A STATEWIDE MODEL — FROM MINNESOTA

The Minnesota Model

Ending veteran homelessness — and showing what's possible for everyone else.

A printable companion to share.mac-v.org — the coordinated model behind a 60%+ reduction in Minnesota's actively homeless veteran count, the independently measured impact it produces, and a practical framework for adapting it elsewhere.

Minnesota Assistance Council for Veterans
In partnership with the Minnesota Department of Veterans Affairs, the U.S. Department of Veterans Affairs homeless programs, counties, tribal nations, health systems, courts, landlords, and community organizations statewide.

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What's in this report.

AT A GLANCE

60%+ Reduction in actively homeless veterans since 2022	**3,281** Veterans served across MACV programs in 2025	**1,022** Veterans prevented from becoming homeless in 2025	**$1.26** In social value created per dollar invested

01 · THE MOMENT

A systemic end is in reach.

Minnesota's count of actively homeless veterans is at the lowest level ever recorded since the creation of the Minnesota Homeless Veteran Registry in 2014 — down more than 60% since post-pandemic highs in 2022. This report documents the coordinated model that made it possible, so others can adapt what works.

For two decades, Minnesota has built — quietly and methodically — one of the country's most coordinated systems for ending veteran homelessness. MACV sits at the center of that work, partnering with the Minnesota Department of Veterans Affairs, the VA, county and tribal veteran service officers, continuums of care, landlords, healthcare systems, the corrections system, the courts, and dozens of local nonprofits.

In 2026, Minnesota is positioned to reach an effective end to veteran homelessness — the point at which homelessness, when it occurs, is rare, brief, and non-recurring. We recognize that ending homelessness is both systemic and individual: while we can achieve milestones in building a proven effective homelessness response system, individuals and their families will continue to encounter situations in their lives in which they will need to rely on this system for their individual solution and path to housing stability. We must continue to invest in our most effective systems and innovate to become increasingly effective.

We built the website this report accompanies to share what worked — not as a finished product, but as a living model that can be studied, debated, and adapted by others ending homelessness for veterans in other states, or for broader populations here in Minnesota.

WHO THIS IS FOR

Other states ending veteran homelessness — use the model as a blueprint for statewide coordination: registry, governance, and dual-path housing.

Minnesota organizations serving other populations — translate what works for veterans to families, justice-involved adults, people facing opioid use disorder, seniors, Native American and Indigenous communities, and youth experiencing homelessness.

Funders & policymakers — understand the funding stack — federal, state, philanthropic — that sustains and scales coordinated systems.

02 · OUR WHY

An open invitation, not a finished product.

The Minnesota Assistance Council for Veterans (MACV) is a nonprofit dedicated to ending veteran homelessness in Minnesota. For decades, MACV has worked alongside the Minnesota Department of Veterans Affairs, the federal VA, county veteran service officers, healthcare systems, courts, landlords, and dozens of partner organizations — building one of the most coordinated systems for ending veteran homelessness in the country.

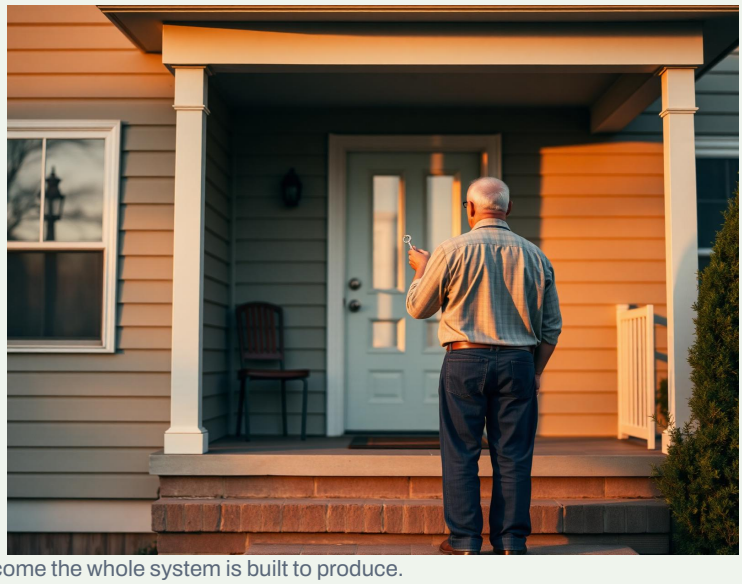
Minnesota's progress is real, measurable, and the result of many hands. We don't claim a finished answer. We do claim a working model — one we believe can be studied, adapted, and improved by others doing this work for veterans elsewhere, or for broader populations facing homelessness.

This report and its companion website are a thought-leadership initiative — separate from MACV's core comprehensive services — built to define the model clearly, share what we've learned, and invite partnership in growing the impact.

WHY IT MATTERS

"From entry to exit, housing stability rose from 16% to 88% for permanent supportive housing tenants — and from 4% to 80% in transitional housing."

WILDER RESEARCH · SROI ANALYSIS · DECEMBER 2025



Housing stability is the outcome the whole system is built to produce.

03 · THE MODEL

Five components. One coordinated system.

