Connecticut Community Action Plan Form

Updated February 2026 by Progress Resources, Inc.

CONNECTICUT COMMUNITY ACTION PLAN FORM

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Section 1: Contact Information

1a. Name of Agency: New Opportunities, Inc.

1b. Principal Contact Name: Gawdys Grullon

1c. Principal Contact E-Mail: ggrullon@newoppinc.org

1d. Principal Contact Phone #: 203-575-4285

1e. Federal Fiscal Year: 2026

1f. Board Roster by Sector (See attachment 2b)

Section 2: Comprehensive Community Needs Assessment

Agencies are federally required to submit a Community Needs Assessment (CNA) as part of their Community Action Plan. NASCSP's *Community Action Guide to Comprehensive Community Needs Assessments* states, "[t]he CAA's assessment is unique within its community and state. It offers a focus on local conditions, analyzing the economic opportunities and barriers for all residents who are at risk of remaining or becoming economically insecure. It identifies existing and potential resources to expand opportunities. It prepares the CAA leadership to plan a multi-year strategy."

RESOURCES: Review all available resources (links and Department issued documents) prior to completing and attaching the Comprehensive Community Needs Assessment Report Template (CNA Template):

CSBG Reauthorization Act of 1998, Public Law 105-285 Section 676 (b) (11):
https://nascsp.org/wp-content/uploads/2019/06/Current-CSBG-Statute.pdf

Community Action Partnership Technical Assistance Guide for Category 3 Community Assessment:
https://communityactionpartnership.com/publication_toolkit/organizational-standards-technical-assistance-guide-category-3-community-assessment/

NASCSP Community Action Guide to Comprehensive Community Needs Assessments:
https://nascsp.org/wp-content/uploads/2018/02/needs-assessment-final-8.22-print-to-pdf.pdf

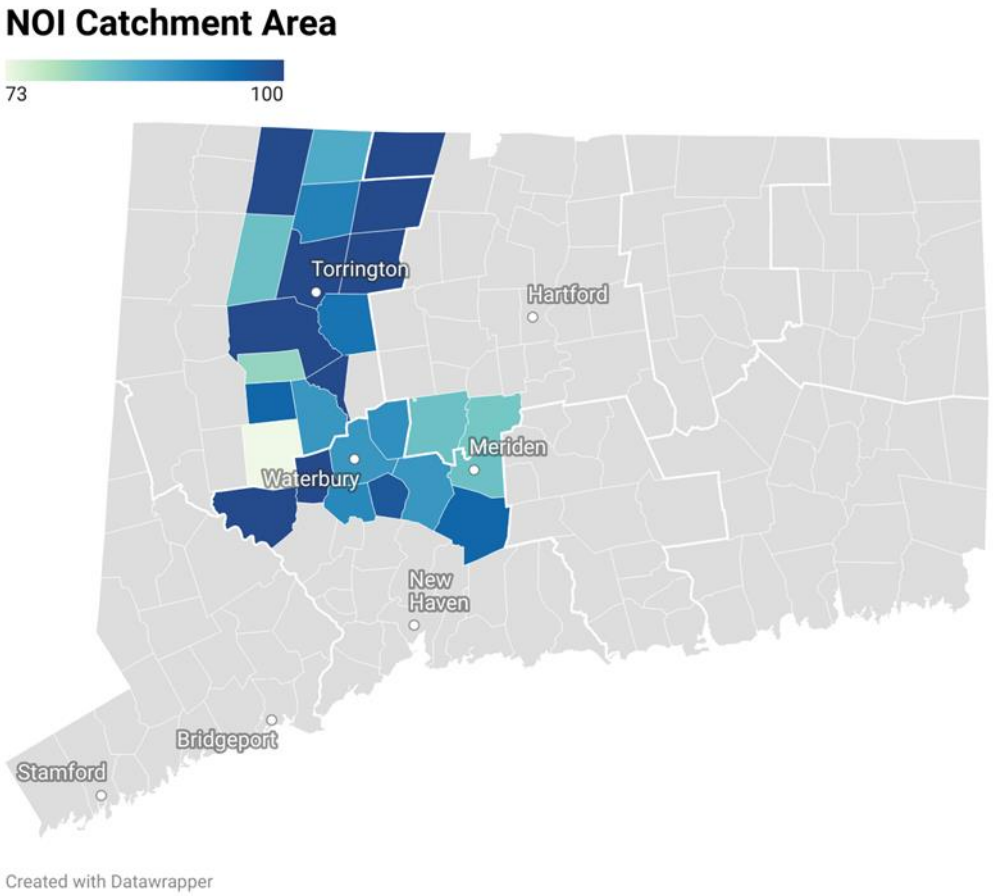
CT CAP Form Guidance (Revised 2026, January)
Self-Assessment Guidance for CSBG Eligible Entities (Revised 2025, November)
DSS Contract Needs Assessment Language (Part I Section D.3-4)

2a. Needs Assessment Attachment: Attach the CNA Report from the Template form approved by the Department.

Section 3: Description of Service Delivery System

3a. <u>CSBG Service Area</u>: List communities (cities/towns) served by the agency inclusive of designated CSBG service areas.

The agency's designated CSBG area covers a total of 26 towns (Barkhamsted, Berlin, Bethlehem, Cheshire, Colebrook, Goshen, Hartland, Harwinton, Litchfield, Meriden, Middlebury, Morris, Naugatuck, New Hartford, Norfolk, Prospect, Southbury, Southington, Thomaston, Torrington, Wallingford, Waterbury, Watertown, Winchester, Wolcott, and Woodbury). These towns encompass the agency designated community action agency catchment area.



<u>3a.1</u> Undesignated Areas: List any undesignated areas served by the agency.

In addition to its designated CSBG service area, the agency provides senior nutrition services in the community of Beacon Falls and Danbury, Fatherhood services in the community of New Britain and also provided vocational rehabilitation services for the disabled population to all regions in Connecticut except the Northeast region until April 30, 2026.

3a.2 Service Location(s): Identify service location(s) for communities described above in 3a. and 3a.1.

The agency provides services through 3 full service locations: (1) New Opportunities of Greater Waterbury at 232 North Elm Street, Waterbury, CT 06702, serving Waterbury and surrounding towns; (2) New Opportunities of Greater Torrington, 62 Commercial Blvd. Torrington, CT 06790, serving Torrington and surrounding towns; and (3) New Opportunities of Greater Meriden, 22 Church Street Meriden, CT 06451, serving Meriden and surrounding towns. The agency has additional satellite locations in Winchester, Energy Services Office 716 Main Street Winsted, CT 06098; and Muriel H. Moore Child Development Center, 444 North Main Street Waterbury, CT 06702. The agency also operates residential facilities located in Bishop House, 31 Bishop Street Waterbury, CT 06704; and New Beginnings Emergency Shelter & Hospitality Center 43 St. Casimir Drive Meriden, CT 06540.

3b. System Overview: Provide an overview of the catchment area's service delivery system; and the role that your agency plays within that system. Identify economic and social conditions in the area that provide context for strategic planning and programmatic decision making.

The agency continues to emphasize an integrated and comprehensive approach built on partnership within the catchment area's various service delivery systems. The diverse network is composed of providers, coalitions, municipal departments and regionals partners that work collectively to meet the needs of low-income individuals and families across the service area. The system includes workforce development agencies, housing and homeless providers, health care and behavioral health organizations, family support programs and community based nonprofit organizations. Together, these entities form a coordinate support to address the complex and interconnected needs of the community experiencing poverty.

Within the system, the agency plays a central role serving as both a direct service provider and a system level convener. The agency collaborates closely with regional workforce partners including the Northwest Regional Workforce Investment Board and Workforce Alliance to expand employment opportunities, support job readiness and connect the community to training and pathways that promote long-term economic stability.

Housing and homelessness services represent another major component of the service delivery system. The agency works with the CT Coalition to End Homelessness, housing providers, and municipal departments to improve housing stability and reduce homelessness. Through the Coordinated Access Network, the agency helps streamline referrals, prioritize vulnerable households and ensure that individuals and families can access shelter, rapid rehousing and long-term housing supports. Collaboration with local landlords, housing authorities and

municipal partners enhances the agency's ability to address housing insecurity and prevent homelessness.

The agency also works with the Department of Children and Families through the Fatherhood program to strengthen family stability and child well-being. Senior programs, community health initiatives and violence prevention efforts further contribute to a comprehensive network of support that promote safety, stability and community wellness.

Across the catchment area, economic and social conditions significantly influence strategic planning and programmatic decision making. Rising housing costs, persistent poverty in urban centers, limited transportation options in rural towns and disparities in access to health and employment and food insecurity all shape the demand for services. The agency's role within the system is to identify gaps, coordinate resources and deliver programs that address the root causes of poverty while advancing the self-sufficient of our customers.

Through partnerships, programs and community presence, the agency serves as a critical access point for low-income households seeking assistance. With the integration of community collaborations, the agency has strengthened the overall service delivery system across the catchment area to access the support needed to achieve stability and long-term success.

Additionally, the agency regularly evaluates its service portfolio to ensure non-duplication of services and to maximize the impact of available resources across the catchment area. As the primary provider of direct services for low-income communities, the agency delivers and coordinates core supports, including early childhood education, energy assistance, elderly services, fatherhood programming, family development services, community health services ensuring residents have access to a comprehensive and integrated service delivery system.

3c. Targeted Services: Describe how your agency's services are targeted for low-income individuals and families and how those services are specifically provided or coordinated with CSBG funds. Include clarification of how you use CSBG to support agency infrastructure and administrative functions related to this work.

The agency's services are designed and delivered to support low-income individuals and families across the catchment area, consistent with the requirements of Section 676(b)(3)(A) of the CSBG Act. All programs funded in whole or in part with CSBG are targeted to households at or below 125% of the Federal Poverty Level, ensuring that resources reach those experiencing the greatest economic hardship. The agency provides a comprehensive array of services including senior services, energy assistance, family empowerment, early childhood education, employment support, and community health and engagement all of which are structured to reduce barriers, stabilize households and promote long-term self-sufficiency. The agency's provision of services to the low-income population includes both direct program linkage and coordinated referrals to community partners. Direct linkage includes the collection and verification of income eligibility

documentation to ensure income guidelines are met. The agency also provides culturally competent services that reflect the ethnic and linguistic composition of the community.

CSBG funding plays a vital role in how services are provided and coordinated. CSBG support planning functions which include the identification and securing of additional funding streams that expand service capacity. CSBG also supports the analysis of community level data, enabling the agency to evaluate impact and adjust service strategies based on emerging needs. In addition, CSBG funds the agency's compliance and quality assurance functions, ensuring that program operates effectively, meets federal and state requirements and maintain high standards of service delivery. CSBG also strengthens the agency infrastructure, supporting essential administrative functions such as fiscal, human resources, IT and planning staff. These supports allow the agency to maintain a centralized, coordinated service delivery system built on strong customer service and robust partnerships with community organizations. Through this combination of targeted services, coordinated resources and infrastructure support, CSBG enhances the agency's ability to meet the unique needs of low-income individuals and families and address systemic barriers within the catchment area.

3d. Use of CSBG Funds: Describe how the agency will use CSBG funds to support addressing the prioritized issues identified in the completed CNA Template and herein at 6a. Description must be consistent with information entered in CORE-CT (Budget Summary for applicable fiscal year).

Based on the prioritized needs identified in the CNA; affordable housing, health care access and food insecurity, the agency will use CSBG funds to directly support service gaps across Meriden, Waterbury and Torrington. CSBG resources will be allocated to staff and programming functions that strengthen access to essential services for households at or below 125% of the Federal Poverty Level.

CSBG funds will support addressing the identified needs through infrastructure support, including administrative staff and agency operations. These functions ensure effective oversight, coordination and management and system integration across the agency's housing, food insecurity and health related services. While most of the direct service staff are not CSBG funded, their work is strengthened through CSBG supported program management and centralized operational support.

Food Insecurity

CSBG funds will support staff for the agency's long-standing food pantry in Meriden, which has operated for more than 30 years, as well as the mobile food pantry serving Meriden. CSBG funded pantry staff coordinate food distributions, maintain food inventory and provide culturally responsive customer services. Staff also distribute community food resources flyers to ensure the customers are aware of nearby pantries, emergency food options and connect customers to additional services either internally or externally. These CSBG supported activities directly

address the CNA identified need for expanded food access and reduce barrier for households experiencing food insecurity.

Affordable Housing

CSBG resources will strengthen the agency's housing program by supporting infrastructure functions that ensure compliance, coordination and effective service delivery. These supports enhance the work of the case managers and housing navigators who assist customers with finding affordable housing, searching for available apartments, completing housing applications, navigating landlord/tenant mediation, eviction prevention and navigating barriers to housing stability. CSBG funded administrative and operational functions also support the agency's effort to maintain and expand landlord relationships in the catchment area, increasing access to safe and affordable units for low-income individuals and families. These activities directly support the CNA identified priority of affordable housing by improving coordination and strengthening navigation support.

Health Care Access

CSBG resources will support infrastructure functions that coordinate the agency's health related services and partnerships. These supports strengthen the work of case management staff who assist customers with health insurance applications, scheduling medical appointments, and completing paperwork and accessing translation support during medical visits. CSBG also support coordination of the agency's partnerships with Hartford Health Care and Yale, which operate mobile clinics at the agency sites in Meriden, Torrington and Waterbury. These clinics provide free medical test, screenings, telehealth, prescriptions, blood draws and vaccines to uninsured and under-insured individuals. Additionally, CSBG supported coordination includes the annual Medical Mission in Meriden, the Hartford Healthcare Neighborhood clinic in Torrington and the upcoming free dental clinic scheduled for August 2026. These activities directly address the CNA identified need for improved access to healthcare.

The planned uses of CSBG funds align with the prioritized needs identified in the CNA report and match the allocations entered in CORE-CT for the applicable fiscal year.

3e. HSI Service Delivery System: Describe the HSI Service Delivery System and how it is operationalized within your agency, i.e., specify how your agency is compliant with the Department's Policy Transmittal No. 1 HSI Integration and Minimum Standards; and the expectations outlined in Transmittal No. 2 HSI/ROMA Implementation.

New Opportunities, Inc. has fully operationalized the Human Service Infrastructure (HSI) service delivery model in alignment with the Department's Policy Transmittal No. 1 HSI Integration and Minimum Standards and Transmittal No. 2 HSI/ROMA Implementation. The agency's approach reflects the HSI vision that individuals can access help easily, receive concrete support when needed and overcome barriers to achieve long-term self-sufficiency.

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The agency subscribe to the guiding principles of ROMA-based case management, recognizing that customers possess strengths, skills and lived experience that inform their service plans. Case managers and customers share responsibility throughout the helping process, following the ROMA cycle of assessment, planning, implementation, achievement of results and evaluation. Case management staff are trained in these procedures, which are detailed in the agency's Case Management Manual.

The agency utilizes a ***No Wrong Door*** approach. Any customer entering through any program receives a universal intake and pre-assessment to identify immediate needs and determine whether a full assessment is appropriate. Customers presenting with two or more self-sufficient barriers are offered a full assessment measuring strengths and challenges across multiple domains. This process ensures that customers are connected quickly to the most appropriate services, whether internal or external.

Another driving principle of the HSI model is that "paper moves," not people. NOI operationalizes this by ensuring customers do not have to navigate multiple offices or repeat their information across programs. Instead, direct service workers take the family's application and then, if necessary, can either approve it or transmit it (to another eligibility worker for the determination of approval. (I.e., early childhood, eviction prevention) In this way, the customer does not need to begin a relationship with another staff member to obtain these services, allowing the initial workers to build trust with the family. This model includes extensive cross-training on agency programming for all direct service staff so that they can remain knowledgeable about the comprehensive services offered within NOI. The HSI model is a partnership between NOI, the Department of Social Services, and 211. . NOI direct service staff receives annual training on the 6 major DSS programs (HUSKY, TANF, SAGA, SNAP, State Supplement, and SAGA Medical) to be able to assist families with State Benefit Assistance applications.

Customers participating in case management receive a comprehensive individual service plan based on full assessment results. Plans prioritize customer identified goals and include S.M.A.R.T action steps. Case managers assist customers with DSS pre-application support, including preparation for Husky, TANF, SAGA, SNAP, State Supplement and SAGA medical applications. The agency annually lists services with 211 to facilitate referrals and ensure customers can access community resources regardless of DSS eligibility.

Case managers arrange and coordinate access to services, provide information and referral with follow-up and monitor customer progress through service implementation and outcome achievement. Progress is measured using the DSS-approved outcome scale matrix and services and outcomes are recorded in the agency's electronic case management system. Service plans are updated at least quarterly to reflect changes in customer circumstances, progress toward goals or regression due to emerging barriers.

The case management process concludes when customers achieve their goals and are reassessed above the prevention line in all applicable domains. Through structured support, customers transition from program dependence to long-term economic independence, equipped with tools, resources and community connections that sustain stability.

The agency also implements a Family Development component that complements HSI by strengthening parent-child relationships, supporting goal setting and empowering families to build assets and improve well-being. Staff assists families with accessing concrete support, navigating community resources and developing individualized plans that reflects family strengths and priorities. This component reinforces the agency's holistic, strength-based model and ensure that families receive comprehensive support across multiple domains of self-sufficiency.

The agency's integrated delivery system ensure that customers, whether DSS-connected or not, receive coordinated, respectful and effective assistance. By combining HSI, ROMA-based case management, No Wrong Door access and Family Development supports, the agency fulfills the state's vision of a human services delivery system that helps individuals and families overcome barriers, connect to resources and achieve lasting independence.

3f. HSI Support of CSBG Objectives: Identify how HSI activities/functions support CSBG objectives within the agency's identified catchment area.

HSI supports CSBG objectives by funding case management staff, including supervisors, who implement the agency's holistic service delivery system. Through this system, staff carry out functions aligned with the purposes of CSBG, including reducing poverty, uplifting low-income communities and empowering individuals and families to work toward self-sufficiency. Case management activities follow a structured, ROMA based flow that includes assessment, planning, implementation, achievement of results and evaluation, supporting eligible individuals and families as they address barriers related to the causes and conditions of poverty.

HSI funded staff help ensure services are responsive to local needs and conditions by maintaining communication with community partners, facilitating referrals and supporting coordination across the service areas. These functions strengthen community-based approaches that address the effects of poverty and promote effective engagement with low-income communities. Staff also support maximum feasibility participation by gathering customer input, facilitating feedback opportunities and helping customers engage in processes that reflect the unique needs within the community.

NOI has a comprehensive, integrated, person-centered approach to working with low-income families, designed to engage and empower families as they move towards healthy collaborations. This approach is supported by the agency's case management system that allows the agency to

track demographics, individual/family level outcomes, and customer progress towards healthy interdependence.

NOI believes in the concept of a continuum of services and a tiered progression for families as they move through the agency. This continuum includes Integrated Service Delivery and overall Family empowerment. The Integrated Service Delivery Component, which is the first step along the continuum for NOI families, works to engage families in services through provision and linkage to concrete services. This design is based on the "Human Services Infrastructure" (HSI) model of social service delivery for low-income families, in which there is a "no wrong door" approach to working with families.

In concert with the integrated service delivery component, staff works on Family empowerment, which further builds trust with the family and engages them in services that support the family and contribute to healthy family relationships. Family empowerment services begin with an assessment of the family's strengths and continues with the creation of a family development plan. This plan is jointly developed by the NOI direct service staff and the family and includes short, medium, and long-term goals with responsibilities for both the staff person and family.

Through these activities, HSI contributes to the accomplishment of CSBG goals by supporting the staff who deliver structured, accountable and community responsive services within the catchment area.

3g. Key CAA Personnel and Trainings: List the key CAA personnel within your agency and describe their role and responsibilities as they pertain to service delivery systems. Enter information in the table below:

Name	Title	Roles & Responsibilities (R&R)	How R&R relate to CSBG and/or HSI, if any
Omar Andujar, Ed.D	Acting President/CEO	Responsible for overall operation of the organization and casting vision to ensure long-term sustainability of the organization.	Oversees the operation of the entire agency and directly supervises a management team that oversees programs and ensures alignment with CSBG Organization Standards and the ROMA model.
Mark E. Kovitch	Chief Financial Officer	Responsible for the financial oversight of agency activities and	Ensures that agency practice and procedures are in

		ensuring financial operations are in accordance with funding source guidelines.	alignment with CSBG Organizational standards for Fiscal Operations.
Gawdys Grullon	Director Research Development and Planning	Responsible for the oversight of the planning functions with the organization including proposal and budget development, and analysis of customer level data. Also responsible for oversight of direct programs.	Ensures that agency practice and procedures are in alignment with CSBG Organizational Standards for Planning and Evaluation.
Julie Turrell	Director Human Resources	Responsible for the day-to-day management of the human resource function within the organization. This includes management of vendor relationships of benefits and employee relations management. Also responsible for the oversight of direct programs.	Ensures the agency's practice and procedures are in alignment with CSBG Organizational Standards for Human Resources.
Steven Burkman	Director of Information Technology	Oversees the agency's IT function, including helpdesk services. Also responsible for generating data reports and maintaining relationships with software vendors. Produces data for analysis and contributes to the	Responsible for ensuring the efficient operation of the agency's IT function in accordance with the contractual guidelines and CSBG requirements. This includes overseeing IT processes, implementing best practices and coordinating with

		agency's strategic planning.	various teams to ensure that technology resources are used effectively to meet the agency's objectives.
Adrienne Ricardi	Director Early Childhood	Responsible for the overall leadership, supervision and direction of the Early Childhood Division. Supports parent involvement and engagement.	Responsible for ensuring the efficient operation of the child development center functions in accordance with the contractual guidelines.

***3g.1 Staff Training*: Attach a list of staff training conducted within the previous federal fiscal year. Listing shall include dates of training; training topic; names of trainers; and position titles of attendees.**

2024 - 2025 Agencywide Training list			
Dates of Trainings	**Training Topic**	**Names of Trainers**	**Position Titles of Attendees**
Early Care and Education (ECD)			
01/15/25	Family Style CACFP	Pam Anderson	All ECD staff
Elder Services			
10/09/24	ASPN Leadership Academy	ASPN facilitated training	FGP Project Coordinator, FGP Director Torrington
10/17/24	HR Roundtable: Best Practices for Supervisors	Leigh Ann Timlen	Director Of RSVP Waterbury
10/30/24	cost disallowance	AmeriCorps-Litmos	Director of Health Equity& Engagement Service Waterbury
10/30/24	nschc bkg checks	AmeriCorps-Litmos	Director of Health Equity& Engagement Service Waterbury
11/01/24	Level up leadership training	Connecticut Community Foundation	Director of Senior Companionship Waterbury
11/13/24	ASPN Leadership Academy	ASPN facilitated training	FGP Project Coordinator, FGP Director
11/12/24	Reporting The Full Value of Volunteer Engagement	Tony Goodrow, Better Impact	Director Of RSVP Waterbury
11/15/24	unconscious bias	paylocity	Director of Health Equity& Engagement Service Waterbury
11/14/24	performance for employee	paylocity	Director of Health Equity& Engagement Service Waterbury
11/14/24	performance for supervisors	paylocity	Director of Health Equity& Engagement Service Waterbury
12/02/24	CMS Training/overview	Shazia Husain	FGP Project Coordinator Torrington

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12/06/24	Level up leadership training	Connecticut Community Foundation	Director of Senior Companionship Waterbury
12/11/24	ASPN Leadership Academy	ASPN facilitated training	FGP Project Coordinator, FGP Director Torrington
12/13/24	Community Leadership Training	William Graunstein Foundation	Director of Senior Companionship Waterbury
12/15/24	Performance For Supervisor	Paylocity	Director Of RSVP Waterbury
12/15/24	Performance For Employee	Paylocity	Director Of RSVP Waterbury
01/03/25	Level up leadership training	Connecticut Community Foundation	Director of Senior Companionship Waterbury
01/08/25	ASPN Leadership Academy	ASPN facilitated training	FGP Project Coordinator, FGP Director Torrington
01/08/25	HR Roundtable: How to Conduct a Performance Review	Leigh Ann Timlen	Director Of RSVP Waterbury
01/10/25	Community Leadership Training	William Graunstein Foundation	Director of Senior Companionship Waterbury
02/06/25	The Science Behind Unconscious Bias	Paylocity	Director Of RSVP Waterbury
02/06/25	Cultivating a Culture of Belonging	Paylocity	Director Of RSVP Waterbury
02/06/25	Why is Data Security Important	Paylocity	Director Of RSVP Waterbury
02/07/25	Level up leadership training	Connecticut Community Foundation	Director of Senior Companionship Waterbury
02/12/25	ASPN Leadership Academy	ASPN facilitated training	FGP Project Coordinator, FGP Director Torrington
02/14/25	Community Leadership Training	William Graunstein Foundation	Director of Senior Companionship Waterbury
02/21/25	Latinas In Leadership Training	Latinas & Power	Director of Senior Companionship Waterbury
03/12/25	ASPN Leadership Academy	ASPN facilitated training	FGP Project Coordinator, FGP Director Torrington
03/14/25	Community Leadership Training	William Graunstein Foundation	Director of Senior Companionship Waterbury
03/21/24	Latinas In Leadership Training	Latinas & Power	Director of Senior Companionship Waterbury
03/28/25	nschc annual cert	AmeriCorps-Litmos	Director of Health Equity& Engagement Service Waterbury
03/28/25	nschc	AmeriCorps-Litmos	Director of Health Equity& Engagement Service Waterbury
04/02/25	AmeriCorps - National Service Criminal History Check	Litmos	Director Of RSVP Waterbury
04/11/25	Community Leadership Training	William Graunstein Foundation	Director of Senior Companionship Waterbury
04/15/25	Fraud Awareness Training for AmeriCorps Grantees	Litmos	Director Of RSVP Waterbury
04/18/25	Latinas In Leadership Training	Latinas & Power	Director of Senior Companionship Waterbury
04/23/25	Youth substance abuse	The Governer Prevention Partnership	Director of Health Equity& Engagement Service Waterbury
05/02/25	CT Mandated Reporter Training	DCF website	Director Of RSVP Waterbury

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05/09/25	Community Leadership Training	William Graunstein Foundation	Director of Senior Companionship Waterbury
05/16/25	Latinas In Leadership Training	Latinas & Power	Director of Senior Companionship Waterbury
Employment/Training			
12/10/24	Performance for Employees	Paylocity	Lead Employment Specialist
02/13/25	CT Customized Employment Training	Laura	Lead Employment Specialist
04/11/25	Tenant Rights & Responsibilities	CAFCA facilitated training	Lead Employment Specialist
04/14/25	Ct-PIE Training: The Party's Not Over		Lead Employment Specialist
05/14/25	211 for Service Responders	Laura Robidoux Cie-Etta Bartell	Lead Employment Specialist
Energy			
07/24/24	Introduction to ROMA Part 1	Shazia Husain	Energy Intake Specialist Waterbury and Energy Supervisor Waterbury
07/25/24	Introduction to ROMA Part 2	Shazia Husain	Energy Intake Specialist Waterbury and Energy Supervisor Waterbury
01/15/25	Health Equity 101	Various trainer	Energy Intake Specialist Meriden
01/17/25	Operation Fuel	Ganong Long	Energy Intake Specialist Meriden
04/08/25	Utility Arrearage Forgiveness and MPP Update	Theresa Washington	Energy Intake Specialist Meriden and Torrington
04/11/25	Utility Arreage Forgivness Program Updates for spring	Eversource	Energy Intake Specialist Torrington
04/16/25	Case Management	Katrina Bresnahan	Energy Intake Specialist Meriden
05/09/25	Sustance Abuse Training	Maria Quiles	Energy Intake Specialist Meriden
05/13/25	DSS Client Data Disclosures and Protections	Online	Energy Intake Specialist Meriden
05/14/25	Connecticut Mandate Training	Tracey Davis	Energy Intake Specialist Meriden
05/28/25	Service Plan Development	CAFCA facilitated training	Energy Intake Specialist Torrington
Executive			
01/24/25	Community Health Worker	UCLA	Strategic Plan Director/CHW
03/01/25	Mentoring /Coaching	OEC	Strategic Plan Director CHW
03/28/25	Asthma educator	National Respitory Board	Strategic Plan Director /CHW
04/12/25	QPR Suicide Prevention	National QPR Board	Strategic Plan Director/CHW
05/15/25	DSS Disclosures	CT DSS Learnuing Center	Strategic Plan Director/CHW
Family Development Services (FDC)			
10/02/24	CDSMP Tomando Control de su Salud	Linda Castagnola, M.P.H	Community Health Worker Torrington
10/02/24	QPR-Question. Persuade. Refer Training	QPR Institute Website	Community Health Worker Torrington

10/04/24	Wow - Empowering Women of the World Training	Maria Coutant-Skinner	Community Health Worker Torrington
10/16/24	Direct Service Day	CAFCA facilitated training	HSI and SSBG Family Development Specialist Torrington, Family Development Supervisor Torrington, Community Health Worker Torrington, Director of Community Service and HIS and SSBG Family Development Specialist Waterbury
10/17/24	CTBOS training review	CTBOS	Housing Navigator Waterbury
10/18/24	HR Roundtable/HR Best Practice for Supervisors	Leigh Ann Timelin	Family Development Supervisor Waterbury and Torrington, Director of Community Service Waterbury and Torrington
10/21/24	SNAP Outreach Civil Rights Training: Log and Screenshots	DSSLearnCenter	Community Health Worker Torrington
10/24/24	Energy Assistance Training	Marianela Rivera	SSBG Family Development Specialists Waterbury
10/24/24	New MPP	Theresa Washington	Family Development Supervisor Torrington, PL Outreach & Intervention Manger, PL Social Service Coordinator & PL Outreach and Intervention Specialist
10/24/24	2024-2025 PIT Housing Inventory Training	Nutmeg	Director of Community Service Waterbury
10/24/24	civil rights training	DSS	Director of Community Service and HIS Family Development Specialist Waterbury
10/24/24	UConn -Olli Training	Fiona De Merell	HSI Family Development Specialist Waterbury
10/28/24	Session 1 Adult Mental Health First Aid Training	Elizabeth Demerchant	LEP Family Development Specialist Meriden
10/29/24	Session 2 Adult Mental Health First Aid Training	Elizabeth Demerchant	LEP Family Development Specialist Meriden
10/30/24	Rapid Cycle Learning (RCL)	Tanaysia Jefferson	Director of Community Service Waterbury
10/31/24	CTHMIS Training	Nutmeg Specialist	Housing Navigator Waterbury
10/30/24	DPH CHW/Diabetes Workforce Inservice on Brain Health	Selma Alves	Community Health Worker Torrington
11/07/24	CCADV-RRHDV program overview training	Racheal	Director of Community Service and Housing Navigator Waterbury
11/18/24	VOAD Disaster Case Management Foundations	John Stewart FEMA region 1	Director of Community Service & Supervisor
11/21/24	Western CT Network of Care Providers and Families	CT Youth Excellence Project	Community Health Worker Torrington
11/26/24	Housing solution Training	Adrianna Rocca	Housing Navigator Waterbury
12/15/24	Performance for Employees	Paylocity	LEP Family Development Specialist Torrington

12/19/24	Goal Plan Refresher Training	Shazia Husain	PL Outreach & Intervention Manger, PL Social Service Coordinator & PL Outreach and Intervention Specialist, HIS, SSBG Family Development Specialist Waterbury, Director of Community Service Waterbury, Housing Navigator Waterbury
12/24/24	RED Renewal Evaluation Training-CTBOS	CTBOS	Director of Community Service
12/24/24	PIT Training	CTBOS	Director of Community Service
12/27/24	Certified Application Counselors-CAC Access Health CT	AHCT Learning Center Noverant Online - Enterprise	HSI Family Development Specialist Torrington
12/30/24	Certified Application Counselors-CAC Access Health CT	AHCT Learning Center Noverant Online - Enterprise	HSI Family Development Specialist Torrington
01/09/25	Service Plan	Shazia Husain	LEP, SSBG and HSI Family Development Specialist Torrington
01/08/25	HR Roundtable/How To Conduct A Performance Review	Leigh Ann Timelin	Family Development Supervisor Waterbury and Torrington, Director of Community Service Waterbury and Torrington
01/14/25	Session 1 -Let's Talk Energy Presentation w/New Opportunities, Inc. Staff	Eversource-OHADOMA, GREGORY O	LEP Family Development Specialist Meriden
01/17/25	Managing Narcissists, Blamers	Mark Murphy Founder, Leadership IQ	Director of Community Service
01/24/25	HMIS nutmeg training	Nutmeg specialist	Housing Navigator Waterbury
01/29/25	Opioid use disorder	National Council for mental wellbeing PIC1	LEP Family Development Specialist Meriden
01/29/25	YHDP Shelter Diversion/Rapid Exit Refresher Training	Various Trainer	Director of Community Service
02/03/25	Detention Preparedness Red Project Training	Tabitha Sookdeo	HIS, SSBGFamily Development Specialist Waterbury
02/06/25	Navigating potential grant freeze Webinar	Alice Ruhnke is the President of GrantStation	Director of Community Service
02/07/25	Session 2 - Let's Talk Energy Presentation w/New Opportunities, Inc. Staff	Eversource-OHADOMA, GREGORY O	LEP Family Development Specialist Meriden
02/14/25	Artful Mindfulness	NOI Wellness Committee	HSI Family Development Specialist Torrington
02/14/25	LISC program overview training	CCADV- Yolanda Potter	Housing Navigator Waterbury
02/27/25	Northwest CT Perinatal Initiative	Charlotte Hungerford Hospital	HSI Family Development Specialist Torrington
03/10/25	Train the Trainers	Dona Ditrio	HSI Family Development Specialist Torrington

