Data-Powered: Paving the Way for Meaningful Impact

Coming Home of Middlesex County Annual Report 2022-23

COMING HOME

Ending Homelessness in Middlesex County

Company Overview

Who We Are

- Established in 2012, Coming Home leads efforts in the County to end homelessness by uniting key stakeholders such as affordable housing developers, municipalities, employment services, financiers, philanthropists, health and social service providers, educators, and individuals experiencing homelessness and fostering collaboration to eliminate barriers to stable housing.
- Coming Home plays a crucial role in managing the Homeless Management Information System (HMIS) in Middlesex County. The organization also oversees the county-wide Coordinated Entry and Assessment program, ensuring consistent assessment and prioritization of homeless individuals' daily needs. By providing real-time data on homelessness and its underlying causes, Coming Home enables the development of effective planning and targeted intervention strategies.

Mission

- Our Mission is to create a system to end homelessness.
- At Coming Home, we aim to build a system that prevents, and ultimately ends, homelessness in Middlesex County. We are dedicated to achieving this mission by nurturing collaborations and forging public-private partnerships among all stakeholders. Our collective aim is to ensure that every individual has a stable place to call home and access to community resources, empowering them with choices and opportunities to pursue healthy lifestyles.

Contents

Letter from the Executive Director & Chairman of the Board

Eileen O'Donnell, JD, MPP, MSW
Executive Director

Jamie Schleck
Chairman of the Board of Directors

"The insights gained, and the successes achieved in 2022 and 2023 have been invaluable. They underscore the critical need to persist in our community collaborations, expand our use of data-driven decision-making, and initiate strategies that significantly reduce the duration of homelessness."

Dear Friends and Supporters:

As we present our Annual Report for the years 2022 and 2023, we reflect on our continued efforts to dismantle the barriers to stable housing and the challenges that lead to homelessness in Middlesex County. Building on the foundation set in our previous report, "Unmasking Homelessness," we have expanded our strategic initiatives, adapting to the evolving landscape of challenges that persist in our community.

These past two years have been a testament to our adaptive strategies and the deepening of our commitment to eliminating homelessness. Through our ongoing work with Community Solutions: Built for Zero (BFZ) initiative, the introduction of the Data Driven Decision Making Organizational Change Program (3DM-OCP), and the expansion of Coordinated Entry through Physical Access sites, we have tailored our resources to better meet the diverse needs of those we serve.

Our targeted demographic analysis has continued to reveal significant engagement with the most vulnerable populations, particularly older adults and persons of color. These groups endure ongoing economic challenges, such as low income and limited income mobility, alongside insufficient access to affordable housing, steering our focused responses and innovations over the years.

The insights gained, and the successes achieved in 2022 and 2023 have been invaluable. They underscore the critical need to persist in our community collaborations, expand our use of data-driven decision-making, and initiate strategies that significantly reduce the duration of homelessness. This commitment is especially crucial for supporting those with disabling conditions and the aging populations in our community.

We invite you to delve into this report, which not only details the impacts and insights of the last two years, but also reinforces our resolve to continue this vital work. Thank you for your unwavering support and partnership in our mission to ensure that everyone in Middlesex County has a place to call home.

With gratitude,

Eileen O'Donnell

Eileen O'Donnell, JD, MPP, MSW
Executive Director

Jamie Schleck

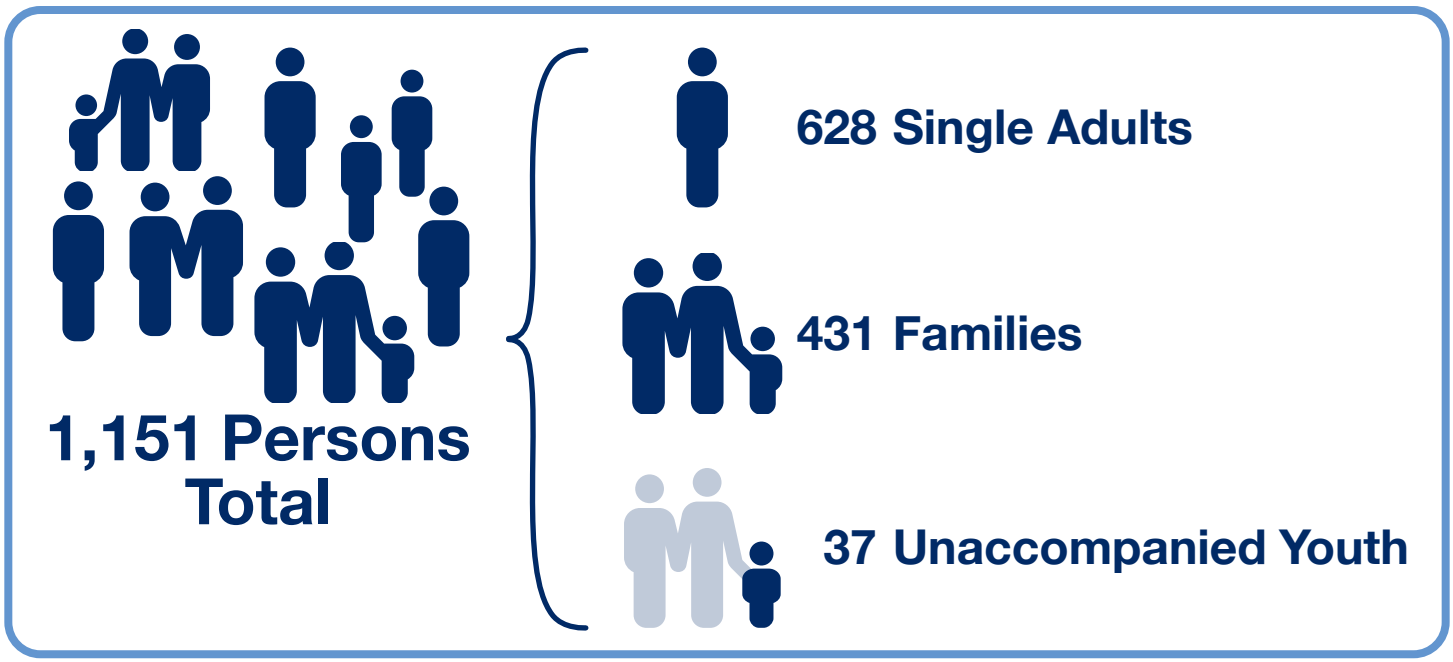
Jamie Schleck
Chairman of the Board of Directors

Coming Home at a Glance

The State of Homelessness in Middlesex County

This report highlights discrete information from 2022 through 2023. We are using our increased capacity for data analysis to bring these numbers down in 2024 and beyond.