Minnesota's progress isn't the result of any single program — it's the discipline of operating prevention, intake, housing, services, and data as one connected system across the entire state.

01 Entry & Intake

Multiple front doors, one front office.

- Veterans initially get connected to services through a combination of outreach efforts, community events, referrals from local partner organizations (nonprofits, shelters, government services), referrals from county and tribal veteran service officers throughout Minnesota, and through key partnerships with the Minnesota Department of Veterans Affairs and the federal Veterans Affairs homeless programs.
- An online Initial Contact Screening captures basic info, income, and household so triage can begin immediately.
- All cases are routed into a single coordinated workflow — no cold hand-offs between agencies.

02 Veteran Enablement (Barrier Removal)

Treat the cause, not just the symptom.

- Specialized pathways address healthcare, legal, employment, and justice involvement.
- Targeted services and direct financial assistance address root causes — income instability, legal issues, lack of access to care.
- Case management runs alongside placement, not after it.

03 Housing Supply

A dual-path housing portfolio matched to need.

- Veterans are matched to transitional or permanent housing based on intensity of need (low-, medium-, or high-touch).
- Subsidies — HUD-VASH, SSVF, MNVEST — are layered with case management to support sustained tenancy.
- MACV owns and operates 230 supportive housing units for the highest-need veterans, plus a landlord-engaged market portfolio offering additional barrier-flexible units.

04 Partnership Ecosystem

Same table, shared accountability.

- Coordinated work across housing providers, Continuums of Care, healthcare systems, corrections, and community organizations.
- Active landlord engagement to expand unit access for veterans with high barriers to private-market housing.
- Statewide visibility through the MN Department of Veterans Affairs and county Veteran Service Officer network.

05 Data & Infrastructure

One source of truth — only as powerful as its integrity and analysis.

- The Minnesota Homeless Veteran Registry is the system's backbone — a real-time, by-name list shared across agencies.
- Salesforce serves as MACV's system of record; Tableau dashboards drive resource allocation and case prioritization.
- Shared data across HMIS, partner referrals, and MACV programs enables end-to-end visibility, not fragmented snapshots.
- Data sharing only works when paired with rigorous data integrity — consistent definitions, timely entry, and clear governance — so the registry remains trustworthy.
- Dedicated capacity to analyze that data turns shared records into program improvements, targeted services, and early warning of where the system is falling short.

04 · END-TO-END PATHWAY

From first contact to long-term stability.

Coordinated intake, subsidy, and support pathways that enable scalable housing placement and long-term stabilization — across five layers of the system.

LAYER 1 **State & Policy Layer**	1. Define eligibility (VA + MDVA) 2. Maintain the Veteran Registry 3. Statewide visibility & reporting 4. Funding allocation & benchmarking
LAYER 2 **Intake & Triage**	1. Veteran contacts MACV (outreach, referral, web) 2. Initial Contact Screening 3. Needs & urgency assessment 4. Pathway routing: low / medium / high touch
LAYER 3 **Case Management**	1. Assigned case manager (every veteran) 2. Stabilization plan 3. Connection to specialized services 4. Ongoing case management & support
LAYER 4 **Housing Supply & Navigation**	1. Subsidy match (HUD-VASH, SSVF, MNVEST) 2. Coordinate with VA + housing authority 3. Landlord engagement / unit sourcing 4. Place in MACV housing if needed
LAYER 5 **Continuum of Care**	1. Health systems & corrections 2. Continuums of Care + county coordination 3. Housing developers & landlords 4. Long-term stability & follow-up

Intensity of service, matched to need

LOW-TOUCH	MEDIUM-TOUCH	HIGH-TOUCH
Stipend + light coordination; veteran secures unit with minimal barriers.	Landlord engagement + structured case coordination to address barriers.	Placement in MACV-owned housing + cross-team stabilization support.

05 · THE BACKBONE

Data is the system.

Unlike fragmented systems, Minnesota's Homeless Veteran Registry creates a single source of truth — enabling coordinated action across agencies and reducing duplication and delay.

Sharing data is only the starting point. The system depends just as much on data integrity — consistent definitions, timely and accurate entry, and clear governance — and on the analytic capacity to turn that data into program improvements, targeted services, and honest measurement of what is and isn't working.

MN Homeless Veteran Registry

Real-time, by-name list shared across state, county, and provider partners.

Salesforce

MACV's system of record — intake, referrals, case workflows, housing placement, and ongoing case management.

Tableau dashboards

Operational reporting that drives data-driven decisions and surfaces gaps in service delivery.

HMIS + partner systems

Integrated data flows into and out of the registry, creating a 360° view for each veteran.

06 · IMPACT

What the model produces — measured.

In December 2025, Wilder Research published an independent Social Return on Investment analysis of MACV's programs. The findings show what a coordinated, statewide system actually delivers — for veterans, for taxpayers, and for communities.

$26.8M
in estimated annual social and economic benefits
RANGE: $20.3M – $55.2M DEPENDING ON ASSUMPTIONS

$1.26
of social value created per dollar invested
UP TO $2.59 UNDER LESS CONSERVATIVE ASSUMPTIONS

6,100+
veterans served between 2019 and June 2025
ACROSS ALL MACV PROGRAM AREAS STATEWIDE

Housing stability — entry to exit

The clearest measure of a housing intervention is whether people are still housed when they leave. MACV's tenants exit stably at rates that transform what's possible for high-acuity populations.

