

NEURO-INCLUSIVE
HOUSING SOLUTIONS

SEPTEMBER
2025

# NEURO-INCLUSIVE INTENTIONAL COMMUNITIES IN COLORADO: INVESTIGATING DEMAND & POLICY RECOMMENDATIONS

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## LIST OF ACRONYMS



ADA – Americans with Disabilities Act
ADL – Activities of Daily Living
AHTC – Affordable Housing Tax Credit
AMI – Area Median Income
APITW – A Place in the World
ASU – Arizona State University
CFPD – Colorado Fund for People with Disabilities
CHFA – Colorado Housing and Finance Authority
CHIF – Colorado Housing Investment Fund
CMS – US Center for Medicaid & Medicare Services
CNAs – Certified Nurse Assistant
DD Act – Developmentally Disabled Assistance and Bill of Rights Act
DD waiver – Developmental Disabilities waiver
DDD – Division of Developmental Disabilities
DOH – Colorado Division of Housing
DOLA – Colorado Department of Local Affairs
DVR – Department of Vocational Rehabilitation
EU – European Union
FHFC – Florida Housing Finance Corporation
FIC – Fellowship for Intentional Communities
GJRC – Grand Junction Regional Center
HCBS – Home and Community Based Services
HCB-DD – Home and Community Based Services for the Developmentally Disabled (DD waiver)
HCPF – Colorado Department of Health Care Policy & Financing
HCV – Housing Choice Voucher
HMIS – Homeless Management Information System
HMA – Housing Market Analysis
HTF – Housing Trust Fund
HUD – US Department of Housing and Urban Development
ICF/IID – Intermediate Care Facilities for Individuals with Intellectual Disabilities
I/DD – Intellectual/developmental disabilities
IDDEAS – Denver Human Services I/DD Equitable Access to Services Program
IHC – Inclusive Housing Coalition
ISH – Integrated Supportive Housing
LIHTC – Low-Income Housing Tax Credit
LTSS – Long-Term Support Services
MFP – Money Follows the Person
MIHTC – Middle-Income Housing Tax Credit
NED Vouchers – Non-Elderly Disabled
OPWDD – New York's Developmental Disability Agency
PASA – Program Approved Service Agency
PCAs – Personal Care Attendant
PHA – Public Housing Authority
PRA – Project Rental Assistance
QAP – Qualified Allocation Plan
RAD – Resident Advisory Board
SIB – Social Impact Bond
SLS – Supported Living Services waiver
SSI – Supplemental Security Income
TOC – Transit-Oriented Communities
WHO – World Health Organization

***This work was made possible through the leadership and funding from the Colorado Developmental Disabilities Council.***

Colorado Developmental Disabilities Council

***Facilitation of the project was led by Neuro-Inclusive Housing Solutions in partnership with the Inclusive Housing Coalition of Colorado and the Autism Housing Network.***

NEURO-INCLUSIVE HOUSING SOLUTIONS

INCLUSIVE HOUSING COALITION
INCREASING HOUSING OPTIONS FOR ADULTS WITH I/DD

AUTISM HOUSING NETWORK

***With gratitude and acknowledgment of the dedication and efforts from those on the research team:***

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Autism Community Store
Aspen Public Radio
Ascendigo Autism Services
Boulder County Human Services
Broomfield Housing Alliance
Colorado State University Center for Community Partnerships
COI- Community Options, Inc
Developmental Pathways
FRIENDS of Broomfield
Imagine! Colorado
University of Colorado School of Medicine, JFK Partners
L'Arche NoCo
Pueblo's Center for Independent Living
Trailhead Community
The Arc of Northeast Colorado
The Resource Exchange

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The Espinosa Group

KEPHART

the espinosa group llc
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# EXECUTIVE SUMMARY

The demand for affordable and accessible housing for adults with intellectual and developmental disabilities (I/DD) in Colorado is a converging crisis of public health, equity, and social inclusion. Over 95,000 Coloradans with I/DD live with family caregivers, more than 21,000 of whom are over age 60. As Colorado ascends the ranks of the least affordable states for housing and the population of adults with I/DD continues to grow—particularly those living with senior caregivers—the risks of displacement, institutionalization and homelessness are intensifying. This demographic bulge raises an urgent question: Where will adults with I/DD live and how will they thrive when family can no longer provide support?

Without access to affordable housing and needed community-based support, Colorado faces the threat of re-institutionalizing adults with I/DD when individuals have no choice but to be displaced from their communities into "the next empty bed" of a provider-controlled setting, psychiatric facility, skilled nursing facility or one of Colorado's hospitals.
Seeking something different from the status quo, families and service providers have embarked on new paths forward, including intentional housing communities designed from the ground up to be inclusive for adults with I/DD.