03/17/25	CMS Portal	Shazia Husain	Family Development Supervisor Torrington, Director od Community Service Waterbury and Torrington, PL Outreach & Intervention Manger
03/18/25	CT BOS Housing Requirements (1-part) training	CTBOS	Director of Community Service Waterbury and Housing Navigators
03/19/25	Fathering Conference Why Dads Reading to kids Mtter	Various Trainer	Director of Community Service Waterbury
03/19/25	Fathering Conference Child support enforcement	Paul Bourdoulous, Director , CT Judicial Support Enforcement Services	Director of Community Service Waterbury
03/20/25	Fathering Conference Successful Reentry-Reconnecting to Family	John o Neil and Daniel Revallion	Director of Community Service Waterbury
03/21/25	Fathering Conference caring Dads A collaborative approach to DV	Judge Lia Stuhlsatz and John Reis	Director of Community Service
03/21/25	CMS Portal	Shazia Husain	Family Development Supervisor and director Torrington
03/24/25	CMS Portal	Shazia Husain	Family Development Supervisor Torrington and Director of Community Service Torrington and Waterbury
03/27/25	Intimate Partner Violence	CCADV Presenter: Linda Bloize-Trainer	Director of Community Service Waterbury
03/27/25	Investing in Community Health workers	National Health Center Training and Technical Assistance Partners Presenter: Marie Yardis, CHCI	Director of Community Service Waterbury, HSI Family Development Specialist Waterbury
03/31/25	Security deposit guarantee training	Adrianna Rocca and CT BOS	Housing Navigator Waterbury
04/01/25	CTBOS housing requirement training	CT Bos team	Housing Navigator Waterbury
04/01/25	CTBOS Housing Requirements (2-part) Training	CTBOS	Director of Community Service Waterbury and Housing Navigators
04/03/25	Community Health Waker Advocacy Training	Dona Ditrio	HSI Family Development Specialist Waterbury
04/03/25	Community health worker advocacy training	Dona Ditrio	Housing Navigator Waterbury
04/04/25	CMS Portal PD Session 4	Shazia Husain	Director of Community Service Waterbury
04/09/25	Professional Boundaries training	Isabella Dickens-Bowman Training & Resource Manager |MASSCAP	Director of Community Service Waterbury and Family Development Supervisor Waterbury
04/09/25	Pilot Digital Navigator Training	NOI Torrington Staff	HSI Family Development Specialist
04/09/25	Airtable Onboarding	Caroline Stratton	HSI Family Development Specialist and supervisor Torrington
04/11/25	Tenant Rights & Responsibility training	Chelsea Connery CT Fair Housing of CT	HIS, SSBG Family Development Specialist Waterbury

04/16/25	Introduction to the Family-Centered Coaching Toolkit training	Martha Oesch Principal Consulting Coach	HIS, SSBG Family Development Specialist Waterbury and Director of Community Service Waterbury
04/16/25	Case Management Uncovered	Katrina Bresnaham	LEP Family Development Specialist Torrington
04/17/25	Obstetric Life Support: Preparing Healthcare Workers to Optimize Equitable Treatment of Maternal Medical Emergencies-Webinar	Andrea Shields, MD, MS, Associate Professor	HSI Family Development Specialist Torrington
04/21/25	Train the Trainers	Dona Ditrio	HSI Family Development Specialist Torrington
04/28/25	Airtable session	Caroline Stratton Katie Knox	LEP, HSI Family Development Specialist Torrington
05/07/25	Case Note Training	Katrina Bresnaham	HIS, SSBG Family Development Specialist Waterbury
Fatherhood			
10/17/24	CT Prevention Summit 2024	CT DMHAS, TGPP	Director of Fatherhood Waterbury
10/30/24	Domestic Violence DSS Mandatory Training	DSS - CT Coalition Against Domestic Violence	Director of Fatherhood Waterbury
11/12/24	Violence Prevention Series (Virtual Sessions)	University of New Mexico	Director of Fatherhood Waterbury
11/13/24	Violence Prevention Series (Virtual Sessions)	University of New Mexico	Director of Fatherhood Waterbury
11/13/24	De-Escalating Post-Traumatic and Dissociative Crises	Silver Hill Hospital & Emily E. Haas, MD	Director of Fatherhood Waterbury
11/13/24	The Role of Parenting in Substance Use Prevention	CT Clearinghouse	Director of Fatherhood Waterbury
11/15/24	Performance For Employees	Paylocity	Fatherhood Specialist Lead Meriden
11/15/24	Performance For Supervisor	Paylocity	Fatherhood Specialist Lead Meriden
11/19/24	Violence Prevention Series (Virtual Sessions)	University of New Mexico	Director of Fatherhood Waterbury
11/20/24	Violence Prevention Series (Virtual Sessions)	University of New Mexico	Director of Fatherhood Waterbury
12/11/24	Human Trafficking for care givers	CT Coalition for Domestic Violence	Director of Fatherhood Waterbury
12/17/24	Cannabis use in adolescence; What Parents need to know	NEPHTC	Director of Fatherhood Waterbury
01/08/25	Exploring Intersection of AI and Psychiatry	Silver Hil Hospital	Director of Fatherhood Waterbury
01/16/25	Understanding Flavored E-Cigarette/Vaping Products Among Young and Young Adults.	CT Clearinghouse	Director of Fatherhood Waterbury
01/21/25	Engaging in critical conversations building equity competency	SERC, Bianca Irizarry & Malik Camplain	Director of Fatherhood Waterbury
01/22/25	Anti-Harassment	WEB Paylocity	Fatherhood Specialist Meriden

03/12/25	Substance Use Disorders: with a Focus on the Current Understandings, Efficacy, and Risks of Cannabis	Silver Hil Hospital, Snehal Bhatt, MD	Director of Fatherhood Waterbury
03/13/25	Brain Injury, Mental Health and Substance Use - A Primer	Silver Hil Hospital	Director of Fatherhood Waterbury
03/19/25	Fatherhood And Postpartum Depression	Albert Pless	Fatherhood Specialist Lead Meriden
03/19/25	Why Dads Reading To Kids Matter	Malik Champlain	Fatherhood Specialist Lead Meriden
03/19/25	The Tree Cannot Stand Without Roots	Dr. Naka Black	Fatherhood Specialist Lead Meriden
03/20/25	Leaving A Legacy	Troy Ellison/Kwasi MFFa	Fatherhood Specialist Lead Meriden
03/20/25	Fathers And Domestic Violence	Jeffery Trahant	Fatherhood Specialist Lead Meriden
03/20/25	Living Apart/Brainstorming Conflicts	Shari Doherty	Fatherhood Specialist Lead Meriden
03/21/25	The Impact of Language	Shaneka Hernandez	Fatherhood Specialist Lead Meriden
03/21/25	Fatherhood Advocacy and Collaboration	Sal Hannaif/Da'ee McKnight	Fatherhood Specialist Lead Meriden
03/21/25	Parenting And Those Who Has Experience Loss	Jeannie Fitzgerald	Fatherhood Specialist Lead Meriden
04/02/25	CT Cannabis Landscape Analysis: Examining the Illegal THC Retail Market in CT	PTTASC	Director of Fatherhood Waterbury
04/03/25	Community Health Worker Advocacy training	NOI / CT Association for Community Action Agencies	Director of Fatherhood Waterbury
04/09/25	Advocacy Skills for Underserved Communities	NAADAC	Director of Fatherhood Waterbury
04/16/25	Co-Occurring Substance Use and Mental Health Problem	New England PTTC	Director of Fatherhood Waterbury
04/16/25	INTIMATE PARTNER VIOLENCE POLICY AND PRACTICE GUIDE	WEB DCF	Fatherhood Specialist Meriden
04/17/25	This is DCF	Zoom DCF	Fatherhood Specialist Meriden
04/23/25	Motivational Interviewing for Edible THC	NAADAC	Director of Fatherhood Waterbury
04/30/25	Understanding Sate Preemption: Local Opportunities in Alcohol Policy	SPTAC / SAMHSA	Director of Fatherhood Waterbury
04/24/25	Cultivating a Culture of Belonging	WEB Paylocity	Fatherhood Specialist Meriden
Human Resources (HR)			
10/25/24	Annual Labor & Employment Law Seminar	Carmody, Torrance, Sandak, & Hennessey	Human Resources Generalist
11/5/24	Utilize Core	Thomas Molinowski, OneSource	Human Resources Generalist
11/7/24	Workplace Violence	Mike Kowal, CISA	Human Resources Generalist

11/20/24	A Deep Dive into ADA	Acai Bailey, Guardian Beverley Wild-Simmons, Guardian Tracy Christian, Guardian	Human Resources Generalist
2/5/25	Building An All-Inclusive Workplace with Reasonable Accommodations	Atty. Joshua Hawks-Ladds, Atty. Bianca LoGiurato - Pullman & Comley	Human Resources Generalist
2/6/25	The Accelerating Changing Role of HR: What CEO's Want in CHRO's	Alice Benson, CEO, Benson Executive Search	Human Resources Generalist
4/17/25	FMLA 201	Matthew Ceurvels, Guardian Shauna Bryngelson, The Partners Group	Human Resources Generalist
Information Technology System (IT)			
10/31/24	Endpoint Detection and Response	Cyber Threat Intelligence	Director of Information Technology
11/12/24	Public Key Cryptography standards	Cyber Threat Intelligence	Director of Information Technology
12/17/24	Wireshark filtering	Cyber Threat Intelligence	Director of Information Technology
01/22/25	Error log tracking and monitoring	Mohammed Fahad	Director of Information Technology
02/26/25	SS7 attack vectors and prevention	Mohammed Fahad	Director of Information Technology
03/04/25	Top security threats worldwide Q4 24	Corey Nachreiner and Trevor Collins	Director of Information Technology
03/25/25	Security enhancement- secure authentication comparisons	Cyber Press	Director of Information Technology
04/08/25	IAM controls for compliance	Cyber Press	Director of Information Technology
04/29/25	PDF malware analytics	Kaaviya Balaji	Director of Information Technology
New Beginnings Emergency Shelter and Hospitality Center			
02/10/25	NARCAN Training	Elizabeth DeMerchant	Program Development Support Specialist
10/24/25	2024-2025 PIT Housing Inventory Training	Jim Bombaci	Program Development Support Specialist
10/07/24	Identifying & Working with Survivors of Human Trafficking: Training for the Homeless Sector Confirmation		Program Development Support Specialist
10/18/24	HR Roundtable: HR Best Practices for Supervisor	Leigh Ann Timlen	Program Development Support Specialist
03/17/25	CMS Portal Professional Development Session1	Shazia Husain	Program Development Support Specialist
03/21/25	CMS Portal Professional Development Session2	Shazia Husain	Program Development Support Specialist
03/24/25	CMS Portal Professional Development Session3	Shazia Husain	Program Development Support Specialist

04/04/25	CMS Portal Professional Development Session4	Shazia Husain	Program Development Support Specialist
Research, Development and Planning (RDP)			
10/16/24	Direct Service Day 2024	Various Trainer	Contract Compliance Manager
01/08/25	HR Roundtable - 2025 Performance Review	Leigh Ann - NOI HR	Director of Research, Development and Training
01/09/25	Shelter Point in Time Count	Nutmeg	Contract Compliance Manager
01/29/25	Grant Solutions Master Series: Grant & Application Messages Training for Recipients!	Grant Solutions facilitated the training	Director of Research, Development and Training
02/19/25	The Compliance Compass: Understand Homecare Billing Rules	HHA Exchange team facilitated the training	Director of Research, Development and Training
02/20/25	Upcoming BOS Webinars CoC Fiscal Requirements Trainings	BOS/COC Team facilitated the training	Director of Research, Development and Training
02/20/25	American Red Cross Response and Relief Services	American Red Cross facilitated the training	Director of Research, Development and Training
03/07/25	HMIS Reporting	Nutmeg	Contract Compliance Manager
03/22/25	2025 ICEP ROMA Training	Barbara Mooney and Carey Gibson	Contract Compliance Manager
03/24/25	2025 ICEP ROMA Training	Barbara Mooney and Carey Gibson	Contract Compliance Manager
03/24/25	CMS Portal Session 3	Shazia Husain - NOI	Director of Research, Development and Training
04/03/25	Connie HIE Admin Training for DSS' HCBS Program Confirmation	Connie team facilitated the training	Director of Research, Development and Training
04/04/25	CMS Portal PD Session 4	Shazia Husain - NOI	Director of Research, Development and Training
04/08/25	Planning for Your CNA + Measure What Matters 201 (CAAs)	CT Data Collaborative facilitated the training	Director of Research, Development and Training and Contract Compliance Manager
04/22/25	CoC Grant Management Requirements	BOS/COC Team facilitated the training	Director of Research, Development and Training
04/30/25	Making Sense of Numbers 201: Learn How to Analyze Quantitative Data (CAAs)	CT Data Collaborative facilitated the training	Director of Research, Development and Training and Contract Compliance Manager

***3g.2 ROMA Training for Staff*: Was ROMA training provided to staff during the previous year? Note: There are options for provision of ROMA training to staff. Training may be provided by a ROMA Professional (Trainer or Implementer), online webinars presented by a federal partner such as Community Action Partnership or CAA program manager/director with ROMA experience/knowledge; and topics may include but not be limited to ROMA overview, ROMA cycle, etc.**

- ***If yes: List ROMA staff training date(s); provide ROMA trainer name(s); attendee staff position(s); and ROMA topic presented.***

Training Date	Trainer Name	Attendee Staff Positions	ROMA topic presented
03/22/2025	Carey L. Gibson and Barbara Mooney	Contract Compliance Manager	2025 ICEP ROMA Virtual Training. Session 1 – *Approach for ROMA Professionals*
03/04/2025	Carey L. Gibson and Barbara Mooney	Contract Compliance Manager	2025 ICEP ROMA Virtual Training. Session 2 – *Assessing Service and Strategies – How are we doing?*
02/18/2026	Shazia Husain	Family Development Supervisor, Energy case worker, and Housing Navigator	ROMA Overview

- ***If no: Why was ROMA training not provided? How will this be addressed during the next year?*** N/A

***3h. Board Training*: Was ROMA training provided to the Board during the previous year?**

- ***If yes: List ROMA Board training date(s); provide ROMA trainer name(s); and number of attendees.***

Training Date	Trainer Name	Number of Attendee	ROMA topic presented
05/28/2025	Shazia Husain	6 Board members 1 Executive staff member 2 RDP staff members 1 Senior administrative staff	ROMA – Assessment

- ***If no: Confirm whether your CAA plans to provide ROMA training to the Board during the next year.*** N/A

3i. Board Roster: Attach the Board Roster and identify each member by sector.
Please see attachment 2.b.

3j. Alliances with Key Partners: Describe alliances with key community partners and providers and how you specifically work together to address the causes and conditions of poverty. The description must reference at least one (1) condition and one (1) cause of poverty related to the agency's work with partners and providers.

Condition of Poverty	
Partner/Provider	**Hartford HealthCare**
Poverty Condition	According to the 2025 Connecticut Consumer Healthcare Experience State Survey (Healthcare Value Hub, 2025), nearly two in three adults (64%) experienced at least one health care affordability burden in the past year, and 61% delayed or went without needed medical care due to cost. Families living in poverty face significant challenges navigating the health care system. Although many individuals have some form of health insurance through Medicare, Medicaid, or employer-based coverage, many plans include co-pays, high deductibles, or exclusions for certain medications and procedures. With limited financial resources and rising costs for housing, food, and transportation, individuals living in poverty experience higher rates of chronic illness and unmet medical needs.
Description of Alliance	The agency maintains an informal partnership with Hartford Healthcare to support low-income families and individuals who cannot afford medical care. Hartford Healthcare operates a mobile clinic at the Torrington office and Meriden food pantry one to two times per month. The mobile clinic provides free medical tests and screenings to the community. Program staff refer NOI customers who lack health insurance or access to medical care to the mobile clinic and conduct follow-ups after each referral. When the mobile clinic recommends additional testing or specialty care, staff assist customers with transportation, translation services and ongoing support to ensure continuity of care.

CONNECTICUT COMMUNITY ACTION PLAN FORM

Cause of Poverty	
Partner/Provider	**CT Food Share**
Poverty Cause	Inflation and the high cost of living force families to spend a disproportionate share of their income on rent, utilities, and other essential expenses, leaving little to no money available for groceries. The Connecticut Commission on Women, Children, Seniors, Equity and Opportunity (CWCSEO, 2025) identifies similar barriers statewide, noting that rising grocery prices, transportation limitations, and lack of culturally appropriate food options disproportionately impact low-income households and communities of color.
Description of Alliance	The agency maintains a formal partnership with CT Food Share through a Memorandum of Understanding (MOU). Through this partnership, CT Food supplies the agency's food pantry with fresh and healthy food options, including fruits, vegetables, meat and other staples. CT Food Share also operates a biweekly mobile pantry in Meriden and in the agency's parking lot in Waterbury, expanding access to nutritious food for families in the NOI catchment area. During each mobile pantry event, program staff in Waterbury and Meriden conduct outreach to engage families and provide information about the SNAP program, case management services and other agency supports that can help address barriers related to food insecurity and overall household stability.

Section 4: Performance Management Systems

Basic principles of Results Oriented Management and Accountability (ROMA) indicate that agency data that is collected, reported and analyzed is used in the Re-Assessment process that leads to Planning for the future. This section of the CAP Form includes information about the systems your agency uses in tracking and reporting of data.

Identify your data systems and how you use them to manage agency performance.

4a. Client Data Systems: List all the client data systems in your agency and programs associated with those systems.

System	Programs Associated
Captain	Energy Assistance, Family Development, New Beginnings Emergency Shelter, Foster Grandparent (FGP), Retired Senior Volunteer Program (RSVP), Senior Companion Program (SCP), Project Longevity Outreach, Project Longevity Housing, Assurance 16; Bishop House
HMIS	Meriden Middlesex Wallingford Coordinated Access Network (MMW CAN), New Beginnings Emergency Shelter, Meriden Supportive Housing and Freedom Walk
PDMS	Bishop House
Veoci	Project Longevity Outreach and Project Longevity Housing
CXM, ServTracker	Meals on Wheels and Congregate Meals
CattMatt	Senior Dine
Volunteer Reporter	Foster Grandparent (FGP), Senior Companion, Retired Senior Volunteer Program (RSVP) and Senior Companion Program (SCP)
Procare	Muriel H. Moore Child Development Center

4b. Issues with Client Data Quality: Describe issues with client data quality and how the agency plans to address. Be specific in identification of issues. Utilize quarterly ROMA-HSI reports and Department feedback as guidance for this response.

In February 2026, the agency transitioned its case management system from CMS to Captain. During this transition, the agency initially configured the system to align with CSBG 3.0; however, the agency later reverted to CSBG 2.1 after learning that permission from the Department had not yet been granted. As of this submission, the agency has completed two

quarters of reporting using Captain, and Department feedback on those ROMA-HSI reports has not yet been received.

Historically, CMS did not require staff to complete all data fields. As a result, staff could leave certain fields blank, which contributed to the high count of "unknown/not reported" entries on the All-Characteristic report. Captain now requires completion of all data fields, including verification of income, before staff can procced in the system. This feature has significantly reduced the number of "unknown/not reported" entries over the last 2 quarters.

A small number of incomplete fields remain. To address this issue, the agency will continue communicating with program supervisors and directors, monitor completion of required fields, and reinforce expectations that staff update customer information consistently. Ongoing monitoring and internal review will support continued improvement as Captain becomes fully integrated into agency operations.

4c. Unduplicated Client Counts: Describe how your agency ensures that the CSBG Annual Report includes unduplicated client counts. If the agency utilizes multiple client intake/tracking systems, the response must specify how data is de-duplicated.

The agency ensures accurate unduplicated customer counts in the CSBG annual report by requiring all programs to use Captain in conjunction with their program specific systems. Captain operates two distinct platforms: Energy Assistance (CEAP) and Central Intake, which is used for case management and all other agency programs.

To prevent duplicate reporting, Captain is designed to pull each customer's All Characteristics data from only one platform: the platform where the customer first received a service, either CEAP or Central Intake. For example, if a customer receives case management services through Central Intake and later receives Energy Assistance through CEAP within the same quarter, Captain will only extract the All Characteristics record from the platform associated with the initial service interaction. This system logic ensures that each customer is counted once, even when they receive multiple services across different programs.

4d. Data Tracking Methods: Organizational Standards 9.1 and 9.2 require organizations to have systems in place to track and report client demographics, services customers receive, and family, agency and/or community outcomes.

Describe method(s) in which your agency tracks agency, family, and community goals. Responses must be specific. If, for example, community level goals are tracked manually, the response must detail the method of manual tracking (e.g., staff position(s) responsible, how progress/achievement tracked, etc.).

Level	*Data Tracking Method(s)*
Family	Demographics information, service data, outcomes, and other required data elements are entered by agency staff into the Captain client management database. Program staff maintains regular contact with customers, updating action plans and completing reassessments at least quarterly to ensure the database accurately reflects any changes in the customer's circumstances and status.
Agency	Agency-level strategies and outcomes are developed through the agency's strategic plan. Strategies are informed by agency staff, supervisors, and management team, and progress is tracked through meeting minutes, sign-in sheets, and strategic plan updates. Previously, the Director of Strategic Planning maintained this documentation. Following that position's departure, the interim CEO and the Director of Research, Development and Planning will track agency-level progress and maintain supporting documentation going forward.
Community	Community-level strategies and outcomes are tracked manually through coalition participation, meeting minutes, strategic plan updates, and annual CSBG IS reporting. For example, work related to increasing the supply of affordable housing units was previously tracked by the former CEO and reported in the agency's annual CSBG IS report. Community-level strategies developed through the strategic planning process were also tracked through meeting minutes by the former Director of Strategic Planning. Going forward, the interim CEO and the Director of Research, Development and Planning will be responsible for tracking these outcomes and maintaining documentation.

4d.1 Data Reporting Procedures: Identify your procedures for creating reports – for CSBG, other funding sources and other uses, both internal and for external communication. Include: Who is responsible for downloading data (including client demographics, services, and outcomes) and creating reports? How often is this done? Is data analyzed prior to reports being shared? Are narratives of data analysis included in the report(s)? With whom are reports shared?

The Contract Compliance Manager is responsible for generating the agency's quarterly HSI reports and annual CSBG reports, including customer demographics, services, outcomes, assessment results, and progress. Data is pulled from Captain on a quarterly schedule to align with funder reporting requirements. Before reports are finalized, the Contract Compliance Manager reviews the data for accuracy, analyzes trends, and identifies discrepancies or data quality concerns that may require follow-up.

Completed reports are shared with the Director of Research, Development and Planning and the senior management director overseeing customer-facing programs. Once reviewed, findings are distributed to program directors and supervisors for review, follow-up, and corrective action when needed. Narrative analysis is included when required by the funder and when internal review identifies trends, discrepancies, or program performance concerns that need explanation.

Programmatic reports for CAFCA from the agency's three Family Development Center are completed and analyze by the program directors or supervisors. These reports are then submitted to the Contract Compliance Manager for review and compilation into a single agency report. Statistical reports are completed quarterly, and the narrative reports are completed every six months, consistent with funder requirements. Some data is generated through the agency case management software, while other information is tracked manually using an Excel spreadsheet and/or word document. These reports include demographic data, services delivered and client outcomes. The SNAP Outreach Time and Effort report is shared with Fiscal Department, while the compiled statistical report is shared with Director of Research, Development, and Planning and the senior management team director that oversees the Family Development Centers.

The Assurance 16 report is generated quarterly by an Energy supervisor. The report includes customer demographics data and services provided; no narrative is required. The supervisor analyzes data and submits the report to the funders. A copy is also shared with the senior management team director overseeing the Energy Department.

Programmatic reports for AmeriCorps are completed annually by the Director of Foster Grandparent, Director of Senior Nutrition, and Director of Retired Senior Volunteer Program. These reports are generated using the funder-require data collection system (Volunteer Tracker) and include demographic data, volunteer services data, and outcome. Each director reviews and submit the report to the funder, shares it with the senior management team director overseeing the program.

The agency DOH programmatic statistical reports are completed quarterly, with narrative reports submitted every 6 months. The CAN Manager and Residential Program Manager generate these reports using the funder-required HMIS system, review the data, and submit the reports to the funder. Copies are also shared with the senior management team director overseeing the program. Data includes customer demographic and contractual outcome. The Contract Compliance Manager, who serves as the agency's HMIS Data Coordinator occasionally assists generating or reviewing these reports.

The Early Childhood (ECD) program submits monthly enrollment reports to funders. These reports include basic demographic information and do not require a narrative. The Director of Early Childhood generates and submits the report and shares it with the senior management assigned to the department.

***4e. Progress Toward Outcome Achievement*: Describe the progress that the agency has made toward reaching the identified outcomes and indicators as specifically identified in its previous CAP (FFY2023). The response must identify at least one (1) outcome and detail the progress.**

Identified Need from Prior CAP	*Identified Outcome and Target from Prior CAP*
Low-income individuals/families lack access to quality of care and healthcare	**Target:** 45% of individuals will self-report improved physical and well-being during the program year
Progress Toward Outcome	
Since the update of the previous CAP in FFY2024/25, the agency has made progress toward this outcome by establishing and maintaining partnerships with health care agencies such as Hartford HealthCare, Yale, and Community Health and Wellness. These partnerships helped low-income individuals access health care services and support better health outcomes. During the reporting period, 48% of NOI customers seeking health care services self-reported improved physical health and well-being, exceeding the prior CAP target of 45%.	

Identified Need from Prior CAP	*Identified Outcome and Target from Prior CAP*
Individuals lack employment skills in our catchment area	**Target:** 60% of program participants will complete the employment training program during the program year.
Progress Toward Outcome	
To help individuals in the catchment area improve employment skills, the agency received a small grant through the Connecticut Community Foundation to provide work readiness training. Forty-two individuals enrolled in the work readiness program, and all 42 participants completed the program, resulting in a 100% completion rate. Of those served, 25 individuals, or 60%, obtained full- or part-time employment. The agency met its employment target and exceeded its projected training completion target.	

Identified Need from Prior CAP	*Identified Outcome and Target from Prior CAP*
Families lack access to affordable and quality early childhood education	**Target:** 70% of children will demonstrate skills for school readiness during the program year.
Progress Toward Outcome	
During FFY2023, the agency's Early Childhood Development program served 339 children, and 100% of children served demonstrated skills for school readiness. During FFY2024, the agency served 533 children, and 100% achieved the outcome. During FFY2025, the agency served 424 children, and 95% achieved the outcome. Across the three-year period, the agency exceeded	

its projected target, and participating children demonstrated the skills needed to move on to the next grade level.

Identified Need from Prior CAP	***Identified Outcome and Target from Prior CAP***
There is a lack of affordable housing for low-income residents in our catchment area	**Target:** 75% of low-income residents will avoid eviction during the program year.
Progress Toward Outcome	
From FFY2023 to FFY2025, the agency served 1,499 individuals at risk of eviction. Of the individuals served, 95% avoided eviction. The agency exceeded its projected target, and the families NOI served during this reporting period remained stably housed. However, the rising cost of living and housing continues to place additional burdens on low-income families.	

4f. Change of Priorities as a Result of Data Collected: related to service provision, strategy progress or outcome achievement. Have your priorities changed because of data collected by your client management systems?

- ***If yes: please describe by including at least one (1) specific example.***
- ***If no: please explain why not.***

Yes. Data collected through the agency's case management system showed a significant increase in customers using the food pantry, mobile pantry, and SNAP application assistance to supplement household food budgets. Food insecurity was not a primary focus in the previous CAP. However, the most recent Community Needs Assessment survey, focus groups, and case management data led the agency to identify "Families cannot afford to buy nutritious food" as a priority need. In response, the agency extended mobile pantry hours to 6:00 p.m. every Tuesday and Thursday so working families can access nutritious food, and the agency will seek grant funding to provide food vouchers for eligible households.

4g. Change of Priorities as a Result of Change In Community Needs or Resources: Have needs, outcomes or plans to address these (services and/or strategies identified in the previous CAP) changed as a result of changes in community needs?

- ***If yes: please describe by listing original goal/strategy, change in community need, and change in goal/strategy.***
- ***If no: please explain.***

Yes. The previous CAP included a strategy to advocate for increased investment in early childhood education by supporting policy changes and securing funding for infrastructure expansion to increase program capacity. Since the prior CAP was developed, the agency's Muriel Moore Child

Development Center increased toddler slots by 17, allowing more families to access early learning opportunities. In addition, Connecticut announced the addition of up to 1,000 new Early Start CT spaces, expanding access to early childhood education and childcare statewide. As a result, the agency's strategy related to expanding early childhood education access has been advanced through both local program expansion and increased state investment.

(https://portal.ct.gov/governor/news/press-releases/2025/11-2025/governor-lamont-announces-connecticut-adding-1000-early-childhood-education-spaces?language=en_US)

***4h. Board Minutes Related to Updates*: Provide Board minutes confirming governing board's receipt of annual update on the success of specific strategies included in the Community Action Plan (most recent prior to this submission) in compliance with CSBG Organizational Standard 4.4.**

Board minutes confirming the governing board's receipt of the annual update on the success of strategies included in the most recent prior Community Action Plan is attached, referenced attachment 2.c.

Section 5: Community Action Plan Development

***5a. Description of Planning Process*: After the CNA data and Agency Performance Management data are analyzed and prioritized, it is used to inform the identification of outcomes, services and strategies for the CAA's next Strategic Plan and the Community Action Plan.**

Identify steps that were taken to create the Community Action Plan, including who was involved in the decision making process.

To develop the Community Action Plan, the agency followed the ROMA cycle by first using data from the completed Community Needs Assessment, focus group, and by gathering additional data to assess from the Agency's Performance Management System. First, the Contract Compliance Manager compiled, analyzed and created a report on the CAN findings, quarterly ROMA-HIS report and customer feedback. These findings were shared with the RDP team, program directors and supervisors, and the senior management team. Next, the RDP team worked closely with the senior management team to identify desired outcomes and assets available. The team ensured that outcome was focused on changes at the individuals, community, and agency level.

Based on the feedback from the senior management team, the RDP team developed strategies and services designed specifically to reduce the prioritized causes and conditions of poverty, such as food insecurity, housing affordability, and barriers to health care access. Each strategy was assessed to ensure it aligned with the anti-poverty purpose of the CSBG ACT, the agency mission and The National Community Action Network Theory of Change.

After the CAP is reviewed by the RDP team then it will be submitted to the Acting CEO for final review. The Community Action Plan will be formally represented to the Board of Directors at the August meeting. Because the Board does not convene during the summer recess, the CAP could not be presented earlier for acceptance. Following the August meeting, the meeting minutes will be included for Board approval at the September meeting.

5b. Strategic Plan/CAP: Describe the agency's Strategic Plan objectives which informed the CAP; provide at least one example.

Goal and/or Objective Identified in Strategic Plan
Strategic Plan Goal – Expand NOI's image in the community by strengthening customer service, using customer feedback to improve service delivery, and increasing public awareness of agency programs and outcomes.
Programs and Approaches Identified in CAP to Meet Strategic Goals and/or Objectives
The CAP supports this strategic goal by monitoring customer service delivery and effectiveness through regular supervision, observation, customer satisfaction surveys, develop and execute a public relation strategy, enhance relations with the business community, and review of service data. The resulting information is used to improve service delivery, strengthen staff practice, and ensure customers receive consistent information about available programs and eligibility requirements.

5c. Incorporation of Customer Voice in Planning Process: CSBG Organizational Standard 6.4 specifically ask agencies to identify the inclusion of customer satisfaction and customer input data, collected as part of the Community Needs Assessment, in the strategic planning process. Provide one example of how customer satisfaction data was incorporated into the strategic planning process and one example of how customer input data was incorporated into the strategic planning process.

Customer Satisfaction Data Specifically Incorporated in the Strategic Planning Process
How did customer satisfaction data influence the strategic planning process?
Customer satisfaction surveys are completed throughout the year, compiled and analyzed annually by the RDP department. The results are presented to the board of directors and shared with the former Director of Strategic Planning and the senior management team. The former Director of Strategic Planning reviewed the survey findings and used the results to update strategies within the agency's strategic plan.
What outcome, service, strategy or action was developed as a result of customer satisfaction data analysis?
Results from the 2023 customer satisfaction survey were overall positive, with an average of 90% of customers reporting satisfaction with services. However, a small percentage (2%) indicated that staff did not properly explain program eligibility and guidelines. In response, the former Director of Strategic Planning, former Director of Regional Programs, and the Chief Administrative Officer developed additional training for the Train-the-Trainer cohort. Selected staff met bi-weekly to design professional development focused on strength-based family case management strategies. Training on the agency's case management manual,

customer service and case management software was provided to program staff, supervisors and directors in April 2025, June 2025, and October 2025.