Homelessness in Middlesex County as of January 31, 2024:

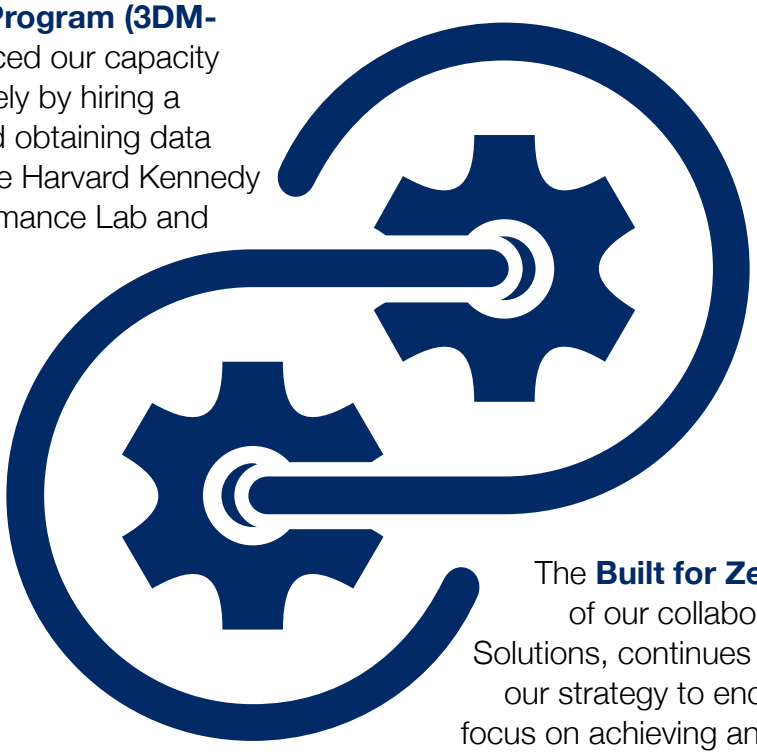


Highlighted Initiatives

Data-Powered: Paving the Way for Meaningful Impact

3DM-OCP

Our commitment to data-driven decision-making was exemplified by implementing the State's **Data-Driven Decision-Making Organizational Change Program (3DM-OCP)**. This initiative enhanced our capacity to utilize data more effectively by hiring a dedicated Data Analyst and obtaining data strategy training through the Harvard Kennedy School Government Performance Lab and Delivery Associates.



Built for Zero

The **Built for Zero** (BFZ) initiative, part of our collaboration with Community Solutions, continues to play a pivotal role in our strategy to end homelessness. BFZ's focus on achieving and sustaining results by working within a structured and collaborative framework drives continuous improvements.

3DM-OCP + Built For Zero = Impact

Together, the 3DM-OCP and BFZ initiatives form a powerful synergy, driving our mission to end homelessness in Middlesex County. The 3DM-OCP enhances our data-driven decision-making capabilities, enabling us to tailor our interventions and allocate resources efficiently. Meanwhile, the BFZ initiative provides a structured, collaborative framework that ensures continuous improvement and sustained progress towards functional zero homelessness. By integrating these two initiatives, we are better equipped to address the complex challenges of homelessness with precision and effectiveness, ultimately creating a lasting impact in our community.

Ricky's Story

Ricky's home burned down on January 11, 2022, resulting in his family—wife and children ages 12 and 18—becoming homeless. The Red Cross paid for a hotel for six nights. After that, Ricky paid for the hotel from his own funds.

Ricky and his wife, Melinda, were both employed at the time, but Melinda, a diabetic who also suffered from depression, was unable to cope with the trauma and stopped working. Mark continued to work as an Uber driver. He reached out to 211 and was referred to Coming Home for case management.

Shelter was offered but Mark declined due to his wife's pre-existing medical and mental health issues. Forced to leave the hotel, the family began living separately, with Melinda staying with a friend, and Ricky renting a room for him and the girls at another location. Clothing, food, toiletries, book bags, coats, and holiday gifts were collected by Coming Home and delivered to the family.

Ricky and Melinda were provided employment counseling. Ricky participated in counseling with the goal of obtaining his CDL license. Melinda's mental health remained a roadblock in efforts to help her find employment. Family conferences were necessary and Coming Home provided ongoing support and guidance. Eventually, Melinda was motivated to obtain a job as a cashier at ShopRite.

Coming Home assisted Ricky and his family with rental assistance from the residual of a pandemic-period program whereby Coming Home provided rental assistance for a limited time while providing intensive case management to ensure that the family was self-sufficient once the rental assistance ended. Today, Ricky remains united with his family, living in an apartment and paying the monthly rent on time.

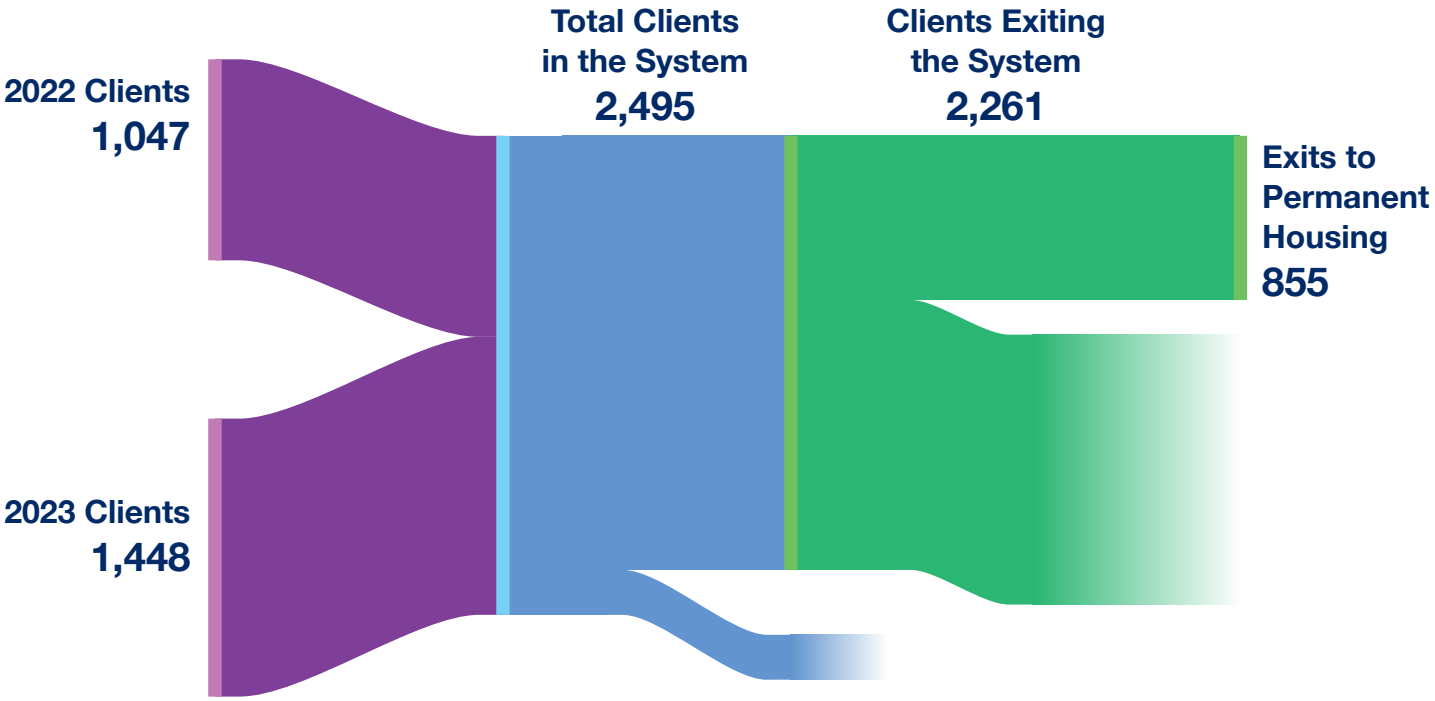
System Performance

A Glance at our Management System

What Our System Performance Measures

Coming Home is central to managing Coordinated Entry & Assessment (CEA) and the Homeless Management Information System (HMIS) for Middlesex County. CEA is the process by which clients enter and exit our homeless service system and through which clients' needs are assessed and prioritized. We evaluate overall system effectiveness through System Performance Measures (SPM), focusing on outcomes that reflect our collective impact on homelessness and align with our commitment to our silo-busting "open system."