PERMANENT SUPPORTIVE HOUSING

16% → 88%

Stable housing at program exit, among MACV permanent supportive housing tenants with available data, 1/1/2019 – 6/30/2025.

TRANSITIONAL HOUSING

4% → 80%

Stable housing at program exit, among MACV transitional housing tenants with available data, 1/1/2019 – 6/30/2025.

2025 — by the numbers

3,281
Veterans served across all MACV programs

1,022
Veterans prevented from becoming homeless

736
Veterans placed in housing suited to their needs

200
Veterans housed in MACV-owned or managed properties

Beyond the numbers

The SROI captures a substantial portion of the measurable economic impact — but only a portion. Stable housing, consistent income, and access to support services produce better physical and mental health, stronger family relationships, and a greater sense of security and self-determination for veterans. These improvements in quality of life are difficult to quantify, but they are central to what this work actually is.

SOURCE

Warren, C. (2025). Social Return on Investment Analysis of Minnesota Assistance Council for Veterans. Wilder Research, December 2025.

07 · DRIVERS OF IMPACT

Where the value comes from.

Ten program areas make up the operating core of the model. Each is described below in the same structure: its purpose in the system, how it works, who it serves, how it connects to the rest of the model, and the design choices another organization could borrow. The language is generalized deliberately — these functions are not veteran-specific.

Outreach

Consistent staff presence in homeless shelters and reaching veterans who are unsheltered to build an initial relationship as the foundation for connecting them to broader services and support for their pathway to housing stability.

PURPOSE

Outreach is the front door of the system — the function that finds people who aren't already engaged with services and builds enough trust to start a housing pathway.

HOW IT WORKS

- Recurring, predictable staff presence inside shelters, drop-in centers, libraries, and other places people experiencing homelessness already are.
- Direct, in-person engagement with people who are unsheltered, on their own terms and timeline.
- Repeated, low-pressure follow-up to convert a first conversation into a working relationship.
- Hands-on help gathering the documents (ID, income verification, eligibility paperwork) that downstream housing programs require.
- Warm hand-off to a housing case manager once the person is ready and documentation is in place.
- Public presence at community events, partner agencies, and provider networks to keep referral pipelines flowing.

WHO IT SERVES

People experiencing homelessness — especially those who are unsheltered or disconnected from mainstream services and unlikely to walk into an office on their own.

HOW IT FITS THE LARGER SYSTEM

Outreach feeds every other part of the system. Without it, the rest of the model only reaches people already savvy enough to ask for help. Outreach staff often stay with a person through documentation gathering, then transfer the case to housing-stability staff once the person can engage with structured services.

DESIGN NOTES FOR REPLICATION

- Consistency beats intensity — the same staff showing up on the same day each week is what builds trust.
- Outreach is a relationship role, not a transaction role; measure it on engagement and hand-off quality, not on units of service.
- Equip outreach staff to start paperwork in the field so momentum isn't lost between first contact and intake.

Direct financial assistance

Rental assistance accounts for the largest share of measurable benefit — preventing eviction and homelessness while reducing public-system costs.

PURPOSE

Direct financial assistance is the flexible fuel of the system — short-term dollars that resolve an immediate housing crisis and longer-term subsidies that keep rent affordable once a person is housed. It is essential, but it is never sufficient on its own.

HOW IT WORKS

- A blended funding stack drawn from federal, state, local, and philanthropic sources, so a single rigid grant rule never becomes the reason a person loses housing.
- Short-term, temporary assistance focused on overcoming barriers to housing access or stability: security deposits, first month's rent, time-limited rental arrears, utility arrears and reconnections, moving costs, emergency food, work-related supplies, equipment, training or certification fees, transportation, and similar one-time needs.
- Longer-term assistance in the form of ongoing rental subsidies (vouchers and shallow-subsidy models) that close the gap between what a household can pay and what the unit costs, so affordability is sustained, not just patched.
- Every assist is paired with a thoughtful stability plan co-developed with the participant — the dollars move alongside case management, not in place of it.
- Disciplined decision-making guided by four questions on every request: Is there a strong likelihood the assistance will move the household toward housing stability? Are there options other than financial assistance that would resolve the crisis? Are there other funds or supports that could be explored first? What are the anticipated consequences if assistance is not provided?
- Active braiding with other resources before tapping flexible funds — public benefits enrollment (SNAP, TANF, general assistance, waivered services), disability income (SSI/SSDI), housing vouchers, VA service-connection and healthcare, utility assistance programs, 2-1-1 community resources, and partner emergency grants.
- Built-in checkpoints — recertification reviews, escalation when a household has multiple consecutive assists over 3+ months, and supervisor consultation on large or recurring requests — so financial help does not quietly become a cycle.

WHO IT SERVES

People at imminent risk of losing housing, people moving from homelessness into a unit, and housed participants whose affordability gap or one-time shock would otherwise push them back into crisis.