Customer Input Specifically Incorporated in the Strategic Planning Process
How did customer input data influence the strategic planning process?
Customer input is collected annually through surveys and focus group and is compiled and analyzed by the RDP department. Over the past two years, individuals consistently expressed concerns about the rising living costs and grocery prices. Many shared that they often worry about running out of food before the end of the month. These findings were shared with the former Director of Strategic Planning who oversees the strategic plan process.
What outcome, service, strategy or action was developed as a result of customer input data analysis?
As a result of customer feedback, a subgroup was created under the community team in May 2025, to explore and identify strategies to address changes in food availability and customer needs. The team consisted of three senior management team members, one program director and the former Director of Strategic Planning. Following the departure of the Director of Strategic Planning and two senior management team members, the interim CEO will review and reassess the agency's strategic plan strategies, services and outcomes.

Section 6: Identification of Outcomes for Prioritized Needs through Services and Strategies

The Community Action Plan must describe how the agency will address the needs identified in the Community Needs Assessment (CNA). Present information for the three-year period, to be updated on an annual basis as priorities and conditions change.

Describe how the agency plans to provide services and engage in strategies to address each of the needs that were prioritized by the agency and identified in the CNA over the next three years. This section demonstrates the outcome-focus of the CAP by identifying the changes that will be produced, as well as the activities you will provide. Include indicators and measurement tools for each need. Note: Services, strategies and indicators may reference, but are not limited to, those found in the CSBG Annual Report.

Planning activities must align with need levels i.e.:

- ***Family level needs are addressed via services;***
- ***Agency level needs are addressed via agency level strategies; and***
- ***Community needs are addressed via community level strategies.***

Connect your projected work to the National Community Action Network Theory of Change. The Community Action Goals in that document are as follows:

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- ***Goal 1: Individuals and families with low incomes are stable and achieve economic security.***
- ***Goal 2: Communities where people with low incomes live are healthy and offer economic opportunity.***
- ***Goal 3: People with low incomes are engaged and active in building opportunities in communities.***

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***6a. Outcomes, Activities, Indicators and Measures*: The chart below includes the inter-connected elements of the ROMA process to demonstrate that the organization's Community Action Plan is outcome-based, anti-poverty focused, and ties directly to the community assessment. (CSBG Organizational Standard 4.2)**

Need #1 : Families are at risk of eviction	**Domain: Housing**	
Designated Service Location	**Outcomes, Services/Strategies, Indicators and Measurement Tools**	**Level (F, A, or C), National Goal #**
Meriden, Torrington, Waterbury	Service (F) or Strategy (A or C) to address the need: • SRV 4c. Rental payments (includes Emergency Rent Payments). • SRV 4g. Landlord/Tenant Mediations • SRV 7a. Case Management	Family Level Goal #1: Individuals and families with low incomes are stable and achieve economic security.
	Outcome (what will change): Families avoid eviction.	
	National Performance Indicator (number expected to be served, number expected to achieve outcome and projected percent of success): FNPI 4e. The number of individuals who avoided eviction 85/100 or 85% of families will avoid eviction in the program year.	
	Output Measurement Tool(s): • Initial and follow-up case notes • customer service/goal plan • copy of check or payment records from the fiscal department.	
	Outcome Measurement Tool(s):	

	• Confirmation email/text/phone call from landlord that payment was receive.	

6a.1 Service/Strategy Methodology: Describe how the service or strategy above will be implemented. If a service was identified, include such things as who will provide the service, frequency and duration of the service and any special characteristics of the service. If a strategy was provided, include who will be involved, how activities will be coordinated, the expected time frame for the strategy and any other special characteristics of the strategy.

The agency will continue to use existing funds and seek new funding to assist eligible customers with rental arrears and eviction prevention. Family Development Center case managers will enroll 100 households at risk of eviction to receive financial assistance and case management support. Case managers will complete the universal intake, pre-assessment, and full assessment to identify two or more barriers and verify household income eligibility. A client service plan will be developed with each customer, and follow-up meetings will occur quarterly or sooner based on the customer's needs.

The FDC case manager will complete a budget sheet with the customer to determine whether the household can maintain rent after financial assistance is provided. The case manager will also provide landlord/tenant mediation support by attempting to reduce rental arrears, request forgiveness of late fees, or establish a payment plan. Once the customer is found eligible for financial assistance, the case manager will collect all required documents from the customer and landlord and submit the request to the fiscal department. The fiscal department will mail the rental arrears payment to the landlord. The case manager will then contact the landlord to confirm that payment was received and document progress in the case notes, action plan, and conduct reassessment. Data will be reported in the quarterly ROMA-HSI report.

Need #2 : Families cannot afford to buy nutritious food	**Domain: Food Insecurity**	
Designated Service Location	**Outcomes, Services/Strategies, Indicators and Measurement Tools**	**Level (F, A, or C), National Goal #**
Meriden, Torrington, Waterbury	Service (F) or Strategy (A or C) to address the need: • SRV 7a case management • SRV 7b Eligibility Determinations • Application assistance - SNAP	Family Level Goal #1: Individuals and families with low incomes are stable

	Outcome (what will change): Families can afford to buy nutritious food	and achieve economic security.
	National Performance Indicator (number expected to be served, number expected to achieve outcome and projected percent of success): FNPI 7a. The number of individuals who achieved one or more outcomes in the identified National Performance Indicator on one or more domains. 175/200 or 87.5% of families can afford to buy nutritious food in the program year	
	Output Measurement Tool(s): • Initial and follow-up case note • customer service/goal plan • DSS SNAP application and supporting documents submission	
	Outcome Measurement Tool(s): • Copy of DSS benefit notice letter	

6a.1 Service/Strategy Methodology: Describe how the service or strategy above will be implemented. If a service was identified, include such things as who will provide the service, frequency and duration of the service and any special characteristics of the service. If a strategy was provided, include who will be involved, how activities will be coordinated, the expected time frame for the strategy and any other special characteristics of the strategy.

The Family Development Center will enroll 200 families with two or more barriers, including food insecurity, to receive coordinated services through the HSI service delivery model. Services will include SNAP application assistance and referrals to local food pantries and mobile pantries. The FDC case manager will complete the universal intake, pre-assessment, and full assessment, including review of the food security, income, employment, job skills and training, community involvement, and household budgeting domains. A client service plan will be developed with each customer, and follow-up meetings will occur quarterly or sooner based on the customer's needs.

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The FDC case manager will help the customer complete the DSS SNAP application online, review the application for completeness, and submit all required supporting documentation. The case manager will also assist the customer with the SNAP interview process when needed. Once approved, the case manager will work with the customer to identify employment, volunteer opportunities, or job training programs that may help the customer maintain SNAP benefits under applicable program requirements.

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<table>
<tr><td colspan="2">Need #3 : Families lack affordable transportation for health care services</td><td>Domain: Health Care Access</td></tr>
<tr><td>Designated Service Location</td><td>Outcomes, Services/Strategies, Indicators and Measurement Tools</td><td>Level (F, A, or C), National Goal #</td></tr>
<tr><td rowspan="5">Meriden, Torrington, Waterbury</td><td>Service (F) or Strategy (A or C) to address the need:
• SRV 7a. case management
• SRV 7d. transportation services (e.g. bus passes, bus transport, support for auto purchase or repair; including emergency services)
• SRV 7c. Referrals
• Help make an appointment</td><td rowspan="5">Family Level

Goal #1: Individuals and families with low incomes are stable and achieve economic security.</td></tr>
<tr><td>Outcome (what will change):

Families have affordable transportation for health care services</td></tr>
<tr><td>National Performance Indicator (number expected to be served, number expected to achieve outcome and projected percent of success):

FNPI 7a. The number of individuals who achieved one or more outcomes in the identified National Performance Indicator on one or more domains.

75/100 or 75% of families will have affordable transportation for health care services in the program year</td></tr>
<tr><td>Output Measurement Tool(s):
• Initial and follow-up case note
• customer service/goal plan
• copy of bus pass log/acknowledgement</td></tr>
<tr><td>Outcome Measurement Tool(s):
• Customer self-report survey</td></tr>
</table>

***6a.1 Service/Strategy Methodology*: Describe how the service or strategy above will be implemented. If a service was identified, include such things as who will provide the service, frequency and duration of the service and any special characteristics of the service. If a strategy was provided, include who will be involved, how activities will be coordinated, the expected time frame for the strategy and any other special characteristics of the strategy.**

The Family Development Center will enroll 100 families with two or more barriers, including a transportation barrier, to receive coordinated services through the HSI service delivery model. The FDC case manager will complete the universal intake, pre-assessment, and full assessment, including the transportation, adult health insurance, and child health insurance domains. A client service plan will be developed with each customer, and follow-up meetings will occur quarterly or sooner based on the customer's needs.

The FDC case manager will refer customers to the mobile clinic located at the three Family Development Center locations, help customers schedule medical transportation when covered by their health insurance plan, provide bus passes when available, or arrange transportation assistance to medical appointments when needed. Customers who receive a bus pass will complete a bus pass acknowledgment form that will be kept in the file. The agency will also create a self-report survey to measure whether transportation assistance improved access to health care. The agency will seek new funding and use existing funding, when available, to cover transportation costs.

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<table>
<tr><td colspan="2">Need #4 : Families do not understand what their health insurance cover</td><td>Domain: Health Care Access</td></tr>
<tr><td>Designated Service Location</td><td colspan="2">Outcomes, Services/Strategies, Indicators and Measurement Tools</td><td>Level (F, A, or C), National Goal #</td></tr>
<tr><td rowspan="5">Meriden, Torrington, Waterbury</td><td colspan="2">Service (F) or Strategy (A or C) to address the need:
SRV 5j. Health insurance options counseling
SRV 7a case management
Teach customers how to look up and understand their health insurance plan</td><td rowspan="5">Family Level

Goal #1: Individuals and families with low incomes are stable and achieve economic security.</td></tr>
<tr><td colspan="2">Outcome (what will change):
Families will better understand what their health insurance covers.</td></tr>
<tr><td colspan="2">National Performance Indicator (number expected to be served, number expected to achieve outcome and projected percent of success):
FNPI 7a. The number of individuals who achieved one or more outcomes in the identified National Performance Indicator on one or more domains.

50/100, or 50%, of families will better understand what their health insurance covers during the program year.</td></tr>
<tr><td colspan="2">Output Measurement Tool(s):
Initial and follow-up case note
customer service/goal plan
Fact sheet on how to review summary of benefits and coverage</td></tr>
<tr><td colspan="2">Outcome Measurement Tool(s):
Pre-post survey</td></tr>
</table>

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***6a.1 Service/Strategy Methodology*: Describe how the service or strategy above will be implemented. If a service was identified, include such things as who will provide the service, frequency and duration of the service and any special characteristics of the service. If a strategy was provided, include who will be involved, how activities will be coordinated, the expected time frame for the strategy and any other special characteristics of the strategy.**

The agency will create a one-page fact sheet explaining how customers can check their health insurance policy and coverage and what questions to ask when calling a doctor's office to schedule a medical appointment. The Family Development Center will enroll 100 families with two or more barriers, including an adult or child health insurance barrier, to receive coordinated services through the HSI service delivery model. The FDC case manager will complete the universal intake, pre-assessment, and full assessment. A client service plan will be developed with each customer, and follow-up meetings will occur quarterly or sooner based on the customer's needs.

The agency will create a pre- and post-survey to measure whether customers improve their understanding of health insurance coverage. Customers seeking assistance with applying for or renewing health insurance will complete the pre-survey before receiving services. After services are provided, the FDC case manager will review the fact sheet with the customer and ask the customer to complete the post-survey. The materials will be available in English and Spanish and will be added to the agency's outreach materials.

<table>
<tr><td colspan="2">Need #5 : There is a lack of community focus on preventative healthcare</td><td>Domain: Health Care Access</td></tr>
<tr><td>Designated Service Location</td><td colspan="2">Outcomes, Services/Strategies, Indicators and Measurement Tools</td><td>Level (F, A, or C), National Goal #</td></tr>
<tr><td rowspan="2">Torrington</td><td colspan="2">Service (F) or Strategy (A or C) to address the need:
• SRT 6 G2a. Development of Health and Social Service Provider Partnerships
• Conduct healthcare workshop at the Torrington FDC location.
• Participate in community healthcare outreach</td><td rowspan="2">Community Level
Goal#2 Communities where people with low incomes live are healthy and offer economic opportunity.</td></tr>
<tr><td colspan="2">Outcome (what will change):
Our community improved educational access to preventative healthcare</td></tr>
</table>

	National Performance Indicator (number expected to be served, number expected to achieve outcome and projected percent of success): CNPI 5a. Numbers of accessible and affordable physical health assets or resources created in the identified community. 2/5 or 40% of accessible and affordable physical health assets or resources will be created in NOI Torrington catchment area during the program year.	
	Output Measurement Tool(s): • Sign-in logs from healthcare workshop meeting • Emails, memos or correspondence showing coordination • Healthcare workshop flyer	
	Outcome Measurement Tool(s): • Pre and post test	

<u>6a.1 Service/Strategy Methodology</u>: Describe how the service or strategy above will be implemented. If a service was identified, include such things as who will provide the service, frequency and duration of the service and any special characteristics of the service. If a strategy was provided, include who will be involved, how activities will be coordinated, the expected time frame for the strategy and any other special characteristics of the strategy.

The lack of community focus on preventative healthcare was identified as a need across NOI's catchment area through current and prior focus group results. To address this need at the community level, NOI will coordinate with health and social service partners to offer preventative health care workshops at the Torrington Family Development Center. The Torrington Director of Community Service will coordinate with partners to identify workshop topics and schedule sessions. Program staff will assist with distributing outreach flyers collecting sign-in sheets and administer pre- and post-tests to measure changes in participant knowledge. The agency will also participate in community health outreach events to increase awareness of preventative care resources and strengthen linkages with providers.

Section 7: Linkages

CT CAAs are contractually required to establish linkages with other agencies in the community to improve coordination, avoid duplication, and enhance the delivery of services to alleviate the causes, and improve the effects of poverty on the target population. Such linkages promote the development of improved delivery systems for services that include, but are not limited to, community-based services designed to promote active participation in the community; and other social services designed to specifically promote and facilitate strengthened family and other support systems.

A compliant response will include:

- ***Description of linkages used to fill identified gaps in services through the provision of information, referrals, case management, and follow-up consultations.***
- ***If an identified community need exceeds your agency's capacity to meet it and/or there are others already working to address the need, description of methods your agency will utilize to bring more attention to this need in the community.***
- ***Account of leveraged resources to meet identified need(s).***
- ***Agency plans to fill service gap(s) by coordinating with others to address community needs.***

7a. Avoiding Duplication of Services: While you work with many organizations in the community, identify the three (3) organizations you feel are most important to the work of your agency. They can be governmental or other social service agencies with anti-poverty programs (other than DSS and CAFCA), with whom your CAA works. Then describe how you work together to assure effective delivery of and coordination of CSBG services to low-income people and communities while avoiding duplication of services.

Organization	Coordination of activities to provide services & avoid duplication
American Job Center (AJC)	The American Job Center provides employment services, including career counseling, education, training, and job search support. NOI provides holistic case management services and refers customers seeking employment support to the American Job Center. The Meriden Family Development Center shares office space with the American Job Center, allowing staff from both organizations to make direct referrals, coordinate services, and track referral progress. This coordination helps customers receive services in one location while avoiding duplication of employment-related supports.
Waterbury Police Activity League (PAL)	The Waterbury Police Activity League connects local youth with police officers and the community through sports, education, employment,

	and violence prevention programs. PAL is also a gun violence prevention partner. NOI's Project Longevity Outreach program meets with PAL weekly to discuss individuals preparing for release from incarceration and determine whether they meet eligibility requirements for referral to Project Longevity. Family Development case managers also refer youth to PAL programs and activities when appropriate. This coordination helps ensure that customers are connected to existing youth and violence prevention services rather than duplicating those services within NOI.
Meriden/Middlesex/ Wallingford Coordinated Access Network (MMW CAN)	The Meriden/Middlesex/Wallingford Coordinated Access Network is a network of agencies that assist individuals and families experiencing homelessness by connecting them to local services and housing assistance. The MMW CAN consists of 12 providers focused on homelessness prevention, diversion, emergency shelter placement, and emergency housing assistance. NOI serves as the CAN manager and first point of contact for individuals and families experiencing homelessness, coordinating with other providers within the MMW CAN and statewide systems to better serve customers. The MMW CAN oversees the by-name list and housing voucher coordination. NOI's emergency shelter also serves as the CAN triage and overflow site. This structure reduces duplication by ensuring that providers use a coordinated process for assessment, referral, shelter placement, and housing resources.

7b. Ongoing Initiative: Describe one (1) on-going initiative that your agency undertook during the previous federal fiscal year in which you work with another community partner or partners to leverage services and prevent duplication within your catchment area. Say if this will be continued in the coming period or not.

The City of Meriden has seen an increase in homelessness, particularly in the downtown area. Local emergency shelters have longer wait times, which has pushed some individuals into outdoor encampments. This increase is driven primarily by rising rents, the high cost of living, and the lack of affordable housing. To address this issue, Meriden Mayor Kevin Scarpati invited community partners, including New Opportunities Inc. (NOI), to participate in the Meriden Coalition to End Homelessness. NOI's former Director of Strategic Planning serves as coalition co-chair, and the agency's MMW CAN and New Beginnings Emergency Shelter program supervisors also participated. The coalition's goal is to identify aspects of homelessness that need to be addressed and develop sustainable programs and proposals by using the resources and skills of

coalition participants and their partners. NOI's MMW CAN and emergency shelter programs provide monthly statistics on homelessness trends in the MMW region, updates on available cooling and warming centers, information about the hospitality center where individuals and families can do laundry and shower, and education on the definition of homelessness under HUD and McKinney-Vento.

This initiative will continue during the coming period because homelessness remains an ongoing community need and the coalition provides a coordinated structure for sharing data, leveraging partner resources, and avoiding duplication of services across the Meriden service area.

The agency's MMW CAN, emergency shelter, and Family Development Center (FDC) case managers provide case management services to individuals experiencing homelessness. These services include assisting customers in locating apartments, securing financial assistance to obtain housing, completing housing applications, and connecting the customer to additional community resources. As homelessness remains an ongoing issue. The agency will continue participating in this committee.

7c. Utilizing Linkages: to Fill Gaps: Pursuant to the assurance under Section 676(b)(3)(B) of the CSBG Act, describe how your agency utilizes linkages to fill identified gaps in service, through the provision of information, referrals, case management, and follow-up consultation. In other words, if an identified community need exceeds your agency's capacity to meet it and/or there are others already working to meet it in the community, have you answered questions such as: Can our agency bring more attention to this need in the community? Can our agency leverage resources to meet this need? Can our agency fill a service gap by coordinating with others to address this need?

The agency's approach is designed to avoid duplication by filling service gaps rather than recreating services already available in the community. In response to health care access gaps identified in the previous CNA, program staff and directors developed and strengthened linkages with medical and behavioral health providers, including Wellmore Behavioral Health, StayWell Health Center, Community Health and Wellness, and Hartford HealthCare. Through these partnerships, case managers provide information and referrals, warm handoffs, and follow-up. Staff assist customers with scheduling appointments, coordinating transportation, accompanying customers to medical appointments when needed, assist with paperwork, providing translation support, and ensuing continuity of service.

***7d. Cultivating Additional Partnerships*: Describe how your agency will cultivate additional partnerships with non-profits, charitable organizations, faith-based organizations, and community organizations.**

NOI will cultivate additional partnerships by actively engaging community members and organizations through outreach, inviting community stakeholders to participate in roundtable discussions, attending local coalition meetings, and occupying board seats within partner organizations when appropriate.

Program staff and supervisors who attend local coalition meetings provide presentations and informational materials to community partners about NOI services and programs while identifying opportunities for collaboration. The Torrington Director of Community Services conducts community stakeholder roundtables, or community talks, at least annually to raise awareness of community needs and identify existing resources or resource gaps. Program staff also participate in outreach activities throughout the community. Through these activities, the agency will expand its partner network and strengthen its ability to address unmet community needs.

Section 8: Coordination of Funding

Describe how your agency leverages CSBG and HSI dollars with other resources, both public and private, to ensure service delivery to low-income clients and families. The response should provide at least one (1) narrative example for CSBG dollars and one (1) narrative example for HSI funding. You may also complete the following or similar chart in addition to the provision of specific examples.

Coordination of funding:

The agency strategically coordinates CSBG and HSI funding to enhance services delivery and maximize the impact of resources available to low-income individuals and families. These funding streams provide the support needed to maintain a comprehensive customer-centered service model while utilizing additional public and private resources throughout the community.

CSBG Coordination of Funding

CSBG dollars are leveraged by aligning agency operations with external resources such as food distribution links, community health initiatives, employment services, and local philanthropic giving. This coordination expands the reach of the agency services, increases access to supportive programs and ensures customers receive assistance that addresses multiple areas of need. CSBG funding also strengthens the agency's ability to demonstrate measurable outcomes, which supports additional grant opportunities and community partnerships. These activities position the agency to collaborate with a wide range of partners, including municipal departments, nonprofit organizations, healthcare providers, and private grants.

HSI Coordination of Funding

HSI dollars are leveraged by integrating case management activities with external resources and community supports. This coordination allows the agency to connect customers to services beyond what HSI alone can provide, these collaborations provide a comprehensive service delivery model that allows for the development of staff/customer relationships while also being strengths-based and outcome driven. Aligning these activities with other public and private resources, the agency ensures customers benefit from a more comprehensive and coordinated network of support.

FFY 2025		
Source	**Amount**	**Percentage**
Federal	$25,913,347	69.79%
State	$7,879,330	21.22%
Local	$0.00	0.00%
Private	$1,374,580	3.70%
Other	$1,962,479	5.29%
Total CAA Revenue	$37,129,736	100%

CSBG	$1,342,009	3.61%
HSI (State & Federal)	$643,427	1.73%

8a. Utilization of In-Kind Services: Describe your agency's utilization of in-kind services or contributions for the delivery of services.

The agency utilizes in-kind contributions to strengthen service delivery and expand access to resources for individuals and families across the community. The Elder Services division utilizes in-kind resources that support senior volunteer programming designed to help older adults maintain independence. The senior nutrition supplements its operations through community fundraising efforts and donated resources. The tax assistance program relies on trained volunteers who provide free tax preparation services to income eligible individuals and families. The food pantry and emergency shelter in Meriden receive donated items from local grocers and community partners to support at-risk and currently homeless families in meeting their food assistance needs.

8b. New Funding Streams: Identify new funding streams your agency is attempting to obtain to address the needs in your community. Specify purpose, funding source, amount seeking, and application submission date.

Funding Source	Purpose	Amount Seeking	Application Submission Date
Department of Public Housing	Launch the Health Access Program, a community-based initiative that connects uninsured and underinsured residents to specialty healthcare and essential wrap-around supports.	$622,317	11/1/2025
Department of Housing	Upgrade the shelter facility to enhance the overall health, safety and well-being of residents. Planned improvements include repairs and renovations to the roof, windows, bathrooms and ceiling, along with other interior and exterior upgrades.	$987,589	11/1/2025

Webster Bank	Support the Meals on Wheels program, which provides critical nutrition services to seniors in the Greater Waterbury area. This funding will address budget constraints that threaten the program's ability to deliver freshly prepared, diet-specific meals to older adults who rely on these services to maintain their health and independence.	$10,000	11/1/2025
National Council on aging (NCOA)	Expand access to benefits for low-income Medicare beneficiaries via the BEC model. The goal is to transform assistance for older adults and adults with disabilities in benefits enrollment and retention.	$300,000	11/1/2025
Community Investment Fund (CIF) Round 8	Support the replacement of the agency's HVAC system and elevator. The proposal outlined the need for this critical building infrastructure to improve the overall service reliability of the HVAC units and the elevator.	$2,900,174	12/1/2025
Community Investment Fund (CIF) Round 8	Support the development of a future capital project proposal for Muriel H. Moore Child Development Center HVAC replacement.	$250,000	12/1/2025

USDA Food & Nutrition Service	Provide fresh, locally grown produce to schools through its CT Food 4 Thought program. This initiative provides hydroponically grown, pesticide-free produce to schools while integrating agricultural education into curriculums.	$133,334	12/1/2025
Department of Correction	To continue operating the Community Residential Support Services at Bishop House. The program provides safe housing, supervision and structured support services for individuals returning from incarceration.	$4,915,081.146	2/1/2026
TJX Foundation	Support families experiencing food insecurity with $100 food vouchers. The vouchers will be distributed during the intake based on comprehensive assessment conducted by Family Development Specialists.	$10,000	2/1/2026
Connecticut Community Foundation	To fund the Chef on Site program and continue providing well-balanced restaurant-style meals to meet the nutritional needs and desires of a growing diverse older population while enhancing programming and services offered by the Woodbury Senior Centers.	$20,000	3/1/2026

Safety Grant Program	To address potential slip, trip and fall hazard in the loading dock hallway. This area is a critical operational corridor used daily by staff and Meals on Wheels delivery drivers. The flooring in this space has deteriorated, with multiple tiles missing or lifting, creating uneven surfaces in this high traffic area.	$7,905	3/1/2026
Connecticut Department of Transportation	To provide safe and accessible active transportation options for vulnerable road users by providing bicycle helmets and bicycle locks to low-income individuals and families served by the agency as well as children enrolled in Muriel Moore Child Development.	$5,000	3/1/2026
Union Savings Bank Foundation	To fund the Youth Opportunities program, an after-school mentoring and educational initiative in Torrington. This program provides low-income youth with mental and behavioral support.	$10,000	3/1/2026
Northwest Regional Workforce Investment Board	The Waterbury Youth Employment project runs for six weeks. In the program, 75 in-school youth ranging in age from 14-21 will be placed in jobs throughout the City of Waterbury.	$236,034.80	4/1/2026

Northwest Regional Workforce Investment Board	The Torrington Youth Employment project runs for six weeks. In the program, 60 in-school youth ranging in age from 14-21 will be placed in jobs throughout the City of Torrington.	$188,697.80	4/1/2026
Congressionally Direct Spending	To support the replacement of the agency's HVAC system. The proposal outlines the need for this critical building infrastructure to improve the overall service reliability of the HVAC units.	$2,759,654	4/1/2026
CT Health Foundation	To serve as a Trusted Messenger helping residents about changes to HUSKY and SNAP eligibility, enrollment and renewal. As a trusted messenger the agency will assist families maintaining access to essential health and food benefits.	$20,000	5/1/2026
United Way of Northwest CT	To support individuals and families who are at immediate risk of eviction by providing timely, flexible financial assistance to stabilize households, prevent homelessness, and promote long-term self-sufficiency.	$20,000	5/1/2026
CDBG of Meriden	To provide short-term housing and stabilization services for three vulnerable groups: single men, single women, and families with children	$60,000	5/1/2026

	who are experiencing literal homelessness and have no safe, reliable housing options.		
CDBG of Meriden	To expand our Emergency Food Pantry operations in Meriden and our Rental Assistance Program for extremely low- and low-income households.	$70,000	5/1/2026
Connecticut Office of Early Childhood	To repair and replace its failed HVAC system to ensure safe and compliant classroom temperatures. Due to system failure, two classrooms were closed after temperatures fell below the Connecticut Office of Early Childhood required minimum of 66 degrees.	$49,999	5/1/2026
Justice Education Center, Inc.	To provide social services to participants unable to meet their basic needs independently and reduce recidivism.	$155,597.50	6/1/2026
United Way of Greater Waterbury	To help fund activities and resources for staff and clients to support The Family Development Center in Waterbury.	$300,000	7/1/2026
The Community Foundation of Greater New Haven	To help fund activities and resources for staff and clients to support The Family Development Center in Meriden	$300,000	7/1/2026
FEMA – CT Division of Emergency Management and	Security upgrades and enhancements to the 232 N. Elm Street	$50,000	7/1/2026

Homeland Security (DEMHS)	building. NOI requested funding for cameras for the front entrance following a recent security assessment.		
FEMA – CT Division of Emergency Management and Homeland Security (DEMHS)	Security upgrades and enhancements to the 31 Bishop Street building. NOI is requested funding for cameras for the interior following a recent security assessment.	$15,000	7/1/2026

2.a. Community Needs Assessment

Comprehensive Community Needs Assessment Report Template

Updated January 2026 by Progress Resources, Inc.

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A. Contact Information & Board Acceptance

Name of Agency: New Opportunities, Inc.

Principle Contact Name: Gawdys Grullon

Principle Contact E-mail Address: ggrullon@newoppinc.org

Principle Contact Phone Number: 203-575-4285

Federal Fiscal Year: 2026

Dates of the Community Needs Assessment Process: 12/16/2025, 1/13/2026, 2/20/2026; 3/24/2026; 4/7/2026; 4/28/2026; 5/5/2026; 5/12/2026, 5/19/2026, 5/26/2026, 6/2/2026, 6/9/2026, 6/16/2026, 6/25/2026, 7/8/2026, 7/13/2026, 7/22/2026, 7/22/2026.

Date of Board Acceptance of Community Needs Assessment (CNA) report:

The Community Needs Assessment will be formally represented to the Board of Directors at the August meeting. Because the Board does not convene during the summer recess, the CNA could not be presented earlier for acceptance. Following the August meeting, the meeting minutes will be included for Board approval at the September meeting.

B. Executive Summary

New Opportunities, Inc. has completed its Comprehensive Community Needs Assessment (CNA) to understand the conditions and causes of poverty affecting individuals and families living with low incomes in the catchment area. The CNA was guided by several central questions: What challenges most affect households with low income? What underlying causes contribute to persistent poverty? How do these challenges interact to limit progress toward self-sufficiency? And which needs are most urgent, widespread and aligned with NOI's mission and capacity?

To answer these questions, NOI used a mixed-methods approach that incorporated quantitative and qualitative data, community voices, demographic analysis and resource mapping. Some of the data sources included HUD, National Low Income Housing Coalition, Feeding America's Map the Meal Gap, CDC, DataHaven, CT Foodshare and NOI's CNA survey and focus groups. These sources provided a clear picture of local housing instability, barriers to health care access and food insecurity. Community voice was gathered through a CNA survey of 222 respondents and focus groups conducted in March 2026. Participants shared lived experiences related to eviction, food shortages, rising costs, transportation barriers and difficulty accessing medical care. This information validated the qualitative findings and ensured the CNA reflected real conditions in the community.

The CNA team then applied a structured prioritization process. The team used a counting method to identify the domains areas that rose to the top. Each domain was scored based on how frequently it appeared across survey responses, focus group themes and service request trends. Domains with the highest percentages were considered the strongest indicators of community need. Housing, health care access and food insecurity consistently appeared with the highest frequency across all data sources, demonstrating both severity and widespread impact.

The CNA team then applied additional criteria, including alignment with NOI's mission and Strategic Plan, availability of community resources and NOI's capacity to intervene. High utility costs were also identified as a significant concern; however, reducing utility rates is outside NOI's scope and year-round financial assistance is not feasible. Therefore, utilities were not selected as a priority domain.

Through this combined quantitative and qualitative process, NOI identified Housing, Health Care Access and food insecurity as the three priority domains.

Housing

Housing instability is one of the most significant challenges facing families in NOI's catchment area. According to DataHaven, 50% of renters are cost-burdened, compared to 32% of homeowners and eviction activity remains high, with 11,542 renters facing eviction and 4,308

evictions filed between 2023 and 2026. Rising home values, including a 31% increase, have made homeownership unattainable for many households whose wages have not kept pace.

Historical inequities continue to shape housing conditions in the catchment area. Past housing and lending practices limited where many low-income residents were able to live, often placing low-income households in neighborhoods near industrial sites with inadequate environmental conditions. These patterns reduced access to safe and stable housing and contributed to long-term disparities in housing quality.

These conditions place families at risk of eviction, homelessness and displacement. Even individuals who are employed cannot keep pace with rising rents and home prices, leading more households to rely on rental assistance and support programs to maintain stability.

Health Care Access

Families in NOI's catchment area struggle to access adequate medical care. Survey and focus groups data show that 53% lack income for dental, hearing or vision care and 46% lack affordable transportation for medical appointments, grocery stores and food pantries. Many insured families have high-deductible plans or co-pays they cannot afford, and some participants shared experiences of delaying or refusing medical procedures due to cost of insurance limitations.

Environmental factors including housing conditions, income, transportation, access to nutritious food and literacy also shape health outcomes. Participants described the health insurance process as complex and unpredictable, with some losing long-term doctors because their insurance was no longer accepted. These barriers contribute to higher rates of chronic illness and worsening health conditions among families living in poverty.

Food Insecurity

Food insecurity is widespread and closely tied to high housing costs and inflation. CT Foodshare reports that food insecurity affects 23% of Waterbury residents, 18.3% of Meriden residents and 17% of Torrington residents, exceeding local poverty rates. Survey data show that 63% of respondents worry they will run out of food before they can buy more, and 62% cannot afford nutritious food.