From 2022 to 2023, the system assisted 2,261 households to exit our system out of the 2,495 that engaged with it. The remaining 234 households either self-resolved their homelessness, were in active case management and awaiting housing opportunities, or remained actively homeless due to various challenges, including chronic disabling conditions that led to disengagement.



Who Is in the Middlesex County System

- **17** Homeless Service Providers managed data in our systems.
- **5** Providers manage outside our system; however use Coordinated Assessment.
- **2** new providers added to the system.
- **2** new providers pending admission to our system.

Note: Domestic Violence, HIV, Board of Social Service and Child Protective services providers do not manage their data in our system due to individual compliance guidelines set by law or their agencies. However, they utilize Coordinated Assessment which provides Coming Home the ability to assist and gather necessary insights needed to prioritize and provide critical homeless interventions for their clients.

Coordinated Assessment & HMIS

The Impact of Our Coordinated Entry & Assessment System

Throughout the year, our dedicated Access Navigators, in collaboration with the NJ 211 helpline, skillfully addressed a wide array of inquiries. We provided essential resources and personalized support, ensuring that each individual's unique needs were met with compassion and efficiency.

211 Call Management
50-80 calls are received and addressed weekly. Each call is meticulously tracked for follow-ups and comprehensive support.

Escalation & Responsiveness
We escalated 2-6 critical cases weekly to provide intense interventions for timely and critical intervention.

Expansion to Physical Access Sites

In the summer of 2023, we enhanced our service delivery model by establishing several physical access sites across the County, in addition to the ability to call 211. These sites provide direct, face-to-face assistance and are strategically positioned to ensure they are accessible to community members in need of both prevention resources and crisis intervention. During the first eight months of the expansion, we engaged 240 individuals throughout the various sites.

→	**Unity Square Community Center** 81 Remsen Avenue, New Brunswick, NJ 08901	**91 Engagements**
→	**Center for Support, Success & Prosperity** 392 Smith Street Perth Amboy, NJ 08861	**71 Engagements**
→	**First Presbyterian Church of Metuchen** 270 Woodbridge Avenue Metuchen, NJ 08840	**41 Engagements**
→	**Middlesex College Resource Hub** Room CC 170A 2600 Woodbridge Avenue Edison, NJ 08818	**31 Engagements**

Homes for All

Catalyzing the Creation of Affordable Housing

The goal of the Homes for All (H4A) program is to catalyze the creation of affordable housing units specifically for families and individuals experiencing homelessness. We achieve this goal by forming partnerships with affordable housing developers and providers, consulting on projects, and building relationships with municipalities, asking them to devote resources to affordable housing construction, remove zoning roadblocks and to include us in their discussions with developers of new housing projects.

Two H4A houses in Perth Amboy

During 2022, CHM formed a development partnership with Region Nine Housing Corp., (RNHC), a large affordable housing provider in Middlesex County, and throughout the States of New Jersey and Pennsylvania. The new partnership has already identified our first project site and we are eager to begin our work together. CHM also furthered progress on our current development projects with our two existing partners, BCUW/Madeline, and The Perth Amboy YMCA. Both projects are expected to be completed by end-of-year- 2024, with eight new units of permanent supportive affordable housing for the chronic homeless population.

The population of Middlesex County has steadily increased on average 0.63% year-over-year for the past decade. The 2020 Census stated the population count to be 863,162, and 2023's World Population Review count states that number has increased by almost 16,000 to 879,152. Adding 16,000 people to a high cost of living area (HCOL) suffering through a housing shortage crisis, while experiencing higher-than usual inflation 8% in 2022 versus 1.88% over the past decade, (Forbes.com) presents a challenge to affordable housing developers that would seem insurmountable.

The widely acknowledged increased cost of building materials has stalled many affordable housing projects throughout the County over the past three years, and several developers have abandoned projects entirely due to budget gaps of millions of dollars. To attempt to combat these issues, the government has allocated funds to fill the gaps, with over $300 million in pandemic recovery funds. This large cash infusion into affordable housing creation is expected to assist in the creation of over 11,000 units statewide, a good start but far short of the number needed to solve the ongoing housing crisis.

Our mission at Coming Home is unchanged, and, even with these new challenges, we are as determined as ever to catalyze the creation of new housing units to house the clients we serve. Our focus remains on forming new partnerships with like-minded affordable housing providers, and concentrating on smaller projects in existing neighborhoods, while searching for new funding sources to plug our construction budget gaps.

Consumer Participation

Advice from Persons with Lived Experience

Coming Home, on behalf of the homelessness service system, has led a Consumer Participation Committee since 2020 for the benefit of both the system and homeless or recently homeless persons The Committee strives for a process by which people are able to become genuinely involved in defining the issues of concern to them; in making decisions about factors affecting their lives; in formulating policies; developing and delivering services and in taking action to achieve change.

Consumer Participation Committee members

Our mode of securing consumer participation is through the frontline case managers of the CoC service organizations: the case manager sponsors a client, i.e., they are responsible for disseminating committee scheduling information and facilitating the clients' participation in consulting sessions. There is both strength and comfort for all, meeting regularly in this group as opposed to prior practices of asking individual consumers to sit on already established boards and committees. We have discussed all aspects of the homeless system, recording specific concerns and recommendations for improvement, and formed work groups to develop improvement implementation plans.

The system benefits from the perspective and advice of persons who are going, or have gone, through our system in its continuous efforts to improve itself, and homeless persons benefit from having a space where they can talk about their struggles, make suggestions for improvement to the system, help those who are still homeless suffer less, and feel good about themselves for the conduct of productive, meaningful work. This year, to help homeless persons navigate the labyrinth necessary to obtain documents needed to access resources, committee members created a document production flyer, named the "Cheat Sheet." It contains workarounds for clients and case managers when strict adherence to the formal guidance is not possible to be followed. We, in Middlesex County, are at the forefront of the movement encouraged by the federal government's All In Plan to include persons with lived experience in the work of our system and will continue to build on our progress thus far.

