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HUD-000401

RURAL NEIGHBORHOOD HOUSING SERVICES DEMONSTRATION

NEIGHBORHOOD REINVESTMENT CORPORATION

1850 K Street NW
Washington, DC 20006

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Conducted Under Cooperative Agreement with the

OFFICE OF POLICY DEVELOPMENT AND RESEARCH
U.S. Department of Housing and Urban Development
HA-5458

SUMMARY OF ACCOMPLISHMENTS
RURAL NHS VERMONT DEMONSTRATION

I. INITIAL GOALS:

The overall goal of the project was to demonstrate the feasibility and effectiveness of the NHS partnership model to meet the special housing needs of rural areas. Vermont represented an excellent test site in that we had interest from the Federal Home Loan Bank of Boston, HUD, and the New England District staff who had some previous NHS experience in the State of Maine. Our initial goals were to:

- Identify and recruit private financial resources that could fullfill the lender/business partnership commitments.
- Identify and recruit government (local, regional, state, and federal) resources that could fulfill the public government partnership role and commitments.
- Identify and recruit a group that could initially represent the resident housing needs in Vermont.

Once these groups could be identified and recruited, we had these specific objectives for them to address:

1. Explore and identify the special housing needs in Vermont and the difficulties in addressing them.
2. Assess interest and support for addressing these housing needs through a cooperative NHS partnership approach.
3. Formulate methods to develop partnership groups to address these issues on a state-wide and local basis.
4. Identify methods and potential sites to improve housing through the NHS approach.
5. Identify and develop methods to raise needed operating and revolving loan funds.

II. RECAP OF EFFORTS AND MID-COURSE CORRECTIONS:

Our work began in Vermont back in 1980 with the assignment of field staff to identify and recruit representatives of the partnership groups in our initial goals. After a period of research and individual meetings, we reached the following conclusions:

- Local private financial resources were small and were most often served by regional or statewide branches.

- Local governments were small and had limited or no professional housing services staff, so that they depended on regional, state and federal resources.

- Most resident services and needs were met through regional or state-wide non-profit organizations rather than through locally controlled resident organizations.

- All three groups had an awareness and concern about the housing needs, and expressed an interest in discussing better solutions.

- Formulation of a state-wide partnership group to address the specific objectives was feasible if it was initially recruited from the regional and statewide network identified above, with an attempt to also include some local representation.

A workshop which included representatives from all three partners was organized and held in June 1980 with excellent results. A group of about 60 people attended and made a commitment to address the objectives and to develop a partnership structure. Several ad hoc committees were formed (structure, site selection, resource development, and operations) resulting in the creation of a statewide non-profit organization, Vermont Community Housing Services, in March 1981. The initial Board of Directors was formulated on a complex partnership and geographic representation model (2 representatives from each of the twelve regions, and 6 representatives from each of four partnership groups: private, government, non-profit organizations, and residents) which later proved cumbersome and unmanageable.

It was at this point that Vermont was reaffirmed as an excellent rural demonstration site, and we committed additional resources to enhance and leaverage their success. We provided a $50,000 start up grant to hire an Executive Director and cover support costs, and committed seed money for a local NHS development. The initial Board formed five permanent working committees:

Executive - to act for the corporation between Board meetings.

Program Development - to establish site selection criteria and methods for recruiting applicants.

Program Operations - to establish necessary VCHS administrative procedures and local operating options.

Resource Development - to identify local and VCHS operating and loan resource needs and to establish fundraising plans to collect these resources.

Personnel - establish Executive Director job description and recruit and hire a Director.

In general, the Program Development and Operations committees (they eventually combined) took on the task of addressing the first four objectives identified earlier, while the Resource Development committee was responsible for the fifth objective. A director was hired by August 1981 to staff the Board and committees, with a special priority on resource development. As usual, we increased up our staff support for the operational transition in order to support and train the new Board, committees, and staff.

During the period from their incorporation in March 1981 until December 1982, several uniquely "rural difficulties" arose that severely tested everyone's commitment and ingenuity. The fact that the project survived this stage, accomodating many frustrations and unplanned mid-course corrections, is a testimony to their and our belief in the NHS process and model. The greatest difficulties arose in the following areas:

A. Board and Committee Structure

The original desire to recruit equal representation from all twelve regions and to maintain a four group partnership balance ultimately became unmanageable and very time consuming for the Executive Director and board leadership. In their attempt to preserve this structure they devoted too little time and energy to important development and operating activities. The Executive Director was burdened with several problems in arranging Board and committee meetings:

- rotating the meetings among the different regions made travel time (2 to 4 hours round trip) longer than meeting times

- quorums were hard to maintain and depending on the meeting location different representatives would attend

- inconsistent attendance and lack of quorums forced issues to be rediscussed and prevented crucial decision from being made in a timely manner

- travel time had its greatest impact on the lender and resident sectors so that the non-profit and government representatives evolved as a more dominant force (the opposite of most NHS's) on both the Board and committees

- out of necessity decisions were made by small ad hoc groups with limited opportunity to coordinate and assess the impact at the Board level

- the Executive Director spent 50% or more of his time on these structural issues and received little direction or decisions on program priorities.

The lack of consistent, available leadership made it difficult to resolve this dilemma quickly. The issue of providing adequate representation over a large rural area (that still includes the typical NHS partners) is still problematic. Some suggestions that evolved are:

- limit Board meetings to a few agreed upon most central locations and provide for travel reimbursement (especially residents) and meals where needed

- formulate Board and committee membership based on purpose, function and needed resources. If geographic representation is important for a few members, than recruit those who can travel

- maximize the clustering of members of a working committee (if statewide) as much as possible. In Vermont most key private resource people were in the Burlington area while government resources were in Montpelier (only 1 hour away)

- chose resident representation from the chosen target areas and provide support for their attending statewide or regional meetings.

B. Resource Development

Aside from the problems above and the large amount of time and energy it took from the director and Board, the "rural setting" imposes some very substantial resource development handicaps. From the beginning, the fundraising in Vermont was hampered by four major factors:

- Vermont's small private financial resource base

- severe financial problems for the State's thrift industry

- the lack of a mechanism and commitment of funds to establish a statewide loan pool (normally we have a commitment of loan funds which is use to leaverage private contributions).

In the early stages, the Vermont CHS explored a variety of options to raise a statewide revolving loan fund. There was an expectation that it would be initially capitalized by public dollars (as with most NHS's), however no mechanism was readily available. Fundraising focus then shifted to private fundraising for operating and potentially loan funds. Private institutions were reluctant to contribute operating funds due to their small resources and the lack of a target area and loan fund commitments.

The program made a tremendous effort at raising these funds (they even proceeded with chosing the target area discussed next), and ultimately collected $22,000 from private sources. Given the factors above this was somewhat successful, however it was only enough to continue the statewide Executive Director through May 1983. Without the availability of a substantial statewide loan pool, the statewide corporation's (Vermont CHS) role and operating expense needs became less clear. Several factors arose for future planning:

- If there is a goal of establishing a statewide loan fund to be administered by Vermont CHS, then it will require a commitment of resources from key state governement representatives.

- If program operation and loan funds are to be committed to local NHS's through their minicipal governments, then it will be extremely difficult to raise and justify a large statewide (VCHS) operating budget.

- The Resource Development committee must be dominated by the private and government resource representatives rather than the non-profit resident sectors.

- A chosen target area, program service model and local partnership commitments are essential for raising funds from statewide contributors. Or there needs to be a clear and specific need for statewide expenses that either benefits the contributor or the local NHS's.

C. Site Selection

The project made what I think are its greatest contributions to benefiting rural housing needs through the partnership discussions of needs, criteria and priorities. All the participants were excited about the potential of the NHS partnership approach with its emphasis on local control and management of resources. Their desire to identify and address the needs of rural housing created an interesting definition and criteria:

1. There are three areas of housing needs within a rural state like Vermont. They are:

   - housing within the population centers of 2,000 people and above

   - housing within the small towns and villages of 200 to 2,000 people

   - housing in the rural farm areas

2. The greatest needs and fewest resources and services exist in the rural farm areas and small villages. Resources implies both funds and professional staffing to seek and manage housing services.

3. Vermont CHS will require that population center applicants must include a consortium approach with the small towns and rural areas that surround them and feed into their economy.

4. Areas that do not include a population center must demonstrate the capacity to attract the private sector partnership participation in order to demonstrate the NHS model. (This area caused the greatest debate and re-emphasized the need for flexible statewide resources and service models that could address a completely rural housing need.)

Rather than targeting their "request for applications" to specific population centers and small towns that had the greatest need, potential and resource sector interest; VCHS marketed the project statewide. They also required extensive work in preparing the application as opposed to a simpler "letter of interest and concept fact sheet". Consequently the strongest applications came from the areas with existing professional staff and experience through a non-profit or municipal government. The follow-up assessment and decision by the Site Committee focused too much on the application document and not enough on need, potential for partnership and private resource development, and proximity of consortium participants.

Despite these remarks, the committee chose the best applicant in the Barre/Randolph applicant. The only barrier that existed was that the locations were twenty-five miles apart and that Barre was in the middle of an existing C.D. funded housing rehabilitation program. The result was to develop the Randolph component first and to set up the Barre program a year later. This would still allow the project to demonstrate the effectiveness of the NHS model in both a small village on a Central Vermont (three region) basis.