Focus group participants described food as "expensive," with budgeting no longer feasible. Many shared that despite careful planning, food often runs out before the end of the month. Working families struggle to access food pantries because many operate during work hours. Changes in SNAP eligibility have further strained budgets, with statewide enrollment dropping by 39,000 people.

These conditions affect physical and mental health, limit stability and reduce families' ability to take action toward self-sufficiency.

Overall Observations

The CNA shows that housing instability, food insecurity and limited access to health care are interconnected. High housing costs reduce the ability to purchase food and pay for medical care. Food insecurity affects health, which in turn affects employment stability. Lack of adequate medical care leads to worsening conditions that further strain household budgets. Together, these domains reinforce one another, creating a cycle that keeps families in poverty.

NOI prioritize these areas because they rose to the top though the counting method, demonstrating the highest percentage of need, aligned with NOI's mission and Strategic Plan, and represents areas where community resources are insufficient to meet demand. Addressing these domains is essential to improving conditions for families and supporting long-term pathways out of poverty.

C. What is a Comprehensive Community Needs Assessment (CNA)?

A Community Needs Assessment (CNA) is an integral part of a community action agency's (CAA) performance management process and sets the direction for the agency's work by establishing a profile of the catchment area, noting both the needs and resources. It is a requirement of the CSBG Act [Section 676(b)(11)] and is a key component of the Results Oriented Management & Accountability (ROMA) cycle of Assessment, Planning, Implementation, Achievement of Results, and Evaluation.

"Local control of Federal CSBG resources is predicated on regular comprehensive CNAs that take into account the breadth of community needs as well as the partners and resources available in a community to meet these needs. Regular assessment of needs and resources at the community level is the foundation of Community Action and a vital management and leadership tool that is used across the organization and utilized by the community to set the course for both CSBG and all agency resources." (Community Action Partnership Technical Guidance, 2015)

The community needs assessment and the resulting report provide data and information for the agency-wide strategic plan and the CAA agency-wide community action plan.

This assessment process starts with questions such as, "What are the causes and conditions of poverty in our region?" "How have causes and conditions changed over time?" "Which causes and conditions of poverty are most impactful to people living in poverty in our region?" Using both quantitative and qualitative data analysis, the CNA determines the needs in a community that can be addressed and the population that is most impacted by the need. Data considered during the process informed agency-wide strategic choices.

The analysis of the data collected identifies needs on three levels: those related to individuals or families (having to do with knowledge, skills, behavior or status), to the community as a whole (having to do with access to services and resources, public policy or social, economic or environmental conditions) and also needs of the agency itself to have the resources and capacity required to provide high quality services and strategies to help families and communities achieve results.

Ultimately, the CNA's identification of prioritized needs on family, community and agency levels is the foundation of the strategic planning process and the basis for determining each CAA's planned achievement of outcomes.

The report that follows is based on the premise that a comprehensive assessment process has been completed and now the report of the process and findings is being presented. This report will be used to "identify yearly (or multi-annually) specific improvements or results it plans to help achieve in the lives of individuals, families, and/or the community as a whole." The CNA

helps Community Action Agencies “organize and operate all its programs, services, and activities toward accomplishing these improvements, or outcomes, including linking with other agencies in the community when services beyond the scope of the entity are required. All staff is helped by the entity to understand the direct or indirect relationship of their efforts to achieving specific client or community outcomes.” (Information Memorandum 49 [2001] issued by the Office of Community Services, U.S. Department of Health and Human Services)

C.1 CNA Process and Methodology

All Domain Areas Selected for Data Collection:

The agency conducted a comprehensive Community Needs Assessment (CNA) between February and March 2026, using a mixed methods approach that incorporated both quantitative and qualitive data to ensure compliance with CSBG Organizational Standard 3.3. The CNA process was led by the Research, Development and Planning (RDP) Department, with support from program staff, and community partners.

Data Collection Methods:

To understand the needs, barriers and conditions experienced by individuals living in the agency's catchment area, the agency utilized four primary data collection strategies:

1. **Community Survey (Quantitative Data)** The RDP department developed and administered the NOI 2026 Community Needs Assessment Survey in both English and Spanish. The survey was available electronically through SurveyMonkey and in paper format at all agency sites. It was also distributed via email to community partners and posted on the agency's social media platforms. A total of 222 completed surveys were collected (156 English and 66 Spanish). The survey captured demographic information, community roles, and specific needs related to housing, health care, food access and other social determinants. Only fully completed surveys were included in the final dataset. The RDP team analyzed the results collectively to identify trends and priority needs.

2. **Focus Groups (Qualitative Data)** Three focus groups were conducted on March 10, 12, and 26 in 2026, at the agency's Meriden and Torrington locations. One session was held in English and two were conducted in Spanish with a translator to ensure accessibility for Limited English Proficient participants. Participants included the community and a community provider. Recruitment occurred through staff outreach and social media postings. All participants signed consent forms and sessions were audio recorded and transcribed by the Contract Compliance Manager. Of the 27 participants in attendance, 21 were confirmed to be living at or below the 125% FPL. Through qualitive analysis, eight major themes emerged including:

    - Lack of affordable housing and rising rental costs.
    - Requirement of multiple months' rent upfront.
    - Increasing food prices.
    - High cost of medical care.
    - Need for employment and skills training opportunities.
    - High utility costs.

- Immigrations related concerns.
- Transportation and safety challenges.

3. **Case management System Review (Internal Data Source)** In addition to the focus groups and community survey, the agency reviewed the case management system to identify trends in customer needs and service requests. This review provided insight into the frequency and types of assistance sought by individuals and families engaged with the agency programs. The case management system data helped reinforce the needs identified through surveys and focus groups, particularly in the areas of affordable housing, health related barriers and food insecurity.

4. **Online Research (External Data)** in addition to focus groups, surveys and the agency's case management data, the agency conducted secondary research using publicly available data sources. This research provided broader context on housing affordability, health care access and food insecurity within the agency's catchment area. Data Sources include U.S. Census Bureau's American Community Survey, HUD Fair Market Rent data, the USDA Food Insecurity Report, the Department of Public Health indicators, and more. These sources were used to validate local findings and ensure alignment with broader demographics and economic developments.

Stakeholder Engagement

Stakeholder engagement was central to the CNA process. Individuals with low incomes participated directly through survey and focus groups, ensuring their lived experiences shaped the findings. The community partners contributed by distributing the surveys and participating in the survey as well. The agency staff across various departments supported the outreach efforts and RDP conducted the data collection and analysis.

Data Analysis

Quantitative survey data were compiled and analyzed by the RDP department to identify frequency patterns and priority needs. Qualitative focus groups transcripts were reviewed to identify recurring themes and related factors influencing community conditions. The case management system was reviewed, and research was conducted to validate and cross reference emerging needs.

Domains selected

Based on the data collected and the needs identified, the following domains were selected for analysis in Section F:

- Housing
- Health & Social/Behavioral Development: Health Care Access

- Health & Social/Behavioral Development: Food Insecurity

These domains align with the priority needs identify through surveys, focus groups, case management system and research, specifically affordable housing, health care access and food insecurity.

Supporting Materials

Samples of the survey instrument and focus groups protocol are included in the Attachments section.

C.1a Rationale for Domain Selection

Include your rationale for each of the domains listed above. Why did you seek data about this specific domain? Why did you select the data elements you collected? What is the importance of this data related to the population with low income in your service area?

Domain Area #1_____Housing_____

Need Area: Affordable Housing

- In the previous program year, the agency observed a significant increase in housing related requests in the case management system, including rental assistance for first month rent, security deposit and eviction prevention. These requests came from households across the service area, with increases among seniors and families with children. During the focus groups, participants described rapidly rising costs and landlords requiring multiple months of rent upfront that made it difficult to maintain stable housing (NOI Focus Group Report, 2026). The community survey further confirmed that housing at 65% was one of the most frequent selected areas of need among respondents (NOI CNA Survey, 2026). The online research reinforced these findings. HUD's Fair Market Rent data shows continued increases in the rental costs across Connecticut (HUD, 2025), while the National Low Income Housing Coalition's Out of Reach report demonstrates that the hourly wage needed to afford modest rental unit far exceeds what many low-income households earn (NLIHC, 2025). The 2026 Connecticut Housing Profile also highlights a shortage of affordable units statewide (NLIHC, 2026). These observations prompted the agency to investigate Housing conditions more within our service area.

Domain Area #2___Health & Social/Behavioral Development___

Need Area: Health Care Access

- Throughout the year, the agency saw recurring referrals for health, behavioral health providers, including referrals to doctors' office, application for Medicare and Medicaid, and high attendance for the free mobile clinic. Many customers reported delaying care due to cost. In the focus groups, participants described the high cost of medical care, lack of insurance and difficulties accessing affordable providers (NOI Focus Group Report, 2026). The community survey also identified health care as a top need at 64% amount respondents (NOI CNA Survey, 2026). Online research supported these findings. Health People 2030 identified cost barriers and access gaps as major drivers of poor health outcomes (Healthy People 2030, 2025). The Connecticut Health Equity Dashboard highlights persistent disparities in health outcomes for low-income households (CT DPH, 2022). Additional research from the CDC and UConn's Health Disparities Institute shows that low-income residents face higher rates of chronic illness and reduced access to preventive care (CDC, 2026; Chen, 2024). These indicators prompted the agency to prioritize Health Care within our service area.

Domain Area #3___Health & Social/Behavioral Development___

Need Area: Food Insecurity

- Food insecurity emerged as a major concern across all four data sources. The agency's case management system showed frequent requests for emergency food resources and SNAP application assistance. During the focus groups, participants described rising food prices and difficulty affording groceries (NOI Focus Group Report, 2026). The community survey also identified Food Insecurity at 56% as a top need (NOI CNA Survey, 2026). Online research confirmed these trends. Feeding America's Map the Meal Gap shows elevated insecurity rates in Connecticut counties (Feeding America, 2025). The Connecticut Commission on Women, Children, Seniors, Equity and Opportunity reported that food insecurity remains a persistent challenge for low-income households (CWCSEO, 2025). The Bureau of Labor Statistics also reported continued increases in food prices, disproportionately affecting low-income families (BLS, 2025). These findings prompted the agency to prioritize Food Insecurity within our service area.

C.2 Gathering Data

C.2a Quantitative Data

Describe the overall process for quantitative data collection.

The agency's RDP department used a multi-source quantitative data collection process to ensure a comprehensive understanding of community needs across the service area. Quantitative data was gathered through 4 primary methods: The Community Needs Assessment Survey, The Case Management System, external research databases and online available datasets. These sources provided numerical indicators related to housing affordability, health care access and Food Insecurity.

The Community Needs Assessment Survey served as the primary quantitative tool. It was administered in English and Spanish, available both electronically and in paper format and distributed across all agency sites, community partners and social media platforms. The completed surveys were entered into SurveyMonkey, where RDP compiled and prepared the dataset for analysis. Only fully completed surveys were included to ensure accuracy and consistency.

RDP also reviewed quantitative data from the agency's Case Management System, which tracks customer services, demographic information and program utilization. The Case Management data provided internal indicators of the frequency and type of needs experienced by customers already engaged with agency services.

To supplement internal data, RDP conducted online research using online sources. These included the U.S. Census Bureau, HUD Fair Market Rent data, National Low Income Housing Coalition, Bureau of Labor Statistics, Feeding America and Connecticut specific sources such as the CT Health Equity Dashboard and CWCSEO Food Insecurity Report. These datasets provided quantitative indicators that contextualized local findings.

Complete the chart below to Identify the specific data elements you collected to show the scope and range of your collection efforts.

Data Source	Data Type	Geographies	Method of Collection	Date/Date Range of Dataset	Page(s) Where Info is Applied in CNA	Domain Area(s)
Community Needs Assessment	Quantitative survey responses	Agency catchment area	Paper survey, SurveyMonkey Link, QR code, distribution at sites, emails to partners and social media	Feb-Mar 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63	Housing Health & Socia/Behavioral Development
HUD Fair Market Rent Data	Federal housing cost indicators (rent levels, affordability metrics)	Connecticut Statewide; county level	Online research; HUD User database	FY2024-2025	Section C.1a, Page 12 Section F.2b, Page 57	Housing
National Low Income Housing Coalition Reports	Housing affordability metrics; wage to rent comparison	Connecticut statewide	Online research; Out of Reach & Housing Profiles	2025-2026	Section F.2b, Pages 57-58	Housing
Bureau of Labor Statistics CPI	Food costs and inflation indicators	Northeast region; national	Online research; CPI monthly reports	2025-2026	Section F.2b, Page 61	Health & Socia/Behavioral Development
U.S. Bureau of Labor Statistics	Consumer Price Index Summary	U.S. city average	Online research; CPI monthly reports	2026	Section C.1a, Page 13	Health & Socia/Behavioral Development
Feeding America – Map the Meal Gap	Hunger & poverty in Connecticut	Connecticut statewide	Online research; Feeding America database	2023	Section F.2b, Page 60	Health & Socia/Behavioral Development
CT Health Equity Dashboard	Health access and disparity indicators	Connecticut statewide	Online research; CT DPH dashboard	2022-2025	Section C.1a, Page 13	Health & Socia/Behavioral Development
CWCSEO Food Insecurity Report	Statewide food insecurity indicators	Connecticut statewide	Online research; state report	2025	Section C.1a, Page 13 Section F.2b, Page 61	Health & Socia/Behavioral Development
DataHaven Report	Report: New Census Data Product Maps 40,000	Connecticut statewide	Online Research; Datahaven	2026	Section b, Page 5 Section F.2b, Page 57	Housing

Data Source	Data Type	Geographies	Method of Collection	Date/Date Range of Dataset	Page(s) Where Info is Applied in CNA	Domain Area(s)
	New Connecticut Homes Since 2020: Not Enough to End the Housing Crisis		report dashboard			
CT Data Interactive Eviction Map	Interactive Eviction Map	Connecticut statewide	Online Research; Datahaven housing crisis report	2023-2026	Section F.2b, Page 57	Housing
CT Food Share	Hunger in Connecticut	Connecticut statewide	Online Research; Hunger in Connecticut	2025	Section b, Page 6 Section F.2b, Page 60	Health & Socia/Behavioral Development
Healthy People 2031	Social Determinates of Health	Connecticut statewide	Online Research; Healthy People 2030	2020	Section F.2b, Page 63	Health & Socia/Behavioral Development
CT Consumer Healthcare Experience Sate Survey	CT Survey respondents struggle to afford high health care costs; worry about affording health care in the future; express bipartisan support for policy solution	Connecticut statewide	Online Research; Health Promotion	2025	Section F.2b, Page 64	Health & Socia/Behavioral Development

C.2b Qualitative Data

C.2b1 Describe the overall process for qualitative data collection.

The agency's RDP team used qualitative methods to gather perspective from customers, individuals with low incomes and community stakeholders. The RDP team coordinated all qualitative data collection activities, including the development of questions, facilitation of sessions and preparation of data for analysis.

The RDP team developed open-ended questions for the Community Needs Assessment Survey to capture narrative feedback about needs, barriers and lived experiences. Questions were reviewed internally to ensure clarity and alignment with the CNA domains.

For the Focus Groups, the RDP team created a structured set of discussions prompts covering general topics such as housing stability, access to health care, food Insecurity and overall community needs.

The primary qualitative method was a series of focus groups conducted in March 2026 at two agency locations. One session was held in English and two were conducted in Spanish with a translator to ensure full participation from Limited English Proficient individuals. Participants (agency customers, non-agency customers and community partners) were recruited through staff outreach and social media postings. Upon arrival, participants completed consent forms and facilitator reviewed the purpose and confidentiality expectations. Each session was audio recorded to ensure accuracy and recordings were later transcribed by the Contract Compliance Manager. Transcriptions were organized and prepared for analysis by identifying recurring statements, concerns and experiences.

Qualitative input was also gathered through open ended responses included in the Community Needs Assessment Survey. Respondents were able to provide narrative comments about their needs, barriers, and experiences. These comments were exported from SurveyMonkey and compiled into a qualitative dataset. The RDP team reviewed and organized these responses to prepare them for analysis.

C.2b2 Complete the chart below to identify the specific data elements you collected to show the scope and range of your collection efforts.

Who provided the data?	Location(s) of Respondents	Method of Collection	Date/Date Range of Collection	Page(s) where Info is applied in CNA	Domain Area(s)
Participant from English focus group	NOI Meriden – 22 Church St. Meriden, CT 06451	Using set of questions developed by the RDP department, Contract Compliance Manager conducted a focus group with NOI customers, non-customer and community partner	03/12/2026	Section b, Page 6 Section C.1a, Pages 12-13 Section F.2b, Pages 58, 61, 64	Housing and Health & Social/Behavioral Development
Participant from Spanish focus group	NOI Meriden - 22 Church St. Meriden, CT 06451	Using set of questions developed by the RDP department, Contract Compliance Manager conducted a focus group with NOI customers and non-customer	03/10/2026	Section b, Page 6 Section C.1a, Pages 12-13 Section F.2b, Pages 58, 61, 64	Housing and Health & Social/Behavioral Development
Participant from Spanish focus group	NOI Torrington – 62 Commercial Blvd. Torrington, CT 06790	Using set of questions developed by the RDP department, Contract Compliance Manager conducted a focus group with NOI customers and non-customer	03/26/2026	Section b, Page 6 Section C.1a, Pages 12-13 Section F.2b, Pages 5, 61, 64	Housing and Health & Social/Behavioral Development
NOI customer, non-customer and community partner	All of NOI catchment area	CNA survey with open ended questions distributed to everyone and community partner in NOI catchment area	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63	Housing and Health & Social/Behavioral Development

Who provided the data?	Location(s) of Respondents	Method of Collection	Date/Date Range of Collection	Page(s) where Info is applied in CNA	Domain Area(s)
Residents of Mascoli Manor (affordable rental apartment complex)	885 North Main Street Waterbury, CT 06704	CNA survey with open ended questions distributed to complex residents and collected via drop box in the complex lobby	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63	Housing and Health & Social/Behavioral Development

Qualitative Data Collection Tools.

Tool Type	**Description**	Copy attached
Community Needs Assessment Survey	Survey with open and closed ended questions	Yes
Focus Groups	Questionnaire with open ended prompts	Yes

C.2c Engaging Customers and Other People With Low Income

C.2c1 Describe the process for collecting 1) customer input, 2) customer satisfaction data and 3) data from other people with low income.

The agency used multiple methods to gather input from customers and other individuals with low incomes. All activities were coordinated by the RDP department, which developed questions, managed data collection tools, and ensure accessibility for English and Spanish speaking participants.

1. Customer Input

Customer input was collected through two primary tools: the Community Needs Assessment Survey and Focus Groups.

Community Needs Assessment Survey

The CNA survey included both quantitative questions and open-ended items that allowed the respondents to describe their needs, barriers, and experiences. The survey was offered in English and Spanish, available online through SurveyMonkey, and distributed in paper form at agency sites and partner locations. The RDP department compiled all responses and prepared them for analysis. Customers self-reported their household composition and annual household income, and data was analyzed and compiled by the Contract Compliance Manager and out of the 222 individuals that completed the survey, 136 self-reported that they are living at or below 125% FPL.

Focus Groups

Three focus groups were conducted in March 2026 in Meriden and Torrington. One session was held in English, and two were conducted in Spanish with a translator. Participants were recruited through staff outreach and social media. Upon arrival, participants completed consent forms, and facilitator reviewed confidentially expectations. Sessions were audio recorded and transcribed by the RDP department.

2. Customer Satisfaction Data

Customer satisfaction data was collected through the 2025-2026 Customer Satisfaction Survey, which was offered from August 2025 through March 2026.

Customer Satisfaction Survey

The survey was anonymous and available in English and Spanish. It included questions about service delivery, access, and impact. Survey were completed by 79 individuals who had

received services from the agency. Responses were entered into SurveyMonkey and compiled by the RDP department.

3. Data from Other People with Low Income

The agency collected data from individuals with low incomes who were not current agency customers through the CNA Survey and Focus Groups.

CNA Survey: Non-Customer Respondents

The survey was distributed across the catchment area, including through community partners, social media and public locations. This ensured participation from individuals with low incomes who had not previously received agency services.

Focus Groups: Non-Customer participants

Recruitment efforts included individuals who were not current customers but lived in the catchment area. The RDP department verified income eligibility for participants when possible, and the majority of participants (22 of 27) were confirmed to be at or below 125% FPL. The agency used the case management system to identify participants who never received a service at the agency.

Assurance that input is provided by people with low income.

Who provided the data?	Determination of low-income	Where Included in CNA?	Input or Customer Satisfaction?
NOI customer, non-customer and community partners	Program eligibility for NOI customers	Section b, Page 6 Section C.1a, Pages 12-13 Section F.2b, Pages 58, 61, 64	Customer input – focus group
Individuals and community partner in NOI catchment area	Self-report income from participant on CNA survey	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63	Customer input – CNA survey (close and open-ended question)

Data Collection Tools. See examples in Handbook.

Data Collection Tools	Description	Copy attached
Compilation of CNA survey responses with open and close ended question (qualitative and quantitative)	Separate reports were created using data from individuals at or below 125%	Yes

Focus group questions	Questions created by the facilitator	Yes
Customer satisfaction survey (quantitative)	14 item survey, both paper and electronic	Yes

C.2d Information from Key Sectors of the Community

Organization	Location(s) of Org	Method of Collection	Date of Collection	Page(s) Where Info is referenced in CNA
LIST Community-Based Organizations in the rows below. *Examples: United Way, Salvation Army or other multi-services non-profits*				
McCall Behavioral Health Network	Torrington	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
EdAdvance	Torrington	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
The Hispanic Coalition	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
NEST	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
CHD	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
Mental Health of CT	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
Waterbury Hospital	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13

Organization	Location(s) of Org	Method of Collection	Date of Collection	Page(s) Where Info is referenced in CNA
				Section F.2b, Pages 57, 61, 63
United Way	Waterbury/Meiden	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
Brian Gibbon's Homeless Outreach	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
Legal Aid	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
Apex Community Care	Waterbury/Torrington	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
Project Safe	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
StayWell Health Center	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
Waterbury Youth	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
CCADV	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
Career Resource Center	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
Wellmore	Waterbury	Online survey	February - March 2026	Section B, Page 13

Organization	Location(s) of Org	Method of Collection	Date of Collection	Page(s) Where Info is referenced in CNA
				Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 63
Meriden Housing Authority	Meriden	Focus group	03/10/2026	Section b, Page 6 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 64
LIST Faith-Based Organizations in the rows below. *Examples: Salvation Army, local churches, synagogues, mosques, interfaith service organizations*				
God Provides Ministries Int	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 64
Interfaith Ministries	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 64
LIST Private Sector sources in the rows below. *Examples: Local for-profit sources, Chambers of Commerce, local business representatives*				
Quinnipiac Chamber of Commerce	Wallingford	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 64
Midstate Chamber of Commerce	Meriden	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 64
LIST Public Sector sources in the rows below. *Examples: Department of Social Services, Public Health departments*				
Waterbury Senior Center	Waterbury	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 64
Meriden Health Department	Meriden	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 64
Wallingford Health Department	Wallingford	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13

Organization	Location(s) of Org	Method of Collection	Date of Collection	Page(s) Where Info is referenced in CNA
				Section F.2b, Pages 57, 61, 64
DCF	Meriden	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 64
Meriden City Hall	Meriden	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 64
LIST Educational Institutions in the rows below. *Examples: Local school districts, universities/community colleges, trade schools, early childhood service*				
Meriden Public School	Meriden	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 64
Wallingford Public School	Wallingford	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 64
Wallingford Adult Education	Wallingford	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 64
Wilcox Technical High School	Meriden	Online survey	February - March 2026	Section B, Page 13 Section C.1a, Pages 12-13 Section F.2b, Pages 57, 61, 64

C.3a Community Needs Assessment Workgroup

Component	Description
Role of the CNA Workgroup	The RDP team served as the agency's CNA workgroup and was responsible for designing and implementing all components of the Community Needs Assessment. The RDP team developed the CNA timeline, created the data collection plan and ensure that tools were accessible to individuals with low incomes, including Spanish speaking residents. The team reviewed draft survey questions, focus groups prompts and strategies to ensure that the CNA process reflects the needs of the agency's catchment area.
What the Collaboration Looked Like	The collaboration process was facilitated internally. The RDP department shared responsibilities based on the roles and strengths, including survey development, internal and external survey distribution and focus groups facilitation. Because RDP is a small team we were able to meet frequently, for review and refinement of the tools and communication. Although the RDP team served as the formal CNA workgroup, they collaborated with the Board of Directors, program director, and front-line staff for survey distribution and recruitment efforts for the focus groups.
Frequency & Methods of Collaboration	The team collaboration included weekly in-person RDP team meetings beginning in December 2025, with meetings continuing through June 2026 to support data collection, analysis and CNA development. Additional review sessions were held during peak periods, such as survey distribution, focus groups, analysis of results, and CNA/CAP plan development. The team also used a shared folder to track all related information.

C.3b Workgroup Members

Name	Role in the Workgroup	Organization/Program Area Represented
Gawdys Grullon	Leader, provides oversights, contributes to report development and writing.	New Opportunities, Inc. Director of Research, Development and Planning
Shazia Husain	Manages and conducts focus groups, surveys, data analysis, interprets findings, and contributes to report writing.	New Opportunities, Inc. Contract Compliance Manager
Jasmin Garcia	Assist and support with overall report writing, development, and review drafts.	New Opportunities, Inc. Planner

C.4 Analysis of the Data

The RDP led the analysis of all quantitative and qualitative data analysis through the Community Needs Assessment. The team analyzed data across three domains used in this CNA: Housing and Health & Social/Behavioral Development. Within these domains, the team examined the three priority needs: Affordable Housing, Health Care Access and Food Insecurity. Different analyses were used depending on the domain and type of data.

Aggregate the Data: The RDP team aggregated the data by domain areas and by need. For example: Housing data was grouped around high rent costs, lack of affordable housing units and insufficient subsidized housing. Health care access data was organized around adult dental/vision/hearing affordability, transportation barriers and lack of preventive care focus. Food insecurity data was aggregated around affordability of nutritious food, concerns about running out of food and lack of affordable food options in neighborhoods.

Survey responses and focus groups were combined into unified datasets to identify consistent patterns.

Count: The team used counting techniques to determine the frequency of needs and concerns. Examples include: counting how many respondents identified high rent cost as a barrier. Counting how many participants reported lack of income for dental/vision/hearing care. Counting how many families reported worrying about running out of food. Also, the CNA survey responses were sorted by household size and household annual income to identify individuals that represent the low-income population.

Compare: The team conducted comparative analysis across: Domains (e.g., comparing housing instability with food insecurity patterns), Geographic areas (difference between towns in the catchment area), Demographics (age, race/ethnicity, income level), customer vs. non-customer input and current CNA vs. previous CNA. For example: Housing concerns were compared across towns to identify where rent burden was most severe; Health care access issues were compared by age group to understand differences in dental and vision needs; Food insecurity concerns were compared by income level to identify where affordability was most critical.

Five Whys: The Five Whys was used to explore root causes behind each priority need. Here are some examples: Housing: asking why is housing unaffordable? Let to deeper causes such as high rental market, limited subsidize units, and insufficient income growth. Health Care Access: asking why can't adults access dental/vision/hearing care? Revealed underlying issues such as lack of insurance coverage, high out of pockets costs and transportation barriers. Food Insecurity: asking why do families worry about running out of food? Led to causes such as low wages, rising food prices, and limited access to affordable grocery options.

Force Field Analysis: The team used the force field analysis to identify the driving forces (supports that help families meet needs and the Restraining forces (barriers that worsen conditions) of the priority needs. Per example: per housing, restraining forces included high rent costs and limited subsidized units, while the driving forces included existing rental assistance programs and tenant/landlord mediation. For Health Care Access, restraining forces included lack of affordable transportation for healthcare visits and limited preventive care focus, while driving forces included community clinics and mobile health clinics/events. For Food Insecurity, restraining forces include rising food prices and limited neighborhood options, while driving forces included food pantries and SNAP benefits.

Trend Analysis: The team conducted trend analysis using secondary data and agency records. Trends were reviewed for: Housing costs and rent burden, transportation access for medical appointments, food prices and pantry usage and health care access indicators.

C.5 Limitations

Description of situation(s) that limited the application of analysis.

The purpose for this section is transparency. The following limitations describe factors that influence the scope of the data collected and how RDP team applied the analysis in decision making. These limitations also help readers understand how the result should be interpreted.

What Limited the Data Collection Activities

Weather Related Disruptions in Waterbury: Both Waterbury focus groups; English and Spanish experience no attendance. The English session coincided with a snowstorm, preventing participants from attending. The Spanish session also had no attendees, despite outreach efforts. As a result, no qualitative data was collected from Waterbury, limiting representation from one of the largest areas in the service region.

Low Attendance in Torrington: The English session had only one participant. An individual interview was conducted; however, because it did not meet the threshold for group-based analysis, it was not included in the final dataset. The Spanish session, however, had a full group and those results were included. This imbalance limited the ability to compare English and Spanish speaking perspectives within the same town.

Uneven Representation Across the service area: While Meriden had full groups in both English and Spanish, other service areas had limited or not participation. This created uneven

qualitative representation across the catchment area, specifically for: Housing affordability, health care access barriers and food insecurity challenges.

Who Was Not Involved & How That Limited Results

Survey Non-Response and Partial Completion: Not all individuals who received the CNA Survey returned it, and some surveys were partially completed. While we are very pleased to have 222 fully completed surveys, other surveys were missing demographic fields and skipped questions, limited the ability to compare needs across age groups, towns and income levels, identify differences between customer and non-customer respondents and fully quantify the prevalence of certain needs. This reduce the completeness of the dataset and require RDP team to only rely on fully completed responses.

Under Representation of Certain Groups: Because of survey non-response and focus group attendance challenges the following groups *may* be underrepresented: older adults, individuals with Limited English Proficiency, residents without reliable transportation and households not currently engaged with agency services.

What Data Could Not Be Collected or Found

Limited Qualitative Depth in Certain Towns: Because some focus groups did not occur or had extremely low attendance, certain community specific issues *may* not have surfaced. This is relevant for housing cost variations, transportation barriers related to accessing health care, and neighborhood food access.

How These Limitations Affect Interpretation: These limitations influenced how the RDP team interpreted the data, for example: Housing themes *may* be more reflective of areas with higher participation (e.g., Meriden). Health Care Access barriers *may* be under reported in towns with low survey return rates and Food Insecurity concerns *may* not fully capture the experiences of families who did not participate in focus groups or surveys.

D. Introduction to the Agency

D.1 Agency's Mission

Mission Statement

The agency's mission is to improve the quality of life for economically disadvantaged individuals by providing the necessary resources to increase their standard of living, foster self-improvement, and maximize self-empowerment.

Vision Statement

The agency's vision is to building on our roots and branching out to transform the community into a safe and prosperous place.

Values

Maintaining a work ethic that insists on professionalism and confidentiality while demonstrating trust, compassion, respect and a willingness to extend ourselves to others.

Assuring that our staff is committed to high quality service delivery in an efficient, effective and consistent manner.

Providing a safe and secure environment for both our staff and visitors.

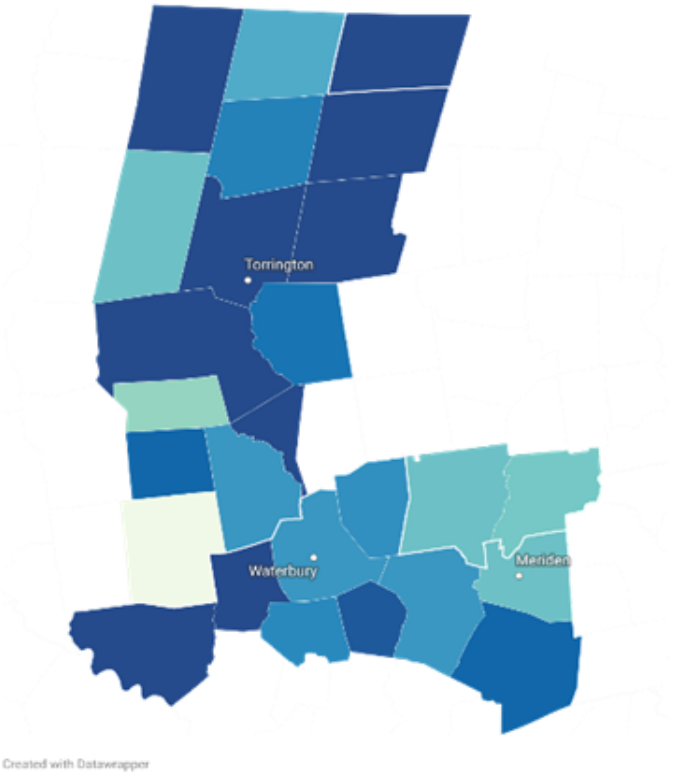
Assuring that our staff is knowledgeable about all of our services and prepared to refer to other providers when NOI cannot provide the service.