Consumer Participation Committee members

Community Based Case Management

Community Based Case Management

Homeless Hotline and Social & Healthcare Integration

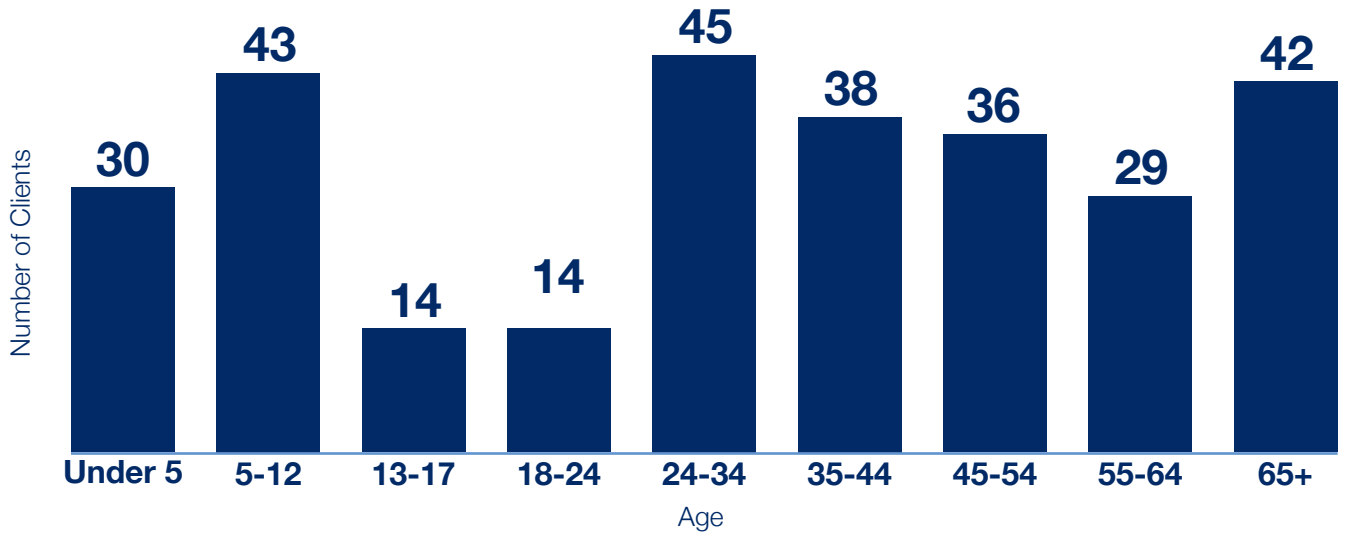
Homeless Hotline Case Management

Our Homeless Hotline Case Management (HHCM) program strives to meet the housing needs of persons for whom there is no other assistance, providing targeted, brief case management services and start-up rental assistance. Our two-year journey has witnessed some growth and impact, serving **169 households**, consisting of **291 individuals** of all ages who faced housing crises.

Gender Distribution

Male	Female
122	179

Age Distribution

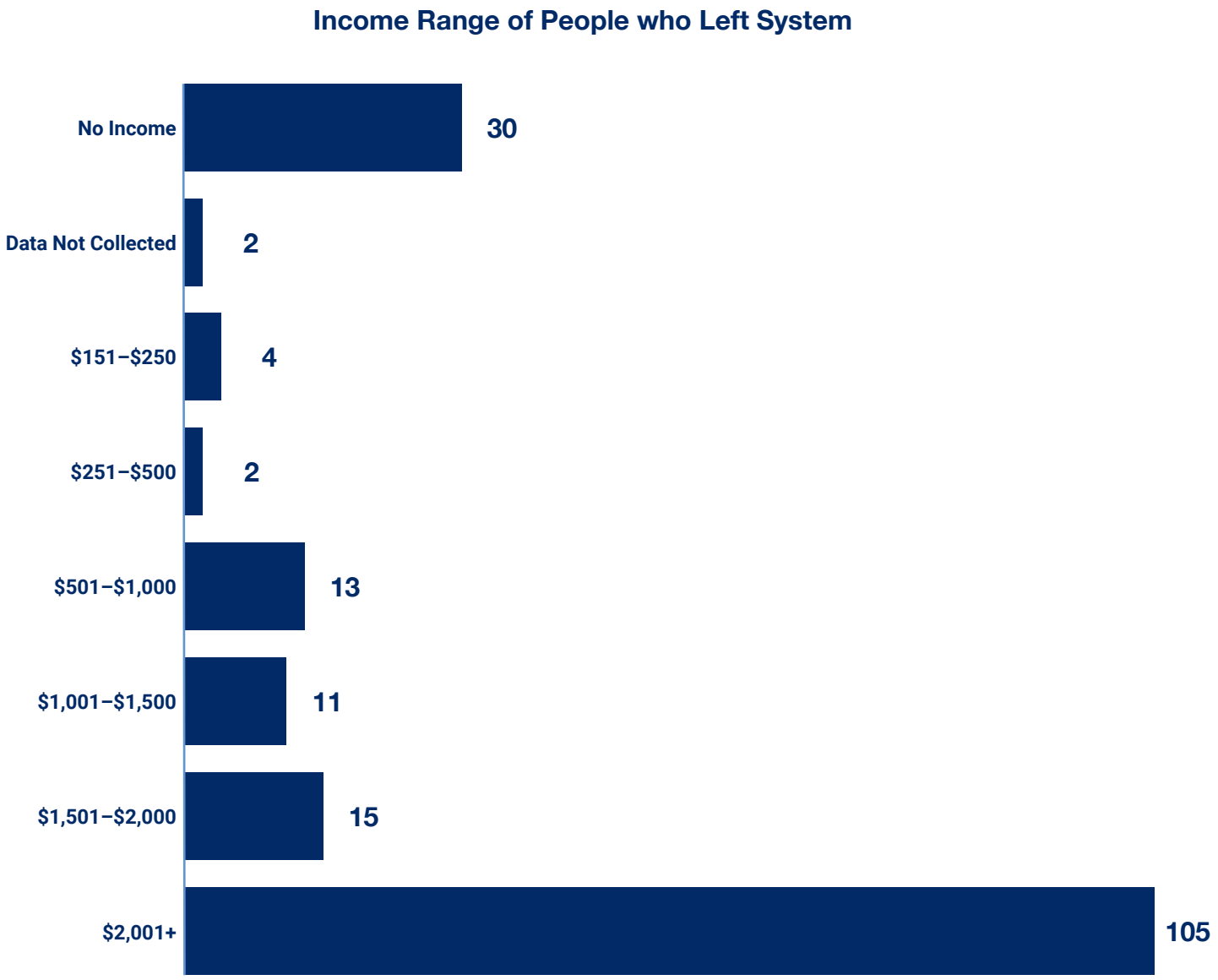


The ages of our clients encompassed a growing number of seniors, middle-aged adults, and families, a testament to the pervasive reach of homelessness. The gender distribution predominantly featured women, many at the helm of their households, compared with a slightly smaller presence of single-male households, some of whom were also single parents. This demographic pattern underscored the substantial responsibilities of many one-parent family households, especially those led by women, in addition to their housing challenges. Our data underscored the urgency of our timely interventions, revealing the complex, varied needs within our community and compelling us to work hard to effectively support every individual facing these critical circumstances.