HOW IT FITS THE LARGER SYSTEM

Financial assistance is the connective tissue between every other driver. Outreach and case management identify the need; landlord engagement and housing programs supply the unit; financial assistance closes the gap to get keys in hand and keeps the tenancy intact while employment, benefits, healthcare, and legal services work on the underlying drivers of instability. Used alone — without case management, employment supports, healthcare

navigation, or legal help — financial assistance reliably underperforms and recreates the same crises it was meant to solve. Sustained outcomes require the dollars and the wraparound.

DESIGN NOTES FOR REPLICATION

- Treat financial assistance as a tool of a stability plan, not a program in itself. Every dollar should answer a specific question in that plan.
- Stack funding sources intentionally — federal, state, local, and philanthropic dollars each have different rules and time horizons; using them in the right order preserves flexibility for the next household.
- Distinguish short-term (crisis resolution and access) from long-term (ongoing affordability) and resource them differently. Short-term funds need speed and flexibility; long-term subsidies need stable, recurring sources.
- Build in creativity and advocacy at the case-manager level — negotiating with landlords for payment plans or reduced settlements often prevents an assist from being needed at all, or stretches the dollars further.
- Name the limits up front. Financial assistance will not fix unaddressed income, health, legal, or relational drivers of instability; complementary services have to be on the table from day one.
- Steward funds visibly. Clear thresholds for asking for help (recurring assists, large totals, recertification moments) and shared decision-making protect both the participant and the long-term capacity of the system.

Emergency Housing

Targeted use of short-term hotel stays for unsheltered individuals and families as a step towards longer-term housing options.

PURPOSE

Emergency housing fills the gap when the traditional shelter system is unavailable, inaccessible, or inappropriate — providing a short-term, stabilized place to sleep so case management can begin immediately and the person can move quickly toward transitional or permanent housing.

HOW IT WORKS

- Identification of people who are unsheltered and unable to enter the shelter system — due to capacity limits, family structure, companion animals, medical needs, gender, safety concerns, or geographic distance.
- Short-term hotel stays of up to 60 nights, used as a bridge from unsheltered homelessness into transitional or permanent housing, not as an ongoing destination.
- Intensive case management that begins immediately upon placement: housing search, documentation gathering, benefits enrollment, connection to specialized services (health care, employment, legal), and daily or near-daily check-ins to keep momentum.
- Partnerships with hotels and motels to secure efficient, predictable rates over time, often at costs comparable to or lower than per-night shelter operations when the full cost of staffing and facilities is counted.
- A dedicated financial assistance funding stream to cover room costs, so the program is not competing with other emergency funds and stays can be authorized quickly.
- Coordination with outreach and landlord engagement so that as soon as a longer-term unit is identified, the person can move directly without returning to the street.

WHO IT SERVES

People who are unsheltered and cannot access the shelter system — including families with children, people with companion animals, individuals with significant medical or behavioral health needs, people in smaller or rural communities where no shelter exists, and anyone for whom shelter bed availability, gender restrictions, or safety concerns make congregate settings impossible.

HOW IT FITS THE LARGER SYSTEM

Emergency housing is the pressure valve that keeps people from falling through the cracks while the rest of the system works. Without it, outreach staff build relationships with people who have nowhere to sleep that night; housing case managers search for units while the person remains unsheltered; and all the gains of the model stall at the first point of failure. Emergency housing also accelerates progress: the intensive case management during a hotel stay — daily housing search, benefits work, and service connections — often moves a person to permanent housing faster than a shelter stay, where waitlists and program requirements can delay action.

DESIGN NOTES FOR REPLICATION

- Build hotel partnerships before you need them. A pre-negotiated rate and a standing relationship with a small set of properties turn an emergency into a same-day placement.
- Do not operate emergency housing without embedded case management. A hotel room alone is not a solution; it is a platform for the services that produce housing stability.
- Track cost per placement and compare it to shelter per-night costs, including the full staffing and facility overhead. Hotel stays with intensive case management are often more cost-effective and produce faster outcomes.
- Design for the populations shelters exclude: families needing privacy, people with pets, individuals with complex medical needs, and rural geographies where shelters are nonexistent. These gaps are where the highest-need, highest-barrier people are lost.
- Set a clear time boundary — typically 60 nights — and pair it with an active housing plan reviewed weekly. The goal is to never need the 60th night because the person has already moved to longer-term housing.

Permanent supportive & transitional housing

Substantial benefit from increased housing stability and reduced public expenditures related to homelessness and incarceration.

PURPOSE

Owning and operating a portfolio of transitional and permanent housing — with property management, supportive services, and case management blended together — gives the system a guaranteed supply of units for people the private market won't house, and the wraparound support to keep them housed.

HOW IT WORKS

- A mix of transitional units (time-limited, typically up to ~12 months, designed as a stabilization step) and permanent units (long-term leases, intended as a person's home) sized to local need.
- In transitional housing, every resident is paired with a case manager who co-builds a housing stability plan: document collection, budget and savings, debt review, benefits and voucher navigation (federal housing vouchers, public benefits, disability income), and a concrete move-out plan to permanent housing.