III. ACCOMPLISHMENTS IN RANDOLPH AND BARRE

The most satisfying and exciting part of the project has been the development of the local NHS's in Randolph and Barre. Their enthusiasm and commitment has surpassed that of many larger, urban NHS organizations. Their small size and personal relationships have facilitated an active partnership with easy access to each other. This has allowed them to maximize their limited resources to make the greatest impact over a shorter period of time. As individuals they seem more familiar with getting the most out of their resources and in cooperating to creatively solve problems.

The NHS partnership approach seems to be a natural individual process in the rural setting, however it was missing the organizational structure and focus on neighborhood revitalization and impact. Surprisingly, both the Randolph and Barre target areas had all the same housing problems (poor image and market, eyesore and undermaintained houses, vacant houses and units, commercial/business intrusion, vacant or underutilized public buildings, absentee owned problem properties, etc.) that existed in larger urban areas. When these are combined with the small rural incomes and the cold Vermont winters, the NHS's have a major challenge.

A. Randolph Accomplishments

Randolph is a small town of some 2,000 people, however the initial target area of East Valley is made up of the small villages of North, East, and South Randolph running along a six mile stretch of Route 14. The target neighbrhood is therefore six miles long and 1000' wide with about 114 structures. The village of East Randolph is in the middle and is the population center for the valley with 60% of the structures. The Town of Randolph attempted a housing rehabilitation loan and grant program in this area eight years ago and only one resident responded.

The East Valley NHS has had "unbelievable success" (as expressed by the Town Manager) in one short year. The difference was the active recruitment and involvement of the long term resident leaders of the three villages in managing and running the program. They were initially organized as a "divisional board" of Vermont Community Housing Services in March 1983. We assisted in hiring and training their staff (and Board and Committees) so they began operations by that summer. In that first year they accomplished:

- twelve loans to homeowners from the NHS Revolving Loan Fund totalling over $100,000
- $234,000 private reinvestment by East Valley residents in their homes
- A successful campaign to return a polling place to East Valley. The return of the polling place became a strong symbol of renewed confidence and pride on the part of residents and their successful effort dramatically increased resident confidence in their ability to have their voices heard.
- A successful effort on the part of NHS to persuade the town to commit revenue sharing funds to restore the Community fire hall for community use. Work will include heating and insulation and will be performed by community volunteers. The hall will once again become the focus of East Valley activities and meetings and help re-establish their sense of community.

Of greatest significance has been the development of the East Valley community and its renewed pride and commitment to make the valley a community of choice and focus of activity for the residents that live there and surround it. It has become an example of an NHS at its best, where housing rehabilitation and loan services are only a tool for neighborhood revitalization and partnership development.

Their renewed sense of confidence and demonstrated ability has resulted in their forming their own corporation, the East Valley Neighbrhood Housing Services, to manage and expand their program. They have demonstrated the capability of a small village to organize and manage a successful housing and neighborhood revitalization program, with the potential for self-sufficiency and growth beyond the statewide corporation. This will allow Vermont CHS to focus on other areas while ensuring a mechanism to maintain the initial efforts.

B. Barre Accomplishments

As stated earlier, the Barre NHS development was scheduled a year behind Randolph in order to match their community development grant cycle. Barre is a city of 8,000 to 10,000 people and is next to the state capital in Montpelier. It is the fourth or fifth largest city in Vermont and has a poor, working class image. The target neighborhood chosen overlooks the downtown on a hill across a small river. It is made up of ninety houses and is cut up by the geography (steep hills) and granite industry sheels. Parts of it are considered the poorest and less desirable areas of Barre. Like the East Valley neighborhood it has all the typical housing problems, except that 40% of the housing units are rental.

After an initial partnership workshop in February 1983 with the Randolph group, the development was handled only by a small steering committee. Everyone felt that they should not build up people's hopes until funds were secured through a community development grant. In March 1984, Barre received a $608,000 two year grant to fund the NHS and some need neighborhood capital improvements. They expect to operate for three years by adding our grant of $75,000, raising $36,000 from the private sector, and by revolving loan funds. Then they hope to expand to a next neighborhood.

Since March 1984, we and they have been meeting weekly to incorporate, form a Board, organize committees, hire staff and provide essential training and assistance to all three. They incorporated as the Barre NHS on April 26, 1984 and just completed committee formation and staff hiring. Training is underway and I expect they to be operational by the end of July. They already have twenty-two requests for services.

Barre represents the perfect rural population center housing needs and the NHS has already captured the interest and commitment of key resident, government and private sector leaders. The Mayor and community development director serve on the board as does a representative from each of the four financial institutions and two key neighborhood businesses. Seven resident leaders are also on the Board representing each major sub-neighborhood. They have already established the mechanism to develop, manage, maintain and expand their program, allowing Vermont CHS to move on to other activities.

IV. FUTURE FOR RANDOLPH AND BARRE

The East Valley NHS is planning some exciting additions to their already successful program. These include:

- A fundraising campaign, currently underway, to raise $10,000 from private sources to partially fund NHS operations. Leadership and potential sources have been identified, tours have been scheduled and literature developed.

- Focus on remaining eyesore properties through a Problem Properties Committee and a targetted approach (includes 7 vacants, 6 rental, 2 vacant commercial).

- Submission to State for a planning grant to assess and develop plans to expand services to the 140 farms that surround the village as well as possible rehabilitation and reuse of other vacant public buildings.

- Completion of core service delivery in the East Valley villages.

- Possible submission of RDAG application for renovation of the local Grange and old schoolhouse that are currently vacant.

When you realize that these plans are in the works only a year after operations began and that they are both appropriate and realizable for the NHS, it demonstrates just how effective the model can be in a small rural setting. The Town Manager is already getting requests from other areas of Randolph and surrounding towns to duplicate the program. The interest and need is there to continue and expand for some time.

Barre NHS will focus the next two years on accomplishing their current goals, however they have already established the expectation to expand the NHS to other neighborhoods and to explore its potential for commercial revitalization. A successful NHS in Barre will have a major impact on other Vermont population centers and their respective private and public resources. Robert Gillette of National Life Insurance, Co. attended their incorporation meeting and express his interest for the project in Barre.

V. OTHER POTENTIALS IN VERMONT

All of the original goals and objectives shared between Neighborhood Reinvestment and HUD for the NHS Rural Initiative have been met successfully in Randolph and Barre. The question remains as to the goals and role for Vermont Community Housing Services in expanding the model to other areas of Vermont in conjunction with Neighborhood Reinvestment and the existing NHS's.

We are currently exploring other cities that fit the original criteria to identify those with the greatest need and potential to develop necessary resources within the partnership and consortium approach. We are also discussing ways to reduce the statewide organizational handicaps identified in Section II in order to maintain and maximize partnership participation. Special attention will be focused on statewide government and private sector resource commitment and leadership development.

RECOMMENDATION FOR SITE SELECTION
RURAL NHS DEMONSTRATION
COOPERATIVE AGREEMENT HA-5458

I. Objectives and Tasks:

HUD and Neighborhood Reinvestment entered into a cooperative agreement for a rural NHS demonstration with a mutual interest in testing the feasibility of developing an NHS partnership outside of its traditional urban environment. (The goal of this partnership is to explore methods to facilitate housing rehabilitation, financing and construction to meet the special needs of rural areas). The shared objectives of this demonstration include:

- o improving the housing delivery system in rural areas
- o increasing lender participation in FHA and FhMA housing programs
- o providing a local liaison mechanism (NHS) among residents, financial institutions, and governments at local, state and federal levels
- o securing the interest and support of private sector business leaders, local, state and federal officials, and community residents
- o assisting in the formulation of locally controlled boards of directors, in obtaining non-profit status and in the installation of board procedures
- o recruiting, training and orientation of local NHS staff
- o assisting in raising operating and revolving loan funds

The initial task to be undertaken is the selection of an appropriate demonstration site, in consideration of the following criteria:

1. The site should have the potential of meeting the demonstration's shared objectives
2. HUD's preference is a multi-county, regional or other coherent substate model
3. The site (and initial NHS service area) should be non-metropolitan and predominantly rural
4. The site should contain places of less than 10,000 population which are economically independent of urban or suburban areas, and include some remote and isolated communities

II. Recap of Efforts Toward Site Selection:

Neighborhood Reinvestment has concentrated its efforts throughout the past year on the identification of an appropriate rural NHS demonstration site. Specifically, we have sought a predominately rural setting where the degree of need, partnership potential and financial resources appear to provide for a successful demonstration.

Through a series of meetings and discussions with both HUD and Neighborhood Reinvestment staff, possible demonstration sites were narrowed to 2 broadly defined areas for assessment purposes. The board areas selected for full assessment include an eleven-county region in Central Pennsylvania and an area located in Taos City/County, New Mexico.

The initial assessment visits were jointly conducted by HUD and Neighborhood Reinvestment staff and resulted in a mutual decision to further explore possibilities in both central Pennsylvania and Taos City/County. Both areas contained suitable demonstration sites and the level of local interest in the NHS concept appeared equally high. As the assessment process continued, however, the limited potential for raising meaningful private financial resources became increasingly apparent, and a firm commitment to proceed in either locality became dependent on their successful applications for small cities grant funds. With HUD's concurrence, a determination to delay the demonstration pending the outcome of the small cities process was made.

Over the last few months, we have maintained contact with both localities and have provided assistance with their small cities grant applications and with private sector and foundation research. We have also been available for information meetings as appropriate.