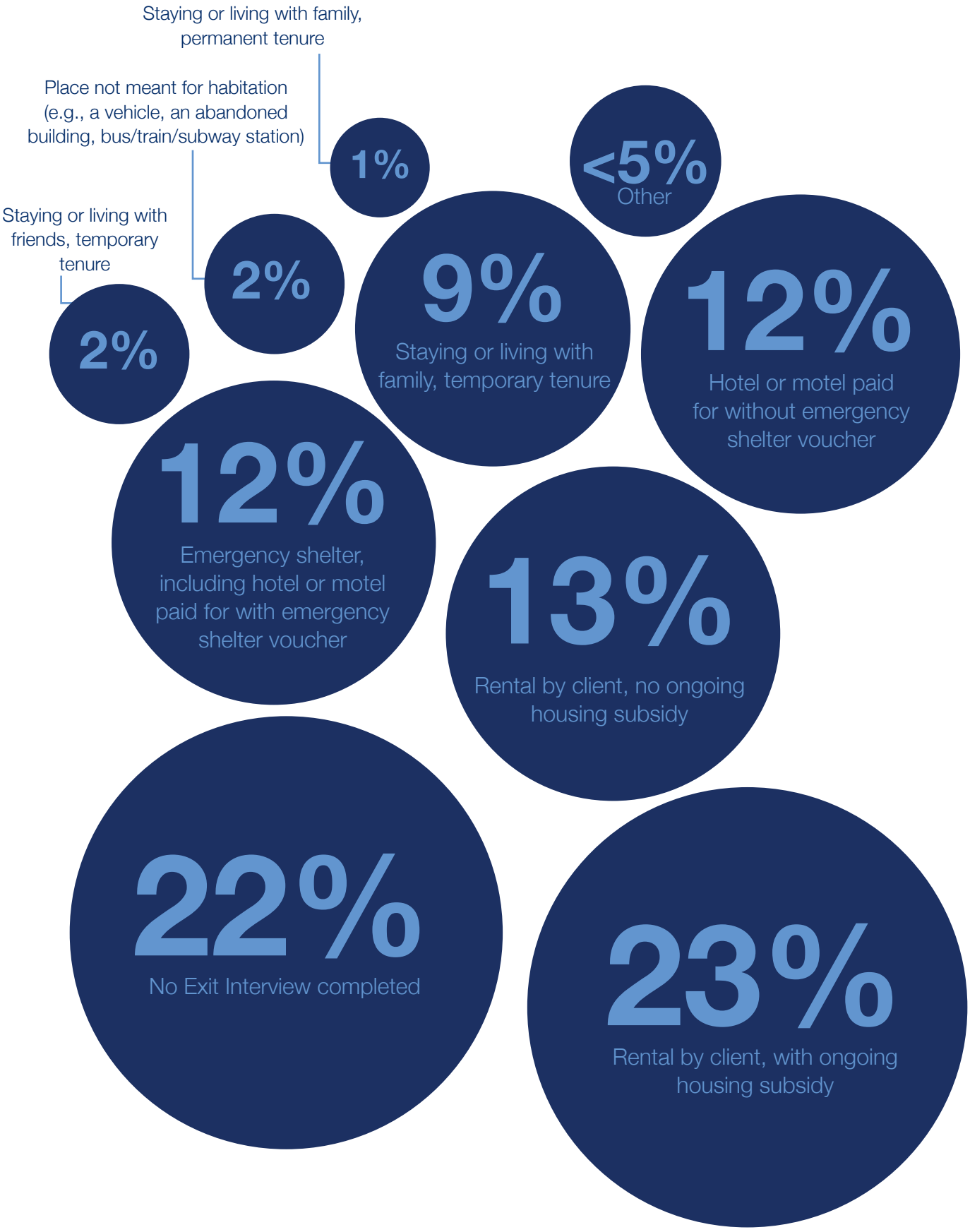
Homeless Hotline Case Management

Pathways to Stability

We succeeded in helping clients secure financial assistance, obtain vouchers, and enhance income support. Most clients exited our system with monthly incomes exceeding $2,000, marking critical, albeit modest, financial progress. These insights underscore the vital support provided by our services in collaboration with the emergency shelters and our placement programs.



Program Exit Destination



Social & Healthcare Integration

Addressing the Social Determinants of Health

Celebrating five years of operation, the Social & Healthcare Integration (SHI) Program stands as a beacon of support for individuals who repeatedly turn to emergency departments due to issues like housing instability, food insecurity, lack of knowledge of preventive services, and health system navigation difficulties. SHI focuses on addressing these root causes by targeting housing placement and then addressing the other social determinants of health. Through personalized case management, SHI empowers individuals to achieve stability and resilience, reducing their reliance on emergency services and fostering long-term quality of life.

In partnership with New Brunswick's two acute-care hospitals—Robert Wood Johnson University Hospital and St. Peter's University Hospital—we are making a positive difference.

66 Participants

over the course of the program agreed to services, drawn by the prospect of personalized support from SHI case managers as a pathway to stability, reclaiming their lives with hope and empowerment.

The high prevalence of chronic health conditions and mental health disorders including substance abuse among SHI participants underscores the complex and multifaceted challenges they face. Due to these significant barriers, most cases remain open for an average of 18 months, indicating the intensive and ongoing support required to address their needs effectively.

COMING HOME Ending Homelessness in Middlesex County

RWJBarnabas HEALTH | Robert Wood Johnson University Hospital

SAINT PETER'S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

Social & Healthcare Integration

Client Demographics

The program has served a richly diverse participant demographic, with the majority identifying as Black, African American, or African, followed by White. Additionally, there are smaller but significant groups of mixed race and ethnicities, such as White & Hispanic/Latino, Asian American, and Hispanic/Latino. The gender distribution reveals a higher proportion of men compared to women. Age-wise, the program has predominantly supported individuals aged 45-54 and 25-34, including a notable number of participants 65 and older.