Providing an organizational environment that maximizes morale by emphasizing teamwork, internal collaboration and growth potential for all employees.

D.2 Agency History and Service Area

New Opportunities, Inc. (NOI) is a Waterbury, CT-based Community Action Agency (CAA) that carries out Community Action Programs (CAPs). NOI was established in 1964 in Connecticut as a private, tax-exempt 501 (c) (3) non-profit and corporation. Headquarters in Waterbury, with additional offices in Meriden, Torrington, and it serves twenty-three surrounding towns.

NOI Catchment Area



NOI is also one of Connecticut's nine Community Action Agencies based in Northwest with the mission of supporting individuals and families with low incomes by providing programs, services and opportunities that promote stability and self-sufficiency. Since its establishment the agency has expanded its services and strengthened its role as a key community resource, responding to emerging needs and adapting to changes in the economic and social landscape. We pursue this mission with a deep sense of caring, compassion, and collaboration, supporting over 37,000 individuals and families. Over the years, the agency has developed a strong presence across its designated service area and has built partnerships with local organizations, municipalities and community stakeholders. These relationships support the agency's ability to deliver programs aligned with its mission, vision and values and to respond effectively to the needs of individuals and families with low incomes.

New Opportunities implements its mission by providing a broad range of services that encompass the following areas:

- Energy Assistance
- Fatherhood Initiative
- Employment services
- Early Childhood Education Programs
- Elderly Services
- Homeless Shelter and Transitional Housing
- Ex-Offender Programs and Re-entry Services

D.3 Agency Services and Impact

New Opportunities provides coordinated services to the community designed to reduce poverty and strengthen pathways to stability for individuals and families in our catchment area. Though integrated support the agency helps households address immediate crises while building presence and strong partnerships to allow the agency to serve thousands of customers annually, preventing homelessness, reducing hunger, improving access to services and supporting families as they work toward greater stability and independence.

MURIEL H. MOORE CHILD DEVELOPMENT CENTER: Provide full-year early childhood education program serving children from infancy through preschool. The center provides comprehensive early learning services designed to support children's cognitive, social-emotional, and physical development while also supporting families within the community. The agency serves a diverse population of children and families, including low-income households and families requiring full-day, year-round childcare services.

The program on average serves approximately 278 children at one time and operates year-round to ensure consistent care and educational support for working families. Muriel Moore Child Development Center maintains strong partnerships with local school systems, community agencies, healthcare providers, and family support organizations to ensure children and families receive comprehensive services.

The agency is funded through CTOEC Early Start funding sources and maintains accreditation through the National Association for the Education of Young Children (NAEYC). This accreditation reflects the program's commitment to high-quality early childhood education standards, health and safety practices, family engagement, and continuous program improvement.

The agency continues to identify needs related to staffing recruitment and retention, rising operational costs, classroom resources, and the growing demand for infant and toddler care within the community. Continued funding and community partnerships remain essential to sustaining and expanding services for children and families.

MIDDLESEX-MERIDEN-WALLINGFORD COORDINATED ACCESS NETWORK (MMW CAN): Works collaboratively to prevent and end homelessness across the region through coordinated outreach, housing navigation, shelter diversion, emergency response, and system coordination. MMW CAN oversees several interconnected programs designed to support individuals and families experiencing homelessness or housing instability, including the Coordinated Access Network (CAN), the HUB, Homeless to Housing (H2H), Overflow and Triage services, and regional Warming Center operations.

THE MMW COORDINATED ACCESS NETWORK serves as the regional entry point for individuals and families experiencing homelessness. Through coordinated assessment, diversion services, case conferencing, and housing matching, the CAN connects participants to emergency shelter, rapid rehousing, permanent supportive housing, and mainstream benefits. The CAN served 346 families, 1,293 individual adults, and 164 youth ages 18–25. The CAN collaborates closely with shelters, hospitals, municipalities, behavioral health providers, and housing agencies to ensure vulnerable residents are connected to services and housing resources as quickly as possible.

THE MMW HUB provides centralized navigation and stabilization services for individuals and families experiencing housing crises. HUB staff assist participants with housing applications, benefits enrollment, transportation coordination, employment referrals, document recovery, and connections to medical, behavioral health, and social service providers. During the reporting period, the HUB received 723 walk-in visits and 287 calls from community members seeking housing assistance, referrals, and stabilization services. The HUB also serves as a collaborative access point where partner agencies can directly engage with clients and coordinate services.

THE HOMELESS TO HOUSING (H2H) program provides ongoing case management and housing navigation services that begin while a household is unhoused and continue through the process of obtaining and maintaining permanent housing. H2H staff work closely with participants to address barriers to housing stability, connect households to resources and supports, coordinate landlord engagement, and promote long-term housing retention.

MMW CAN also operates **OVERFLOW AND TRIAGE SERVICES** located within New Beginnings Shelter. Through this program, MMW CAN was able to assist 23 families, ensuring households with minor children were connected to life-saving shelter services and did not remain unsheltered during times of crisis.

MMW CAN also coordinates **seasonal WARMING CENTER** operations in Meriden to provide overnight emergency shelter during the winter months for unsheltered individuals facing dangerous weather conditions. During FY25, the Meriden Warming Center served 304 unduplicated individuals. These programs provide life-saving shelter, meals, transportation coordination, case management, and connections to permanent housing resources and mainstream services.

MMW CAN's work is highly collaborative and supported through strong partnerships with local, regional, and statewide organizations including Rushford, St. Vincent de Paul Middletown, Mercy Housing and Shelter Corporation, Chrysalis Center, New Horizons, Community Health Center, River Valley Services, Columbus House, United Way, and Meriden-Wallingford Chrysalis. MMW CAN also works closely with statewide partners and agencies including the Connecticut

Coalition to End Homelessness (CCEH), Connecticut Coalition Against Domestic Violence (CCADV), the Connecticut Department of Housing (DOH), and the Department of Mental Health and Addiction Services (DMHAS). In addition, MMW CAN collaborates with Connecticut CAN backbone agencies and regional homelessness response partners including United Way of Greater New Haven, The Housing Collective, Journey Home, and TVCCA to coordinate homelessness response efforts, system planning, and housing resource development statewide.

Across all programs, MMW CAN serves hundreds of vulnerable residents annually through coordinated homelessness response services, housing placement assistance, crisis intervention, and community-based partnerships. Through these collaborative efforts, MMW CAN continues working to improve housing stability, reduce unsheltered homelessness, increase access to supportive services, and strengthen regional systems of care for individuals and families experiencing housing insecurity.

NEW BEGINNINGS EMERGENCY SHELTER: Provides shelter to single men, single women, and families with children that are facing homelessness. Clients may contact 211 CT to coordinate access to this program by calling 211 or visiting 211ct.org. Services provided include housing, coordination of community service, employment assistance, medical referrals, counseling, substance abuse treatment/referral and recreational activities. Additionally, workshops, counseling sessions, and AA/NA/CA meetings are held on-site at the shelter. In the last year the shelter has served 106 single adults and 48 families. Clients' demographics consist of 24 youth and 14 seniors, with 97 of total clients identifying as male and 77 identifying as female.

Services Provided:

Apart from Emergency Shelter placement, New Beginnings provides several related services to provide a well-rounded experience for each client. Services in New Beginnings include case managers working with clients directly to identify areas of assistance required for the client, such as employment search, addiction services, legal assistance, vital document replacement, medical needs, housing navigation, DSS applications and other areas of concern on a case-by-case basis. Partnership with Community Health Center (CHC) helps provide medical treatment and therapy services to residents. New Beginnings also serves as a local service hub for community members to take showers, have access to free laundry cleaning services, receive donations, and meal pickups. Along with these services, New Beginnings actively participates in general advocacy, local city events, and alongside other local agencies to create awareness and highlight needs to improve overall client services and resources.

Linkages & Partnerships

Apart from Community Health Center, mentioned above, we also participate in the Meriden Coalition for Homelessness town planning meetings where we interact with Mayors Office,

Police Department, and other local agencies on planning for homeless services. We also work closely with the local warming center, food pantry and soup kitchen, Meriden Senior Center, Meriden Library, American Job Center, Colombus House Outreach, and many other local agencies and services to promote a well-rounded service experience for all clients.

BISHOP HOUSE: is a community residential reentry program serving adult men transitioning from incarceration back into the community in partnership with Connecticut Department of Correction. The program provides structured housing, supervision, individualized case management, employment services, treatment coordination, discharge planning, and community resource linkages designed to support successful reintegration and promote public safety. Through partnerships with organizations such as The WorkPlace, Wellmore Behavioral Health, St. Vincent de Paul Mission of Waterbury, healthcare providers, housing resources, and local employers, Bishop House connects residents with the tools and supports necessary to achieve long-term stability and self-sufficiency.

Between January 2025 and May 2026, Bishop House provided residential reentry services to 156 unduplicated individuals. During this period, residents received individualized assessments, service plans, employment assistance, treatment referrals, financial literacy support, and discharge planning. Employment remains a cornerstone of the program's success, with 54 residents securing employment across a variety of industries, including manufacturing, transportation, retail, food service, landscaping, automotive services, and state government. In addition, 13 residents established bank accounts to support financial independence and long-term stability.

SENIOR NUTRITION: Provides a holistic approach to health and community that goes far beyond a basic meal program, helping Western Connecticut older adults maintain their independence and well-being. For homebound clients, our Meals on Wheels program delivered 352,194 nutritious meals to 1,263 individuals, ensuring their daily safety through vital wellness checks and friendly visits; this crucial service was supported by $48,108.09 in total donations alongside Title III funding from the Western Connecticut Area on Aging (WCAAA), third-party support from CCCI & WCAAA, and private payment options. To effectively combat isolation and foster a vibrant community, we also offer dynamic social dining programs. Our innovative Senior Dine initiative partnered with 9 local restaurants to serve 354,282 meals to 1,263 clients with the help of $38,274 in donations. Additionally, our Congregate lunch program partnered with 4 regional senior centers to serve 14,485 meals to 435 clients—meeting two to four times weekly per center—backed by $15,430.66 in donations and supplemental municipality funding from Waterbury, CT for two of the participating locations. We also make pet food available for delivery once a month for the pets of Senior Nutrition Meals on Wheels participants.

AMERICORPS SENIORS FOSTER GRANDPARENT PROGRAM: The AmeriCorps Seniors Foster Grandparent Program engages adults age 55 and older in meaningful volunteer service that supports children who need additional academic, social-emotional, developmental, or behavioral support. By placing older adults in schools and early childhood education settings, the program creates intergenerational relationships that benefit both children and seniors while helping reduce social isolation and promoting purposeful community engagement among older adults. During the 2024-2025 program year, 30 Foster Grandparent volunteers contributed 29,718 hours of service through 9 K-12 volunteer stations and 5 early childhood education volunteer stations. The program partners with Waterbury and Wolcott Public Schools, charter schools, Catholic schools, child development centers, and other community organizations throughout Greater Waterbury. The program targeted 125 K-12 students and served 80, with 68 demonstrating measurable improvements in academic performance, social-emotional development, behavior, or other identified needs. In early childhood education settings, the program targeted serving 165 children and served 75, with 72 demonstrating gains in school readiness. AmeriCorps provide positive outcomes for participating children and older adults, highlighting the effectiveness of the program and continued need for volunteer recruitment and retention efforts throughout the community.

RETIRED SENIOR VOLUNTEER PROGRAM (RSVP): Provides multiple areas such as tutoring with America Reads, Elder advocacy through Elder Justice/Financial Fraud Prevention, Nutrition/ Food Support and other Community Priorities providing service to a diverse group of community members. Approximately 100 Pre -K – 5th grade students received tutoring and academic support from 80 volunteers. Our Elder Justice/Financial Fraud Prevention Program supports 8 older adults with financial education and timely bill payments assistance by 6 volunteers. While providing social visits and giving caregivers respite. Monthly, over 200 individuals and families receive nutrition and food support to combat food insecurity through partnerships with Meals on Wheels, local food pantries, and soup kitchens by 24 volunteers. We also provide support to local nonprofit organizations, thrift stores and office operations benefiting the Community.

THE AMERICORPS SENIORS SENIOR COMPANION PROGRAM (SCP): Connects trained volunteers age 55 and older with older adults and adults with disabilities who need assistance to remain independent in their homes. Senior Companions provide companionship, emotional support, assistance with daily living activities, and respite services for family caregivers. The program helps reduce social isolation, promotes independent living, and improves quality of life for vulnerable adults. AmeriCorps Seniors programs nationwide support tens of thousands of adults each year through volunteer-based services designed to strengthen communities and support aging in place.

Our agency provides Senior Companion services that include social and emotional support, assistance with daily living activities, wellness checks, caregiver respite services, and referrals to community resources. The program has enrolled 36 volunteers and has helped 40 clients remain independent in their homes while decreasing social isolation.

Linkages and Partnerships

The program collaborates with local aging services providers, healthcare organizations, community centers, faith-based organizations, housing agencies, and social service partners to identify clients, coordinate care, and connect individuals with needed resources.

VOICE CARE: Offers Personal Emergency Response Systems (PERS) in conjunction with ConnectAmerica to 330 older adults and those with long-term health conditions to remain in their homes and communities, enjoying a better quality of life while providing support and peace of mind for their loved ones and caregivers. The Voice Care PERS directly links clients to an On-Call Response Center 24 hours a day, 7 days a week and 365 days a year. The system consists of either a mobile wearable device with GPS or a two-way console and a long-range wearable activator that is light-weight, compact and water-resistant. Clients have the option to include fall detection with their unit or opt for a modern smartwatch. When a person needs assistance, they simply press the activator button, which immediately opens a two-way voice connection with the On-Call Response Team. A trained and supportive care specialist assesses the situation, determines the type of help required whether emergency assistance, a caregiver, or a family member or friend and coordinates the appropriate response. The care specialist remains in communication with the client throughout the interaction, providing reassurance and ensuring that help arrives promptly.

Family Development Center (FDC): Provides a number of services and programs to both families and individuals. The center provides a “no wrong door” approach to customer service and case management, ensuring that individuals and families can access services regardless of their point of entry. Case Managers provide comprehensive intake, assessment, and follow-up services designed to assist clients in moving toward self-sufficiency while also tracking clients’ progress. Clients are also linked to appropriate community resources through information and referral services to address needs outside of the scope of FDC. Staff assist customers in completing DSS applications such SNAP, Medical and TANF, and connect them to community resources through information and referral services. This approach strengthens the agency’s ability to respond to immediate needs while supporting long-term stability.

The case management program serves as a central point of support, helping individuals navigate complex systems and connect with community resources. Through strong partnerships with

local service providers, government agencies, healthcare organizations, and housing programs, ensuring clients have access to comprehensive support services.

Social Services Block Grant (SSBG): Provides individualized support to adults ages 18 and older, serving both males and females throughout the community. Services are designed to help individuals and families achieve greater stability and self-sufficiency by addressing barriers related to employment, education, housing, financial management, and daily living skills. Case managers assess client needs, assist with job readiness, training, budgeting and financial literacy, and provide resources for educational opportunities and housing.

Working in collaboration with local service providers and community partners such as CCEH, God provides Ministry, AJC, Salvation Army, Osterman funds, St. Vincent Depaul, United Way, Hartford Health Care, Winsted Town Hall, etc., the program helped clients navigate challenges and access critical support needed to improve their quality of life.

Fatherhood DSS: Provides structured parenting education and support through a 12-week group-based curriculum. Utilizing the 24/7 Dad Program, the program is designed to strengthen parenting skills, promote responsible parent engagement, improve family relationships, and support positive outcomes for children and families.

Participants are considered served when they attend and actively participate in at least 9 of the 12 sessions. To successfully complete the program and become eligible for an adjustment to state-owed child support arrearages, participants must attend and participate in all 12 sessions. The curriculum focuses on building parenting knowledge, communication skills, healthy relationships, and personal responsibility, helping participants become more engaged and effective parents.

In 2025, a total of 151 clients were served through the fatherhood program. However, 85% of participants successfully completed all 12 sessions, demonstrating a strong level of engagement and commitment to achieving program goals. Through participation in the program, clients gained practical parenting tools, increased their understanding of positive parenting practices, and strengthened their ability to provide stable and supportive environments for their children.

Project Longevity Outreach: Is a law enforcement and community-based initiative to provide services and supports to victims of gun violence and/or offenders who are working with Adult Parole, Probation, or are known to the community and in need of services. Through our partnership with Project Longevity coordinators, New Opportunities provides violence prevention outreach, community engagement, care coordination, and case management services to adults in the Waterbury community. The program is designed to build trust within neighborhoods impacted by violence, connect individuals to critical support services, and promote positive decision-making that contributes to safer and healthier communities.

Outreach efforts include neighborhood canvassing, participation in community events, one-on-one engagement with at-risk individuals, and reinforcement of Project Longevity's violence prevention messaging. Staff also collaborate closely with Project Longevity partners and community organizations to connect participants with employment, education, housing, and other supportive services.

In 2025, the program served 181 participants through outreach, case management, and care coordination services. Through individualized support and service referrals, participants were connected to resources designed to improve stability and reduce risk factors associated with violence and involvement in the justice system. As a result of these efforts, 76 participants obtained employment, helping them achieve greater financial independence and economic stability. 55 participants earned industry-recognized certifications that enhanced their workforce readiness and increased their qualifications for employment opportunities.

A key component of the program's success is its strong network of employer partnerships. New Opportunities collaborates with local employers and workforce development partners to identify job opportunities, match participants with available positions, and support successful employment placements. These relationships help create pathways to sustainable employment while addressing workforce needs within the community. By connecting participants to training, certifications, and employment opportunities, the program helps individuals overcome barriers to employment and build long-term self-sufficiency.

Project Longevity Housing: Is a law enforcement and community-based initiative to provide services and supports to victims of gun violence and/or offenders who are working with Adult Parole, Probation, or are known to the community and in need of services. We provide housing stabilization and case management services to at-risk individuals, helping participants obtain and maintain safe, stable, and permanent housing. The program is designed to support long-term self-sufficiency by addressing barriers related to housing, income management, and access to essential health and human services. Staff work closely with participants to develop individualized plans, connect them with critical resources, and provide ongoing support to achieve measurable outcomes in housing stability, financial management, and self-sufficiency. Through comprehensive case management, participants gain the skills, knowledge, and support needed to remain housed, improve their economic situation, and take meaningful steps toward long-term independence.

Freedom Walk: Is a Permanent Supportive Housing (PSH) program designed to provide long-term housing stability and comprehensive supportive services to individuals experiencing housing challenges. Under the contract, we are funded to provide services to 25 participants, and we have successfully provided services to all 25 contracted participants this last reporting year.

The program's primary goal is to ensure that participants have access to safe, stable, and affordable permanent housing while receiving the individualized support needed to maintain their housing and enhance their overall quality of life. Participants work closely with a case manager to develop and pursue goals that promote self-sufficiency, independence, and long-term stability.

The program offers a range of supportive services tailored to each participant's unique needs. These services may include case management, resource coordination, life skills development, and referrals to community-based supports. This Supportive Housing model also partners with local social service organizations to provide wraparound services to clients.

CCADV-RRH: Program establishes a collaborative partnership between victim service providers and housing providers to increase survivors' access to safe and stable housing resources. This intervention is designed to prevent homelessness and rapidly re-establish permanent housing for survivors of domestic violence, dating violence, sexual assault, stalking, human trafficking, and other dangerous or life-threatening situations.

Housing Specialists work closely with victim service providers utilizing a housing-first, trauma-informed, and survivor-centered approach to secure housing for participants within thirty (30) days or less whenever possible. Housing Specialists maintain an active inventory of housing opportunities, conduct housing searches and inspections, negotiate with landlords, and work diligently to identify safe and affordable housing options that meet the needs of survivors.

During 2025, the program received a total of 72 referrals for housing assistance. Through ongoing collaboration with victim service providers, landlord engagement efforts, and intensive housing search activities, 68 participants were successfully housed. Four referrals were not successfully housed due to circumstances that created barriers to placement, including participant disengagement, or an inability to identify an appropriate housing match within the program timeframe.

Operation Pantry: Provides Emergency Food Pantry providing nutritious food and household essentials to individuals experiencing food insecurity. The pantry serves approximately 1,500 individuals each month, helping households maintain access to healthy and nutritious food. In addition to food assistance, clients are connected to supportive services and community resources, including SNAP assistance, case management, energy assistance, and referrals to programs that support overall well-being and self-sufficiency.

The pantry operates in partnership with FoodShare, Stop and Shop, Aldi, BJs, and Midwest from which food is picked up weekly and monthly to help maintain a consistent supply of food for the community. We also partner with UCONN Extension Expanded Food and Nutrition education and healthy eating resources for pantry participants monthly. This provides opportunities for shoppers to select the items they will use rather than simply providing pre-

selected items that may not be useful or relevant to all shoppers. Allowing shoppers to feel a sense of pride and dignity as they are empowered to make their own decisions about their groceries.

POWER UP Workforce - United Way of Meriden and Wallingford: Helps individuals and families improve their employment opportunities, increase their income, and work toward long-term financial stability through career development and workforce support. Services include referrals to job training, employment opportunities, resources to childcare support, mental health support, food assistance, and other community services. The program aims to improve employment opportunities, increase financial stability and well-being.

Support for Pregnant and Parenting Teen Program: Provides non-clinical support services to pregnant and parenting teens and young adults age 22 and younger. The program helps participants continue their education, enroll in job training or certification programs, and work toward achieving their academic and career goals. The goal is to ensure short-term stabilization of housing for participating teens parents while concurrently, building their capacity to maintain long-term residential stability beyond the period of assistance.

Fatherhood DCF – Meriden/New Britain: Supports parents who are seeking constructive ways to better care for and parent their children and generally maintain healthy relationships. The program provides services to parents that have a reliable relationship with a DCF Worker that maintain close contact with the parent and serve as a mentor during all phases of the program. Services include parental skill training, personal budgeting services, and referrals to other wraparound services. Program participants must have a referral from DCF or the court.

Volunteer Income Tax Preparation (VITA): Is a volunteer program that provides free tax preparation Services to income-eligible families and individuals. Volunteers complete a training course facilitated by the IRS. 1040-EZ and 1040-A tax returns are electronically filed at the site and direct deposit is available for clients with bank accounts.

Youth Program: Provides a continuum of services designed to support career readiness and long-term professional development. During 2024-2025 program year, the agency delivered three core youth initiatives that collectively engaged hundreds of young people. The After School Program served 150 youths, the Summer Camp engaged 300 participants, and the Summer Youth Employment Program supported 125 youths ages 14-24. Together these programs help youth build confidence, develop leadership skills, and gain meaningful exposure.

A notable success from the 2024-2025 cycle includes 10 Summer Youth Employment participants who secured permanent employment with the site where they completed their summer placement. These outcomes demonstrate the program's effectiveness in preparing youth for the workforce and creating pathways to sustained employment.

Energy Assistance Program: Provides a comprehensive set of services designed to help households maintain safe and reliable heat throughout the winter months. Through a

combination of LIHEAP, Generation Power CT (GPCT), Utility Mediation, and Assurance 16 supports, the program assists eligible households with managing energy costs, preventing utility shutoffs and addressing heating system needs. The federally funded LIHEAP program provides direct financial assistance toward a household's primary heat source, whether utility based or deliverable fuel. Depending on the heating type, benefits may be applied to utility account, oil or propane deliverable fuel. For households where heat is included in the rent, the program also offers rental assistance, issuing payments directly to eligible tenants to offset heating costs. In addition to bill assistance, the program supports heating system repairs or replacements for eligible single-family, owner-occupied homes to ensure that households have safe and functioning heating equipment. The agency also completes an annual Clean, Tune and Test (CTT) for eligible oil heated households each year they qualify, helping improve system efficiency and reduce long-term heating expenses. Through Utility Mediation, staff work directly with utility companies to help customers avoid shutoffs, establish payment arrangements and resolve billing issues. Assurance 16 services provide additional support such as budgeting assistance, energy education, and referrals to help households maintain long-term stability. During the FY 25 program year the agency provided 33,049 utilities payments. The number of payments reflects the scale of community needs and the agency's capacity to deliver critical services that help families remain warm and safe during the winter months.

SNAP Outreach

Conduct outreach events in the community to engage and inform individuals and community partners about the SNAP program and eligibility process. Conduct pre-screening for potentially eligible customers and assist with the application process, which includes helping the customer set up a DSS Myaccount with ConnectCT, reviewing customer supporting documents, assisting with the submission process and follow-ups with customer to check on application progress

Diaper Bank – Waterbury and Torrington

In collaboration with CT Diaper Bank, NOI provides incontinence pads in a variety of sizes to seniors in need from the community. Incontinence essentials are delivered to qualifying homebound participants bimonthly who receive home delivered meals. All other recipients must pick up the incontinence essentials from the Senior Nutrition Services department. incontinence essentials are available for distribution to recipients bi-weekly.

Diaper Distribution Program

The Diaper Distribution Program offers families a monthly supply of diapers, wipes, and ointment. Case managers work closely with participating families, providing wraparound services to address barriers to health and well-being. This program also connects families with other initiatives aimed at addressing the root causes of poverty, empowering them to work toward greater self-sufficiency.

Meriden Supportive Housing

The scattered-site Housing Program serves individuals living with documented disabilities and their families, in the Greater Meriden communities. Family Development specialists assist the families in tenant/landlord mediation and provide case management services. Clients must receive a referral through the Coordinated Access Network (CAN).

E. Community Profile

E.1 Poverty in the Community

NOI assessment of this area provides a demographic overview of the catchment area focusing on how poverty affects residents across gender, age, race and ethnicity. This section examines the population being assessed including youth, older adults and working age individuals and explores how demographic shifts in population size, age distribution and racial and ethnic composition influence the prevalence of poverty. Using 2023 data alongside 2021 comparison points, the analysis highlights changes in economic conditions and identifies areas within the service area where poverty is more concentrated.

The agency is utilizing the same poverty data sources used in the previous year, as updated datasets have not yet been released by CTData or other state and federal agencies.

Demographic Profile of NOI Catchment Area

Across the catchment area, population size varies significantly, ranging from small rural towns with fewer than 2,000 residents to large urban centers such as Waterbury and Meriden. In 2023, Waterbury remained the largest community in the service area, with a total population of 114,356 residents, including 25,729 youth under the age of 18 and 88,627 adults. The gender distribution was balanced, with 55,706 males and 58,650 females. Waterbury's racial and ethnic composition reflects significant diversity: 34,909 residents identify as White non-Hispanic, 27,144 as black non-Hispanic, 2,814 as Asian and 5,098 as two or more races. The city also had a significant Hispanic/Latino population of 42,895 residents, making it one of the most culturally diverse communities in the region. These demographic characteristics

2023 Demographics of NOI Catchment Area

Under 18 | 18 years and over | Male | Female | White alone NH | Black or African American alone NH | American Indian and Alaska Native alone NH | Asian alone NH | Native Hawaiian and Other Pacific Islander alone NH | Some other race alone NH | Two or more races NH | Hispanic or Latino

	Under 18	18 years and over	Male	Female	White alone NH	Black or African American alone NH	American Indian and Alaska Native alone NH	Asian alone NH	Native Hawaiian and Other Pacific Islander alone NH	Some other race alone NH	Two or more races NH	Hispanic or Latino
Barkhamsted	658	2,994	1,806	1,846	3,369	1	0	23	0	0	15	253
Berlin	4,824	14,186	10,075	10,135	17,382	176	0	957	0	102	345	1,248
Bethlehem	696	2,702	1,687	1,711	3,335	34	0	0	0	23	86	170
Cheshire	6,368	22,494	14,229	14,553	21,167	776	21	2,781	0	122	2,020	1,965
Colebrook	240	1,223	741	722	1,331	23	0	31	0	0	55	23
Goshen	586	2,595	1,547	1,634	2,749	0	0	126	0	0	124	191
Hartland	314	1,567	1,039	842	1,774	3	0	0	0	13	36	55
Harwinton	1,084	4,445	2,936	2,593	3,870	0	0	32	0	0	95	332
Litchfield	1,351	6,898	3,938	4,311	7,129	81	0	278	0	93	361	313
Meriden	13,949	47,309	29,872	31,346	29,719	4,463	104	1,421	0	135	1,808	22,777
Middlebury	1,808	5,928	3,505	4,231	6,397	35	0	574	0	38	381	311
Morris	372	1,728	1,146	954	1,997	31	9	0	0	0	34	29
Naugatuck	6,874	25,269	15,912	15,822	19,179	3,590	0	1,393	0	115	1,916	5,441
New Hartford	1,396	5,288	3,423	3,261	4,276	0	0	85	0	65	100	158
Norfolk	278	1,454	842	890	1,447	16	0	22	0	2	94	151
Prospect	2,122	7,292	4,554	4,860	7,381	350	0	159	0	44	513	457
Southbury	3,882	10,891	6,427	10,546	10,468	372	0	646	0	114	427	1,749
Southington	8,607	34,908	20,867	22,708	37,610	662	6	1,225	0	270	1,636	2,166
Thomaston	1,611	5,865	3,888	3,608	5,946	153	0	153	0	0	565	661
Torrington	6,247	29,294	17,053	17,828	25,767	2,070	3	1,053	0	210	1,544	4,834
Wallingford	7,870	36,809	21,196	22,843	35,248	913	4	1,559	0	315	1,134	4,866
Waterbury	25,729	88,627	55,706	58,650	34,909	27,144	29	2,814	51	1,416	5,098	42,895
Watertown	3,891	13,949	10,059	11,512	12,769	407	0	737	0	195	581	2,483
Winchester	1,492	8,759	5,185	5,087	8,917	184	10	4	0	23	230	874
Wolcott	3,275	12,917	8,184	8,038	13,380	681	2	145	0	0	1,135	649
Woodbury	1,607	8,188	4,641	5,146	8,523	207	12	251	0	24	393	377

2025 CTData Data Spreadsheet, April 2025.
https://informct.sharepoint.com/:x:/s/CTDataFiles/ETH2KfgdAmJMqJdLZINDV50Bw99FitDvRNYfUfRqAQkb1w?e=U1BWvM. Created with Data Wrapper

2021 Demographics of NOI Catchment Area

	Under 18	18 years and over	Male	Female	White alone NH	Black or African American alone NH	American Indian and Alaska Native alone NH	Asian alone NH	Native Hawaiian and Other Pacific Islander alone NH	Some other race alone NH	Two or more races NH	Hispanic or Latino
Berlin	4,206	15,801	9,731	10,376	17,234	73	0	1,078	0	83	348	991
Hartland	366	1,605	1,005	966	1,763	1	73	0	0	14	110	10
Southington	8,779	34,796	21,914	22,460	37,845	1,004	8	1,245	0	125	1,041	2,206
Barkhamsted	745	2,914	1,809	1,850	3,508	2	0	12	0	0	35	102
Bethlehem	728	2,680	1,764	1,644	3,110	30	0	75	0	22	59	112
Colebrook	246	1,176	752	670	1,338	19	0	12	0	0	41	12
Goshen	557	2,582	1,623	1,516	2,708	3	0	149	0	46	119	114
Harwinton	1,205	4,294	2,918	2,581	5,284	59	0	11	0	0	80	65
Litchfield	1,275	4,886	3,952	4,209	7,196	169	0	195	0	54	306	333
Morris	419	1,730	1,059	1,090	2,031	59	7	0	0	0	26	26
New Hartford	1,671	5,014	3,573	3,112	6,256	2	10	106	0	72	111	88
Norfolk	328	1,357	757	928	1,514	7	0	12	0	10	73	69
Thomaston	1,585	5,912	4,009	3,488	6,947	82	0	193	0	0	218	657
Torrington	6,192	24,355	17,879	17,468	29,818	1,026	39	834	0	123	965	3,650
Watertown	3,704	18,486	11,178	10,932	18,884	298	0	396	0	0	334	2,248
Winchester	1,413	9,982	5,289	5,046	9,488	116	33	1	0	0	206	541
Woodbury	1,501	8,291	4,631	5,131	8,971	75	13	186	0	21	203	293
Cheshire	5,653	24,119	13,864	13,702	24,728	1,113	37	1,781	0	242	1,289	1,576
Meriden	12,376	48,014	24,148	31,650	30,526	5,209	260	1,575	0	215	1,558	21,647
Middlebury	1,650	8,007	3,527	4,090	6,909	30	0	356	0	0	182	350
Naugatuck	6,249	25,387	14,419	15,167	23,122	2,443	0	1,028	0	121	1,120	3,752
Prospect	1,996	7,305	4,609	4,752	8,309	297	0	26	0	0	306	363
Southbury	3,841	14,825	9,385	10,481	17,154	426	3	626	0	34	346	1,277
Wallingford	7,632	36,796	20,915	23,513	35,967	522	0	2,096	0	189	701	5,753
Waterbury	26,904	86,870	55,862	57,921	44,718	20,350	16	2,449	21	750	3,570	41,289
Wolcott	3,330	12,592	8,101	8,131	13,598	332	2	300	0	0	333	1,267

Chart: Created By New Opportunities, Inc. • Source: 2023 CTData Spreadsheet, CAP PLAN 2023. • Created with Datawrapper

2025 CTData Data Spreadsheet, April 2025. https://informct.sharepoint.com/:x:/s/CTDataFiles/ETH2KfqdAmJMqJdLZINDV50Bw99FitDvRNYfUfRqAQkb1w?e=U1BWvM. Created with Data Wrapper

highlights the ongoing need for bilingual services, culturally responsive programming and support for multilingual households.