This is a stark shift from the last few decades of the disability rights movement advocating for small, integrated settings scattered within the greater community. There is palpable concern among policymakers and other stakeholders that these new settings may separate adults with I/DD from their communities, mirroring the restrictive institutions of the past.

This report presents a comprehensive analysis of intentional communities based on research that included a literature review, county-level I/DD prevalence mapping, analysis of over 70 intentional communities across the United States, and robust public feedback.

**127,000**
Est. people with I/DD in CO

**73%**
Living with family

**21,000+**
Living with a family caregiver 60+ years

**165,000** (less than 50% AMI)
**Affordable rental unit deficit**

**Under 6% accessible housing**

**3,038**
(As Soon As Available)
**people with I/DD on a waiting list for needed services**

**28,491**
reported disabling condition (CO HMIS)
**homeless population w/disability**

**No Funding Source**
**targeting adults with I/DD for rental assistance or neuro-inclusive housing development**

# MAIN FINDINGS

**93% OF THE 258 COLORADO STAKEHOLDERS WHO PARTICIPATED IN THE STUDY WANT TO HAVE INTENTIONAL COMMUNITIES AS A HOUSING CHOICE. REASONS FOR THIS DESIRE INCLUDE:**

- Access to cognitively accessible and affordable housing,
- Built-in social connections and planned activities,
- Support beyond individualized long-term support services, such as meal plan options, transportation and life skill classes,
- Living in a neuro-affirming space, a place where differences in the way people's brains function are recognized, respected, and valued,
- Enhanced security for emergencies or prevention of predatory relationships, and
- Third-party advocates to be "eyes and ears" when family are no longer present.

**COLORADO STAKEHOLDERS LARGELY DO NOT BELIEVE INTENTIONAL COMMUNITIES ECHO INSTITUTIONAL SETTINGS. THEY IDENTIFIED INSTITUTIONAL SETTINGS AS HAVING THE FOLLOWING CHARACTERISTICS:**

- Institutional architecture and sterile atmosphere
- Lack of privacy and personal space
- Top-down, staff-controlled environment
- Group-based, depersonalized living and support
- Rigid schedules and limited freedom of choice
- Segregation from the broader community
- Emphasis on safety over independence

**POLICY GUARDRAILS SHOULD BE GROUNDED BY THE LIVED EXPERIENCE AND VOICES OF ADULTS WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES, NOT ARBITRARY METRICS.**

- Require residents with I/DD to have a voice and be part of development from pre-planning to design and ongoing operations,
- Use of outcome-oriented metrics versus density limitations or "checkbox" requirements
- Identify a third-party evaluator to conduct on-site evaluations to ensure the property is not segregating or overstepping rights of people with I/DD.

**COLORADO NEEDS TO PLAN AND PROACTIVELY INVEST IN SOLUTIONS TO PREVENT RE-INSTITUTIONALIZATION DUE TO LACK OF AFFORDABLE, ACCESSIBLE HOUSING.**

- Creation of a neuro-inclusive housing funding stream for development and provision of supportive amenities. Options could include a neuro-inclusive state tax credit, I/DD Housing Trust Fund, I/DD-specific project-based vouchers, Neuro-Inclusive Social Impact Bond, or earmarked item in the Colorado state budget.
- Mandate a robust housing initiative within the emerging Community Integration Plan (HB) 25-1017 to prevent the displacement and/or re-institutionalization of people with I/DD due to lack of housing options. This plan should also inform local governments and community leaders how to meet the needs of their residents with I/DD in the future.

## COLORADO STANDS AT A PIVOTAL CROSSROADS.

By establishing a dedicated neuro-inclusive housing funding source, and creating a system grounded in stakeholder feedback loops for accountability, the state can ignite a new era of neuro-inclusive community development—one built on the voices, values, and lived experiences of Coloradans with I/DD. The alternative is not neutrality—it is neglect. **The cost of inaction will be measured in trauma, displacement, and the erosion of civil rights**. Adults with I/DD are ready to contribute, connect, and thrive in every corner of our state, from Denver's urban core to the high plains and mountain towns. It's time for Colorado's leaders to act boldly: to build the infrastructure that transforms aspiration into access, and equity into everyday reality.