Racial Composition of Clients Enrolled through Case Management and SHI

51% Black, African American, or African

22% White

16% Hispanic/Latino & White

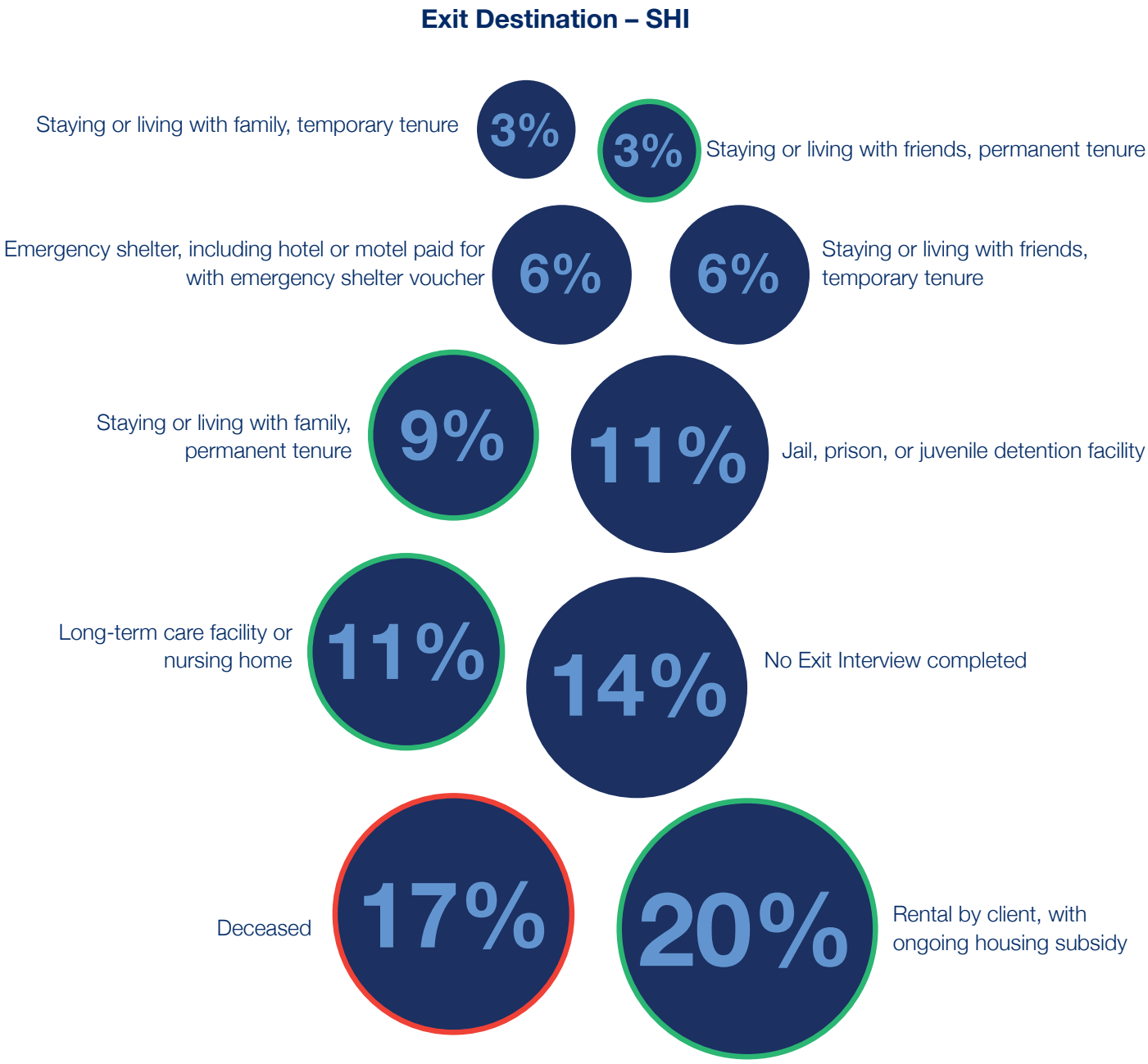
3% Hispanic/Latino & Black, African American, or African

8% Other

Total number of clients served in this period: 358.

Social & Healthcare Integration

Housing Stability Through Holistic Support



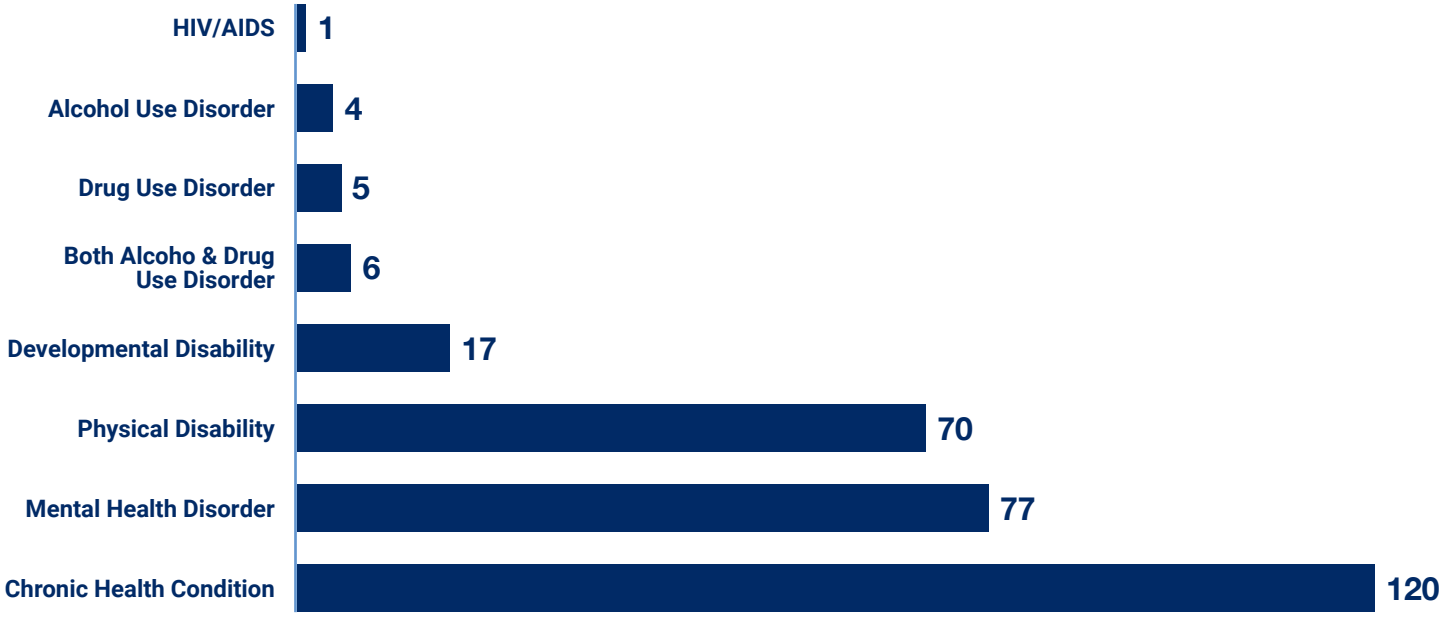
Impressively, **32%** of participants who exited the program moved into permanent housing; **9%** being reunited with family—a significant success for many who have been separated due to the chronic barriers they faced. This highlights the program's success in securing stable housing. We sadly saw **17%** of participants pass away, which underscores the urgency and importance of our work and the ability to intervene through our collaboration with hospitals.

Community Based Case Management

Addressing Interconnected Needs

The majority of our clients were contending with chronic physical health conditions. Mental health disorders and physical disabilities were also significantly represented. This prevalence of health-related disabilities highlights the intense challenges our clients confront daily. Our integrated partnerships within the Continuum of Care agencies are vital, addressing not only immediate housing needs but also the broader social determinants of health, ensuring equitable access and support for all our clients.

Type of Disability



Nearly half of our clients identified as Black, African American, or African, underscoring the deep-seated issues of racial disparity within the homeless population. Additionally, we served a broad spectrum of clients, including White and multi-race White & Hispanic/Latino groups, reflecting the diverse communities impacted by homelessness.

Race Distribution: Case Management

49% Black, African American, or African

20% White

18% Hispanic/Latino & White

4% Hispanic/Latino & Black, African American, or African

9% Other

Client Stories

KP's Story

KP, a single mother with two kids from New Brunswick, reached out to 211 requesting assistance for her housing situation. She had been staying with different family members to avoid being on the streets. Unfortunately, these were all very toxic environments for both her and her children. Fortunately, through a residual pandemic program, she was able to submit an application for rental assistance through Coming Home as well as be connected to a case manager. After several apartment denials due to poor credit, KP's application was approved. Her case manager was able to connect to a landlord willing to work around the credit issue and accept a voucher.