In central Pennsylvania, the SEDA-Council of Governments has recently advised us that funding for a rural NHS program under the State-administered Pennsylvania Small Community Program is not possible. They intend to pursue revolving loan fund grant money through the Appalachian Regional Commission, but do not plan to establish an NHS structure or initiate additional private sector involvement.

In Taos, both the county and city made a small cities application. These are still pending. The possibility of any significant private sector support is increasingly slight. While approval for their applications looks favorable, the level of funding, if approval, does not appear adequate to meet operating and revolving loan fund needs.

III. Current Alternatives for Site Selection:

Given the prospect for further delays in either of the above locations, our mutual interest might well be served by focusing our combined resources on an existing rural NHS development. Present options along this line include Durango/La Plata County, Colorado and Barre/Randolph/East Bethel, Vermont.

Durango is a town of about 13,000 in population, located within La Plata County, in Southwest Colorado. We have been involved in assessing the feasibility of a successful rural NHS development in Durango over the past several months, and have found appropriate target areas, particularly in the southern portion of the town. We have also found a high level of interest in the NHS concept, and a willingness on the part of state and local government officials and local business representatives to pursue development. At present, key local actors include representatives of Centennial Savings and Loan, Burns National Bank, Southwest Community Resources, the Chamber of Commerce, the State Department of Local Affairs, the State Impact Advisory Committee, the County Commission, and the city manager. While we are encouraged by events to date, we are proceeding very cautiously as the availability of adequate financial resources is still uncertain. The ability to secure private resources seems heavily dependent on a successful small cities grant application, the outcome of which will not be known for a few months.

Development of a rural NHS program in Vermont has progressed in three stages. First, a thorough assessment of the feasibility of developing a successful program in Vermont was conducted at the request of the Federal Home Loan Bank of Boston. This request was initiated in response to the Vermont savings and loan industry's interest in addressing rural housing needs in the northeastern part of the state, an interest found to be shared by various state officials.

Due to the interest of state-wide institutions and government, and because of an apparent need for an effective rural housing services delivery mechanism in areas throughout the state, the second stage of development focused on the organization of a state-wide, public-private corporation. At the same time, cooperative relationships were established with the Vermont Housing Finance Agency (VHFA), Farmers Home Administration, the Rural Conservation Corporation (a utility funded weatherization program), and various state-wide lending institutions, businesses, agencies and civic leaders.

Vermont Community Housing Services (VCHS) is presently in place and governed by an 18-member Board of Directors, representing lending institutions, a variety of businesses, state government offices and agencies, and the community at large. Recently, following the organization of VCHS, initial target areas were selected through an appication process. These target areas include portions of Barre, Randolph and East Bethel, which are located within Washington, Orange and Windsor counties. The population of the combined broader area is just above 10,000, and the median family income for each target area are at or below 70% of the median income for the State of Vermont.

The third stage is the development of local partnership support and participation through an educational workshop process. Although this process is still underway, cooperative relationships with local residents, government officials, lending institutions, businesses, state agency and Farmers Home county offices have already been established.

Securing adequate financial resources has been difficult, but the inclusion of local participants has been a highly positive experience, resulting in a reaffirmed momentum to succeed. To date, private financial support expected in the near future is in the range of $22,000. Barre, the only entity to presently be a CDBG recipient, has identified within its limited existing resources, about $6,000, and Randolph expects to set aside funds next year, pending a successful small cities grant application. While these limited resources are insufficient to support full operations at this time, we are confident that other identified funding sources will be more inclined to participate once a track record is established. Our staff and local participants agree that the potential for comparatively significant private involvement exists, but greatly depends on the program's ability to demonstrate some successes.

IV. Recommendation:

Vermont offers the best opportunity for presently moving forward. While we plan to continue exploring development in Durango and will maintain contacts in Taos, Vermont activities have progressed to a point where operations could soon begin.

We recommend that rural Vermont be selected as the rural NHS demonstration site pursuant to Cooperative Agreement (HS-5458). We also propose that the $100,000 grant be provided to us in support of direct development, training and technical assistance costs. We have made a grant of $50,000 to Vermont Community Housing Services and anticipate making additional grants for local operational ($25,000) and revolving loan fund ($100,000) purposes.

The next steps shift from development to operations. Initial efforts would be made to market and coordinate various applicable public and private initiatives, including Farmers Home, Vermont Housing Finance Agency and Rural Conservation Corporation (weatherization) programs. The revolving loan fund would be used, when appropriate, in conjunction with these programs and conventional sources to maximize the impact of existing resources and encourage health and safety corrections. Once a positive image and track record is established, other projects are anticipated, such as the rehab and conversion of a vacant school house to a much needed day care and community meeting center. Construction of low-cost housing is considered important by local participants. This may not be achieved, however, during early stages of operations.

We feel that the key to this demonstration is not in the developmental phase, but the operations phase. The operations of the rural NHS will give us the opportunity to test and observe: 1) the partnership approach in facilitating rural housing services; 2) the coordination of resources available from HUD, FHA, FhMA, state and local government and conventional institutions; 3) the promotion of new, creative financing mechanisms; and 4) adaptive re-use projects in a rural setting.

Rural NHS Demonstration

HUD - Neighborhood Reinvestment

Cooperative Agreement (HA - 5458)

Development Report

July 28, 1983

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INTRODUCTION

The purpose of this report is to describe Neighborhood Reinvestment's rural NHS development experience, to date, and contrast this experience with that of NHS development in urban settings.

Neighborhood Reinvestment historically has concentrated its NHS development efforts in urban areas. The original NHS model in Pittsburgh featured a partnership of residents, business leaders and city government officials working through a non-profit vehicle and a small staff to revitalize an inner-city neighborhood. The organization that was the forerunner of Neighborhood Reinvestment, the Urban Reinvestment Task Force, became involved in testing whether or not the Pittsburgh NHS concept could be adapted to other urban areas around the country.

At the time the first test NHS replication programs were being developed, the urban neighborhoods being addressed by these programs had distinctly similar issues of disinvestment by government, lending institutions and residents, with the common result of neighborhood decline. The proliferation and success of NHSs in the 1970's proved that the original NHS partnership elements and strategy components could be adapted to other urban environments. As these environments have changed and have been affected by fluctuations of the economic climate, NHSs have had to be innovative to survive, but the majority of NHSs have stood the test of time. In terms of a stabilizing influence and catalyst for revitalization impact in urban neighborhoods, NHS has been a success story.

Over the last several years, Neighborhood Reinvestment has begun to address the question of whether the NHS concept can be adapted to rural settings. We have seen the compelling need for revitalization in rural areas reflected in the numerous rural requests for assistance. As with the early testing of NHS in urban settings, we have approached the work of rural adaptation as a careful learning process.

To date, Neighborhood Reinvestment has been involved in testing NHS in six rural locations. They are Cattaraugus County, New York, Clackamas County, Oregon, Durango, Colorado, Richland Center, Wisconsin, Mabton, Washington and the State of Vermont. We have also made NHS assessments (but did not proceed with development) in Taos, New Mexico and the State of Pennsylvania.

The following is a review of the above rural developments and assessments. This review is followed by a closing commentary on the unique issues in NHS rural development (in contrast to NHS urban development) and the prospects of successful NHS rural adaptation.

CATTARAUGUS COUNTY

Cattaraugus County is a rural county in the southern tier of western New York State. The county has a population of approximately 100,000 people. As a result of discussions between the New York State Division of Housing and Community Renewal (DHCR) and Neighborhood Reinvestment staff, serious consideration was given to the application of the NHS partnership development process in a rural setting. DHCR was funding a number of Rural Preservation Companies (RPCs) throughout the State, however, DHCR had indicated a lack of complete satisfaction with RPCs' progress in addressing housing needs. Aware of the Neighborhood Housing Services program success, DHCR requested that Neighborhood Reinvestment become involved in an experiment to replicate the program in a rural area in New York. Many State Legislators had expressed a deep concern over the deteriorating housing stock in their rural districts (much of New York is dairy/farm land) and DHCR was seeking a solution.

Five rural areas were presented by the DHCR staff for consideration. Four of the five were eliminated for lack of partnership representation, i.e. no lending institutions, local government structure or adequate resident presence, lack of salvageable housing stock, inadequate access, no paved roads, bus service, etc. and a clear inability of residents to identify themselves as part of a community. The fifth area was Cattaraugus County. The County possessed the first-cut criteria which was established by both DHCR and Neighborhood Reinvestment staff.

Since Neighborhood Reinvestment had little experience in assesing a rural area and DHCR had no criteria for the development of a housing program, the basics of the NHS assessment process were used in Cattaraugus, with a good deal of flexibility being exercised. A number of site visits and discussions with the traditional partnership representatives indicated a need and desire for NHS activity. The weak link was funding. There is little industry or corporate activity in the county and while there were a number of financial institutions, they were small and their ability to support a professional staff was limited. However, they did indicate during the assessment their willingness to explore the possiblity of financial support. Also, DHCR indicated their RPC fund would support the program once it was incorporated. At that point in the assessment process, a contractual agreement with the State had not been drawn up.

The assessment lasted over four months, with site visits increasing in frequency and interviews increasing in numbers. Almost two-hundred people were interviewed criss-crossing the 1500 square mile county. The result was a decision by Neighborhood Reinvestment to proceed, knowing full well that the experimental nature of the development could not assure success. The major concerns discussed at the conclusion of the assessment and which had not been resolved included a lack of a target area, possible difficulty in producing visual impact, questionable financial institution participation, the projected length of the development process, issues of structure of the NHS program, staffing pattern issues, and the size of the area under development.