- Weekly in-person case management contact during a transitional stay, plus follow-up after the person moves into permanent housing to confirm stability before the case closes.
- In permanent housing, an on-site residential services coordinator is offered to every tenant on a voluntary basis — a liaison between tenant, property management, and outside case management who handles tenancy education (lease, handbook, fair housing, rent timing, sanitation, pet policy), mediates neighbor and landlord disputes, and helps tenants prepare for inspections and recertifications.
- A property management function that handles leasing, rent collection and payment plans, quarterly inspections, vendor and maintenance coordination, and lease enforcement — kept structurally distinct from supportive services so that the people helping a tenant stay housed are not the same people who would have to evict them.
- Tight coordination between property management, residential services, and clinical and benefits partners so a brewing problem (late rent, a lease violation, a maintenance issue masking a health crisis) is caught and addressed jointly before it becomes a termination.
- A referral pathway that routes prospective tenants through a single intake point (landlord engagement) so unit assignments are matched to the highest-priority candidates rather than first-come.

WHO IT SERVES

People exiting homelessness who need more than a voucher to succeed — including those with histories (eviction, criminal record, low or no income, untreated health conditions) that would screen them out of the private market. Transitional units serve people who need a stabilization runway; permanent units serve people ready for a long-term home with light- to moderate-touch support.

HOW IT FITS THE LARGER SYSTEM

Owned housing is the supply backstop for the rest of the model. Outreach, landlord engagement, and case management can identify and prepare people, but without a guaranteed pool of units the system runs out of places to put them. Transitional units feed the permanent portfolio and the broader private-market landlord network; permanent units anchor people who would otherwise cycle. Residential services keep tenancies intact, which protects the operating model and frees case managers to focus on new placements.

DESIGN NOTES FOR REPLICATION

- Separate property management from supportive services. A tenant should be able to trust their service coordinator without confusing them with the person who collects rent or signs eviction paperwork — collaboration is constant, but the roles are distinct.
- Make supportive services in permanent housing voluntary. Mandatory services erode trust and conflict with fair-housing principles; voluntary services that are easy to access get used.
- Treat transitional housing as a stabilization tool with a clear exit, not a destination — a time-bounded stay with active case management, a savings plan, and a named next unit beats indefinite stays.
- Avoid crime- and drug-free lease addendums; they are often unenforceable and disproportionately exclude people with disabilities or in recovery. Lead with supportive services and lease accountability instead.
- Centralize tenancy records, leases, ledgers, and case notes in one shared system so property staff, residential services, and case managers are working from the same picture.
- Plan capital and operations together. Owning the building is only half of the model; the property cannot deliver outcomes without the residential-services and case-management staffing budgeted alongside it.

Employment services

Increases earnings and tax contributions for participating veterans — measurable economic value to both individuals and the public.

PURPOSE

Employment services exist to convert housing stability into long-term income stability — so a person's ability to stay housed doesn't depend indefinitely on subsidy.

HOW IT WORKS

- Readiness assessment to determine whether the person is ready to job-search now or needs a different path first (treatment, benefits, stabilization).
- An individualized employment plan built around the person's strengths, barriers, and goals.
- Supportive services: résumé help, mock interviews, job-search coaching, employment workshops.
- Direct, immediate-need spending: bus passes, work clothing, required tools, certification fees.
- Job-driven training — on-the-job training, apprenticeships, short occupational credentials when a specific credential unlocks a wage increase.
- Active employer cultivation, with a focus on employers who are flexible about justice history.
- Follow-up at 30, 60, 90, 180, and 365 days post-placement to catch problems before they become job loss.

WHO IT SERVES

People who are housing-unstable and able and willing to work. Employment is paired with housing services rather than offered standalone — the two reinforce each other.

HOW IT FITS THE LARGER SYSTEM

Employment is the off-ramp from subsidy. Without it, housing programs become indefinite. Tight coordination with housing case management is essential: a job that requires a commute the person can't afford, or a schedule that conflicts with court or treatment, will fail.

DESIGN NOTES FOR REPLICATION

- Invest in employer relationships the same way the system invests in landlord relationships — a small network of trusted, barrier-flexible employers does more than a long generic job board.
- A full year of post-placement follow-up is the difference between a placement and a retention.
- Keep a separate, smaller pool of direct-spend funds for employment barriers; routing every $50 expense through a housing-assistance grant slows things down to the point of failure.

Legal assistance

Helps veterans avoid eviction and increase future wages through criminal record expungement.

PURPOSE

An in-house legal team removes the legal barriers — eviction filings, old criminal records, family law issues, license suspensions — that keep people out of housing or push them back into homelessness.

HOW IT WORKS

- Intake line and email for people to request legal help directly.
- Advice and brief services: phone consultation, court form drafting, explaining options.
- Full representation in a focused set of practice areas, primarily housing court (eviction defense), criminal expungement, and family law issues that affect housing.
- Consultation for non-attorney case managers on landlord ledgers, eviction notices, and the legality of landlord demands — before they escalate.
- Training for the rest of the organization on the legal topics that recur in housing work.
- Referrals to external counsel when the case is outside the team's scope or capacity.