Meriden, the second largest city in the service area, reported 60,418 residents in 2023, including 13,049 youth under age 18 and 47,369 adults. The city's population includes 29,710 White non-Hispanic, 4,463 Black non-Hispanic residents and 1,421 Asian residents, and 1,808 residents of two or more races, along with 22,777 Hispanic/Latino residents. Meriden's demographic profile reflects a community with no single racial or ethnic majority, reinforcing the need for language access, culturally inclusive services and family support.

Suburban communities such as Southington, Wallingford, Cheshire and Naugatuck also contribute significantly to the region's population base. Southington reported 43,575 residents, with 8,607 youth and 34,968 adults, and continues to show moderate diversity, including 1,225 Asian residents and 2,166 Hispanic/Latino residents. Wallingford, with 44,039 residents, demonstrate increasing diversity, including 913 Black non-Hispanic residents, 1,559 Asian residents and 4,866 Hispanic/Latino residents. Cheshire, with 28,852 residents, shows notable growth in its Asian population, reporting 2,781 Asian residents in 2023 reflecting a steady increase in cultural diversity. Naugatuck, with 31,634 residents, continues to diversify as well, with 3,590 Black non-Hispanic residents, 1,393 Asian residents and 5,441 Hispanic/Latino residents.

In contrast, many rural towns including Colebrook, Hartland, Goshen, Norfolk, and Bethlehem maintain small, stable population with limited racial and ethnic diversity. For example, Colebrook reported 1,463 residents in 2023, including 1,331 White non-Hispanic residents and fewer than 50 residents in most minority categories. Hartland, with 1,881 residents, and Goshen, with 3,181 residents, show similar patterns of low diversity and aging populations. These communities typically report youth population under 700 and small minority representation, reflecting limited immigration and potential challenges related to transportation, access to services and social isolation. While these towns may not experience the same cultural and linguistic shifts as urban and suburban areas, they face distinct needs related to aging in place supports, health access and outreach to residents who may experience hidden poverty.

The demographic patterns across the catchment area illustrate a region that is diverse in both population, size, and composition. Urban centers such as Waterbury and Meriden continue to show a region with large, diverse populations and significant youth representation. Suburban towns show steady growth and increasing diversity, while rural communities face aging populations and limited access to services.

Key Findings:

- The catchment area includes a mix of urban, suburban and rural communities.
- Waterbury is the largest and most diverse community in the service area.
- Meriden is the second largest population center with substantial diversity.
- Suburban communities show steady population with moderate diversity.
- Rural towns maintain small, aging population with limited diversity.
- Youth populations are concentrated in urban and largest suburban towns.
- Working age adults (18-64) make up the largest share of the population across all towns.

Poverty and Its Prevalence in the Community

2023 Poverty and Its Prevalence

Town	Year	Classification	Population	Overall
Barkhamsted	2023	Rural	3,652	172
Berlin	2023	Suburban	20,132	911
Bethlehem	2023	Suburban	3,381	278
Cheshire	2023	Suburban	27,054	1,133
Colebrook	2023	Rural	1,436	99
Goshen	2023	Rural	3,181	204
Hartland	2023	Rural	1,881	61
Harwinton	2023	Suburban	5,523	222
Litchfield	2023	Rural	8,160	350
Meriden	2023	Urban Periphery	59,733	8,461
Middlebury	2023	Suburban	7,685	413
Morris	2023	Rural	2,100	90
Naugatuck	2023	Urban Periphery	31,318	1,910
New Hartford	2023	Suburban	6,684	108
Norfolk	2023	Rural	1,727	166
Prospect	2023	Suburban	9,350	217
Southbury	2023	Suburban	19,727	648
Southington	2023	Suburban	43,279	1,792
Thomaston	2023	Rural	7,459	197
Torrington	2023	Urban Periphery	34,787	4,731
Wallingford	2023	Suburban	43,435	2,498
Waterbury	2023	Urban Core	112,614	26,915
Watertown	2023	Suburban	22,038	1,089
Winchester	2023	Rural	10,084	1,415
Wolcott	2023	Suburban	16,102	245
Woodbury	2023	Suburban	9,787	553

2025 CTData Data Spreadsheet, April 2025.
https://informct.sharepoint.com/:x:/s/CTDataFiles/ETH2KfqdAmJMqJdLZINDV50Bw99FitDvRNYfUfRqAQkb1w?e=U1BWvM. Created with Data Wrapper

Overall Poverty Pattern across the region

The 2023 data show that poverty is most heavily concentrated in the region's urban centers, particularly Waterbury, Meriden, Torrington and Naugatuck. Waterbury, classified as an Urban Core community, reported the highest number of residents living in poverty, with 26,915 individuals affected. Meriden, an Urban Periphery community, reported 8,461 residents in poverty, while Torrington reported 4,731 residents, and Naugatuck reported 1,910 residents. These figures reflect the continued concentration of economic hardship in the region's most densely populated areas, where residents often face intersecting barriers related to housing affordability, employment stability, transportation access and the rising cost of living. Suburban communities also experience notable levels of poverty, though at

2021 Poverty and Its Prevalence

Town	Year	Classification	Population	Overall
Barkhamsted	2021	Rural	3,659	169
Berlin	2021	Suburban	20,040	791
Bethlehem	2021	Suburban	3,356	198
Cheshire	2021	Suburban	26,351	925
Colebrook	2021	Rural	1,378	94
Goshen	2021	Rural	3,139	195
Hartland	2021	Rural	1,949	31
Harwinton	2021	Suburban	5,481	194
Litchfield	2021	Rural	8,064	432
Meriden	2021	Urban Periphery	60,088	8,179
Middlebury	2021	Suburban	7,575	274
Morris	2021	Rural	2,149	214
Naugatuck	2021	Urban Periphery	31,309	1,529
New Hartford	2021	Suburban	6,668	78
Norfolk	2021	Rural	1,676	192
Prospect	2021	Suburban	9,227	108
Southbury	2021	Suburban	19,665	794
Southington	2021	Suburban	43,194	2,017
Thomaston	2021	Rural	7,492	330
Torrington	2021	Urban Periphery	34,639	4,715
Wallingford	2021	Suburban	43,561	2,803
Waterbury	2021	Urban Core	111,920	24,247
Watertown	2021	Suburban	22,044	936
Winchester	2021	Rural	10,209	1,164
Wolcott	2021	Suburban	16,117	454
Woodbury	2021	Suburban	9,751	423

2025 CTData Data Spreadsheet, April 2025. https://informct.sharepoint.com/:x:/s/CTDataFiles/ETH2KfqdAmJMqJdLZINDV50Bw99FitDvRNYfUfRqAQkb1w?e=U1BWvM. Created with Data Wrapper

lower concentrations than their urban counterparts. Southington reports 1,792 residents living in poverty, Wallingford reported 2,498 residents and Cheshire reported 1,133 residents.

While these communities have larger overall populations and higher median incomes, the presence of more than one thousand residents in poverty for each town highlights the need for accessible services, transportation supports and outreach strategies that reach low-income households who may be dispersed across wider geographic areas.

Rural communities show smaller numbers of residents living in poverty, but the impact can be significant due to limited access to services, transportation barriers and geographic isolation. Winchester reported 1,415 residents in poverty, one of the highest rural poverty counts in the region. Other rural towns such as Litchfield, Goshen and Thomaston reported between 197 and 350 residents in poverty. While these numbers are lower than those in urban and suburban areas, the challenges faced by rural residents such as limited public transit, fewer local service providers and longer travel distance can intensify the effects of poverty and make it more difficult for individuals to access needed supports.

Across the catchment area, the 2023 data illustrates a clear pattern; poverty is present in every community, but its scale and impact vary significantly by geography. Urban centers experience the highest concentration and the most complex needs, suburban communities show meaningful pockets of economic hardship and rural towns face unique barriers related to isolation and access. These patterns reinforce the importance of tailoring services to the specific needs of each community ensuring that support are accessible, culturally responsive and aligned with the lived experience of the residents. The poverty data provided essential context for understanding the distribution of need across the region.

Poverty and its prevalence by gender

Gender disparity in poverty are evident across all community types in this dataset. In every town where poverty counts are reported by gender, women represent a larger share of individuals living in poverty than men. This pattern appears consistent in urban core, urban periphery, suburban and rural communities.

In Waterbury, the region's largest urban center, 14,707 women live in poverty compared to 12,208 men, making women the majority of residents experiencing economic hardship. A

similar pattern is seen in Meriden, where 4,939 women live in poverty compared to 3,522 men.

2023 Poverty and Its Prevalence By Gender

Population Male Female

	Population	Male	Female
Barkhamsted	3,652	86	86
Berlin	20,132	359	552
Bethlehem	3,381	163	115
Cheshire	27,054	519	614
Colebrook	1,436	41	58
Goshen	3,181	110	94
Hartland	1,881	44	17
Harwinton	5,523	110	112
Litchfield	8,160	102	248
Meriden	59,733	3,522	4,939
Middlebury	7,685	132	281
Morris	2,100	68	22
Naugatuck	31,318	706	1,204
New Hartford	6,684	85	23
Norfolk	1,727	42	124
Prospect	9,350	69	148
Southbury	19,727	262	386
Southington	43,279	654	1,138
Thomaston	7,459	84	113
Torrington	34,787	2,269	2,462
Wallingford	43,435	1,167	1,331
Waterbury	112,614	12,208	14,707
Watertown	22,038	545	544
Winchester	10,084	571	844
Wolcott	16,102	131	114
Woodbury	9,787	208	345

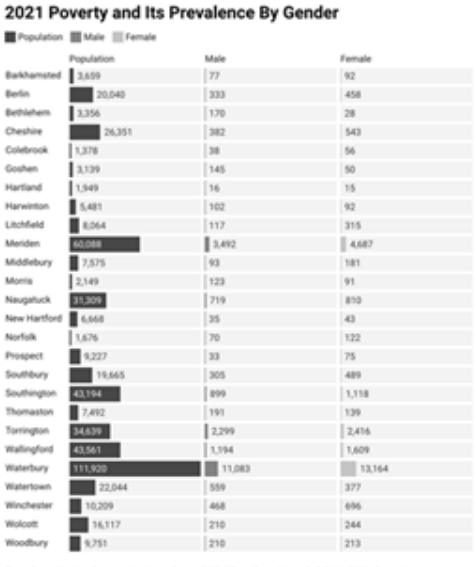
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In Torrington, 2,462 women live in poverty compared to 2,269 men and in Naugatuck, 1,204 women live in poverty compared to 706 men. These figures show that gender disparities in poverty are not limited to the largest cities but are present across all urban classifications.

Suburban communities show the same pattern, Southington reported 1,138 women and 654 men living in poverty, while Wallingford reported 1,331 women and 1,167 men. Cheshire reported 614 women and 519 men living in poverty. Although suburban towns have lower overall poverty counts than urban centers, the gender imbalance remains consistent.

Rural communities also reflects this trend, Winchester reported 844 women and 571 men living in poverty, one of the highest rural poverty totals in the region. Other rural towns, such as Litchfield (248 women and 102 men) show similar patterns, with women representing either the majority or a significant share of residents experiencing poverty.

These gender differences are also visible in the 2021 dataset, which shows the same directional pattern, women consistently outnumber men among residents living in poverty. For example, in 2021, Waterbury reported 13,164 women in poverty compared to 11,083 men and Meriden reported 4,687 women compared to 3,492 men. While the exact numbers differ from 2023, the overall pattern remains stable.



2025 CTData Data Spreadsheet, April 2025. https://informct.sharepoint.com/:x:/s/CTDataFiles/ETH2KfqdAmJMqJdLZINDV50Bw99FitDvRNYfUfRqAQkb1w?e=U1BWvM. Created with Data Wrapper

Key findings:

- Women experience higher poverty rates than men in nearly every community.
- The largest gender gaps appear in the region's urban centers.
- Suburban communities also show consistent gender disparities.
- Rural communities show smaller totals but the same directional pattern.
- The 2021 dataset show the same pattern, confirming stability over time.

- Women represent the majority of residents in poverty across all community classifications.
- The largest concentration of women in poverty are in Waterbury, Meriden, and Torrington.

Poverty and Its Prevalence by Age

2023 Poverty and Its Prevalence By Age

Town	Year	Classification	Population	Under 18	18 to 64	65 and over
Barkhamsted	2023	Rural	3,652	57	91	24
Berlin	2023	Suburban	20,132	224	410	277
Bethlehem	2023	Suburban	3,381	19	195	64
Cheshire	2023	Suburban	27,054	214	652	267
Colebrook	2023	Rural	1,436	37	56	6
Goshen	2023	Rural	3,181	109	95	0
Hartland	2023	Rural	1,881	0	45	16
Harwinton	2023	Suburban	5,523	61	129	32
Litchfield	2023	Rural	8,160	30	238	82
Meriden	2023	Urban Periphery	59,733	2,927	4,686	848
Middlebury	2023	Suburban	7,685	77	296	40
Morris	2023	Rural	2,100	0	67	23
Naugatuck	2023	Urban Periphery	31,318	699	857	354
New Hartford	2023	Suburban	6,684	0	71	37
Norfolk	2023	Rural	1,727	37	97	32
Prospect	2023	Suburban	9,350	59	114	44
Southbury	2023	Suburban	19,727	0	221	427
Southington	2023	Suburban	43,279	473	963	356
Thomaston	2023	Rural	7,459	0	169	28
Torrington	2023	Urban Periphery	34,787	1,136	2,793	802
Wallingford	2023	Suburban	43,435	412	1,241	845
Waterbury	2023	Urban Core	112,614	8,694	15,528	2,693
Watertown	2023	Suburban	22,038	241	676	172
Winchester	2023	Rural	10,084	129	896	390
Wolcott	2023	Suburban	16,102	0	169	76
Woodbury	2023	Suburban	9,787	96	298	159

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Urban Core and Urban Periphery

The 2023 dataset shows that poverty affects residents across all age groups, but the highest concentration occur among working age adults (18-64) and children under 18, particularly in urban centers such as Waterbury, Meriden, Torrington and Naugatuck.

In Waterbury, classified as Urban Core community, 8,694 youth under 18 and 2,693 seniors ages 65 and over were identified in poverty. Meriden and Urban Periphery community reported 2,927 youth, 4,686 adults and 848 seniors living in poverty. Similarly, Torrington reported 1,136 youth, 2,793 adults and 802 seniors, while Naugatuck reported 699 youth, 857 adults and 354 seniors.

These figures confirm that poverty among adults remain the largest segment in each urban area, reflecting ongoing challenges related to employment stability, housing affordability and cost of living pressures.

Suburban Communities

Suburban towns show lower overall poverty rates but maintain the same age-based patterns. In Southington, 473 youth, 963 adults and 356 seniors were identified in poverty. Wallingford reported 412 youths, 1,241 adults and 845 seniors, while Cheshire reported 214 youth, 625 adults and 267 seniors. Although suburban communities generally have higher median incomes, these numbers highlight that poverty among working age adults persists even in

2021 Poverty and Its Prevalence By Age

Town	Year	Classification	Population	Under 18	18 to 64	65 and over
Barkhamsted	2021	Rural	3,659	61	101	7
Berlin	2021	Suburban	20,040	278	232	281
Bethlehem	2021	Suburban	3,356	21	177	0
Cheshire	2021	Suburban	26,351	170	483	272
Colebrook	2021	Rural	1,378	40	40	14
Goshen	2021	Rural	3,139	110	71	14
Hartland	2021	Rural	1,949	0	20	11
Harwinton	2021	Suburban	5,481	63	107	24
Litchfield	2021	Rural	8,064	75	236	121
Meriden	2021	Urban Periphery	60,088	2,603	4,718	858
Middlebury	2021	Suburban	7,575	38	187	49
Morris	2021	Rural	2,149	58	143	13
Naugatuck	2021	Urban Periphery	31,309	400	890	239
New Hartford	2021	Suburban	6,668	0	35	43
Norfolk	2021	Rural	1,676	45	118	29
Prospect	2021	Suburban	9,227	0	88	20
Southbury	2021	Suburban	19,665	46	304	444
Southington	2021	Suburban	43,194	673	935	409
Thomaston	2021	Rural	7,492	27	247	56
Torrington	2021	Urban Periphery	34,639	1,006	3,071	638
Wallingford	2021	Suburban	43,561	610	1,446	747
Waterbury	2021	Urban Core	111,920	8,488	13,861	1,898
Watertown	2021	Suburban	22,044	194	575	167
Winchester	2021	Rural	10,209	69	795	300
Wolcott	2021	Suburban	16,117	72	292	90
Woodbury	2021	Suburban	9,751	32	256	135

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economically stable areas, and that youth and seniors also experience measurable levels of need.

Rural Communities

Rural towns show smaller numbers but similar proportionate trends. Winchester reported 129 youth, 896 adults and 390 seniors living in poverty, while Litchfield reported 30 youth, 129 adults and 32 seniors. Other rural towns such as Goshen and Colebrook show small but steady counts of adults and seniors living in poverty. These figures illustrate that while rural poverty affects fewer people overall, the impact can be severe due to limited access to services, transportation and employment opportunities.

Key findings:

- Poverty is the highest among adults ages 18-64 across all community types.
- Youth under 18 consistently represent the second largest group living in poverty.
- Seniors 65+ experience smaller but steady levels of poverty.
- Urban centers show the highest poverty rates across all age groups.
- Suburban communities show meaningful pockets of poverty across all ages.
- Rural poverty is smaller in scale but significant in impact.
- Age based poverty patterns remained stable between 2021 and 2023.

Poverty and Its Prevalence by Race and Ethnicity

The 2023 dataset shows that poverty affects residents across all racial and ethnic groups in the region, with the highest concentration appearing in urban centers such as Waterbury, Meriden, Torrington and Naugatuck. These communities reflect both the largest population and the greatest racial and ethnic diversity among residents living in poverty.

Urban Core: Waterbury Waterbury has the highest poverty counts across every racial and ethnic category in the region: White alone: 34,909; Black or African American: 27,144; Asian Alone: 2,814, some other race 1,416; Two or more races: 5,098 and Hispanic or Latino: 42,895. Hispanic/Latino residents represent the largest ethnic group in poverty, followed by White and Black residents. Waterbury is the region's most racially diverse poverty center.

2023 Poverty and Its Prevalence By Race & Ethnicity

Town	Year	Total	Under 18	18 years and over	Male	Female	White alone NH	Black or African American alone NH	American Indian and Alaska Native alone NH	Asian alone NH	Native Hawaiian and Other Pacific Islander alone NH	Some other race alone NH	Two or more races NH	Hispanic or Latino
Barkhamsted	2023	3,652	658	2,994	1,806	1,846	3,360	1	0	23	0	0	15	253
Berlin	2023	20,210	4,024	16,186	10,075	10,135	17,382	176	0	957	0	102	345	1,248
Bethlehem	2023	3,398	696	2,702	1,687	1,711	3,085	34	0	0	0	23	86	170
Cheshire	2023	28,852	6,368	22,484	14,299	14,553	21,167	776	21	2,781	0	122	2,020	1,965
Colebrook	2023	1,463	240	1,223	741	722	1,331	23	0	31	0	0	55	23
Goshen	2023	3,181	586	2,595	1,547	1,634	2,740	0	0	126	0	0	124	191
Hartland	2023	1,881	314	1,567	1,039	842	1,774	3	0	0	0	13	36	55
Harwinton	2023	5,529	1,084	4,445	2,936	2,593	5,070	0	0	32	0	0	95	332
Litchfield	2023	8,249	1,351	6,898	3,938	4,311	7,123	81	0	278	0	93	361	313
Meriden	2023	60,418	13,049	47,369	29,072	31,346	29,710	4,463	104	1,421	0	135	1,808	22,777
Middlebury	2023	7,736	1,808	5,928	3,505	4,231	6,397	35	0	574	0	38	381	311
Morris	2023	2,100	372	1,728	1,146	954	1,997	31	9	0	0	0	34	29
Naugatuck	2023	31,634	6,374	25,260	15,812	15,822	19,179	3,590	0	1,393	0	115	1,916	5,441
New Hartford	2023	6,684	1,396	5,288	3,423	3,261	6,276	0	0	85	0	65	100	158
Norfolk	2023	1,732	278	1,454	842	890	1,447	16	0	22	0	2	94	151
Prospect	2023	9,414	2,122	7,292	4,554	4,860	7,891	350	0	159	0	44	513	457
Southbury	2023	19,973	3,882	16,091	9,427	10,546	16,665	372	0	646	0	114	427	1,749
Southington	2023	43,575	8,607	34,968	20,867	22,708	37,610	662	6	1,225	0	270	1,636	2,166
Thomaston	2023	7,476	1,611	5,865	3,868	3,608	5,944	153	0	153	0	0	565	661
Torrington	2023	35,481	6,247	29,234	17,653	17,828	25,767	2,070	3	1,053	0	210	1,544	4,834
Wallingford	2023	44,039	7,970	36,069	21,196	22,843	35,248	913	4	1,559	0	315	1,134	4,866
Waterbury	2023	114,356	25,729	88,627	55,706	58,650	34,909	27,144	29	2,814	51	1,416	5,098	42,895
Watertown	2023	22,171	3,831	18,340	10,659	11,512	17,768	407	0	737	0	195	581	2,483
Winchester	2023	10,242	1,492	8,750	5,155	5,087	8,917	184	10	4	0	23	230	874
Wolcott	2023	16,192	3,275	12,917	8,154	8,038	13,580	681	2	145	0	0	1,135	649
Woodbury	2023	9,787	1,607	8,180	4,641	5,146	8,523	207	12	251	0	24	393	377

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Urban Periphery: Meriden, Torrington and Naugatuck

Meriden: White alone: 29,710; Black or African American: 4,463; Asian Alone: 1,421, some other race 135; Two or more races: 1,808 and Hispanic or Latino: 22,777. Meriden has the second largest Hispanic/Latino poverty population in the region. Torrington: White alone: 25,767; Black or African American: 2,070; Asian Alone: 1,053, some other race 210; Two or more races: 1,544 and Hispanic or Latino: 4,834. Naugatuck: White alone: 19,179; Black or African American: 3,590; Asian Alone: 1,393, some other race 115; Two or more races: 1,916 and Hispanic or Latino: 5,441. Urban Periphery towns show broader racial presentation in poverty, though at smaller scales than Waterbury.

Suburban Communities

Suburban towns show lower overall poverty rate but still reflects racial and ethnic diversity. Southington: White alone: 37,610; Black or African American: 662; Asian Alone: 1,225, some other race 270; Two or more races: 1,636 and Hispanic or Latino: 2,166. Wallingford: White alone: 35,248; Black or African American: 913; Asian Alone: 1,559, some other race 315; Two or more races: 1,134 and Hispanic or Latino 4,866. Cheshire: White alone: 21,167; Black or African American: 776; Asian Alone: 2,781, some other race 122; Two or more races: 2,020 and Hispanic or Latino 1,965. Suburban poverty is racially diverse, though at lower volumes than urban areas.

2021 Poverty and Its Prevalence By Age Race & Ethnicity

Town	Year	Total	Under 18	18 years and over	Male	Female	White alone NH	Black or African American alone NH	American Indian and Alaska Native alone NH	Asian alone NH	Native Hawaiian and Other Pacific Islander alone NH	Some other race alone NH	Two or more races NH	Hispanic or Latino
Berlin	2021	20,107	4,206	15,901	9,731	10,376	17,534	73	0	1,078	0	83	348	991
Hartland	2021	1,971	366	1,605	1,005	966	1,763	1	73	0	0	14	110	10
Southington	2021	43,474	8,779	34,695	21,014	22,460	37,845	1,004	8	1,245	0	125	1,041	2,206
Barkhamsted	2021	3,659	745	2,914	1,809	1,850	3,508	2	0	12	0	0	35	102
Bethlehem	2021	3,408	728	2,680	1,764	1,644	3,110	30	0	75	0	22	59	112
Colebrook	2021	1,422	246	1,176	752	670	1,338	19	0	12	0	0	41	12
Goshen	2021	3,139	557	2,582	1,623	1,516	2,708	3	0	149	0	46	119	114
Harwinton	2021	5,499	1,205	4,294	2,918	2,581	5,284	59	0	11	0	0	80	65
Litchfield	2021	8,161	1,275	6,886	3,952	4,209	7,104	169	0	195	0	54	306	333
Morris	2021	2,149	419	1,730	1,059	1,090	2,031	59	7	0	0	0	26	26
New Hartford	2021	6,685	1,671	5,014	3,573	3,112	6,296	2	10	106	0	72	111	88
Norfolk	2021	1,685	328	1,357	757	928	1,514	7	0	12	0	10	73	69
Thomaston	2021	7,497	1,585	5,912	4,009	3,488	6,347	82	0	193	0	0	218	657
Torrington	2021	35,447	6,192	29,255	17,979	17,468	28,810	1,026	39	834	0	123	965	3,650
Watertown	2021	22,110	3,704	18,406	11,178	10,932	18,834	298	0	396	0	0	334	2,248
Winchester	2021	10,335	1,413	8,922	5,289	5,046	9,438	116	33	1	0	0	206	541
Woodbury	2021	9,762	1,501	8,261	4,631	5,131	8,971	75	13	186	0	21	203	293
Cheshire	2021	28,766	5,653	23,113	15,064	13,702	22,728	1,113	37	1,781	0	242	1,289	1,576
Meriden	2021	60,790	12,376	48,414	29,140	31,650	30,326	5,209	260	1,575	0	215	1,558	21,647
Middlebury	2021	7,617	1,650	5,967	3,527	4,090	6,699	30	0	356	0	0	182	350
Naugatuck	2021	31,586	6,249	25,337	16,419	15,167	23,122	2,443	0	1,028	0	121	1,120	3,752
Prospect	2021	9,361	1,996	7,365	4,609	4,752	8,369	297	0	26	0	0	306	363
Southbury	2021	19,866	3,841	16,025	9,385	10,481	17,154	426	3	626	0	34	346	1,277
Wallingford	2021	44,428	7,632	36,796	20,915	23,513	35,167	522	0	2,096	0	189	701	5,753
Waterbury	2021	113,783	26,904	86,879	55,862	57,921	44,718	20,350	16	2,449	21	750	3,570	41,909
Wolcott	2021	16,232	3,330	12,902	8,101	8,131	13,998	332	2	300	0	0	333	1,267

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Rural Communities

Rural towns have smaller populations but still show racial and ethnic representation in poverty. Winchester: White alone: 8,917; Black or African American: 184; Asian Alone: 4, some other race 23; Two or more races: 230 and Hispanic or Latino 874. Litchfield: White alone: 7,123; Black or African American: 81; Asian Alone: 278, some other race 93; Two or more races: 361 and Hispanic or Latino 313. Goshen: White alone: 2,740; Black or African American: 0; Asian Alone: 126, some other race 0; Two or more races: 124 and Hispanic or Latino 191. Rural poverty is smaller in scale but not racially homogenous.

Key findings:

- Poverty affects all racial and ethnic groups across the region.
- Waterbury has the highest poverty rates in every racial and ethnic category.
- Hispanic/Latino residents represent the largest ethnic group in poverty.
- White residents represent the largest numerical group in poverty in many towns.
- Black and multiracial residents show significant representation in urban poverty.
- Asian residents appear in poverty rates across all community types.
- Rural communities shows smaller but meaningful racial and ethnic diversity in poverty.

E.2 Community Resources

See Partnership Chart provided as evidence for Organizational Standard 2.1.

Check here if Chart is attached in Section H. [X]

F. Establishing Priorities

The process of prioritizing the needs that the agency will address is one of the last activities of the Needs Assessment process - they are developed after the data is collected, aggregated and analyzed.

The list of priority areas is limited to 6 domains

These are the domain areas we prioritized:

1. Housing
2. Health & Social/Behavioral Development: Health Care Access
3. Health & Social/Behavioral Development: Food Insecurity

F.1 Prioritization Process

Component	Description
Describe the Prioritization Process	NOI used a structured prioritization process to determine which needs identified in the CNA would be selected as agency priorities. Representatives from the RDP team reviewed the analyzed data, including survey results, focus group themes, demographic indicators and service request trends. Using a counting method, the team scored each domain based on how frequently it appeared across all data sources. Domains with the highest percentages were considered the strongest indicators of community need. After identifying the domains that rose to the top, the team applied additional criteria, including the alignment with the agency's mission and strategic plan, the agency's expertise and capacity, the availability of existing community services and the severity or scope of the need. These criteria helped determine which needs NOI could reasonably address within its catchment area.
Who was involved in identifying the priorities?	The representative of the CNA group is the RDP Department (Director of Research, Development and Planning, Contract Compliance Manager and Planner)
What was major influence on the prioritization process?	The prioritization process was influenced by several key factors. The team considered the demographics of individuals experiencing the need, the location and concentration of the need and the severity of the conditions identified. The analyzed data played a central role in determining which domains rose to the top, ensuring that prioritization was data driven and responsive to the most significant needs within the catchment area. The team also evaluated whether each need aligned with NOI's mission and strategic plan, whether the agency had the capacity and resources to address it and whether existing community services already served the same population. These considerations helped prevent mission drift and ensure that selected priorities reflected both community need and organizational capacity.
What needs were not included in the selected priorities? Why?	High utility costs emerged as a significant concern in the CNA data; however, this need was not selected as a priority. Lowering utility rates is outside the agency's scope and NOI's does not have the capacity to provide year-round financial assistance for utility bills. While eligible customers will continue to receive supports through existing energy assistance program, the agency determined that this need could not be adopted as a priority due to limitations in mission alignment, resource availability and the presence of regulatory factors outside the agency's control.

F.2 Poverty Conditions and Causes by Domain

F.2a Conditions, Causes and Impact

Domain Area 1: Housing

Key findings on the conditions of poverty in your community related to this domain? At what level do you see these conditions?
• Renters in the NOI catchment area experience significantly higher cost burden compared to homeowners, limiting their ability to meet other basic needs such as food, transportation, and health care (Family). • Eviction filings and renter households facing eviction have increased, reflecting widespread housing instability (Community). • Declining housing unit availability has reduced options for low-income families and increased competition for available units (Community). • Demand for crisis and shelter services exceeds available capacity, signaling that more households are cycling through homelessness or near-homelessness (Community).
Key findings on the causes of poverty in your community related to this domain? At what level do you find these causes?
• Household incomes have not kept pace with rising housing costs, making stable housing unattainable for many residents (Family). • Historical discriminatory housing practices have contributed to limited access to safe, affordable housing (Community). • Insufficient inventory of rental units has intensified competition for available housing (Community).
How do these conditions/causes impact your service population?
Housing conditions in the NOI catchment area place individuals and families at risk for eviction, homelessness, and displacement. As rents rise and housing options shrink, households must choose between paying for housing and meeting other basic needs. Even when individuals are employed, wages often do not keep pace with housing costs, leading to increased reliance on rental assistance, shelter services, and crisis support. Focus group participants described being pushed out of their hometowns, living in very small units with family members, and fearing rent increases they cannot afford.

F.2b Supporting Data by Domain

Housing instability is strongly supported by the CNA, including statewide housing reports, NOI's survey reports, focus group results, and case management system data. DataHaven's Crisis Housing Report (2026) reveals a statewide decrease in housing units and a shortage of 120,000 housing units for low-income residents. While this number is based on statewide data, NOI's local data shows similar patterns are present in the service area, where families constantly report difficulty affording rent and maintaining stable housing. HUD's Fair Market Rent data (HUD, 2025) further supports these trends, showing that Fair Market Rents increased between FY 2024 to FY 2025 across Waterbury, Meriden and Torrington. Per example, the two-bedroom FMR increased from $1,418 to $1,445 in Waterbury, from $1,676 to $1,867 in Meriden and from $1,484 to $1,507 in Torrington, widening the gap between wages and rental costs for low-income households.