A kick-off luncheon was held for approximately 60 leaders, businessmen and financial institution representatives. The financial regulators were invited to attend to discuss their successful past experiences with NHS and encourage local participation. While this was standard procedure in other developments, it was perceived in Cattaraugus County as a pointed attempt to pressure financial institutions into NHS participation. The major concerns in relationship to the financial institutions'

participation included their support of an organization which at times would have activity centered outside of their immediate market area, anticipation that there would be no visible impact or way in which to measure success, poor past experience with RPC organizations, and general skepticism regarding an "outside" program development through a process with which they were unfamiliar. Financial institutions in rural Cattaraugus do not have the same personality or corporate character as their counterparts in the cities. Many of the high level personnel who are originally from the area worked for their company when it was "local" or "family owned". Traditional business practices are still used, many of them unfamiliar to urbanites. For example, there still exists a strong distinction between the Banks and S&Ls. It was not until recently that the S&Ls established a formal network of communication between financial institutions.

The development of the resident component in Cattaraugus differed greatly from the development of the private sector support. While skeptical at first, once residents understood the basic NHS philosophy, they were its greatest advocate. The appeal lay in the "help yourself/no reliance on government intervention, pride in community and local talent" relationships that they made between NHS and their own rural philosophy. Through the development, a heightened pride in their county took shape, fostering an awareness that many continued to live there by choice and that by working together, they could resolve mutual concerns, learning from each other's successes and failures. The enormous strength of their belief in that ideology on a county-wide basis was critical to the program's eventual success.

Since the local government representatives were also residents, there was no need for special cultivation on that level. Town Supervisors, Mayors, Assessors and Village Trustees were all on the developmental committees. However, because of carry-over of urban experiences, the cultivation of State and Federal Government officials was neglected and caused some concern toward the end of the process. In the rural area, the State and Federal Officials play a much more important role than in the urban setting and need special developmental attention.

Toward the conclusion of the two year development, a number of issues were brought to the forefront. They included the unwillingness on the part of most of the financial institutions to participate in the program unless activity was centered in their immediate market area, a justifiable uneasiness on the part of RPC's that yet another organization would be competing for both State and local funding, the difficult position DHCR was put in because of that issue, the inability of the State and Federal legislators to support the new organization because they had no "hands-on" experience themselves, and the inability of those not directly involved in the development to appreciate the possible impact the organization could have.

It was the decision of the development committees that had been working toward a structure and mission statement to incorporate without secured funding and (with the addition of technical assistance from Neighborhood Reinvestment) to tackle a project that, if successful, would have major visual impact. The deteriorating commercial strip in the City of Salamanca was the target area. The goal was reinvestment and renewal of local pride.

As the commercial strip project progressed, a joint committee of RPCs and the development committees was formed in the hope of alleviating fears and misconceptions. A government relations committee was also activated to secure support from the Local, State and Federal officials. The development group incorporated as the Rural Revitalization Corporation (RRC). Neighborhood Reinvestment gave minimal financial support to help launch the RRC's operation.

The RRC was eventually funded for its operating budget through the NY State DHCR rural funds. In addition, two banks contributed a share equal to approximately $80.00 per million of local deposits and the Cattaraugus County Employment Training Program assisted with some additional funds. The RRC at present is operating with a traditional three person staff on a budget of approximately $90,000.00 a year. They have the additional resource of a student intern for the summer.

The loan fund consists of Farmers Home Administration money, for which the RRC staff has been designated a packager. They also have some loan fund dollars from Neighborhood Reinvestment, but as yet have not had to use them. They are recognized as a primary source of technical assistance for housing in the County, as well as the only source (with FHA) for low interest housing rehab and mortgage money. Their influence extends beyond the County line, as do their corporate boundaries. Two areas of present activity included villages in both Wyoming County and Erie County.

The revitalization efforts in the City of Salamanca won the Downtown Research & Development Center's 1982 Award of Merit. Because of that success, the Erie County Southtowns Planning & Development Group has funded a Commercial Corridor Manager, supervised by the RRC, to work in three villages in southern Erie County.

Private financial involvement is still a goal of the 15 member RRC board and dialogue with non-participating financial institutions continues. The institutions' major drawback remains the question of impact in their market area. The underpinnings of a fundraising campaign are now being put in place.

The RRC board has set obtainable and realistic goals for the next year. While some are slightly outside the boundaries of a traditional NHS at this stage, they are appropriate for the RRC.

The priorities include the rehabilitation of 20-25 homes in an initial target area, using Farmers Home and other financial sources, the revitalization of the three commercial strips in Erie County, the organization of a crime watch, commercial revitalization and housing rehabilitation programs in the target area, organizing activity in the four geographic divisions within the corporate boundaries, coordination of an industrial child care center in Olean (to be housed in a building that was donated to the RRC and undergoing major rehab through their efforts and those of their leasee, the Olean Child Development Corporation), the rehabilitation of an historic rail depot in Salamanca along with the development of a positive atmosphere for new businesses as the second phase of the Salamanca commercial strip program which will include rehab and reuse of an abandoned movie house continues.

The major problems for the RRC over the next year will continue to be a shortage of staff, increased demand for their diverse services and the size of the area in regard to travel costs for the staff. Their greatest assets are the strength and imagination of their board, their willingness to be flexible and their creative use of resources.

CATTARAUGUS COUNTY BOARD OF DIRECTORS

Residents	Government	Business
Jay Antonio Vice President	Ken White Treasurer (Government affiliation - Town Assessor)	Thomas Andy Mayfield President (Business affiliation - V.P. Citizens Central Bank)
Margaret Bowles Member	Norm Leigh Member (Government affiliation - County Grantsman)	Phil Antonio Member (Business affiliation - Small Businessman)
Tom Brady Member	Mike Kayes Member (Government affiliation - County Planning Department)	Frank Pizzuti Member (Business affiliation - Chessie Railroad)
Sue Jakovac Secretary	Jeff Smith Member (Government affiliation - Village Administrator)	Dan Glendinning Member (Business affiliation - Loan Officer - Empire Savings and Loan)
Mark Lillenstein Member		
John Andrus Member		

CLACKAMAS COUNTY

Clackamas County is a rural county in northwestern Oregon with an approximate population of 245,000. In response to interest expressed by the county government, Neighborhood Reinvestment made an NHS assessment visit to the county in the fall of 1981. The County government had already selected several potential NHS neighborhoods.

Neighborhood Reinvestment staff spent two days traveling throughout the county viewing potential sites for the implementation of a Neighborhood Housing Services program. After a review of the sites within Clackamas County, the County government selected the Overland Park neighborhood as the initial NHS target area with Neighborhood Reinvestment's concurrence. A joint decision was made by Neighborhood Reinvestment and the County government to develop a NHS with an owner built program component.

In January of 1982, the Developmental Agreement with the County was finalized. Advertisement for the position of Local Coordinator began in February of 1982. The County government required the selection be restricted to residents of Clackamas County. The recruitment and selection of a Local Coordinator became the first major development hurdle. The County itself has no major newspaper. This required advertising in a small "town" newspaper, neighborhood papers and weekly or bi-weekly journals.

Interviews for the position of Local Coordinator began in February 1982. The field of qualified candidates was limited, but an intense recruitment process resulted in the hiring of a local coordinator.

Following the hiring of a local coordinator, a business leaders' luncheon was planned (difficult in rural area to find meetings and workshop sites). Financial institutions and corporations are located throughout Clackamas county. This meant a great deal of travel over large distances for the local coordinator and field services officer. An additional consideration was that during this period of time, not only were lenders being contacted, but people in the community at large, County Commissioners and neighborhood residents. These people were also located throughout the county. Since it was necessary to meet when people had the time, it was not usually possible to schedule appointments so they were geographically close together. The extensive amount of travel requred also meant more time involved in making the necessary contacts associated with an NHS development and higher than usual transportation costs were incurred. Also, many of the banks serving Clackamas County are located in downtown Portland. This meant having to travel not only extensively throughout the county, but to downtown Portland from various points throughout the county, and then return. On June 4, 1982 the Business Leaders' Luncheon was held.

Organizing efforts continued and on August 9-11, 1982 the Clackamas County Neighborhood Housing Services Planning and Orientation Workshop was held.

One problem readily apparent at the workshop was the management level of business and financial institutions represented. The private sector represented seemed to have a strong allegiance to their individual cities, but very little to the

county at-large. Businesses headquatered in Portland, but doing business in Clackamas County viewed their corporate/social relationship to Clackamas County with less zeal than their relationship with the city of Portland. Even those businesses headquartered within Clackamas County seemed to affilate with the small town the organization was operating in or adjacent to, rather than the county.

Following Workshop I, several committees were formed. One problem which arose was finding meeting facilities, especially conveniently located meeting facilities for the committees.

Fundraising was an acute problem for several reasons. The largest corporations and financial institutions with the greatest assets have their activities headquartered in downtown Portland. Since middle management represented the private sector at the workshop, and the Portland based private sector felt at a distance from Clackamas County, higher level corporate officers did not become involved in the development. The middle managers involved after the workshop were committed to the NHS, but lacked the clout of the CEO level. While most of the private sector organizations involved contributed, their contributions were less than requested, reflecting the lack of intense commitment at the uppermost level of the corporate hierarchy. The selection of a fundraising leader was predictably very difficult.

While fundraising was an important concern, through the work of the developmental committees, other issues became apparent. The County had neither a code enforcement program for existing construction, nor a minimum housing code to be enforced.

