contributions would be more useful, and what volunteer roles are authorized. The contribution's value should be judged by its usefulness to

[87]Kushel et al., *Evaluation of the Home Safe Program*, 5–6, 19-21, 28–30, 36-37.

[88]OAEH, *Annual Report: Fiscal Year 2025*, 15.

[89]SeniorAge, "Transportation," accessed November 5, 2026; SeniorAge, "Legal Services; OAEH, *Annual Report: Fiscal Year 2025*, 3–4, 10.

residents and service delivery, not by the visibility of the donation event.[90]

Help someone make a connection.

With the older adult's permission, appropriate assistance may include preparing questions, organizing documents, finding reliable contact information, or communicating with a program. Participating organizations should define volunteer boundaries and provide a staff contact for concerns; volunteers should not promise eligibility, offer legal advice, or assume personal-care responsibilities beyond their training and authorized role. These safeguards allow practical help without displacing professional judgment or taking control of the resident's decisions.[91]

Awareness materials should represent older adults as people with agency, relationships, and varied experiences rather than as symbols of tragedy. Photographs, quotations, and personal histories should be used only with meaningful consent and appropriate organizational review. As a proposed campaign standard, consent should distinguish receiving services from agreeing to public disclosure and explain the intended audience and uses of the material. Participation in publicity should never become an explicit or implicit condition of assistance.[92]

Meaningful participation should also extend beyond sharing personal stories. OAEH's Every Voice Counts Council offers an existing model through which people with lived experience contribute direction and expertise to programs and strategic development. An older adult initiative should similarly create opportunities to influence decisions, not merely appear in campaign materials.[93]

Public education cannot substitute for affordable housing, legal representation, or adequate care. It can improve understanding, facilitate connections, and build support for the resources those responses require. Campaign evaluation should therefore distinguish educational participation, donations, and publicity from completed service connections and housing outcomes; activity alone does not establish that a housing problem has been resolved.[94]

The campaign's contribution should be to turn public understanding into sustained local action through verified opportunities to learn, contribute, and help people connect with

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[90]OAEH, *Annual Report: Fiscal Year 2025*, 10.

[91]SeniorAge, "Legal Services"; LSOSM, "Applicants," accessed November 5, 2026.

[92]SeniorAge, "Transportation"; SeniorAge, "Legal Services," accessed November 5, 2026; OAEH, *Annual Report: Fiscal Year 2025*, 3–4, 10.

[93]OAEH, *Annual Report: Fiscal Year 2025*, 13.

[94]OAEH, *Annual Report: Fiscal Year 2025*, 15–16

assistance. Those opportunities should complement professional services and remain accountable to residents' preferences rather than presume that goodwill alone establishes an appropriate response.

Aging in Community

Aging safely in community should not depend on an older adult's ability to navigate disconnected systems, remain entirely self-sufficient, or endure a preventable housing crisis before receiving help. The ethical standard is access to a home that is affordable, safe, usable, and supported when necessary, with meaningful choice over daily life and assistance.

The argument is not that every older resident needs the same intervention. It is that housing stability requires a response proportionate to the person's circumstances: prevention when an existing home remains viable, an appropriate alternative when it does not, and confirmed support when continued residence depends on assistance. Coordination matters when it produces those results, not simply when organizations exchange referrals.

Part Two of *Beyond the Myths* therefore proposes that older adult housing stability become an explicit local responsibility—measured carefully, supported through practical interventions, and discussed without reductive assumptions. Aging in community should be a shared commitment to continuity: preserving housing where feasible, restoring it when necessary, and coordinating support as circumstances change. Success should be judged by sustained housing, safety, and resident choice, not solely by the volume of emergency assistance delivered.