WHO IT SERVES

People experiencing or at risk of homelessness with a legal issue that materially affects their housing. Eligibility is income-tiered: advice for a broader group, full representation reserved for cases with a direct housing impact and lower income.

HOW IT FITS THE LARGER SYSTEM

Legal assistance protects the gains the rest of the system makes. An eviction record blocks future tenancy; an unresolved warrant blocks employment; an old conviction blocks housing screening. Expungement multiplies the value of employment and landlord-engagement work.

DESIGN NOTES FOR REPLICATION

- Define representation criteria explicitly (does the case affect housing? is there merit? is the person capable of self-representation?) so the team isn't pulled into every legal need.
- Open office hours for non-attorney staff catch small legal questions before they become big legal problems.
- Keep the practice areas tight — housing, expungement, related civil matters — and refer the rest out.

Justice-involved case management

Targeted support that reduces recidivism — a high-leverage public-cost reduction.

PURPOSE

A dedicated team that addresses the justice-system barriers — incarceration, supervision, warrants, pending cases — that prevent people from getting or keeping housing.

HOW IT WORKS

- Pre- and post-release case management: identifying people at risk of post-release homelessness, building a housing plan before release, and supporting reentry.
- Direct relationships with state prisons, county jails, and supervision agencies so referrals come in early and reliably.
- Coordination with supervising officers as a single point of contact — so the person's case manager, employer, and housing provider aren't all calling separately.
- Community case management focused on compliance with supervision conditions, resolving warrants, and closing open cases.
- Internal consulting: advising other case managers when justice-system issues surface on existing housing cases.

WHO IT SERVES

People experiencing or at risk of homelessness with active justice involvement — incarcerated, on supervision, with warrants or pending cases, or with histories that block housing screening.

HOW IT FITS THE LARGER SYSTEM

This is a force-multiplier role. It doesn't replace the housing case manager — it sits alongside them and removes the justice-system obstacles that would otherwise block their work. It also coordinates with landlord engagement to find housing for people releasing from incarceration.

DESIGN NOTES FOR REPLICATION

- Pre-release planning needs predictable release dates — state systems work for this, county jails usually don't, so design two different intake patterns.
- Consolidate communication with supervision officers through this one team; multiple staff calling the same officer about the same person damages the relationship.
- Pair this function with legal assistance and landlord engagement — it depends on both.

Health care navigation

Reduces avoidable emergency department use and improves continuity of care.

PURPOSE

Health care navigation addresses the medical and behavioral health conditions that destabilize housing — and the insurance and benefits gaps that prevent people from getting care in the first place.

HOW IT WORKS

- Enrollment support for public health insurance and disability waivers (Medicaid, long-term care waivers, age-based waivers).
- Connecting people to a primary care home rather than relying on the emergency department.
- Non-clinical bio-psycho-social assessment in coordination with the person's clinical team.
- Help attending appointments — including transportation coordination — so chronic conditions don't go untreated.
- Support for disability benefit applications, which often hinge on documented and consistent medical care.

- Ongoing care coordination across the person's clinical providers and their housing case manager.

WHO IT SERVES

People who are housing-unstable and either uninsured, under-insured, or facing a health condition that's a barrier to obtaining or keeping housing. The program is voluntary and prioritized by acuity.

HOW IT FITS THE LARGER SYSTEM

Health conditions are one of the most common reasons housing fails — missed work, ER bills, untreated mental health, untreated substance use. This function keeps health from becoming the variable that unwinds an otherwise successful placement, and it unlocks disability benefits that materially change a person's ability to pay rent long-term.

DESIGN NOTES FOR REPLICATION

- Use a screening tool to prioritize — high-acuity cases get deep case management, lower-acuity cases get a light-touch resource referral.
- The role is navigation, not clinical care — staff coordinate with clinical providers rather than replace them.
- Transportation to appointments is often the actual barrier; budget for it explicitly.

Financial Stability

Financial and budget management coaching, debt reduction counseling, and access to free voluntary representative payee services that help veterans control their finances, prioritize housing stability in their budget, and then spend within their means.

PURPOSE

Financial stability services help people structure their income around rent first — so housing assistance doesn't have to be permanent and so housed people don't slide back into homelessness.

HOW IT WORKS

- Financial coaching: review of current finances, realistic budgeting around basic needs and housing, and goal setting.
- Debt-reduction planning for credit cards, medical debt, payday loans, and back taxes, with resources to reduce the interest burden.
- Credit review and a plan to monitor and improve credit scores over time — directly relevant to future tenancy applications.
- Help opening a basic checking or savings account for people who are unbanked.
- Voluntary representative payee services — typically delivered through a contracted partner — where the person's income (Social Security, VA benefits, or earned wages) is received by the payee, rent and utilities are paid first, and the remainder is distributed back to the person on a budgeted schedule.
- For people receiving Social Security, weekly distributions of remaining funds are required by federal rules; for other income sources, the schedule can be more flexible.

WHO IT SERVES

Two distinct groups: people who are housing-unstable but not in crisis and ready to engage with coaching, and people who have repeatedly struggled to pay rent and utilities and choose to have someone else manage the flow

of their income.