The neighborhood required substantial capital improvements. Lighting, sewers and paved streets were items which the neighborhood needed, but many residents were unable to pay for.

The County government agreed to provide a code inspector and the NHS committee agreed the rehabilitation standard would be commensurate with that used by the County government in its CD funded rehab projects. The County government also agreed to use CD funds to provide capital improvements in the neighborhood.

On October 25 and 26, 1982, a Resident's Inclusion Workshop was held. Following the workshop, efforts of the developmental committees continued.

After the Residents' Inclusion Workshop, a second Contributors' Luncheon was held. The luncheon took place in the dining room of a downtown Portland financial institution. While the luncheon was attended by upper management personnel from financial institutions, the presidents of the institutions did not attend.

A well attended Structure and By-Laws Workshop held on January 18, 1983 that formalized the organization of the Clackamas NHS. On February 22, 1983 the NHS was incorporated and the Board of Directors elected.

The Clackamas program is currently working on, as the initial phase of the NHS service, an owner built project. Once this project is successfully underway, the NHS will begin offering traditional housing rehabilitation services. Neighborhood Reinvestment is providing partial funding for the owner built project, as well as a grant for the NHS revolving loan fund. The Clackamas program must still raise substantial funds from the private sector. The program hopes that the owner built project will attract private sector support to the NHS.

CLACKAMAS COUNTY BOARD OF DIRECTORS

Residents	Government	Business
Wiliam Mainorth President	Dale Harlan Member (Government affiliation - County Commissioner)	Robert Kinnan Vice President (Business affiliation - V.P. Commercial Loans First Interstate Bank of Oregon)
Gean Schlickting Secretary		Michael Stone Member (Business affiliation - V.P. Farwest Federal Bank)
Bruce Ankarberg Member		Samiya Morcardine Treasuer (Business affiliation - U.S. National Bank)
Eric Jamieson Member		Richard Weaver Member (Business affiliation - North West Natural Gas)
Julie Valpel Member		Ray Baker Member (Business affiliation - Carpenters Local Union Finance Secretary
Thomas Webb Member		
Donna Puckett Member		

RICHLAND CENTER

In 1981, the Wisconsin State Department of Development indicated its interest to Neighborhood Reinvestment in the creation of a demonstration NHS program for a small city in Wisconsin. Traditionally, a city government will enter into an agreement with Neighborhood Reinvestment for the development of an NHS program. In this instance, the State's proposal made it suitable for the State to become a party to the development agreement between a city and Neighborhood Reinvestment. Following the award of Community Development Block Grant money to the Department of Development for distribution, smaller Wisconsin cities were invited to apply for CDBG money if they were willing to be considered and selected as the site for the proposed NHS. Richland Center, a city with a population of fewer than 5,000, was selected. In July, 1981, the developmental agreement was made final between the Department of Development, the City of Richland Center, and the Neighborhood Reinvestment Corporation. The agreement made it clear that, although the NHS in Richland Center would be developed in a manner similar to that employed for other NHS programs, the developmental process would be adapted to meet Richland Center's unique circumstances and the NHS would serve the entire community, not just a single neighborhood.

A Local Coordinator, supervised by Neighborhood Reinvestment, was hired in October, 1981. This individual divided her time between responsibilities as Local Coordinator for the development of the NHS and coordinator for the city's CDBG program. In January, 1982, a luncheon was held to acquaint several dozen local civic and business leaders with the plans for the development. Three months later, many of these leaders, also with a group of community residents, spent two days together in the NHS's Workshop I where they learned about the NHS concept, its applicability to Richland Center and the offers that each sector of the community would be willing to make in order to facilitate the development of the NHS. The Richland Center NHS incorporated in November, 1982, strengthened and trained its Board of Directors, and hired its Executive Director in February, 1983.

The Richland Center NHS program can be best described in terms of each of the organizational components which presently comprise the program.

The business and financial sector is a working partner in the Richland Center NHS, just as it is and is expected to be in other NHS programs across the country. Unlike NHS programs in larger communities, however, the Richland Center NHS does not have access to the broad based, more numerous institutional resources that are typically available to NHS programs elsewhere. There are 2 banks, 2 savings and loan associations and a relatively small number of industries and corporations in the town. Usually, NHS programs are able to raise their operating funds locally. In Richland Center, the fund raising base will need to be expanded to businesses, corporations and industries which are outside the immediate community. Some examples of potential contributors include construction companies which do business in the general area, home building organizations, agricultural concerns and public utilities. Fundraising is presently a major priority for the NHS.

The City of Richland Center, while a partner in the program through its associations with the State Department of Development and HUD, is not an active partner at this time. Richland Center is located in an area of very slow economic

growth, which necessitates that those governing the city make careful decisions about social and economic commitments. The city's history is marked by years of passed on traditions and the impact of one or two guiding forces, one of which is the office and personage of the present mayor of Richland Center who has been in office for sixteen years. The Mayor has serious concerns about the NHS approach. Another component of city government, the City Council, does not presently offer leadership beyond that which emanates from the mayoral office. City Council representatives have shaped their role as one of ratification and extension of the mayoral authority. For some years, Richland Center, like many other smaller, rural cities, has been preoccupied with maintaining traditional status and, in some ways, the efforts to develop and support an NHS have been viewed by the city government as disruptive.

In the resident element of this partnership there is a great measure of enthusiasm, a willingness to effect long and short-term plans, a genuinely cooperative spirit and active participation both on the Board and with the program operations. This has been a unique awakening of resident consciousness. Like other NHS programs, the residents in Richland Center are "first among equals". The Board's composition reflects this particular facet of NHS philosophy, with residents constituting the numerical majority.

Most NHS programs can be identified in terms of the composition of the neighborhoods they serve. Although the demographic characteristics of Richland Center reveal a homogeneity which is certainly comparable to that which ordinarily exists for a neighborhood within a larger city, the fact that NHS serves the entire community will probably, over time create yet another bond between neighbors and neighborhoods in an already closely knit community. If the Richland Center NHS continues to attract such intense scrutiny and enthusiasm, the spiraling awareness of the interrelatedness of business, civic, and popular interests could well thrust the NHS into addressing community issues beyond housing.

The management and the administration of the NHS, as a non-profit corporation, rest with its Board of Directors and the staff responsible to that body.

The present Board Chair has acquired experience with both for-profit and non-profit corporations. He is both a resident and a member of the business community in Richland Center.

At this time, the Board is concentrating on the establishment of the program's credibility among residents. One way in which this credibility will be established is through the program's exploration of the relationship between resident input and involvement and programmatic success. Most Board members have expressed their desire that the NHS be perceived as a mechanism or catalyst for both long and short-term community revitalization. On a short-term basis, the Board has agreed that one area in which the NHS can have an immediate and visible impact is that of exterior improvement to the community's 2200 housing units. The plan is to paint every home.

In order to accomplish this, the Executive Director, has secured a substantial discount, nearly amounting to a donation, of paint from a local business and arranged for instruction in housepainting for interested homeowners and a special crew of youth laborers who will assist those who cannot paint their own structures.

A long-term goal for the Richland Center NHS is to bring all of Richland Center's housing stock up to acceptable standards of health and safety, an aim which is consistent with that of other NHS programs. The NHS, in achieving this goal, will have to address the city's outdated code inspection system. The program will also need to address unique circumstances that affect housing, such as the city's flood plain area.

RICHLAND CENTER BOARD OF DIRECTORS

Residents	Government	Business
Lorna Maxwell Member	Alderman Walter Crook Member (also Lender)	John Lewis Member (Business affiliation - President - Farmers & Merchants Bank)
John Fergus Vice President	Calvin Hall Member (Government affiliation - County Highway Department and City Council)	
Holly Frentess Member		
Ray Lawton Secretary		
Patti Masters Member		
Harvey Glanzer President		
Rev. John Gibbs Member		
Dr. Kilian Meyer Member		

MABTON, WASHINGTON

Mabton, Washington is a largely agricultural community of 1,200 people. The first NHS contact came in 1980 as a result of an inquiry by the Yakima Valley Conference of Governments. At that time the Conference of Governments (COG) was interested in putting together a multi-neighborhood NHS program with several small cities in the lower Yakima Valley.

At the request of the COG, Neighborhood Reinvestment began to explain the NHS concept to residents of the lower Yakima Valley. With the assistance of the COG, three cities applied for a small cities grant to develop an NHS. The application was rejected. The following year, with the assistance of the COG, the town of Mabton obtained enough funds to carry out a housing condition survey. In 1982 the town of Mabton, using the data obtained from the COG conducted survey, applied for and received a small cities grant.

Upon receiving the grant, the town of Mabton, through the Yakima Valley Conference of Governments, approached Neighborhood Reinvestment concerning the possibility of developing an NHS in Mabton.

An assessment was conducted of the town. The town has a relatively high degree of home ownership with most residents having low to moderate incomes. However, there is only one financial institution in town, a small branch of a Seattle based institution. While other institutions have branches in the lower Yakima Valley, none are of extensive size. Large industry does not exist in the valley. The primary industry is agriculture with some canneries operating in the area.

Prior to their application for the small cities grant, we shared our judgment with the Yakima Valley Conference of Governments and the town of Mabton that local private financial resources probably could not support an NHS operating budget. It was clear that money for the NHS operating budget would have to be provided through the small cities grant.

After some discussion with the town and the Conference of Governments, it was agreed that the town would contribute (through the small cities grant):

$394,722 for capital improvements,
$764,374 for the revolving loan fund, and
$147,626 to the operating budget.