KP and her children moved into their very first apartment on March 15, 2023. KP says: "I was hopeless until Coming Home helped me get a voucher for my family. Signing the lease and getting the keys to move in was one of the best days of my life! My children and I are very excited for a fresh start!"

Mark's Story

Mark had been residing in a motel with his wife and three children, ages 17, 12 and 10 years old, for over seven years. His family became homeless after he was hit by a car and suffered a heart attack, leaving him permanently disabled, walking with a cane. Mark's wife then lost her job due to caring for him and the family was left with no income.

Mark applied for welfare assistance, but it took a while to receive benefits. His wife became his paid home care provider, but the pay she received was not enough to support the family. She found a second job at the Days Inn, which offered the family one room with two beds at a discounted rate.

A Coming Home Case Manager met with the family to assist them complete a Section 8 voucher application. Upon approval, they started looking for an apartment in the family's preferred area in South Brunswick. Coming Home provided the family with toiletries, food and Christmas gifts for all, and ongoing follow-up and referrals for needed social and healthcare services. The family eventually found an apartment in South Brunswick, and Coming Home provided them with one month's rent and one month's security deposit. They moved into their new apartment on March 1, 2023.

Johnny's Story

Johnny, a high utilizer of both hospitals' emergency departments, is a 56-year-old African American male who resides in his family's home. Johnny struggles with alcohol dependence and would leave the family home to drink out in the community. Out in the community, he struggled with his balance and often fell, resulting in a visit to the hospitals. SHI repeatedly offered treatment options as well as made referrals to outpatient programs. Despite this, Johnny wasn't ready to make a change and stated several times that he enjoyed drinking and was not interested in stopping.

When Johnny's falls grew more frequent, the family feared that he would soon sustain a disabling injury requiring long term care, if he did not stop drinking. As an alternative option, the SHI Team proposed that the family participate in the recovery process. Instead of Johnny hiding his alcohol use by refraining in the home but drinking in the community, he would be able to drink in the home if he agreed to reduce the amount of alcohol he consumed and be open to treatment.

All were in.

This approach resulted in fewer falls which, in turn, meant fewer visits to ER. Most importantly, this fostered an environment where Johnny agreed to voluntarily attend a rehab program, which he successfully completed. To continue with his progress, Johnny now attends an adult day program where he is currently thriving and enjoying services made available to him at the facility.

Gail's Story

Gail is a 66 year-old woman with numerous chronic health conditions. Despite being eligible for assistance through the County welfare agency, Gail refused to engage in services because of her untreated mental illness and mistrust towards people and providers. She slept at the local train station and refused the numerous outreach attempts by local community service providers.

SHI case managers met her at the train station, bringing food and personal items to her to build a trusting relationship. After over six months of visiting Gail and offering her services, she finally felt comfortable and trusting enough of SHI to agree to services. Gail is now placed in an emergency shelter through the County welfare agency, receiving SNAP and General Assistance while her SSI application is pending. At this time, SHI is providing intensive case management services while assisting her to obtain her required documents and completing her Section 8 voucher application to obtain permanent housing.


FILA


G-MEN
KOHL'S
KOHL'S

Looking Ahead

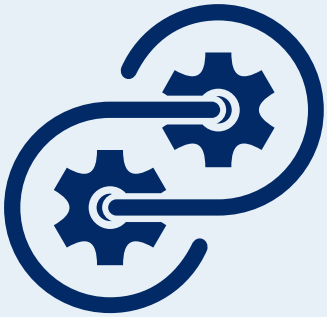
Strategic Insights

Our Path Forward

As we continue to navigate the complex landscape of homelessness in Middlesex County, the data and insights gained from our initiatives over the past two years have been invaluable in shaping our strategic direction. Here, we outline key insights and the path forward based on our comprehensive analysis and the effectiveness of our programs.

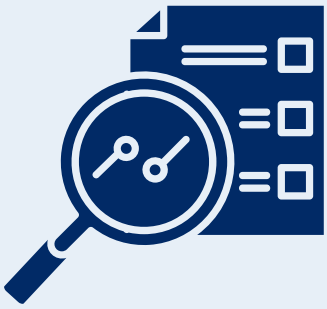
Data-Driven Decision Making and Built for Zero (3DM-OCP and BFZ)

The integration of the Data Driven Decision Making Organizational Change Program (3DM-OCP) and the Built for Zero (BFZ) initiative has strengthened our approach to ending homelessness. By hiring a dedicated Data Analyst and obtaining advanced data strategy training, we are improving our ability to analyze real-time data and make informed decisions. The structured, collaborative framework of BFZ has streamlined housing prioritization and referral processes, reducing the duration of homelessness for many individuals.



Coordinated Entry & Assessment System Expansion

The expansion of our Coordinated Entry & Assessment System to include 211 Physical Access sites has enhanced our service delivery. These sites provide direct, face-to-face assistance, ensuring accessibility for those in need of prevention resources and crisis intervention. In the first eight months, we engaged 240 individuals through various physical access sites, demonstrating the effectiveness of this expansion.



Demographic Insights and Targeted Responses

Our demographic analysis revealed significant engagement with vulnerable populations, particularly older adults and persons of color. Nearly half of our clients identify as Black, African American, or African, highlighting racial disparities. The challenge is to see if our homeless system can alleviate some of the disparities by instituting anti-racist practices.

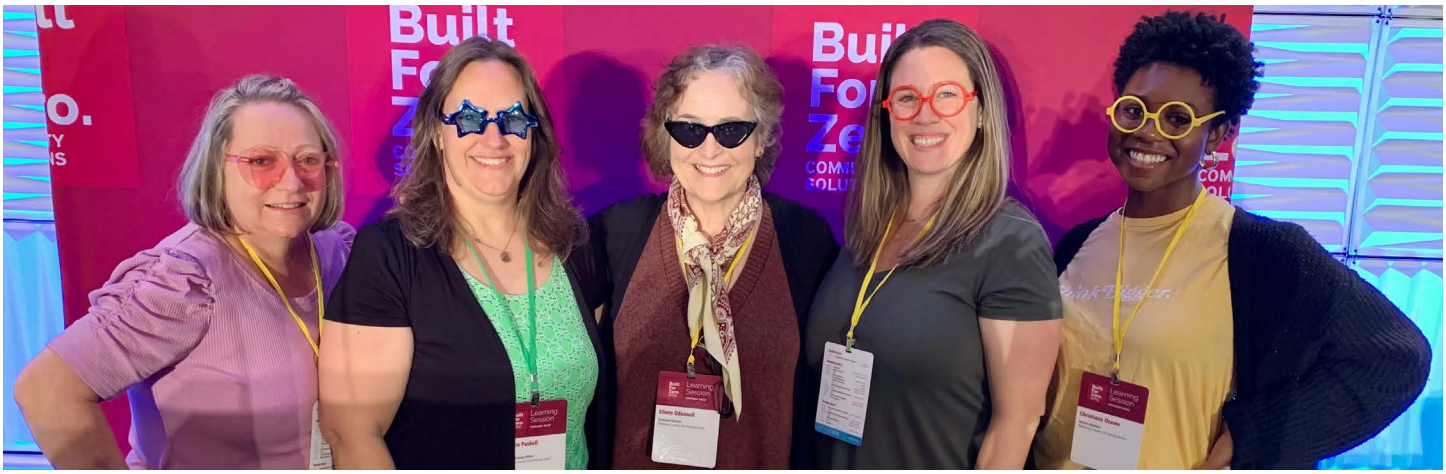
Client Financial and Housing Stability Achievements

Our efforts in securing financial assistance and enhancing income support have led to significant improvements in financial stability for our clients. Most clients exited our programs with monthly incomes exceeding $2,000. Additionally, 20% of participants moved into permanent housing with an ongoing housing subsidy, and 8.57% were reunited with family, reflecting the success of our programs.