HOW IT FITS THE LARGER SYSTEM

Financial stability is the bridge between getting housed and staying housed. It connects directly to employment (income coming in), housing (rent going out), and benefits (Social Security, disability, VA). Without it, rental assistance is a temporary patch rather than a step toward independence.

DESIGN NOTES FOR REPLICATION

- The representative payee function must be voluntary, even when a person's finances are the obvious housing risk — coercion erodes trust and is also prohibited by Social Security rules.
- Disenrolling from Social Security representative payee can take up to four months; explain this clearly up front so people understand the commitment.
- Train every case manager to do basic budget conversations themselves — escalate to the financial-stability team only when the situation is genuinely beyond a normal money conversation.

Landlord engagement

Working directly with landlords who offer flexibility on their tenant screening criteria to support tenancy issues and create housing outcomes for veterans otherwise not possible.

PURPOSE

Landlord engagement creates housing options that wouldn't exist in the open market — units for people whose criminal or rental history would screen them out everywhere else — by trading the organization's ongoing support for the landlord's screening flexibility.

HOW IT WORKS

- A small portfolio of partner landlords who have agreed to be flexible on screening barriers in exchange for a reliable single point of contact and tenancy support.
- Distribution of available units to internal case managers and partner agencies so the highest-priority candidates are matched first.
- Coordination of applications, document collection, and lease signings — the case manager and the landlord don't negotiate directly.
- Proactive tenancy support for the first year of every placement, ranging from light-touch check-ins to twice-weekly visits depending on need.
- A single point of contact for all landlord communication — ledgers, lease violations, maintenance issues — so landlords aren't tracking dozens of separate case managers.
- Coaching for the rest of the organization on how to approach non-partner landlords for people with moderate (not extreme) barriers.

WHO IT SERVES

People who would be rejected by most landlords due to felony histories, evictions, or other serious screening barriers — but who have income or a voucher in place and are ready to be tenants.

HOW IT FITS THE LARGER SYSTEM

Landlord engagement is what makes the rest of the model honest. Without it, people with the highest barriers get caught between programs that say they're 'housing ready' and a private market that says they're not. It depends on financial stability, justice-involved case management, and tenancy support to keep landlord trust intact.

DESIGN NOTES FOR REPLICATION

- Route every landlord communication through one team. Multiple case managers calling the same landlord about different tenants is the fastest way to lose the partnership.
- Treat partner units as a 'next step' — successful tenants are actively helped to move to greater housing choice after a year, which frees the unit and rebuilds the person's rental history.
- Be transparent with landlords about lease-compliance concerns, even when it's uncomfortable; opacity ends partnerships, candor sustains them.
- Prefer larger, experienced affordable-housing landlords who can accept multiple referrals over time — the relationship has to scale to be worth the operational cost.

08 · REPLICATION FRAMEWORK

Take what works. Adapt the rest.

Replication isn't copying. It's preserving the core mechanics that drive outcomes while making honest adjustments for local population, funding, and policy reality.

Keep these intact

- A shared, by-name registry as the system's source of truth.
- A backbone organization with clear ownership of coordination.
- Cross-agency case ownership — assigned, not assumed.
- Layered housing supply (subsidies + owned units) matched to acuity.
- Performance-based governance and measurable outcomes.

Adapt to context

- Eligibility definitions — federal frameworks differ by population.
- Funding stack — federal, state, and philanthropic mix varies widely.
- Housing portfolio — owned vs. leased balance depends on local market.
- Specialized services — opioid response, family supports, justice partnerships, elder care for an aging population, culturally grounded approaches for Native American and Indigenous communities, and youth-specific interventions.
- Outreach channels — what works for veterans may not reach families.

Five levers of replication

LEVER 1

Operating Model Architecture

A swimlane operating model with explicit decision logic — intake, registry, escalation by intensity (low / medium / high touch), assigned ownership across agencies.

LEVER 2

Data & Technical Infrastructure

Standardized intake schema, prioritization scoring, real-time cross-agency case visibility, strong data-integrity practices, and dedicated analytic capacity to inform program improvements and target services — with clear governance over who owns what.

LEVER 3

Financial & Funding Architecture

An aligned funding stack — federal, state, philanthropic — with transparent flow of funds and a deliberate strategy for owned vs. leased housing assets.

LEVER 4

Replication Landscape & Comparable Models

Honest comparison to peer systems (Houston, Built for Zero, functional-zero states) — what scaled, what didn't, and where the model breaks.

LEVER 5

Legislative Advocacy & Policy Alignment

Organized, sustained advocacy at the state and federal level to secure funding and shape policy that supports homeless services and systemic solutions — coordinated voices across providers, partners, and people with lived experience, with clear policy priorities and a regular legislative cadence.