In April 1983 the NHS developmental agreement was finalized. However, the State Department of Planning and Community Affairs requested additions and changes in the document. The agreement was then renegotiated and sumitted for ratification by the Town Council on May 23, 1983.

On May 14, 1983 advertisement began for the position of Local Coordinator in Mabton, Washington. The position was advertised in the Yakima and Walla Walla daily newspapers and two weekly papers published in the nearby towns of Sunnyside and Grandview. These towns are also located in the lower Yakima Valley. Several local organizations were personally contacted by the Field Services Officer in an effort to find people who might be interested in the Local Coordinator position. Approximately twenty (20) resumes were received. Interviews for the position of Local Coordinator were conducted on June 2 and 3. Eight people were interviewed.

Three finalists were selected. No one candidate appeared to have an entire range of skills necessary to facilitate the development. A local coordinator was finally selected in June, 1983.

The Mabton Local Coordinator is required to travel not only to Mabton, but throughout the lower Yakima Valley and to the city of Yakima. This will mean travel more extensive than that normally associated with an urban NHS development and higher development travel costs.

Presently the Mabton development is fully underway. As indicated above, the town of Mabton will contribute a substantial sum to the NHS operating budget, but private sector funding will also be pursued. Private sector fundraising is anticipated to be a difficult task, even for the small amount to be requested. A major factor in the fundraising will be the ability of business leaders to relate to a small community far from regional or corporate headquarters.

Finding workshop sites for the development will be difficult. Also securing the attendance of regional managers or executive decision makers at the first workshop will be difficult. In urban areas, corporations or city governments may have a skilled personnel specialist who can participate on the Personnel Committee. A bank may provide someone from its legal department for the Structure and By-Laws Committee. Financial institution branches and local government in rural areas rarely have the specialized expertise contained in urban areas. In some urban areas, local governments have print shops which can cheaply print NHS brochures, copies of by-laws or committees minutes. These resources are sparce in Mabtons' rural environment. Accordingly, printing costs can be expected to be more costly than usual. Mabton does not have a newspaper. A newsletter will have to be an integral part of the development. Neither does the town have a print shop or copy center. The Local Coordinator will have to use the town's photocopier for all his copying or drive to a larger city nearby which may have copying services.

An ultimate objective of the Mabton development is to demonstrate to the county government the value of an NHS, gaining its participation and convincing potential contributors to identify with the program on a county wide basis.

Of all the challenges to be encountered in the development of an NHS in Mabton, executive director recruitment may be the most difficult. The field of qualified applicants from the lower Yakima Valley or even the city of Yakima may not be large. While outside recruiting is feasible, there are costs associated with bringing people from Portland, Spokane or Seattle to Mabton for an interview. Moreover, it is important that the executive director live in the lower Yakima Valley, if not in Mabton. Mabton is an isolated rural community. The ability to draw a competent person to serve as executive director will be an important element in the program's ability to effectively deliver services.

VERMONT

The development of the Vermont Community Housing Services program began with the interest of the Federal Home Loan Bank of Boston in the development of NHS programs in rural areas of New England. Previous to the development in Vermont, the bank had made available a $60,000 grant to Neighborhood Reinvestment to facilitate the development of a program in South Portland, Maine. Because only $30,000 of the grant was used in the development of the South Portland program, the bank agreed to allow the remaining $30,000 to be used for the development of a similar program in Vermont. The grant allowed Neighborhood Reinvestment to hire an individual who had been the Local Coordinator for the South Portland program, as Field Services Officer for the Vermont development.

After an initial period of research and investigation, it appeared that, because of the small size and financial resources of the population centers in Vermont, it would be best to organize a state wide coordinating board which would be responsible for resource development and the selection of the target communities. To that end, a workshop, which included representation from state and local governments, financial institutions and housing non-profits, was organized in June of 1980. The workshop was very successful and resulted in the establishment of development structure, site selection and personnel committees. In March of 1981, a state wide board was elected which was representative of the partnership groups and of Vermont's various geographic areas. The board elected officers and, with a $50,000 start up grant from Neighborhood Reinvestment, hired an Executive Director and opened an office.

From the beginning, fundraising for the program in Vermont was hampered by three major factors. Vermont's small financial resource base, the severe financial problems of the state's thrift industry and the fact that target communities had not yet been selected (institutions were reluctant to give to a program when they did not know the location of the communities which would benefit).

In order to answer the latter objection, the board designed an application form which was distributed to all Vermont municipalities which explained the intent of the program and asked the communities to describe the need for, and interest in, the program.

Upon receivng the applications and reviewing the submissions the board held informational meetings for the interested communities. Based upon the need of the communities and the commitments which they made to the development, the communities of East Randolph and Barre were selected as the initial target sites.

Despite the fact that fundraising was proving to be an extremely difficult and discouraging process, VCHS decided to continue to move ahead with site selection and local development. It was their strong conviction that to do otherwise would irrevocably damage their credibility and restrict even further the potential for successful fundraising.

Neighborhood Reinvestment and key VCHS Board members, and the Central Director, held lengthy and frequent discussions in an attempt to resolve some critical issues, for example:

- Without assurance of sufficient resources, could we - and should we - proceed to organize local CHS partnerships? Would we be creating unrealistic and unfair expectations?

- What would be our various roles in local development?

- What kinds of alternate strategies could we employ to address the existing fundraising problem?

- Given the fact that Barre and Randolph are very different communities with unique political structures, resources and concerns, how should we best adapt our approach to suit their individual needs?

- How could we maintain the interest of VCHS Board members who did not come from the Central Vermont area?

- How to modify the state wide effort and structure to reflect the realities of limited resources without compromising the important vision of a state wide Program?

All parties to these discussions were extraordinarily committed to developing solutions to these problems and to finding some way to proceed.

It was first agreed that development in Randolph and Barre would continue. Neighborhood Reinvestment agreed to hire a Local Coordinator to organize local partnership with the understanding that we were talking about two separate decision making bodies - one in Barre and one in Randolph, both of which would come under the VCHS umbrella. It was also the concensus of VCHS and Neighborhood Reinvestment that, from the outset, all participants would be straight forward about the status of resource development and continue to work together and with local participants to design fundraising strategies.

It was agreed that development role definitions would be flexible with the following underlying assumptions:

- VCHS would provide oversight for local development, would continue to focus their energies on fundraising and resource development and, as appropriate or desired, individual VCHS Board members would serve on the development committees in Randolph and Barre to provide expertise and liaison.

- Neighborhood Reinvestment staff would facilitate local partnership development, would call on VCHS Board members for assistance, would provide frequent reports on progress to the Central Board and staff and would continue to provide support and technical assistance to the Central Director.

The scarcity of private dollars forced Vermont participants to look at the possibility of securing public dollars for program support. Barre was commencing their second year of a 3 year CDBG program which did not include the neighborhood targeted for CHS activity. Randolph, however was eligible to apply for CDBG funds, and expressed a strong interest in doing so. After meetings with public officials in Barre and Randolph it was agreed that the development process would be conducted in stages, with an initial major thrust to get Randolph off the ground, followed by a similar thrust in Barre. This was the result of the fact that Randolph is smaller, has a much simpler municipal decision making process, was anxious to proceed quickly and was eligible for CDBG assistance immediately. While residents in Barre could have been organized in a relatively short time, the lenders and the City, particularly the City Council, needed more exposure to CHS goals.

The issue of maintaining the interest and enthusiasm of VCHS Board members from elsewhere in Vermont was, and is, a difficult one. It was initially assumed that planning program expansion, creating additional visibility, and conducting fundraising events would sufficiently occupy and energize Board members during the period that the local development was underway in Barre and Randolph. However it became clear that there was a need to establish a track record before actively pursuing funding sources. This, in turn, curtailed the possibility for quick program expansion and postponed state wide fundraising events. These problems were exacerbated by a central director's lack of adjustment to the director role. While a number of VCHS board members have been actively involved in Barre and Randolph, and their interest has thereby remained strong, it is not geographically or logistically feasible for all VCHS Board members to participate locally. As a result, there currently exists a small core of approximately 10 active VCHS Board members and a larger group of Board and corporate members whose primary contact with program activity is through monthly progress reports and newsletters mailed by staff.

Randolph applied for and received $173,000 in CDBG funds to be administered through VCHS for development of Community Housing Services along Rte. 14. $23,000 was earmarked for administrative funds and, supplemented by the HUD rural initiatives dollars granted to Neighborhood Reinvestment, this amount allowed the Randolph Advisory Board to hire three staff, a Director, a rehab specialist and an administrative assistant. The program has elected to use the name East Valley Community Housing Services and has elected a strong partnership Board including very committed residents from the target area. They have local committees, solid and appropriate loan policies and currently have two loans closed and three in progress. Their main focus at the moment is to develop a strategy to maximize program impact. There are a number of large, vacant and highly visible properties on Rte. 14 and the Board views a marketing and rehab strategy as critical to their success. The local banks, though small, are active on the Board and Loan Committee as are municipal officials, Bill Burgess (Town Manager) and Larry Townsend (Selectman).

The success of Randolph's CDGB application as well as the enthusiasm generated in the Barre community through a joint VCHS/Randolph/Barre workshop this past winter, has persuaded the CD department in Barre to aggressively pursue CDBG funds from the state in order to complete Barre development. Sam Lewis (CO-CD Director) has taken a strong lead. Staffing limitations and the timing of the CD process (applications due in September - funding decisions in January) have slowed development in Barre. There is, though, an energetic and competent CD Staff in place who may be appropriate to administer some phases of CHS operations. Some of our dollars are reserved for Barre and even if their application for state funds is not successful, modifications are possible in order to effect the delivery of CHS services in their target neighborhood.