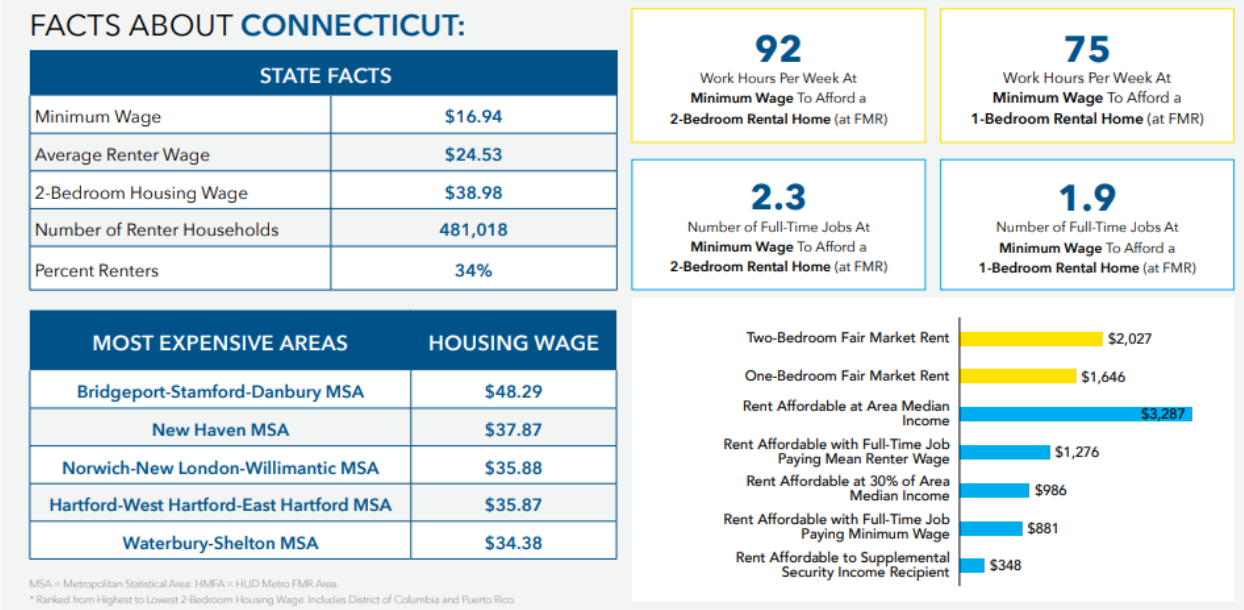
Final FY 2025 & Final FY 2024 FMRs By Unit Bedrooms					
Year	Efficiency	One-Bedroom	Two-Bedroom	Three-Bedroom	Four-Bedroom
FY 2025 FMR	$991	$1,191	$1,445	$1,891	$2,291
FY 2024 FMR	$961	$1,155	$1,418	$1,829	$2,256

Final FY 2025 & Final FY 2024 FMRs By Unit Bedrooms					
Year	Efficiency	One-Bedroom	Two-Bedroom	Three-Bedroom	Four-Bedroom
FY 2025 FMR	$1,421	$1,529	$1,867	$2,319	$2,618
FY 2024 FMR	$1,251	$1,374	$1,676	$2,062	$2,348

Final FY 2025 & Final FY 2024 FMRs By Unit Bedrooms					
Year	Efficiency	One-Bedroom	Two-Bedroom	Three-Bedroom	Four-Bedroom
FY 2025 FMR	$1,033	$1,219	$1,507	$1,884	$2,152
FY 2024 FMR	$1,006	$1,160	$1,484	$1,819	$2,024

The survey revealed that housing at 65% was one of the frequently selected areas of need for respondents (NOI CNA Survey, 2026). Affordable housing remains a significant problem for residents in NOI's service area. Regional data support these concerns. On average, renter households in the NOI catchment area are 50% cost-burden compared to 32% of homeowners in the area (Data Haven 2025). Renters are affected by high costs and struggle to meet basic needs, including food, health care, and transportation. The National Low Income Housing Coalition's Out of Reach Report (NLIHC, 2026), shows that Connecticut renters must earn $38.98 per hour to afford a modest two-bedroom apartment at Fair Market Rent far above the

average renter wage in the NOI catchment area demonstrating that wages are not keeping pace with rental costs. NOI held focus groups to better understand respondents' housing needs. One participant shared that when he first moved into his apartment, he was paying $600 a month for a one-bedroom unit which was affordable, now he is paying $1,100 a month. (NOI Focus Group Report, 2026). The data shows that rent growth has outpaced wage growth.



1National Low Housing Coalition. Out of Reach, 2026. https://nlihc.org/oor/state/ct

These increases also heighten the threat of housing displacement. Another participant from the focus group described feeling "pushed out of my hometown." She lived in Meriden her whole life, and in the current housing market, is moving from a 950-square-foot apartment to a 250-square-foot apartment at $1,000. She shared that the apartment is not worth the price (NOI Focus Group Report, 2026). The increase in participants' rent reflects growing concerns about displacement and the loss of affordable housing options. Data Haven (2026) states that the most rapid increase in housing supply is occurring in downtown areas such as Stamford and New Haven. In the NOI catchment area, there has been a 5.5% drop in housing (DataHaven, Crisis Housing Report, 2026). More than 154 housing units were lost in the last 5 years, contributing to housing instability (DataHaven, Crisis Housing Report, 2026). Focus groups and other data show that vulnerable groups still face barriers to accessing and maintaining housing. The 2026 Connecticut Housing Profile (NLIHC, 2026) reinforces these findings, reporting that only 40 affordable and available units exits for every 100 extremely low-income renters statewide, a shortage that mirrors the limited inventory and high competition documented within NOI's catchment area.

The data show that housing instability in the NOI catchment area is widespread and persistent, driven by economic conditions. Families are facing higher rents, scarce affordable housing

options for families, lengthy waitlists, and high rates of eviction, all of which contribute to displacement and chronic housing insecurity.

F.2c Resources and Service Gaps by Domain

What are the resources available in the agency and in the community that are used to help meet needs in this domain?
NOI case management staff assist customers with landlord/tenant mediation, and the housing navigator staff established landlord relationship in Meriden, Torrington and Waterbury. These relationships help customers with barriers such as eviction and low credit scores to obtain housing. The agency operates an emergency homeless shelter in Meriden that provides temporary shelter to families, single men and single women; administers the Middlesex/Meriden/Wallingford Coordinated Access Network (MMW CAN); and operates two permanent supportive housing programs. Based on available funding, the agency also assists with financial assistance for security deposit, 1st month rent, rental and mortgage arrears. The agency's Waterbury and Meriden sites participate in the Waterbury and Meriden Homeless Taskforce; a community collaboration focused on reducing homelessness. The agency also collaborates other organizations such as the Salvation Army, Unite CT and CCEH to assist customers with eviction prevention or security deposit.
What are the gaps in resources related to this domain area?
Although multiple resources exist, gaps remain due to limited funding for ongoing rental assistance and strict eligibility requirements for eviction prevention programs. These gaps reduce access to affordable housing and limit the ability of households to maintain stable housing. Budget constraints, loss of income, and rising rents place families at ongoing risk of displacement. Focus group participants described being unable to access assistance due to strict eligibility criteria or limited availability of funds.

F.2a Conditions, Causes and Impact

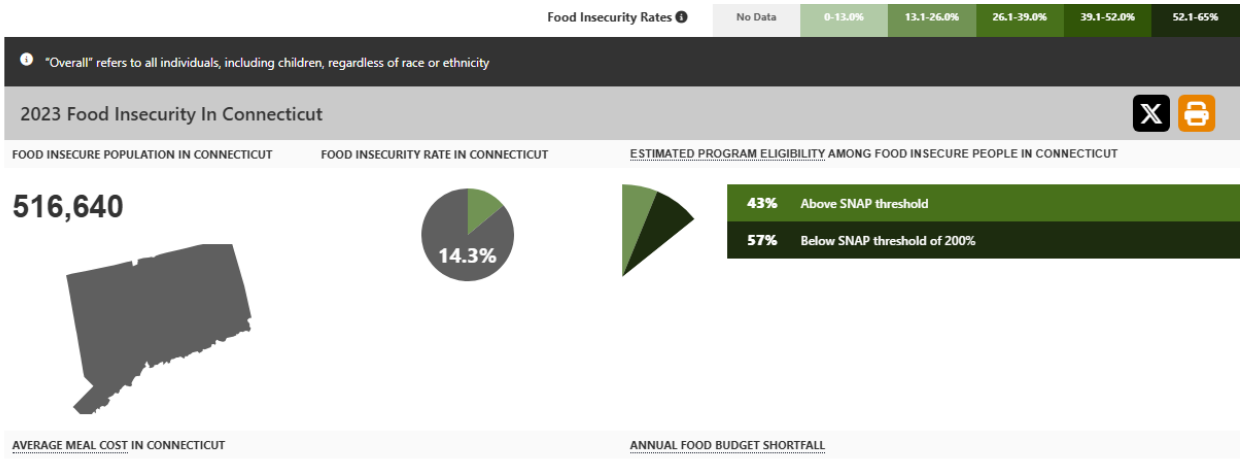
Domain Area 2: Health and Social/Behavioral – Food Insecurity

Key findings on the conditions of poverty in your community related to this domain? At what level do you see these conditions?
• Families in the NOI catchment area struggle to afford nutritious food (Family).

• Many households worry that food will run out before they have money to buy more (Family).
Key findings on the causes of poverty in your community related to this domain? At what level do you find these causes?
• Inflation and high cost of living force families to allocate most of their income to non-food expenses (Family). • Families living in poverty often work low-wage jobs or rely on fixed incomes, which do not keep pace with food prices (Family).
How do these conditions/causes impact your service population?
Survey respondents and focus group participant reported that food is expensive. Many individuals living in poverty are working or are on fixed incomes, often in low-wage jobs and rely on food subsidies such as SNAP. However, the increasing cost of living and higher grocery prices limit people's food options. Focus groups participants shared that, despite trying to reduce their spending, they still run out of food before the end of the month.

F.2b Supporting Data by Domain

According to CT Foodshare, 23.2% of Waterbury's total population live in poverty, while 23% of the total population experience food insecurity; in Meriden, 13.1% of the total population live in poverty, while 18.3% of the total population experience food insecurity; and in Torrington, 13.3% of the total population live in poverty, while 17% of the total population experience food insecurity. This data suggests that food insecurity affects more people than those living in poverty. Feeding America's Map the Meal Gap (2025) supports these findings, showing that food insecurity rates in Connecticut remain higher than pre-pandemic levels and that the average cost per meal has increased, making it more difficult for low-income households to maintain consistent access to nutritious food.



2023 Food Insecurity In Connecticut. https://map.feedingamerica.org/county/2023/overall/connecticut

From February to March 2026, 222 individuals in NOI catchment area were surveyed anonymously. 63% of the individuals that were surveyed reported that families often worry that they will run out of food before they have money to buy more, and 62% reported that families cannot afford nutritious food. The agency also conducted three focus groups in March 2026. Participants in all focus groups shared that food is expensive and that cutting back and budgeting is no longer feasible. One participant shared that she shops for groceries as if she is a family of 4, buying family size meat and dividing it to stretch her supply, but she still runs out of food before the end of the month. Participants also shared that many food and mobile pantries operate during work hours, making them inaccessible to working families. People living in poverty are on fixed incomes or working low-wage jobs. The survey results and focus group stories reinforce the barriers and struggles families in NOI catchment area face around food insecurity. The Connecticut Commission on Women, Children, Seniors, Equity and Opportunity (CWCSEO, 2025) identifies similar barriers statewide, noting that rising grocery prices, transportation limitations and lack of culturally appropriate food options disproportionately impact low-income households and communities of color.

An article by Jeremy Chen reported that a pantry in Waterbury has seen demand nearly triple in recent months. The article noted that the increase in demand is due to rising food prices and changes in SNAP eligibility. According to the article, "fewer people are enrolled in the Supplemental Nutrition Assistance Program, or SNAP, due to policy changes. In Connecticut, enrollment has dropped by about 39,000 people, according to Connecticut Foodshare" (Chen C. 2026). Families rely on SNAP benefits to supplement their budget, and with the high cost of food, high cost of living, and changes to SNAP eligibility, households budget are strained. According to the Bureau of Labor Statistics (BLS, June 2026), the food index increased 3.0% over the past 12 months, with specific categories such as fruit and vegetables rising 5.3% and food away from home increasing 3.4%. These rising costs place additional pressure on households already struggling to afford basic groceries.

F.2c Resources and Service Gaps by Domain

What are the resources available in the agency and in the community that are used to help meet needs in this domain?
Food pantries and other food resources are available to residents in NOI catchment area. The agency's 3 Family Development site maintains a flyer listing each pantry location and its hours of operation, which is available to everyone in the community. Individuals in NOI catchment can also use CT FoodShare and the 2-1-1 CT website to search for available food pantries, soup kitchens and/or mobile food assistance in their area. In partnership with CT FoodShare, the Meriden and Waterbury location host a biweekly mobile pantry that provides fresh bread, vegetables, fruits and roots to the community. The Meriden site has operated a food pantry for more than 30 years and has extended its hours to 6pm every Tuesday and

Thursday to increase access for working families. The pantry also partners with UCONN Extension Expanded Food and Nutrition Education Program to offer monthly healthy eating workshops. These workshops allow participants to select items the families will use, rather than receiving pre-selected items that may not meet their needs.
What are the gaps in resources related to this domain area?
Recent changes to SNAP eligibility guideline has created gaps in food resources for families in the NOI community. Many households rely on SNAP benefits to supplement their food budget, but inflation, the high cost of living, and rising grocery prices continue to strain family finances. During focus groups and in response to the open-ended questions, community members expressed a need for food pantries and mobile pantries to operate during evenings and weekends. Current operating hours make it difficult for working families to access these services, creating additional barriers to obtaining consistent and nutritious meals.

Domain Area 3: Health and Social/Behavioral – Health Care Access

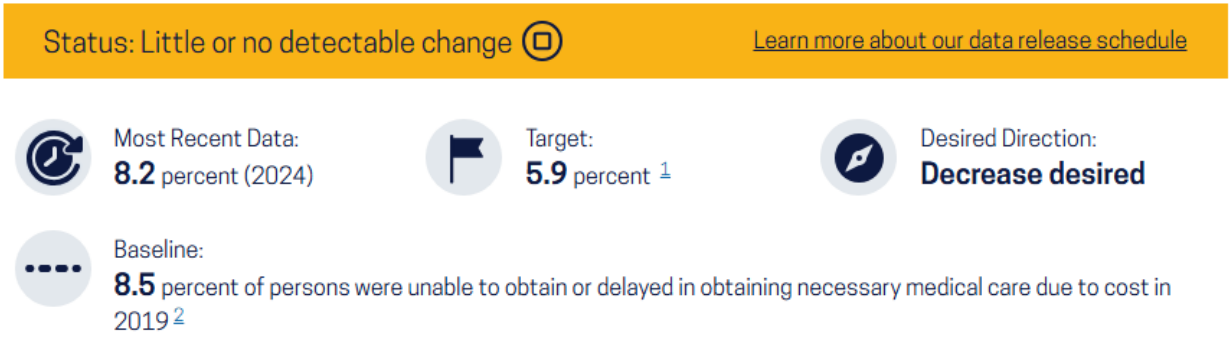
Key findings on the conditions of poverty in your community related to this domain? At what level do you see these conditions?
• Families with insurance often have high-deductible plans or copays that limit access to care (Family). • Many households lack income to pay for medical services (Family).
Key findings on the causes of poverty in your community related to this domain? At what level do you find these causes?
• Many families that are insured have a co-pay and high-deductible plan (Family) • Families in NOI catchment area lack income to pay for medical (Family) • Individuals in NOI catchment area lack access to affordable transportation for health care service, grocery and/or food pantries (Community)
How do these conditions/causes impact your service population?
Families living in poverty struggle to navigate the health care system. Most individuals have health insurance coverage through Medicare, Medicaid, or employment-based plans; however, many of these plans include co-pays, high-deductibles, or do not cover certain medications or medical procedures. Limited finances, combined with the rising cost of living,

housing, food, and transportation barriers, contribute to higher rates of chronic illness among low-income households.

During a focus group conducted by NOI, participants shared that obtaining proper medical care is expensive and that the type of health insurance coverage often determines the quality of care they receive. One participant explained that she did not have adequate dental insurance, which caused her to lose her teeth over time. As a result, she now eats softer foods, which is affecting her stomach.

F.2b Supporting Data by Domain

An analysis of the community needs assessment survey and focus groups conducted by the agency between February to March 2026 found that individuals in NOI catchment area struggle to receive adequate medical care. A total of 222 individuals were surveyed and 53% reported lack of income to pay for adult dental, hearing and/or vision service. Additionally, 46% reported that lack of affordable transportation for health care services, grocery stores, and food pantries is a major factor contributing to health concerns in the catchment area. Focus group participants shared that obtaining proper medical care is expensive and that the type of health insurance coverage often determines the quality of care they receive. Healthy People 2030 (Healthy People 2030, 2025) identifies reducing the proportion of people who cannot obtain, or delay needed medical care due to cost as a core national health objective. National data show that 8.5% were unable to obtain or delayed needed medical care due to cost in 2019, compared to 8.2% in 2024 with an objective's status listed as "little or no detectable change.

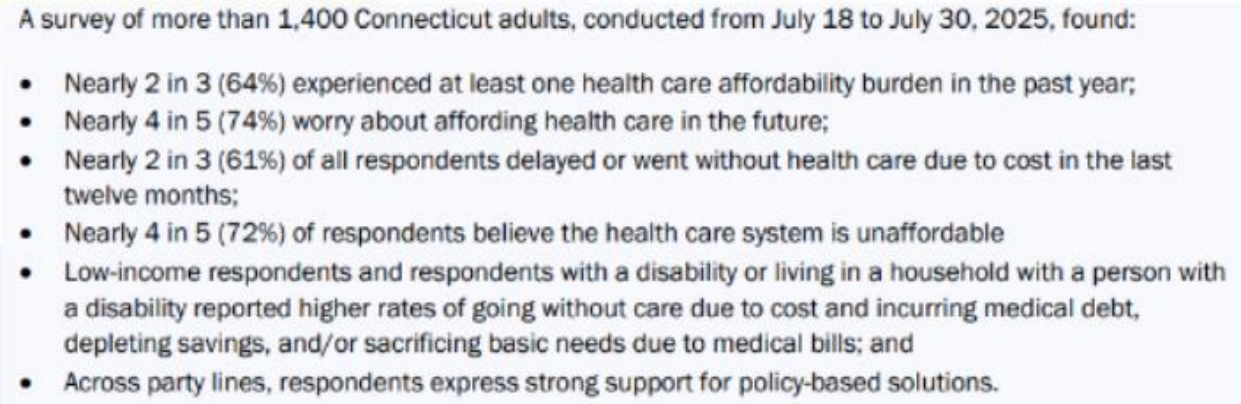


Reduce the proportion of people who can't get medical care when they need it — AHS-04. *https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/reduce-proportion-people-who-cant-get-medical-care-when-they-need-it-ahs-04/data*

An individual's overall health is influenced by the conditions of the environment in which they live in. According to the Office of Disease Prevention and Health Promotion, factors such as

safe housing, employment, income, transportation, access to nutritious foods, environmental hazards, and language and literacy skills all affect access to care, physical and mental health outcomes, and overall quality of life. As noted, in the housing and food insecurity domains, people living in poverty are housing burdened and face food insecurity due to inflation and the high cost of living. Focus group participants shared that they or someone they know have had to refuse certain medical procedures because of the cost and health insurance barriers.

Participants also reported that the health insurance process is complex, and individuals often do not know what their health insurance covers until they need a medical procedure. One participant shared that he had to cancel a colonoscopy appointment at UConn because the provider did not accept his insurance. Another participant explained that he had been seeing the same doctor for years and wanted to continue care, but his doctor no longer accepted his insurance. These individuals are living in poverty and cannot afford to pay for medical care out of pocket, creating additional barriers to maintaining their health. According to the 2025 Connecticut Consumer Healthcare Experience State Survey (Healthcare Value Hub, 2025), Nearly two in three adults (64% experience at least one health care affordability burden in the past year, and 61% delayed or went without needed medical care due to cost. Respondents reported skipping recommended tests, rationing medications and avoiding appointments because they could not afford them.


A survey of more than 1,400 Connecticut adults, conducted from July 18 to July 30, 2025, found:

- Nearly 2 in 3 (64%) experienced at least one health care affordability burden in the past year;
- Nearly 4 in 5 (74%) worry about affording health care in the future;
- Nearly 2 in 3 (61%) of all respondents delayed or went without health care due to cost in the last twelve months;
- Nearly 4 in 5 (72%) of respondents believe the health care system is unaffordable
- Low-income respondents and respondents with a disability or living in a household with a person with a disability reported higher rates of going without care due to cost and incurring medical debt, depleting savings, and/or sacrificing basic needs due to medical bills; and
- Across party lines, respondents express strong support for policy-based solutions.

Connecticut survey respondents struggle to afford high health care costs; worry about affording health care in the future; express bipartisan support for Policy Solutions – healthcare value hub. (2025). https://healthcarevaluehub.org/chess-state-survey/connecticut/2025/connecticut-survey-respondents-struggle-to-afford-high-health-care-costs-worry-about-affording-health-care-in-the-future-express-bipartisan-support-for-policy-solutions/

F.2c Resources and Service Gaps by Domain

What are the resources available in the agency and in the community that are used to help meet needs in this domain?
NOI case management staff assist customers with the application process for health insurance, scheduling medical appointments, and accompanying customers to doctor visit to provide translation support and help with completing paperwork. The Meriden site partnered with Hartford HealthCare, which sets up a mobile clinic once a month at the food pantry to offer free medical tests and screening to individuals in the community. Meriden also participates in the annual Medical Mission with Hartford HealthCare to engage customers and inform them about available services. The Torrington site partners with Hartford HealthCare's Neighborhood Clinic, which visits one to two times a month to provide free medical tests and screenings through a mobile clinic at the Torrington office. In August 2026, the Torrington office will host a dental clinic offering free dental services. Torrington also continues to provide the Mommy and Me class, offering parental support to non-English speaking mothers. The Waterbury site partners with Yale, which operates a weekly mobile clinic in the agency parking lot. Services include free health screenings, telehealth, prescriptions, blood draws and vaccines. The Yale mobile clinic also rotates weekly through different locations across Waterbury. Residents in Meriden, Torrington and Waterbury have access to hospital emergency services and walk-in urgent care for immediate non-emergency needs. Mobile clinics provide free medical services to individuals who are uninsured. Community Health and Wellness in Torrington, Hartford HealthCare and St. Mary's Hospital offer financial assistance programs for individuals with high medical balances who are unable to make payment due to limited income and other hardship.
What are the gaps in resources related to this domain area?
Although some medical facilities offer financial assistance for hardship cases, approval rates are low, and customers as well as program staff report that the application process is lengthy and requires extensive documentation. Transportation and financial barriers continue to prevent people living in poverty from purchasing prescriptions, and many are forced to skip or delay necessary treatment until conditions worsen and require emergency care. The agency do not have the ability to provide financial assistance for prescription or medical bills.

F.3 Identification of Needs by Domain and Level of Need

Based on the evidence from the analysis of the data collected, the following needs have been identified:

Domain Area 1: Housing				
	Need Statement	*Level of Need (F, A or C)*	*Location*	*Included in CAP? Y or N*
1	*Families are at risk of eviction*	*F*	*Meriden, Torrington, Waterbury*	*Y*
2	*Our community has limited affordable housing*	*C*	*Meriden, Torrington, Waterbury*	*N*

Domain Area 2: Food Insecurity				
	Need Statement	*Level of Need (F, A or C)*	*Location*	*Included in CAP? Y or N*
1	*Families cannot afford nutritious food*	*F*	*Meriden, Torrington, Waterbury*	*Y*

2	*Working families lack access to food or mobile pantry during work hours*	*C*	*Meriden, Torrington, Waterbury*	*N*

Domain Area 3: <u>Health Care Access</u>				
	Need Statement	*Level of Need* *(F, A or C)*	*Location*	*Included in CAP?* *Y or N*
1	*Families lack income to pay for medical care*	*F*	*Meriden, Torrington, Waterbury*	*N*
2	*Families lack affordable transportation for health care services*	*F*	*Meriden, Torrington, Waterbury*	*Y*
3	*Families do not understand what their health insurance covers*	*F*	*Meriden, Torrington, Waterbury*	*Y*
4	*There is a lack of community focus on preventative healthcare*	*C*	*Torrington*	*Y*

G. Next Steps

The findings from this Community Needs Assessment will guide NOI's next steps as the agency continues strengthening services across the catchment area. Sharing these results with stakeholders demonstrate that the time and insight they contributed are valued and will be used to inform program improvements, deepen community engagement and support future planning. This transparency helps build trust and encourages continued participation in future assessments.

NOI's RDP department will distribute the results to all service departments to support data informed decision making. Staff across the agency already provide strong support to their communities, and these findings will help departments refine outreach strategies, strengthen cross department collaboration and ensure customers receive comprehensive services.

RDP recognized gaps in both qualitative and quantitative data and is committed to expanding representation in future assessments. To address this, RDP will conduct additional focus groups designed to include populations that did not participate previously. Recruitment efforts will continue to promote focus groups through NOI's website, agency buildings and community partners to reach a broader cross section of the community.

The agency will also use the findings to identify areas where services delivery can be enhanced, where partnerships can be strengthened and where additional resources may be needed. As NOI prepares for the next assessment cycle, the agency will continue improving data collection methods, increasing community participation and ensuring that future reports reflect the diverse experiences and needs of all residents in the catchment area.

These next steps reinforces the agency's commitment to listening to the community, acting on the information shared and continuously improving services to meet the evolving needs of the individuals and families we serve.

H. Attachments

I. 2026 Community Need Assessment – Tool
II. 2026 Focus group questions – Tool
III. Low Income – 2026 Community Needs Assessment Final Result
IV. NOI Customer Satisfaction Survey – Tool
V. NOI Partnership Charts

I. 2026 Community Needs Assessment – Tool

NOI 2026 Community Needs Assessment Survey

As part of an effort to understand the barriers and challenges individuals and families face in their communities, NOI is asking you for your participation in completing our 2026 Community Needs Assessment survey, with the opportunity to enter a giveaway for a chance to win one of two **$50 gift cards**. NOI will be collecting surveys until March 27 and contact the giveaway winner in mid-April. Your opinions are of utmost importance and will be kept confidential. This survey will take 5 minutes for you to complete. Thank you for your time and support.

We kindly ask that all questions be completed, as incomplete responses will result in the survey being excluded from the final results and giveaway.

Select the top six services you think are the most important to prioritize within the community.

- ☐ **Adult Behavioral Health**
- ☐ **Affordable Housing**
- ☐ **Affordable Utility**
- ☐ **Assisted Living**
- ☐ **Before and After School Care**
- ☐ **Child Behavioral Health**
- ☐ **Food Security**
- ☐ **General Employment**
- ☐ **Health Care**
- ☐ **Infant/Toddler Day Care**
- ☐ **Mental Health Support**
- ☐ **Offender Re-entry Support**
- ☐ **Senior Housing**
- ☐ **Substance Use Support**
- ☐ **Transportation**

1. **EMPLOYMENT. What are the primary reasons employment is a challenge in your area? (select 3)**
   - ☐ Lack of jobs with better pay and benefits
   - ☐ Lack of skills to obtain jobs
   - ☐ Lack of affordable transportation to and from job
   - ☐ Lack of affordable childcare during work hours
   - ☐ People lack workforce values and readiness skills
   - ☐ Lack of employment resources in the community
   - ☐ Lack of jobs for ex-offenders reentering the workforce
   - ☐ Limited access to education or training
   - ☐ Discrimination or workplace bias
   - ☐ Other concerns (please specify): _____

2. **HEALTH. What are the main factors contributing to health concerns in this area? (select 3)**
   - ☐ Lack of community focus on preventative Healthcare
   - ☐ Lack of affordable transportation for health care services, grocery, and/or food pantries?
   - ☐ Lack of income to pay for adult dental, hearing and/or vision services
   - ☐ Lack of affordable comprehensive (or primary) health care services
   - ☐ Lack of health resources in the community
   - ☐ Lack of food and nutrition education
   - ☐ Lack of resources for victims of elderly abuse
   - ☐ Lack of resources for victims of domestic violence
   - ☐ Lack of affordable healthy food options
   - ☐ Lack of child behavioral health treatment program
   - ☐ Lack of adult behavioral health treatment program
   - ☐ Mental health support shortage
   - ☐ Substance use support shortage
   - ☐ Environmental pollution or unsafe living conditions
   - ☐ Other concerns (please specify): _____

3. **HOUSING. What are the primary factors contributing to housing challenges in this area? (select 3)**
   - ☐ Families need housing they can afford/lack of affordable housing
   - ☐ Lack of enough subsidized housing
   - ☐ High cost of rent
   - ☐ Families need housing repairs that reduce energy cost

☐ Lack of income based rental housing for disabled and seniors
☐ Lack of community support for homeless families
☐ Lack of available housing for ex-offenders
☐ Lack of senior housing
☐ High cost of utility bill
☐ Displacement due to development or gentrification
☐ Other concerns (please specify): _____

4. **CHILDCARE. What are the primary challenges affecting childcare in this area? (select 3)**
☐ Lack of affordable transportation to and from school
☐ Lack of high-quality childcare
☐ Lack of affordable childcare
☐ Lack of childcare space
☐ Lack of before and after school programs for adolescents
☐ Other concerns (please specify): _____

5. **FOOD SECURITY. What are the primary factors contributing to food insecurity in this area? (select 3)**
☐ Families struggle to find affordable food in their neighborhood
☐ Families often worry that they will run out of food before they can get more money to buy
☐ Families cannot afford to buy nutritious food
☐ Lack of transportation limits people food option
☐ Other concerns (please specify): _____

Basic Demographic Information

6. What is your role in the community? (Please select the best choice which fits your role)
☐New Opportunities Inc (NOI) customer/client/Resident
☐Faith Based Organization Representative (Church/Faith Based groups, clubs, councils, associations, etc.)
☐Community Organization/Partner (local service provider and non-profits)
☐Educational Institution Faculty/staff (local adult eds, schools, college, and universities)
☐Health Care Agencies (clinics, health departments, etc.)
☐Board Member of New Opportunities Inc. (NOI)
☐Staff or volunteer of New Opportunities Inc. (NOI)
☐Local Politician/Government/Public Sector Representative (non-profit, government regulated, funding sources, etc.)

7. In which county/town do you live or represent?
☐Torrington ☐Waterbury ☐Naugatuck ☐Meriden ☐Wallingford ☐Watertown
☐ Other (please specify): _____

8. What is the size of your household?
☐ 1 person ☐ 2 Persons ☐ 3 Persons ☐ 4 Persons 5 Persons ☐ 6 Persons
☐ Other (please specify): _____

9. What is your household income (annually)?
☐ $0-$20,000 ☐ $20,001-$30,000 ☐ $30,001-$40,000 ☐ $40,001-$50,000 ☐ $50,001-$60,000
☐ $60,001-$70,000 ☐ $70,001-$80,000 ☐ $80,001-$90,000 ☐ $90,001-$100,000 ☐ $100,001 or higher

10. How do you learn about things happening in your community? *Please select all that apply.*
☐ Television ☐ Radio ☐ Newspaper ☐ City government website ☐ Community newsletter
☐ Word-of-mouth ☐ Social media (Facebook, TickTok, X (Twitter), etc.) ☐ Other: _____

To enter the giveaway for a chance to win one of two $50 gift cards, complete the following information.

Name: _____

Phone Number: _____

Email Address: _____

We value your opinions. If you have any questions or concerns about this survey, please contact Shazia Husain at 203-575-4357 or via email at shusain@newoppinc.org. We thank you for your continued support and your participation in our 2026 Community Needs Assessment Survey.

II. 2026 Focus Group Questions – Tool

2026 Focus group questions

1. What are the top 3 biggest challenges or needs you or people in your community are currently facing?
    a. *Based on the group's discussion and common themes, probe questions will be asked to explore the impact and cause of the identify issue. The facilitator will sometime paraphrase the common themes to get clarity from the group.*
        i. *Example of probe question:*
            1. *Could you tell us more about….?*
            2. *What do you mean when you say….?*
            3. *What I am hearing from everyone is that ……? Am I correct?*
            4. *What makes that issue so hard for people here?*

2. What are some challenges people in your community are facing around housing?
    a. *Probe questions will be asked and the facilitator will paraphrase the common themes to get clarity from the group.*

3. What are some challenges people in your community are facing around food security?
    a. *Probe questions will be asked and the facilitator will paraphrase the common themes to get clarity from the group.*

4. What are the reasons employment is a challenge in your community?
    a. *Probe questions will be asked and the facilitator will paraphrase the common themes to get clarity from the group.*

5. What are the main factors contributing to health or mental health concerns in your community?
    a. *Probe questions will be asked and the facilitator will paraphrase the common themes to get clarity from the group.*

III. Low Income – 2026 Community Needs Assessment Final Result

NOI 2026 Community Needs Assessment Survey – Low Income

Background/Purpose: To capture the needs of low-income (125% FPL or below) individuals in New Opportunities Inc. (NOI) catchment area, the agency conducted a Community Needs Assessment survey. This survey was done anonymously in Spanish and English from February 2026 to March 2026. The survey included questions to identify specific needs within the community, individual's role within the community and simple demographic data. The demographic data is collected so that the agency can count how many of the survey participants are low-income. 222 individuals completed the survey. Out of the 222 individuals,136 were low-income.

Method: The survey was created by the RDP department. The survey was available in paper form and electronically through Survey Monkey, by using a QR code or weblink. Survey collection box was placed at all of the agency sites, and it was distributed through email to community partners and programs; and was posted on the agency's social media page. The Contract Compliance Manager collected the survey box at each location, entered the paper survey into Survey Monkey and completed the final report. The RDP team analyzed the results of the survey as a group.