Two paths into the model

Other states ending veteran homelessness

OPPORTUNITIES

- Theoretical applicability of the full system
- Comparable funding access (federal + VA programs)
- Statewide governance models translate well
- Clear precedent in Houston / functional-zero states

CHALLENGES TO ACKNOWLEDGE

- State-specific rules and incentives create friction
- Veteran population characteristics differ
- Existing local infrastructure varies dramatically

MN organizations serving other populations

OPPORTUNITIES

- Shared statewide context — same partners, same funders
- Operational lessons translate even when programs don't
- Data and registry architecture is broadly portable
- Applicable to families, seniors, youth, Native American and Indigenous communities, justice-involved adults, and people facing opioid use disorder

CHALLENGES TO ACKNOWLEDGE

- Less-funded missions face funding-stack constraints
- Population-specific drivers (opioid use, family dynamics, aging and medical complexity, youth development, tribal sovereignty and cultural fit) require tailored services
- Stigma and policy environment differ by population

A comparable model: lessons from Houston

Houston's coordinated governance, rapid placement strategies, and shared accountability accelerated veteran housing outcomes — and offer concrete precedent for what scales. Houston is one of many examples of meaningful progress around the country. The opportunity ahead is to learn from the best of them — across cities, states, and populations — and combine what works to keep ending homelessness.

3,650+ Veterans housed in three years	**40%** Reduction in housing placement timelines (Six Sigma)	**67** Veterans housed in a single coordinated outreach event	**1** Unified table — HUD, VA, nonprofit, local agencies

Further reading: "How Houston Moved 25,000 People From the Streets Into Homes of Their Own," The New York Times, 2022.

Where to begin: six next steps

01 Adopt the end-to-end framework

Use MACV's workflow as the organizing model for local systems. Map your current system to the framework and identify priority areas to build or strengthen.

02 Implement core elements

Stand up coordinated entry, case management, housing subsidies, housing supply, and specialized services. Assess what exists, what needs development, and create an implementation plan.

03 Leverage data infrastructure & visibility

Build a centralized registry and reporting infrastructure for real-time case management and outcome tracking. Invest in or partner for a shared data platform — and put equal weight on data integrity (consistent definitions, timely entry, clear governance) and on building internal analytic capacity that turns the data into program improvements and more targeted services.

04 Strengthen partnerships

Build relationships across VA partners, housing authorities, health systems, justice agencies, landlords, philanthropy, and the CoC. Convene local partners and align on roles, referral pathways, and shared outcomes.

05 Prioritize early intervention

Invest upstream in financial assistance and prevention to keep people stably housed and reduce the need for intensive interventions downstream. Pair prevention with long-term stability supports — light-touch follow-up, benefits navigation, and rapid re-engagement when warning signs appear — to reduce recurrences of homelessness, not just first episodes.

06 Plan for an aging homeless population

Build intentional partnerships with health systems, long-term care, hospice, and disability services. A growing share of people experiencing homelessness need a level of medical, cognitive, and daily-living support that exceeds what most homeless-services providers are funded or staffed to deliver alone — bridging into higher levels of care is now part of the work.

09 · ONGOING CHALLENGES

Honest about what's still hard.

Reaching an effective end to veteran homelessness in Minnesota doesn't mean the work is finished. Two challenges stand out for any system — for veterans, and for the broader populations this model can serve.

An aging population needing higher levels of care

More people entering and re-entering homelessness are older adults with serious medical, cognitive, and mobility needs that extend well beyond what most homeless-services providers are designed, funded, or staffed to deliver. Closing this gap takes deliberate partnerships with health systems, long-term care, hospice, and disability services — and funding models that recognize the higher acuity of the population being served.

Reducing recurrences, not just first episodes

Housing someone once is not the same as keeping them housed. Sustained progress requires upstream prevention, financial assistance before crisis, and long-term stability supports — light-touch follow-up, benefits navigation, behavioral health connections, and a clear path back into services if warning signs appear — so that when homelessness does occur, it stays rare, brief, and non-recurring.

10 · SOURCES, RESOURCES & CONTACT

Go deeper.

Full reports and downloads

Wilder Research — Full SROI Study

The complete Social Return on Investment study, including methodology, data sources, full findings, and appendices.

Minnesota Model — Full Report

The full Minnesota Model report completed by MBA students with the University of Minnesota Carlson School Graduate Volunteer Consultants program: framework, components, and implementation guidance.

Pathways to Stability — MACV Programs Overview

Comprehensive overview of MACV's full programs and services portfolio across Minnesota — prevention, housing, employment, legal, and more.

Minnesota Homeless Veteran Registry

The State of Minnesota's real-time, by-name registry — a core component of the model and the shared source of truth across state, county, and provider partners.

All downloads are available at share.mac-v.org/resources. Additional MACV publications — annual reports, financials, and program updates — are at mac-v.org/about-us/digital-resources.

Sources cited

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- Carlson Graduate Volunteer Consultants (2026). Sharing a Model for Ending Homelessness. University of Minnesota.
- Westervelt, E. (2019). How Houston has virtually ended homelessness among veterans. Pacific Standard.
- MACV (2025). Annual Report 2025. Minnesota Assistance Council for Veterans.

LET'S TALK

We share what we've learned with peers, partners, funders, and policymakers working to end homelessness — for veterans and beyond.

Other states & systems — adapting the model for veteran homelessness in your state.
Other Minnesota organizations — translating what works for veterans to other populations: families, seniors, youth, Native American and Indigenous communities, justice-involved adults, and people facing opioid use disorder.
Funders & policymakers — understanding the funding stack and policy environment.
Researchers & press — the data, the methodology, and the people behind the model.

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