VCHS terminated their Central Director in May. He had been paid through a grant from Neighborhood Reinvestment and the grant dollars had been fully expended. While the concensus was that they had made an inappropriate choice in their Director, the loss of administrative support has been difficult and has put an extra burden on local staff in Randolph who have had to assume additional responsibilities.

VCHS is currently in the process of discussing staffing and structural options in light of existing realities. A Committee has been established to address their current key concerns of:

- how best to provide meaningful exchange and input between VCHS and local Boards. Options being explored include making local Board members also VCHS Directors and operating the state wide program through a strong committee process and designating a specific number of seats on the state-wide Board for local CHS Advisory Board members. A joint VCHS/Randolph Board meeting was recently held to hear a preliminary report from the Committee on options for restructuring the Board.

- how to maintain momentum in developing the Barre partnership given the limitations of staff and resources.

- how to recruit additional leadership for the state wide program and how to market the progress in Randolph to elicit such leadership and, eventually, to raise private funds.

- how to approach future expansions.

We are working with VCHS on all of these issues within the limitations of our staff resources. The Randolph Director has also been named Acting Director for VCHS. Despite his extremely heavy workload, he is providing an enormous amount of support to VCHS.

VERMONT BOARD OF DIRECTORS

Residents	Government	Business
Charles Helmer Member	Scott Frazier Member (Government affiliation - Vermont Housing Finance Agency)	R. Stewart Wooster President (Business affiliation - V.P. Vermont Federal Savings and Loan Association)
Lena Metiwier Member	Sam Lewis Member (Government affiliation - Director, Barre Community Development Department)	Jim Lebby Vice President (Business affiliation - Attorney - Director of Housing and Community Development Law Project)
Marcia Lafond Member	Charles Castle Secretary (Government affiliation - Planner, Vermont State Office on Aging)	Donald Dickson, Jr. Member (Business affiliation - Community Businessman)
Betty Carnell Member	Scudder Parker Member (Government affiliation - State Senate)	Joseph Giancola Member (Business affiliation - President Giancola Construction Company)
Jane Reynolds Treasurer		Michael Nemitz Member (Business affiliation - Attorney, V.P. Bank)
Alan Hark Member		John Nutting Member (Business affiliation - Reverend and Director of Vermont Samaranian)
Bruce Roberts Member		Thomas Ryan Member (Business affiliation - Community Business)
Roberta Shippa Member		Marilyn Von Ouhl Member (Business affiliation - Executive Director, Bennington - Rutland Opportunity Council)

DURANGO, COLORADO

Durango is the commercial hub and the largest city within a five county rural region in southwest Colorado. The initial interest in NHS was expressed by the State of Colorado and a local community action program (Southwest Community Resources).

After an assessment period, Neighborhood Reinvestment began development in July of 1982. Funding for the NHS was to emanate from a joint city/county block grant proposal submitted to HUD.

Following an initial orientation and planning workshop in the Fall of 1982, Neighborhood Reinvestment decided to withdraw from the Durango development. The reasons for the withdrawal were several major local factors that, in our judgment, made it extremely difficult to develop a NHS with adequate resident participation and leadership.

CENTRAL PENNSYLVANIA

In 1982, Neighborhood Reinvestment carried out an assessment process in an 11 county rural area in central Pennsylvania. We decided not to proceed with development in central Pennsylvania in light of extremely limited private resources in the area and a lack of readiness on the part of our assessment contacts to proceed with further assessment work.

TAOS, NEW MEXICO

In 1982, Neighborhood Reinvestment was involved in assessment activity in Taos. After extensive assessment work, we decided not to proceed with development due to a lack of local resources to fund a NHS operation.

OBSERVATIONS ON NHS RURAL DEVELOPMENT EXPERIENCE

Our experience in rural development seems to indicate that the NHS model of a private, independent, self-help, voluntary partnership can be adapted to a rural setting.

In the rural NHS adaptations we have been involved in, the unique characteristics of rural environments have presented natural strengths as well as unique challenges for NHS development. The following is an analysis of those strengths and challenges in the context of the key elements needed to organize and operate a NHS.

Partnership Interest

Government has traditionally been a catalyst in initiating NHS assessment activity and development. In our rural experience, we have seen federal, state and county government take the lead in seeking local application of the NHS approach. In New York, the state government initiated our assessment of NHS possibilities in Cattauraugus county, while in Wisconsin, the state government similarly facilitated our work in Richland Center. In Oregon, the Clackamas County government invited Neighborhood Reinvestment to explore NHS feasibility, while in the state of Washington, the Yakima Valley Conference of Governments began the dialogue that resulted in NHS development in Mabton. In Vermont, the Federal Home Loan Bank of Boston was responsible for the launching of NHS development.

In our experience with urban NHS development, most often city governments, with established city planning and community development departments, have solicited NHS information and assessment activity. The rural pattern of entities other than local town governments acting as catalysts to introduce NHS into rural areas is understandable in light of the limited access small rural government subdivisions have to community revitalization information and resources.

Our experience has shown that once rural town governments become involved in the NHS development process, their participation can be extremely important. This participation is not only important in the area of the local government as conduit for program resources, e.g. small cities grant, but also in the area of the support and blessing local officials give to the NHS effort. A key factor in the rural environment is that individuals often wear a number of hats. Public officials most often hold other jobs and consider themselves "community residents" and "business leaders" as well as government officials. Thus, the support of local town government officials in the NHS effort is critical.

In the case of Richland Center, the Mayor, who has lived in the town for many years and has worn many hats, has had ongoing concerns regarding the NHS approach. These concerns have impacted the momentum of the development. In Mabton, local town officials' enthusiasm over NHS has greatly enhanced the prospects of the establishment of a highly successful NHS.

Traditionally, community residents have been viewed as the key cornerstone group of NHS - the "first among equals" in the NHS partnership. We have found that rural community residents have a genuine, experience-based affinity towards the self-help NHS philosophy of voluntary collaboration for the common good. Many of the residents involved in rural NHS are quite accustomed to neighbors reaching out to help other neighbors in need.

In organizing an NHS, identifying key community leadership has always been critically important. Small rural settings where key, influential individuals are usually well known, if not highly visible, lend themselves to successful recruitment of NHS leadership. Often in contrast, urban settings, although having immediately visible political leadership, call for exhaustive NHS leadership recruitment and development (which is made easier if strong community organizations exist). At this point, it is extremely safe to say that our experience indicates a tremendous potential in rural areas for resident involvement in NHS.

In the area of private sector participation in rural NHS efforts, the rural NHSs are finding their greatest challenges and difficulty. In some of the rural areas we are working in, substantial lending institutions and other businesses are simply not present. In some instances, their presence is in the form of a branch or minor outlet. This is in sharp contrast to much of our experience in urban settings where financial institutions and other corporations have home bases or significant assets and operations and accordingly have a strong vested interest in the immediate economic environment.

In Mabton, a major struggle in the development is to attract the high level participation of financial institutions and corporations located in the surrounding area, but not present in Mabton. This will be a very difficult endeavor. The other rural NHS efforts have struggled with similar issues regarding private sector involvement.

As a result of these issues, the rural NHSs have been facing major challenges in the area of private sector fundraising. Experience indicates that rural NHSs will need to turn to public funding (through a variety of vehicles) to supplement private sector funding.

In terms of the health of rural NHS partnerships, we are concerned about the ramifications of extensive public funding of rural NHSs. Large amounts of public funds granted on an annual basis make planning and execution of a multi-faceted NHS strategy subject to abrupt disruptions, as well as changing the basic private, self-sufficient character of the program. Our experience (in urban settings) is that an imbalance of funding from a single source produces an imbalance in the partnership, and that when the program is experiencing difficulties, such as redressing a poor choice of staff, or meeting challenging market conditions, or making difficult strategy choices, the imbalance in the partnership can skew the decision making process in a way which is destructive to the continued partnership governance of the program.

Financial Resources

Based on our urban NHS experience and our rural NHS experience, to date, it is clear that availability of financial resources for program operations will be the major problem in the effort to adapt NHS to the rural setting.

Although some rural NHSs will be implementing a variety of strategies other than or integrated with the basic NHS housing rehabilitation work, evidenced by the Cattaraugus commercial priority and the Clackamas owner built thrust, the NHSs will assuredly need a revolving loan fund resource. We believe that the use of a revolving loan fund which is flexibly designed to meet the needs of those who for one reason or another cannot draw upon other resources present (financial institutions, credit unions, Farmers Home, state programs, friends and relatives), is crucial to success. The wider range of housing structures (larger older frame homes dating back many decades to a variety of manufactured homes recently built) appear to require a very flexible and sophisticated approach to rehabilitation. We would expect the revolving loan funds to be used to supplement existing resources in a wide variety of ways.

We also believe, and our experience certainly indicates, that rural NHSs, as urban NHSs, must have highly competent staff. The staff will need adequate administrative support.

Based on the above loan fund and staffing assumptions, pages 23-25 of this report indicate a 5 year projection of estimated funding needs (operating budget and loan fund) and specific funding assumptions of the rural NHS programs in Vermont, Cattaraugus County, Richland Center, Clackamas County and Mabton. The table also indicates the possible funding resources.