Health-Related Challenges and Aging Populations

The high prevalence of chronic health conditions and mental health disorders among our clients underscores their complex challenges. Our integrated partnerships within Continuum of Care agencies address immediate housing needs and broader social determinants of health. We have noted a need for more and more accessible mental health and substance abuse services and are working with the County to advocate for more providers in this area and working with existing providers and law enforcement to tailor services for this cohort of the homeless population.

Additionally, our data indicates a growing number of aging individuals within the homeless population, emphasizing the need for tailored interventions for older adults. Most of these cases remain open for an average of 18 months, highlighting the intensive support required.



As we move forward, we remain focused on leveraging data to drive systemic and programmatic changes. We are committed to refining our strategies, deepening collaborations, and expanding our impact to ensure that everyone in Middlesex County has a place to call home.

Thank you for your continued support and partnership in this vital mission. Together, we are paving the way for meaningful impact and lasting change.

Coming Home Staff

Coming Home Staff

Executive Director	Eileen O'Donnell
Senior Director of Operations	Meriam Shenoda
Director of System Programs	Bobbin Paskell
Director of Housing Development	Frances O'Toole
Community Based Case Management	Tia Rodgers
Social and Healthcare Integration Program	Migdalia Figueroa Courtland Cobb
System Data Analysis	Talin Upputuri
Access Navigators	Cassandra Jones-Lead Kayla McCellon Crystal Crawford Clermise Corgelas

Coming Home Board of Directors

Jamie Schleck, Chair

Community Solutions

Sharon Grice, Vice Chair

Consultant

Jon Rabinowitz, Treasurer

Managing Director, BayCrest Partners, LLC

Andrew Thomas

Vice President, RWJ Barnabas Health

Bridget Kennedy, GM

Retired, Middlesex County Social Services

Elizabeth Schullstrom, GM

Senior Manager, Withum

Helmin Caba, Ex-Officio

Mayor, City of Perth Amboy

James Cahill, Esq., Ex-Officio

Mayor, City of New Brunswick

Kathleen Gwozdz, GM

Consultant

Melissa Bellamy, Ex-Officio

Division Head, Middlesex County Housing

Melyssa Lewis, Ex-Officio

Director, MC Office of Human Services

Ronald Rios, Ex-Officio

Director, Middlesex County Commissioner

Board Advisory Committee

Brad Caruso

Partner, Withum

Gloria Aftanski

President, United Way of Central Jersey

Sarah Clarke

Executive Vice President, DEVCO, Inc.

Financial Documents

Statement of Activities and Change in Net Assests
For the Year Ended December 31, 2022 and 2023

	Total Jan-Dec 2023	Jan-Dec 2022 (audited)
REVENUES AND SUPPORT		
GRANTS, Government	767,712.00	938,866.00
CORPORATE & FOUNDATIONS Support	154,297.00	274,912.00
INDIVIDUAL/BUSINESS Contrib	1,250.00	4,430.00
In-Kind Support	51,873.00	52,873.00
Special Event	48,214.00	36,070.00
Program Income	28,915.00	36,606.00
Other Income	73,087.00	71,424.00
Total Revenues and Support	**$ 1,125,348.00**	**$ 1,415,181.00**
EXPENSES		
Program Expenses	921,020.00	1,070,671.00
Management and General	111,199.00	174,871.00
Fundraising	41,389.00	45,507.00
Total Expenses	**$ 1,073,608.00**	**$ 1,291,049.00**
CHANGE IN NET ASSETS BEFORE OTHER CHANGES	**$ 51,740.00**	**$ 124,132.00**
OTHER CHANGES		
Loss from Investment in Joint Venture	0	-15,490
CHANGE IN NET ASSETS	**51,740**	**108,642**
Net Assets - Beginning Of Year	1,496,327	1,387,685
NET ASSETS - END OF YEAR	**1,548,067**	**1,496,327**

Statement of Financial Position
December 31, 2022 and 2023

	Total 2023	2022 (audited)
ASSETS		
Current Assets		
Cash	**$ 1,150,606.00**	**$ 1,051,512.00**
Grants Receivable	516,239.00	540,261.00
Current Assets	4,513.00	4,513.00
Total Current Assets	1,671,358.00	1,596,286.00
Investment in Joint Venture		
TOTAL ASSETS	126,717.00	142,207.00
	$ 1,798,075.00	**$ 1,738,493.00**
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable and Accrued Expenses	**$ 428,489.00**	**$ 42,166.00**
Deferred Revenue	207,160.00	200,000.00
Total Current Liabilities	635,649.00	242,166.00
NET ASSETS		
Without Donor Restrictions	1,033,485.00	971,277.00
With Donor Restrictions	514,582.00	525,050.00
Total Net Assets	1,548,067.00	1,496,327.00
TOTAL LIABILITIES AND NET ASSETS	**$ 2,183,716.00**	**$ 1,738,493.00**

Thank you to all of our supporters and partners!

Middlesex County, NJ
RWJBarnabas Health
Saint Peter's Healthcare System
New Brunswick Development Corporation
Windels Marx
Railroad Construction Company
Dan and Marianna's Deli
REVireo
CTBE Bank
Nelson & Ward Company
Bridgeway Senior Healthcare
Nomura
Crew Towing
Climate Pros
Region Nine Housing Corporation
Raritan Bay Area YMCA
Brown & Glynn Construction Company
E.P. Guidi, Inc.
Madeline Corporation
AllianceBernstein
Alessandra Herzog-Cherry (RE/MAX)
The Alpert Group, LLC
The Weston Group
Reilly Financial Group
Woodbridge Community Charity Fund, Inc.
Wilentz, Goldman & Spitzer



Get involved:

Learn more

Visit cominghomemiddlesex.org

Support our mission

Donate on our website or email mshenoda@cominghomemiddlesex.org

Volunteer or join our Board

Email mshenoda@cominghomemiddlesex.org

Join the conversation

Visit facebook.com/ComingHomeMC

COMING HOME

Ending Homelessness in Middlesex County

Coming Home of Middlesex County

75 Bayard St., 2nd Floor

New Brunswick, NJ 08901

cominghomemiddlesex.org