**Let us not delay what justice demands.**



# ABOUT THE INTENTIONAL COMMUNITIES RESEARCH PROJECT

## Goals of Intentional Communities Research Project

This project is a direct response to the growing desire for and development of intentional communities as a residential option in Colorado. In July 2024, the Colorado Developmental Disabilities Council requested proposals to hire an organization or business to conduct a landscape analysis of intentional communities and farmsteads (IHEA 2024000324). **The following was shared as part of the Statement of Work:**

*"The growing interest in intentional communities is a part of the housing landscape for people with disabilities. An intentional community for people with disabilities is a residential setup where individuals with various disabilities come together to live, share resources, and support one another. These communities are designed to provide a supportive environment where individuals can live independently while also having access to necessary accommodations and assistance tailored to their specific needs. While support services are available, residents typically have autonomy and control over their own lives, making decisions about their living arrangements and daily activities.*

*When intentional communities are not integrated and inclusive, they begin to echo past institutional models, such as farmsteads that people with disabilities worked on as labor under the guise of inclusion. Intentional community models risk providing an alternate world for people with disabilities instead of creating an inclusive and integrated community in the world all of us share. The Council seeks to support policies and systems changes that both increase access to affordable, integrated, and inclusive housing and support self-advocates and families. Members of the Council need authoritative information and analysis about these communities in a Colorado context in order to understand the issue(s)... The Council seeks to understand and explore intentional housing options that promote independence, support integrated housing, are inclusive and meet the needs of people with I/DD. The Council further seeks to understand the program methodology, policy framework and implementation that would prevent intentional communities from becoming an "open air institution" in regard to community living options for people with I/DD."*

Neuro-Inclusive Housing Solutions, LLC was contracted for the project and partnered with the Colorado Inclusive Housing Coalition and the Autism Housing Network to conduct a thorough process of investigation, including robust qualitative research with self-advocates (people with I/DD) and/or family members. The goal of this study and report is to:

- Articulate the history of people with I/DD who have been institutionalized and share characteristics of institutional settings described by Colorado stakeholders,
- Understand the growing marketplace of intentional communities that exist across the country,
- Share what matters most to Colorado self-advocates and their families about intentional community options, and
- Provide discussion and recommendations for policy that would protect against institutional characteristics and exploitative developments targeting residents with I/DD in multi-family or mixed-use developments in Colorado.

Although needed, this report is not intended to provide policy recommendations for increasing access to Medicaid-funded support services nor recommendations outside the scope of the development of intentional communities.

## Elements of Study

This report is grounded in a robust qualitative research process weaving together statewide data, national benchmarks, virtual engagement, in-person dialogue, site visits, and housing developer input.



**60 sources included in literature review**



**114 people participated online with 19% self-advocate representation**

Video introduction, learning modules, and accessible surveys were hosted by the Inclusive Housing Coalition (IHC).



**8 in-person focus groups with 51% self-advocate representation**

73 self-advocates with I/DD and 71 neurotypical participants gave over 367 responses to open-ended questions.



**70 Intentional Communities analyzed**

A matrix was created using properties that self-identified in the Autism Housing Network Housing Directory.



**3 site visits to Colorado intentional communities**

Researchers used a checklist to identify the presence of institutional characteristics. The checklist can be found in Appendix.



**15 affordable housing developers**

joined a focus group to discuss draft policy recommendations to help shape the final recommendations of this report.

## Defining Intentional Communities: Speaking the Same Language

The term 'intentional community' is not a disability-specific construct. The Fellowship for Intentional Communities (FIC) defines it as, "a group of people who have chosen to live together or share resources on the basis of common values."[1] The FIC Directory includes hundreds of various forms of intentional communities. [2]

Released in 2020 and updated in 2025, *A Place in the World: Fueling Housing and Community Options for Adults with Autism and Other Neurodiversities (APITW)*, is a collaboration between Arizona State University (ASU) Morrison Institute for Public Policy, ASU Watts College of Public Service and Community Solutions, First Place Global Leadership Institute and the Autism Housing Network.[3] Bringing together multi-sector leaders from across the country, this study provides the foundational shared language needed for realizing, researching, and replicating housing solutions to support adults with I/DD. It includes over 150 definitions and a subsequent Housing Market Guide of 20 properties using the terms.

A Place in the World: Fueling Housing and Community Options for Adults with Autism and Other Neurodiversities (APITW) Report

The APITW report defines intentional communities within the sub-category of 'Lifestyle' as, *"The property or community centers on shared social values and/or interests. They often feature common areas and aim for a high level of social cohesion and interaction. In communities where some or most residents have an intellectual or developmental disability (I/DD) and/or other disability, there may be an emphasis on natural support among neighbors and peer advocacy."*

It was not included in the sub-category of 'Development Type' as intentional communities can be found within development types such as scattered-site settings, neuro-inclusive planned communities, cohousing, etc.