RURAL NHS PROGRAMS: FIVE YEAR FUNDING PROJECTIONS

*(Projections do not reflect Development and Training/Techn. Asst. Costs)

	Barre/Randolph		Catt. County		Richland Cty.		Clackamas Cnty.		Mabton		Total		Overall Total
	$ Oper.	$ Rev. Loan	$ Oper.	$ Rev. Loan	$ Oper.	$ Rev. Loan	$ Oper.	$ Rev. Loan	$ Oper.	$ Rev. Loan	$ Oper.	$ RLF	
Year I:													
Public	20,000	150,000	58,500	-0-	20,000	150,000	-0-	100,000	60,000	270,000	158,500	670,000	828,500
Private	20,000	-0-	13,000	-0-	30,000	-0-	25,000	-0-	3,000	-0-	91,000	-0-	91,000
Neighborhood Reinvestment	50,000	75,000	-0-	100,000	-0-	50,000	100,000	25,000	-0-	50,000	150,000	300,000	450,000
Year II:													
Public	20,000	150,000	88,000	100,000	20,000	-0-	-0-	100,000	60,000	320,000	188,000	670,000	858,000
Private	30,000	-0-	20,000	-0-	30,000	50,000	55,000	-0-	5,000	-0-	140,000	50,000	190,000
Neighborhood Reinvestment	50,000	-0-	-0-	-0-	-0-	-0-	25,000	-0-	-0-	-0-	75,000	-0-	75,000
Year III:													
Public	50,000	150,000	58,000	110,000	20,000	-0-	-0-	100,000	-0-	100,000	128,000	460,000	588,000
Private	50,000	-0-	30,000	40,000	30,000	50,000	80,000	-0-	60,000	-0-	250,000	90,000	340,000
Neighborhood Reinvestment	-0-	35,000 X	-0-	-0-	-0-	-0-	10,000	-0-	25,000	70,000 X	35,000	105,000	140,000
Year IV:													
Public	50,000	150,000	58,000	110,000	20,000		-0-	100,000	-0-	100,000	128,000	460,000	588,000
Private	50,000	-0-	30,000	40,000	30,000		90,000	-0-	85,000	-0-	285,000	40,000	325,000
Neighborhood Reinvestment	-0-	35,000 X	-0-	-0-	-0-		-0-	35,000 X	-0-	-0-	-0-	70,000	70,000
Year V:													
Public	50,000	150,000	58,000	75,000	20,000		-0-	100,000	-0-	100,000	128,000	425,000	553,000
Private	50,000	-0-	30,000	25,000	30,000		95,000	-0-	85,000	-0-	290,000	25,000	315,000
Neighborhood Reinvestment	-0-	-0-	-0-	-0-	-0-		-0-	-0-	-0-	-0-	-0-	-0-	-0-
Public	190,000	750,000	320,500	395,000	100,000	150,000	-0-	500,000	120,000	890,000	730,500	2,685,000	3,415,500
Private	200,000	-0-	123,000	100,000	150,000	100,000	345,000	-0-	238,000	-0-	,056,000	205,000	1,261,000
Neighborhood Reinvestment	100,000	145,000	-0-	105,000	-0-	50,000	135,000	60,000	25,000	120,000	260,000	475,000	735,000
OVERALL	490,000	895,000	443,500	600,000	250,000	300,000	480,000	560,000	383,000	1,010,000	,046,500	3,365,000	5,411,500

* A. Assuming average expansion development costs of $40,000, the 5 projected expansions would increase NR costs by $200,000.

B. Assuming $30,000 per year for training and technical assistance increases NR costs by $750,000 (5 programs X 5 years X 30,000)

RURAL FUNDING NEEDS - CHART I ASSUMPTIONS

1. GENERAL

   A. Projections on Chart I do no include development and Training/TA costs.

   B. Limited staffing.

   C. Reliability on NHSA secondary market purchases (not accounted for on Chart).

   D. Reliability on in-kind services, i.e., space, printing.

   E. Dollars reflect needs conservatively.

   F. Dollars do not include costs for development, training and technical services.

2. VERMONT

   A. Statewide structure/central staffing included in operational budget projections.

   B. Assumes first 2 years of effort in Barre and Randolph, expansion to Burlington end of year 2, full effort in Barre and Burlington with residual services in Randolph in year 3, expansion to Rutland in year 4 with full effort in Burlington and residual services in Barre and Randolph, full services in Rutland and Burlington in year 5.

   C. Funds for expansion development costs not included in projection.

3. CATTARAUGAS COUNTY

   A. Includes a commerical revitalization component and commercial revolving loan fund.

   B. Public operating dollars in year 2 includes one-time grant of $30,000 for commercial.

4. RICHLAND CENTER

   A. Assumes three full years of effort, with phase-down beginning in year 4 and residual services in year 5.

   B. No expansion potential/program includes entire populace of 6,000.

   C. Assumes highly successful private fundraising.

5. CLACKAMAS COUNTY

   A. Assumes owner-built phase will complete by end year 1.

   B. Assumes $10,000 NPP grant in year 3 for one-year temporary staff person to market vacant properties.

   C. Assumes expansion in year 4 with possible phasing to residual services in original site.

   D. Assumes successful funding from Portland private sector.

6. MABTON

   A. Assumes limited staff, but concentrated effort on 133 structures in years 1 and 2 (no significant business or industry located within Mabton itself).

   B. Assumes expansion into Yakima County in year 3, with success in Mabton providing impetus.

   C. Anticipates Yakima County-based industry and business participation and operating support beginning in year 3.

As the table reflects, we believe the rural NHSs, with the exception of the Clackamas program, will need public funds to defray operating expenses, as well as to seed revolving loan funds. Presently, federal and state funds are being used, and projected to be used, by most of the rural NHSs. Community development block grant funds are a critical resource for this public funding, as well as applicable state grant programs.

The table indicates a sharing of operating budget funding by the public and private sectors. As previously discussed, we feel it is critical that the rural NHSs not be totally funded with public dollars. The search for private dollars, though, will be difficult.

The most promising approach to private sector fundraising for rural NHSs has been the Vermont state-wide resources approach. This has involved a state-wide board assuming the private fund raising responsibility, and as private and public resources permit, establising local NHSs which would be active in a community for several years and then after providing a way to deliver residual services to keep the community up to a good standard of continuing maintenance, move its main thrust of services into additional communities. Although the Vermont program has experienced frustrations in attempting to launch its central fundraising function, we feel, with appropriate staffing, the Vermont approach will produce results.

It cannot be stressed enough that the table shows private sector contributions that will be difficult to secure at the indicated levels. A number of the rural NHSs feel that they will need to establish impressive track records before being able to win the ongoing support of the private sector. The Clackamas program is hoping that the popular, visible owner built component will attract private sector funding for future efforts of the NHS.

Neighborhood Reinvestment will continue to play a role in providing fundraising training for rural NHSs, while in several cases providing direct operating budget funding, as well as our normal seed funding for the loan fund. The rural realities of sparce or distant private sector resources commits rural NHSs to an ongoing struggle of tapping into the available private resources, while maintaining needed funding levels from the public sector.

Staffing

As in urban NHSs, a major factor for succcess, along with partnership participation and financial resources, will be securing highly qualified staff. The rural environment presents unique challenges in addressing the NHS staffing need. In many rural areas, individuals qualified for NHS staffing roles are already in political positions or other positions of high responsibility.

In seeking executive director candidates from large cities at a distance from the NHS area, rural NHSs face the stiff challenge of persuading a qualified candidate to move to the NHS area or immediately surrounding area. The NHS also runs the risk of hiring an individual who, although technically qualified, may not have the "people skills" that are needed in the rural setting.

In our work in developing rural NHSs, we have moved in the direction of hiring local coordinators who would be qualified to assume the NHS executive director position if they were later picked for the position. The development period gives the local coordinator a chance to get to know the local program participants and also gives the participants an opportunity to assess the skills of the local coordinator. In Clackamas County, Cattaraugus County and Vermont, local coordinators have been chosen to direct program operations after development was completed.

Structure

The Vermont state-wide board structure was mentioned above as being a promising approach to rural NHS resource development and achievement of programmatic impact. In our work in urban settings, many NHSs have started with a single target neighborhood and board and later expanded into other neighborhoods, at the same time expanding the board to include new representatives. These boards operate as resource development vehicles for all of the neighborhoods under the umbrella of the NHS structure. The Vermont approach has a track record in the urban setting. It seems clear that in the rural environment of small towns and small NHS target areas, the approach of the umbrella NHS structure developing resources and facilitating the ongoing servicing of a number of neighborhoods is probably the most feasible approach. Among the present rural NHSs, the NHS umbrella structure is found on the state level (Vermont) and the county level (Cattaraugus and Clackamas). In Mabton, the hope is that the NHS will evolve into a county-wide operation.

Next Steps

With the above observations as a backdrop, we will be carefully monitoring the progress of rural NHSs. The philosophy of NHS has always had at its center the idea of achieving revitalization impact through partnership cooperation and the implementation of flexible, creative strategies. The realization of this philosophy in the rural setting will be key to the success of rural NHSs. With the major question of resources confronting them, rural NHS partnerships will have to be innovative and reach for every possible, appropriate resource to meet the variety of needs of the areas being addressed. One important, helpful milestone will be when a rural NHS establishes a track record of success that can be shared with other rural programs. This was the pattern of NHSs helping each other that occured in the growth of urban NHSs. We look forward to playing a key role in the networking of knowledge regarding NHS in the rural environment.