Limitation: Only completed surveys were counted in the final result, this resulted in many surveys not being counted.

Results: Below are the results of the data gathered.

Select the top six services you think are the most important to prioritize within the community	
Answer Choices	**Total Responses**
Adult Behavioral Health	64/136 or 47%
Affordable Housing	90/136 or 66%
Affordable Utility	73/136 or 54%
Assisted Living	32/136 or 24%
Before and After School Care	53/136 or 39%
Child Behavioral Health	41/136 or 30%
Food Security	76/136 or 56%
General Employment	73/136 or 54%
Health Care	91/136 or 67%
Infant/Toddler Day Care	48/136 or 35%
Mental Health Support	66/136 or 49%
Offender Re-entry Support	15/136 or 11%
Senior Housing	55/136 or 40%
Substance Use Support	33/136 or 24%
Transportation	63/136 or 46%

EMPLOYMENT. What are the primary reasons employment is a challenge in your area? (select 3)	
Answer Choices	**Total Responses**
Lack of jobs with better pay and benefits	89/136 or 65%
Lack of skills to obtain jobs	50/136 or 37%
Lack of affordable transportation to and from job	67/136 or 49%
Lack of affordable childcare during work hours	58/136 or 43%
People lack workforce values and readiness skills	27/136 or 20%
Lack of employment resources in the community	46/136 or 34%
Lack of jobs for ex-offenders reentering the workforce	21/136 or 15%
Limited access to education or training	29/136 or 21%
Discrimination or workplace bias	40/136 or 29%
Other concerns (please specify)	• Disability rules • Disabled • Always relying on the internet for applications • Babysitter • Sometimes, they don't hire you for no reason. • Excessive and confusing paperwork to get a job.

HEALTH. What are the main factors contributing to health concerns in this area? (select 3)	
Answer Choices	**Total Responses**
Lack of community focus on preventative Healthcare	49/136 or 36%
Lack of affordable transportation for health care services, grocery, and/or food pantries?	61/136 or 45%
Lack of income to pay for adult dental, hearing and/or vision services	77/136 or 47%
Lack of affordable comprehensive (or primary) health care services	37/136 or 27%
Lack of health resources in the community	36/136 or 26%
Lack of food and nutrition education	40/136 or 29%
Lack of resources for victims of elderly abuse	18/136 or 13%
Lack of resources for victims of domestic violence	18/136 or 13%
Lack of affordable healthy food options	40/136 or 29%
Lack of child behavioral health treatment program	11/136 or 8%
Lack of adult behavioral health treatment program	11/136 or 8%
Mental health support shortage	33/136 or 24%
Substance use support shortage	13/136 or 10%
Environmental pollution or unsafe living conditions	12/136 or 9%
Other concerns (please specify)	• Love, going that extra yard • Ask qualified health provider to give out information • Lack of physical fitness programs for communities

HOUSING. What are the primary factors contributing to housing challenges in this area? (select 3)	
Answer Choices	**Total Responses**
Families need housing they can afford/lack of affordable housing	87/136 or 64%
Lack of enough subsidized housing	53/136 or 39%
High cost of rent	109/136 or 80%
Families need housing repairs that reduce energy cost	30/136 or 22%
Lack of income based rental housing for disabled and seniors	64/136 or 47%
Lack of community support for homeless families	39/136 or 29%
Lack of available housing for ex-offenders	11/136 or 8%
Lack of senior housing	16/136 or 12%

High cost of utility bill	52/136 or 38%
Displacement due to development or gentrification	10/136 or 7%
Other concerns (please specify)	• Integration into community participation

CHILDCARE. What are the primary challenges affecting childcare in this area? (select 3)	
Answer Choices	**Total Responses**
Lack of affordable transportation to and from school	69/136 or 51%
Lack of high-quality childcare	81/136 or 60%
Lack of affordable childcare	92/136 or 68%
Lack of childcare space	58/136 or 43%
Lack of before and after school programs for adolescents	103/136 or 76%
Other concerns (please specify)	• ALL OF THE ABOVE OPTIONS & AGE Restrictions. NO Before & Aftercare for HeadStart for a "normal" 9-5 Job • Opportunity for any age the daycare • Maintain trust with parents to demonstrate that you are a responsible and caring person. • Flexible scheduling

FOOD SECURITY. What are the primary factors contributing to food insecurity in this area? (select 3)	
Answer Choices	**Total Responses**
Families struggle to find affordable food in their neighborhood	77/136 or 57%
Families often worry that they will run out of food before they can get more money to buy	74/136 or 54%
Families cannot afford to buy nutritious food	74/136 or 54%
Lack of transportation limits people food option	46/136 or 38%
Other concerns (please specify)	• Lack of resources from the government • Nutritionists and dieticians can do more to

	explain how fruit, veggies, lean meat, etc. benefit us • ALL of the Above- Food waste due to stores also not following FIFO (expiration dates) ingredients used in foods, causes illnesses • Very expensive food

What is your role in the community? (Please select the best choice which fits your role)	
Answer Choices	**Total Responses**
New Opportunities Inc (NOI) customer/client/Resident	88/136 or 65%
Faith Based Organization Representative (Church/Faith Based groups, clubs, councils, associations, etc.)	17/136 or 13%
Community Organization/Partner (local service provider and non-profits)	11/136 or 8%
Educational Institution Faculty/staff (local adult eds, schools, college, and universities)	19/136 or 14%
Health Care Agencies (clinics, health departments, etc.)	19/136 or 14%
Board Member of New Opportunities Inc. (NOI)	9/136 or 7%
Staff or volunteer of New Opportunities Inc. (NOI)	27/136 or 20%
Local Politician/Government/Public Sector Representative (non-profit, government regulated, funding sources, etc.)	8/136 or 5%

In which county/town do you live or represent?	
Answer Choices	**Total Responses**
Torrington	49/136 or 36%
Waterbury	57/136 or 42%
Naugatuck	2/136 or 1%
Meriden	19/136 or 14%
Wallingford	3/136 or 2%
Watertown	5/136 or 4%
Other (please specify)	• Litchfield county

What is the size of your household?	
Answer Choices	**Total Responses**
1 person	25/136 or 18%

2 Persons	32/136 or 24%
3 Persons	34/136 or 25%
4 Persons	23/136 or 17%
5 Persons	14/136 or 10%
6 Persons	6/136 or 4%
Other (please specify)	7 Person

What is your household income (annually)?	
Answer Choices	**Total Responses**
$0-$20,000	87/136 or 64%
$20,001-$30,000	35/136 or 26%
$30,001-$40,000	10/136 or 7%
$40,001-$50,000	3/136 or 2%
$50,001-$60,000	0/136 or 0%
$60,001-$70,000	0/136 or 0%
$70,001-$80,000	0/136 or 0%
$80,001-$90,000	0/136 or 0%
$90,001-$100,000	0/136 or 0%
$100,001 or higher	0/136 or 0%

How do you learn about things happening in your community? Please select all that apply.	
Answer Choices	**Total Responses**
Television	42/136 or 31%
Radio	14/136 or 10%
Newspaper	24/136 or 18%
City government website	20/136 or 15%
Community newsletter	30/136 or 22%
Word-of-mouth	59/136 or 43%
Social media (Facebook, TikTok, X (Twitter), etc.)	88/136 or 65%
Other	• 211ct.org

IV. NOI Customer Satisfaction Survey – Tool

Customer Satisfaction Survey

As part of an effort to know how Community Action Agencies are addressing your interests and needs, this survey has been prepared to get your opinions about service delivery, access and impact. The survey will take 15 minutes for you to complete and your opinions will remain confidential. Thank you very much for your support.

Background Information – Please Check for Gender, Ethnicity/Race and Age

Gender: ___ Male ___ Female

Ethnicity/Race: ___ Black/Not Hispanic ___ White/Not Hispanic ___ Hispanic Origin
___ Native American/Alaskan ___ Asian/Pacific Islander ___ Other

Age: ___ 18-23 ___ 24-44 ___ 45-54 ___ 55-69 ___ 70+

Delivery – Please Underline the Rating that Most Reflects Your Opinion

1. The staff was prompt in responding to my concerns:
   Strongly Agree Agree Undecided Disagree Strongly Disagree

2. The staff was cooperative in working with me:
   Strongly Agree Agree Undecided Disagree Strongly Disagree

3. The staff addressed my issues and concerns:
   Strongly Agree Agree Undecided Disagree Strongly Disagree

4. The staff explained program eligibility and guidelines:
   Strongly Agree Agree Undecided Disagree Strongly Disagree

Access – Please Underline the Rating that Most Reflects Your Opinion

1. The office hours and days for the service were sufficient:
   Strongly Agree Agree Undecided Disagree Strongly Disagree

2. The location, parking and accommodations for the service were convenient:
   Strongly Agree Agree Undecided Disagree Strongly Disagree

3. The telephone assistance for the service was timely and courteous:
   Strongly Agree Agree Undecided Disagree Strongly Disagree

Impact – Please Underline the Rating that Most Reflects Your Opinion

1. The service helped me to become more self-sufficient:
   Strongly Agree Agree Undecided Disagree Strongly Disagree

2. The service improved the conditions in which I live:
   Strongly Agree Agree Undecided Disagree Strongly Disagree

3. The service increased my involvement in the community:
   Strongly Agree Agree Undecided Disagree Strongly Disagree

4. The service assisted me by strengthening family and other support systems:
   Strongly Agree Agree Undecided Disagree Strongly Disagree

V. NOI Partnership Chart

Community Action Agency (CAA)
Partnerships Charts

As part of the CT COE CSBG Organizational Standards review process, the following charts are to be completed and submitted back to your program representative at DSS via secure file directory. These charts present the agency's formal and informal partnerships and shall be utilized to demonstrate compliance with the following CT Center of Excellence (COE) Developed Community Services Block Grant (CSBG) Organizational Standard: 2.1.

Partnership Charts Instructions:

Formal Partnership Chart

1) Enter agency name and document submission date.
2) List the organizations which the agency maintains a formal relationship (i.e., has an established Memorandum of Understanding/Agreement). Indicate specifically identified purpose per CSBG Organizational Standard 2.1: The organization has documented or demonstrated partnerships across the community, for specifically identified purposes; partnerships include other anti-poverty organizations in the area (Maximum Feasible Participation – Category 2: Community Engagement).

Informal Partnership Chart

3) Enter agency name and document submission date.
4) List the organizations which the agency works in partnership with no formal Memorandum of Understanding/Agreement in place. Indicate specifically identified purpose per CSBG Organizational Standard 2.1as written in no. 2) above.

Community Action Agency (CAA)
Partnerships Charts

Formal Partnership Chart

Agency Name:	New Opportunities Inc.
Submission Date:	5/2026

Please list all organizations which the agency maintains a **formal** partnership (i.e., have an established Memorandum of Understanding/Agreement [MOU/A).

	Partner's Name	**Specifically Identified Purpose** (CSBG Organizational Standard 2.1)
1.	Acts 4 Ministry	Community Engagement And Collaboration
2.	Brass City Charter School	Senior Volunteer Station – Education
3.	Bridge To Success	Community Engagement And Collaboration
4.	Children's Community School	Senior Volunteer Station – Education
5.	Ct Food Share	Collaboration For Food Security
6.	Early Childhood Alliance	Community Engagement And Collaboration
7.	Easterseals Children's Academy-East Campus	Community Engagement And Collaboration
8	Easterseals Children's Academy-West Campus	Community Engagement And Collaboration
9.	Housing Collective	Community Engagement And Collaboration
10.	La Casa Hispanic Coalition	Community Engagement And Collaboration
11.	LEAD-Latinos For Educational Advocacy	Community Engagement And Collaboration
12.	LISC	Community Engagement And Collaboration
13.	Meals On Wheels America	Community Engagement, Advocacy, Best Practice
14.	National Association For Education Of Young Children	Community Engagement, Advocacy, Best Practice
15.	National Association Of Nutrition And Aging Services Programs	Community Engagement, Advocacy, Best Practice
16.	Osterman Community Foundation	Community Engagement, Advocacy, Best Practice
17.	Re-Entry Center	Community Engagement And Collaboration

18.	The Diaper Bank Of CT	Community Engagement And Collaboration
19.	United Way-Waterbury	Community Engagement, Collaboration And Advocacy
20.	Western CT Area Agency On Aging	Senior Volunteer Station
21.	Our Lady Of Mt Carmel School	Senior Volunteer Station
22.	Our Lady Of Mt Carmel Little Saints Daycare	Senior Volunteer Station
23.	Hapeville Food Pantry	Community Engagement And Collaboration
24.	Catholic Academy Of Waterbury	Senior Volunteer Station
25.	City Of Waterbury BOE	Community Engagement, Collaboration And Advocacy
26.	Silas Bronson Library	Community Engagement And Collaboration
27.	Sullivan Senior Center	Senior Volunteer Station And Energy Assistance Intake Site
28.	Naugatuck Senior Center	Community Engagement And Collaboration
29.	CT OEC	Community Engagement And Collaboration
30.	Waterbury Early Start	Community Engagement And Collaboration
31.	Early Start CT	Community Engagement And Collaboration
32.	DCF Meriden	Community Engagement, Collaboration And Advocacy
33.	DCF New Britain	Community Engagement, Collaboration And Advocacy
34.	UnitedCT	Community Engagement And Collaboration
35.	Department Of Aging And Disability Services	Community Engagement, Collaboration And Advocacy
36.	Geer	Community Engagement And Collaboration
37.	VITA	Community Engagement And Collaboration
38.	HUD	Community Engagement And Collaboration
39.	Safety Aspects LLC (Osha Training)	Community Engagement And Collaboration
40.	Prospect Towers	Community Engagement And Collaboration
41.	Trios Community Meals	Senior Dine Meal Provider
42.	Amalfi's Restaurant	Senior Dine Meal Provider
43.	Montieros Restaurant	Senior Dine Meal Provider

44.	Nick's Country Kitchen Restaurant	Senior Dine Meal Provider
45.	Pabas Restaurant	Senior Dine Meal Provider
46.	Galyes Farm Shoppe Restaurant	Senior Dine Meal Provider
47.	Seven Villages Restaurant	Senior Dine Meal Provider
48.	CattMatt	Collaboration
49.	Medical Billing of CT	Collaboration
50.	Rotella Arts magnet school	Senior Volunteer Station – Education
51.	B.W. Tinker Elementary School	Senior Volunteer Station – Education
52.	James Morris School	Senior Volunteer Station – Education
53.	John G. Gilmartin Elementary School	Senior Volunteer Station – Education
54.	Hopbrook School	Senior Volunteer Station – Education
55.	Goshen center School	Senior Volunteer Station – Education
56.	John G. Gilmartin Elementary School	Senior Volunteer Station – Education
57.	John Trumbull Primary School	Senior Volunteer Station – Education
58.	Long Meadow Elementary School	Senior Volunteer Station – Education
59.	Middlebury Elementary School	Senior Volunteer Station – Education
60.	Maple Hill School	Senior Volunteer Station – Education
61.	N. Canaan Elementary School	Senior Volunteer Station – Education
62.	Polk Elementary School	Senior Volunteer Station – Education
63.	Pomperaug Elementary School	Senior Volunteer Station – Education
64.	Regan Elementary School	Senior Volunteer Station – Education
65.	Salem School	Senior Volunteer Station – Education
66.	Torrington Public Schools	Senior Volunteer Station – Education

67.	Wakelee Elementary School	Senior Volunteer Station – Education
68.	Western Elementary	Senior Volunteer Station – Education
69.	Woodrow Wilson Elementary School	Senior Volunteer Station – Education
70.	UCONN University	Collaboration
71.	Community Care Team	Community Engagement And Collaboration
72.	Stay Well Health Center Waterbury	Community Engagement And Collaboration
73.	Staywell Harm Reduction	Community Engagement And Collaboration
74.	Yale InMotion Health Clinic & Mobile Pharmacy	Community Engagement And Collaboration
75.	Area Cooperative Educational Services (ACES)	Community Engagement And Collaboration
76.	The governor Prevention Partnership	Community Engagement And Collaboration
77.	CT Fatherhood Initiative Program	Community Engagement And Collaboration
78.	Magnolia Meals	Community Engagement And Collaboration
79.	Judy Prager, RD, Well Fed CT	Community Engagement And Collaboration
80.	CCEH	Community Engagement And Collaboration
81.	ACES Whitney Academy	Collaboration – Job Readiness Training/Preparation For Youth
82.	Achievement First Hartford HS	Collaboration – Job Readiness Training/Preparation For Youth
83.	Bassick	Collaboration – Job Readiness Training/Preparation For Youth
84.	Branford HS	Collaboration – Job Readiness Training/Preparation For Youth
85.	Bridge Academy	Collaboration – Job Readiness Training/Preparation For Youth
86.	Bridgeport Learning Center	Collaboration – Job Readiness Training/Preparation For Youth
87.	Bridgeport Transition Academy	Collaboration – Job Readiness Training/Preparation For Youth
88.	Bristol Transition	Collaboration – Job Readiness Training/Preparation For Youth
89.	Brookfield HS	Collaboration – Job Readiness Training/Preparation For Youth
90.	Bullard Havens	Collaboration – Job Readiness Training/Preparation For Youth

91.	Central HS	Collaboration – Job Readiness Training/Preparation For Youth
92.	Coginchaug Regional HS	Collaboration – Job Readiness Training/Preparation For Youth
93.	Danbury High School	Collaboration – Job Readiness Training/Preparation For Youth
94.	Hamden Transition Academy	Collaboration – Job Readiness Training/Preparation For Youth
95.	Harding	Collaboration – Job Readiness Training/Preparation For Youth
96.	Highlander Transition Academy	Collaboration – Job Readiness Training/Preparation For Youth
97.	Kinsella Magnet HS	Collaboration – Job Readiness Training/Preparation For Youth
98.	Lyman Hall	Collaboration – Job Readiness Training/Preparation For Youth
99.	Newington Transition Academy	Collaboration – Job Readiness Training/Preparation For Youth
100.	Orville Platt HS	Collaboration – Job Readiness Training/Preparation For Youth
101.	Shepaug Transition	Collaboration – Job Readiness Training/Preparation For Youth
102.	Strides	Collaboration – Job Readiness Training/Preparation For Youth
103.	Warren Harding HS	Collaboration – Job Readiness Training/Preparation For Youth
104.	Watertown HS	Collaboration – Job Readiness Training/Preparation For Youth
105.	Wilcox Tech	Collaboration – Job Readiness Training/Preparation For Youth
106.	Karen Smith Academy	Collaboration – Job Readiness Training/Preparation For Youth
107.	Hamden Collaborative Center	Collaboration – Job Readiness Training/Preparation For Youth
108.	Quinnipiac University Transition Program	Collaboration – Job Readiness Training/Preparation For Youth
109.	The Academy - Danbury	Collaboration – Job Readiness Training/Preparation For Youth
110.	Hartford HHS Step Program	Collaboration – Job Readiness Training/Preparation For Youth
111.	A.I. Prince Technical HS	Collaboration – Job Readiness Training/Preparation For Youth
112.	Solterra Academy	Collaboration – Job Readiness Training/Preparation For Youth
113.	Hartford Public HS	Collaboration – Job Readiness Training/Preparation For Youth
114.	211	Collaboration, Referral
115.	CT Department of Rehabilitation Services	Community Engagement, Best Practice, Advocate
116.	CT Department of Social Services	Community Engagement, Best Practice, Advocate
117.	CT Department of Correction	Community Engagement, Best Practice, Advocate

119.	CT Department of Disability Services	Community Engagement, Best Practice, Advocate
120.	CT Department of Housing	Community Engagement, Best Practice, Advocate
121.	Project Longevity	Community Engagement, Best Practice, Advocate

Informal Partnership Chart

Agency Name:	New Opportunities, Inc.
Submission Date:	5/2026

Please list all organizations which the agency partners with but has **no** Memorandum of Understanding/Agreement (MOU/A).

	Partner's Name	**Specifically Identified Purpose** (CSBG Organizational Standard 2.1)
1.	Afro Caribbean Cultural Center	Community Engagement
2.	B.A.G.S Foundation	Community Engagement
3.	Beat The Street	Community Engagement
4.	Boys & Girls Club	Community Engagement
5.	Catholic Charities of Waterbury - Food Pantry	Community Engagement, Food Security
6.	Center for Human Development - Conn. Outreach West	Community Engagement, Referral
7.	Center for Renewal	Community Engagement
8	Center for Youth and Family	Community Engagement
9.	CHD-Hospitality Center	Community Engagement, Referral
10.	Chrysalis Center Inc.	Community Engagement
11.	Columbus House Inc	Community Engagement
12.	Community Partners in Action	Community Engagement
13.	Connecticut Community Foundation	Community Engagement

14.	CT Association for Education of Young Children	Community Engagement
15.	CT Junior Republic	Community Engagement
16.	CT Legal Services	Community Engagement
17.	EdAdvance	Community Engagement, Referral
18.	EMERGE-CT	Community Engagement
19.	Fathers In Education	Community Engagement
20.	FISH of NW CT	Community Engagement, Referral
21.	Food For Friends Food Pantry	Community Engagement, Referral, Food Security
22.	CAFCA	Collaboration, Advocacy, Beast Practice
23.	Gathering Place for Homeless	Community Engagement, Referral
24.	Grace House	Community Engagement
25.	GWIM Soup Kitchen	Community Engagement, Food Security
26.	Hands of Grace	Community Engagement, Food Security
27.	Hispanic Coalition	Community Engagement
28.	Immigration Service (International Institute)	Community Engagement
29.	Independence Northwest (INW)	Community Engagement
30.	Kelly's Kids	Community Engagement
31.	Kids place	Community Engagement
32.	Literacy Volunteers	Community Engagement And Collaboration
33.	Marrakech Inc.	Community Engagement
34.	MASC	Community Engagement
35.	Mattatuck Museum	Community Engagement And Collaboration
36.	Mercy Housing and Shelter Corp	Community Engagement
37.	Meriden Women and Families Center	Community Engagement
38.	Morris Senior Center	Community Engagement
39.	Mt Olive Senior Center	Community Engagement

40.	MY People community services	Community Engagement
41.	NAACP (CT)	Community Engagement
42.	New Reach	Community Engagement
43.	NWCT YMCA	Community Engagement
44.	Open Door Soup Kitchen	Community Engagement, Food Security
45.	PAL – Waterbury	Community Engagement
46.	PAL – Torrington	Community Engagement
47.	PAL – Meriden	Community Engagement
48.	Prime Time	Community Engagement
49.	Public Health Prevention Outreach Services	Community Engagement
50.	Reality Based Services	Community Engagement
51.	RIBA ASPIRA	Community Engagement
52.	Safe Haven	Community Engagement
53.	Salvation Army	Community Engagement
54.	Spanish Community of Wallingford	Community Engagement
55.	St. Vincent DePaul	Community Engagement, Referral
56.	Susan B Anthony	Community Engagement
57.	The Connection - Eddy Center	Community Engagement
58.	The Village	Community Engagement
59.	The Work Place	Community Engagement
60.	Torrington Affordable Housing	Community Engagement
61.	Torrington Historical Society	Community Engagement
62.	Torrington Soup Kitchen	Community Engagement
63.	Torrington The Women and Girls Fund	Community Engagement
64.	Torrington Youth Bureau	Community Engagement

65.	Torrington Youth Opportunities	Community Engagement
66.	United Way-Torrington	Community Engagement, Referral
67.	United Way-Meriden	Community Engagement, Referral
68.	United Way-Waterbury	Community Engagement, Referral
69.	Wallingford Emergency Shelter	Community Engagement
70.	Wallingford Senior Center	Community Engagement
71.	Warner T	Community Engagement
72.	Waterbury Re-entry Welcome Center	Community Engagement
73.	Waterbury Youth Service	Community Engagement
74.	YMCA	Community Engagement
75.	APEX community care	Community Engagement
76.	Waterbury Worship	Community Engagement
77.	Waterbury Baptist	Community Engagement
78.	Trinity Church	Community Engagement
79.	The Heart Church	Community Engagement
80.	Meriden Minister's Alliance	Community Engagement
81.	Grace Baptist Church	Community Engagement
82.	God Provides Ministries	Community Engagement, Referral
83.	First Christian Charismatic Church	Community Engagement
84.	Blessed Sacrament School	Community Engagement
85.	AME ZION Church Torrington	Community Engagement
86.	Center for Youth and Family	Community Engagement
87.	City of Waterbury	Community Engagement
88.	City of Waterbury Public Library	Community Engagement, Outreach
89.	Meriden Library	Community Engagement, Outreach
90.	New Britain City Hall	Community Engagement

91.	Torrington Board of Education	Community Engagement
92.	Torrington Health Department	Community Engagement
93.	Waterbury Department of Public Health	Community Engagement
94.	Waterbury Local Prevention Center	Community Engagement
95.	Middlebury Senior Center	Community Engagement
96.	Waterbury Senior Center	Community Engagement
97.	Winsted Senior Center	Community Engagement
98.	Birth to Three	Community Engagement
99.	CT Dept. of Education	Community Engagement
100.	Care 4 Kids	Community Engagement
101.	DCF Hartford	Community Engagement
102.	DCF Manchester	Community Engagement
103.	DCF Torrington	Community Engagement
104.	New Britain Court	Community Engagement
105.	Meriden Court	Community Engagement
106.	State of CT Public Defender Division	Community Engagement
107.	CT Dept of Aging Services	Community Engagement
108.	Waterbury Housing Authority	Community Engagement
109.	Project Safe Neighborhood	Community Engagement
110.	American Job Corp	Community Engagement
111.	FEMA	Community Engagement
112.	Torrington Y Limited Partnership	Community Engagement
113.	Stokes Counseling Services	Community Engagement
114.	Buzzutos Inc.	Community Engagement, Referral
115.	Kings Catering LLC	Community Engagement, Referral

116.	Greater Waterbury Chamber of Commerce	Community Engagement
117.	Waterbury Regional Chamber	Community Engagement
118.	Bucks Hill School	Community Engagement
119.	Waterbury School District	Community Engagement
120.	Waterbury Adult Ed	Community Engagement
121.	Northwestern Community College	Community Engagement
122.	Clearing House	Community Engagement
123.	M & T Bank	Collaboration – Financial Service
124.	Thomaston Saving Bank	Collaboration – Financial Service
125.	Alzheimer's Association Connecticut Chapter	Community Engagement
126.	Birthright of Greater Meriden	Community Engagement
127.	CCAR	Community Engagement
128.	Charlotte Hungerford Hospital Beh. Health Center	Community Engagement
129.	Charlotte Hungerford Hospital-Torrington	Community Engagement
130.	Community Health and Wellness	Community Engagement
131.	Community Health Center Inc. (CHC)	Community Engagement
132.	Community Health Center, Inc.-Meriden	Community Engagement
133.	Community Health Center, Inc.-Torrington	Community Engagement
134.	Community Health Center, Inc.-Waterbury	Community Engagement
135.	CT Community Care Inc	Community Engagement
136.	Gilead Community Services	Community Engagement
137.	Hartford Health Care	Community Engagement

138.	McCall Center for Behavior	Community Engagement
139.	McCall Foundation	Community Engagement
140.	Mental Health Association of CT	Community Engagement
141.	Mental health of CT-Torrington	Community Engagement
142.	Mental health of CT-Waterbury	Community Engagement
143.	Meriden/Wallingford Substance Abuse Committee (MWSAC)	Community Engagement
144.	River Valley Services	Community Engagement
145.	Rushford Center Inc	Community Engagement
146.	St. Mary's Hospital	Community Engagement
147.	Staywell Health Community Care Team	Community Engagement
148.	Waterbury Hospital	Community Engagement
149.	Wellmore	Community Engagement
150.	Western Connecticut Mental Health Network	Community Engagement
151.	Wheeler Clinic-Meriden	Community Engagement
152.	Wheeler Clinic-Waterbury	Community Engagement
153.	Connecticut Child Day Care Director's Forum	Community Engagement
154.	ECE Workforce Committee	Community Engagement
155.	Women in Leadership Program at The University of New Haven	Community Engagement
156.	American Job Center	Community Engagement
157.	InSTRIDE Community Advisory Board	Community Engagement
158.	The Housing Collective	Collaboration

159.	4-CT	Collaboration
160.	Advancing CT	Community Engagement
161.	Advocacy Unlimited	Community Engagement
162.	American Mural Project	Community Engagement
163.	American Red Cross	Collaboration
164.	Associates for Trainings and Development	Community Engagement
165.	Calendar House	Community Engagement
166.	Casa Boricua	Community Engagement
167.	Children First Initiative - City of Meriden	Community Engagement
168.	City Mission	Collaboration
169.	City Mission of Meriden	Collaboration
170.	Community Solutions, Inc.	Community Engagement
171.	Community Tabernacle	Community Engagement
172.	Connecticut Family Support Network	Community Engagement
173.	Connecticut Humanities	Community Engagement
174.	Connecticut Institute for Refugees and Immigrants	Community Engagement
175.	Archdiocese of Hartford	Community Engagement
176.	Barkhamsted Town Hall	Collaboration
177.	Berlin Senior Center	Community Engagement
178.	Bethlehem Town Clerks Office	Collaboration
179.	Borough of Naugatuck	Collaboration
180.	Cheshire Senior Center	Collaboration
181.	City of Meriden	Collaboration
182.	Colebrook Town Hall	Collaboration
183.	Administration for Children and Families - OCS	Collaboration

184.	Care 4 Kids	Collaboration
185.	Connecticut Department of Agriculture	Collaboration
186.	Connecticut Department Public Health	Collaboration
187.	Connecticut Early Childhood Alliance	Collaboration
188.	Senior Service Corps Association	Collaboration
189.	American Job Corp	Community Engagement, Referral
190.	AmeriCorps	Community Engagement
191.	Birth to Three	Community Engagement, Referral
192.	Child and Adult Care Food Program	Collaboration
193.	Connecticut Office of Early Childhood	Collaboration
194.	Adams	Collaboration
195.	ALDI	Collaboration
196.	AMC Taxes	Collaboration
197.	American Savings Foundation	Collaboration
198.	Ameriprise	Collaboration
199.	Annoulas	Collaboration
200.	Aquarion Water Company	Collaboration
201.	Biglots	Collaboration
202.	Blasius Kia	Collaboration
203.	Borghesi	Collaboration
204.	Carabetta Management	Community Engagement, Referral
205.	Carmody Torrance Sandak Hennessey LLP	Collaboration
206.	Administration of Community Living	Collaboration
207.	Alliance CT General Grants	Collaboration

208.	Alliance for Children	Collaboration
209.	American Job Center Providers Committee (Meriden)	Community Engagement, Referral
210.	Annie Casey-Recruitment Meeting	Collaboration
211.	ASAP Sumer Programs Committee	Collaboration
212.	Care For Kids Advisory Council	Collaboration
213.	Connecticut Association of Non-Profits	Collaboration
214.	Connecticut Child Day Care Director's Forum	Collaboration
215.	Alcott School	Collaboration
216.	Andrew Avenue School	Collaboration
217.	Blessed Sacrament School	Collaboration
218.	Catholic Academy of Waterbury	Collaboration
219.	CCSU New Britain Special Education Department	Collaboration
220.	Cheshire High School	Collaboration
221.	ACES Professional Development and School Improvement	Collaboration
222.	Bank of America	Collaboration
223.	Centerville Bank	Collaboration
224.	A&B Homecare Solutions	Collaboration
225.	Alzheimer's Association	Collaboration
226.	American Dietetic Association & Ct. Dietetic Association	Collaboration
227.	Association of Asthma Educators	Collaboration

228.	Broker Memorial	Collaboration
229.	Care Transitions LLP	Collaboration
230.	CCAR	Collaboration
231.	Central CT Area Health Education Center	Collaboration
232.	City of Meriden Health Dept, FD, PD, Housing, Senior Center,	Collaboration
233.	Connecticut Counseling Methadone Clinic	Collaboration
234.	Connecticut Harm Reduction	Collaboration
235.	Connecticut Health Foundation	Collaboration
236.	Connecticut Coalition Against Domestic Violence	Collaboration
237.	Connecticut Housing Coalition	Collaboration
238.	Waterbury YMCA	Collaboration
239.	American Savings Foundation	Collaboration
240.	CT Harm Reduction	Collaboration
241.	CT Health Foundation	Collaboration
242.	Department of Correction	Collaboration
243.	Griffin Health Hospital	Collaboration
244.	James H. Napier Foundation	Collaboration
245.	Josephine Towers	Community Engagement, Referral
246.	KeyBank Foundation	Collaboration
247.	LaBonne's Market	Collaboration
248.	Palace Theater	Collaboration
249.	Plaza on the Green	Collaboration
250.	QPR Institute	Collaboration
251.	Spirit Cafe	Collaboration

252.	Torrington Latinas Women Association	Collaboration
253.	Unite Us	Collaboration
254.	Waterbury Garden Club	Collaboration
255.	Waterbury Heart Center	Collaboration
256.	Watertown Meat Market	Collaboration
257.	Watertown Social Service	Collaboration
258.	Winsted Salvation Army	Collaboration
259.	Meriden Rotary Club	Collaboration

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