For this study specifically, intentional community was defined in educational materials presented to participants as: "A group of people who choose to live together based on shared values:

- Common Goals
- Shared Spaces
- Supportive Living
- Collaborative Decisions

It's a housing community where you know your neighbors and work together to make life better for everyone!"

**Videos shared representing people who live in various intentional communities**

Plain-language materials

Expanded Materials

In the presentation to both virtual participants and in-person focus groups, the concerns of clustering adults with I/DD as a re-introduction of segregated spaces was also underscored. An example of an intentional community, Hill County Farm, that turned into an exploitative and dehumanizing experience for its residents was presented. The 32 men who were promised a home, job and community were finally rescued in 2009 and received a $240 million verdict in 2013 for the decades they lived in deplorable conditions, suffered abuse, had limited access to needed healthcare, and were paid less than $2 a day for slaughtering turkeys.[4]

## Importance of Self-Advocate Feedback & Cognitive Accessibility

Research around the needs of adults with I/DD must include adults with I/DD. Directly engaging self-advocates enriches research quality and ethical integrity. Their perspectives ground findings in real-world lived experience, ensuring that conclusions reflect genuine needs rather than outsider assumptions. Feedback from people with I/DD highlights misinterpretations or gaps in researchers' assumptions, leading to more accurate data collection and analysis.

Furthermore, partnering with self-advocates shifts the research dynamic from treating people as subjects to collaborators. This participatory approach honors their autonomy, builds trust, and counters historical patterns of exclusion and marginalization in disability research.

For this study, the following was provided to increase participation and accessibility for adults with I/DD:

- Self-advocate consultants were contracted and paid to assist in ongoing process and planning, material review, as well as critical readers of the draft report.
- A video explanation of the study was provided on the website.
- Virtual materials were provided for participation as transportation, lack of in-person support staff, and/or social anxiety are challenges that could prevent in-person participation.
- Plain-language presentation and survey materials were developed and distributed alongside the expanded materials.
- In-person, plain-language focus groups were offered through partnerships with community organizations who serve adults with I/DD to conduct focus groups at programming locations.
- A plain-language summary of report produced.

**THANK YOU AGAIN TO THE FOLLOWING SELF-ADVOCATE CONSULTANTS WHO ARE AVAILABLE FOR HIRE BY OTHERS:**

- **BRIAN BE**
- **MARY SANDERS**
- **JULIAN WANG**

Contact Desiree@neuroinclusivehousingsolutions.com to get in touch.

***"Finding a house is manageable. I can inherit the house but can't live without constant help. Finding care providers when parents are gone is what is scary. These communities must provide staff for ADL's, push my wheelchair, social, etc. can't rely on a neighbor or unpaid people."***

**-Plain-language survey respondent**



# COLORADO I/DD POPULATION DEMOGRAPHICS

**Identified Coloradans with I/DD relying on family**

**95,000**

**Exceeding capacity for a Broncos game at Empower Field at Mile High Stadium.[5] Risking housing and care gaps as caregivers age.**

**Living with caregivers aged 60+**

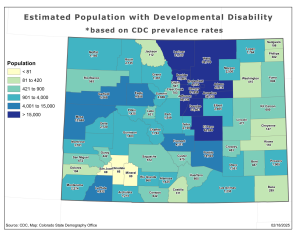
**21,000**

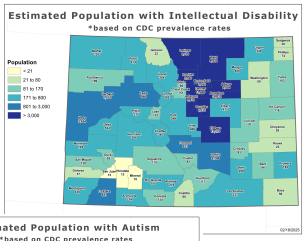
**About double the capacity of Red Rocks Amphitheater.**

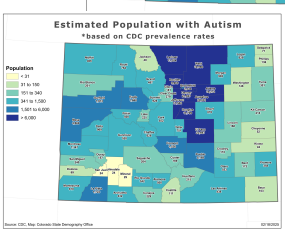
According to the latest Colorado Department of Health Care Policy and Financing (HCPF)'s Report to the Community, only 13,583 people were receiving Medicaid-funded services from the programs specifically designed to serve adults with I/DD in the community.[6] The Developmental Disabilities (DD) waiver had 8,603 participants and the Supported Living Services (SLS) waiver had 4,980. Although other programs could be utilized by adults with I/DD, these two programs were created specifically to address the needs of adults with I/DD.

**It is important that local communities in Colorado get a clearer picture of the number of people with I/DD that may live in their community and understand their access to support services in order to include this population in local housing strategies and planning.**

Therefore, this study requested the help of the Colorado Department of Local Affairs (DOLA) to prepare maps reflecting the estimated number of persons with autism, intellectual disability, and broader developmental disabilities using prevalence data from the Centers for Disease Control.[7](See Appendix for full size maps.) It is important to note that some autistic adults and some adults with developmental disabilities may not qualify for Medicaid-funded services due to not meeting eligibility requirements despite having a diagnosis. These individuals are at greatest risk of homelessness if supportive housing cannot be secured.

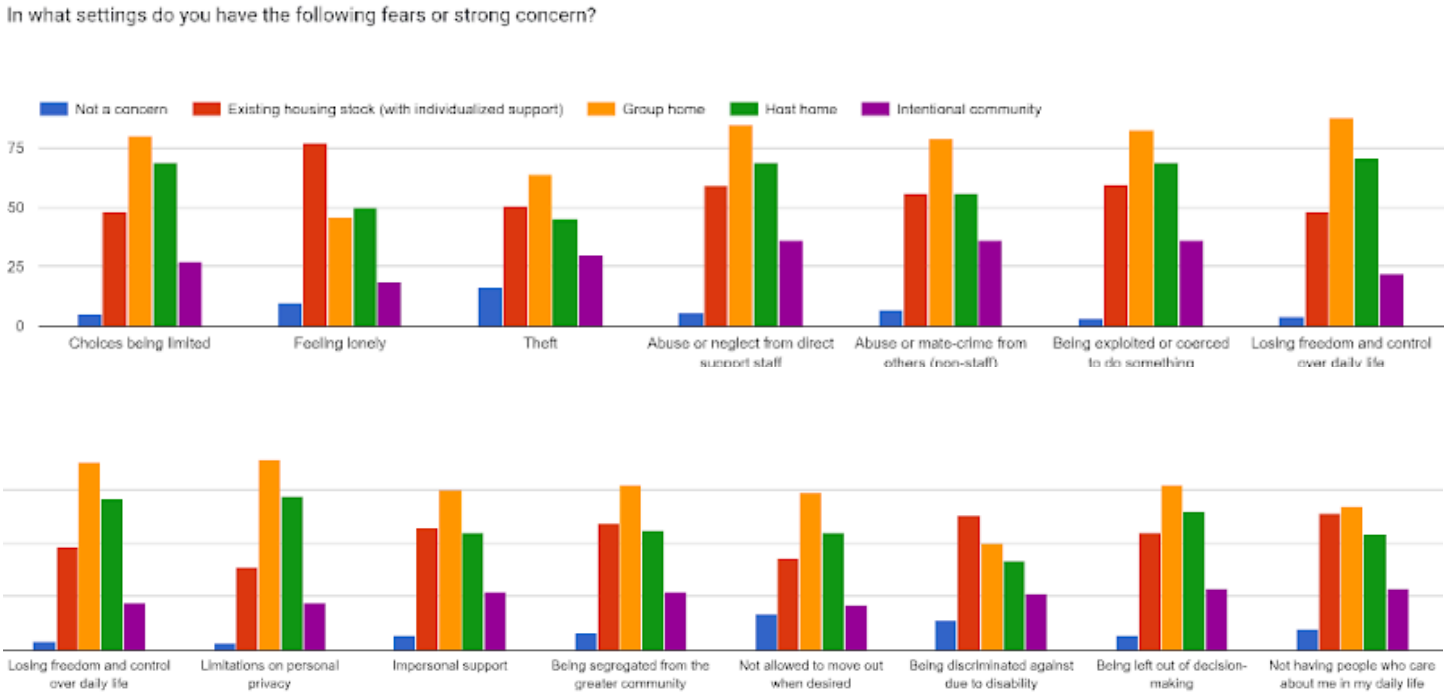


## Stakeholder Concerns Across Settings & Recommendations

In the Intentional Community Research Project survey, a stacked bar chart was used to understand, "In what settings do you have the following fears or strong concern?" Each bar represents a housing setting, and segments within the bar show how many respondents have that concern in the different types of settings. This shows which settings triggered the most concern and how stakeholder concerns vary across setting options.




Every concern presented had at least 50% of respondents indicating it was a concern in at least one setting type. Generally, group homes are perceived as high-risk across all categories of fear, especially regarding autonomy and safety. Over 65% of respondents had concerns within host home settings about being exploited or coerced, limited in their choices, left out of decision making, experiencing limitations on privacy, or loss of freedoms. The typical housing stock raises flags around isolation and financial or housing insecurity, especially for parents worried about their adult children living alone. Intentional Communities show lower concern overall in all categories, particularly among self-advocates.

***"For an IC I should be able to walk in and out at any time, feel I have a safe space to call my own. I should feel that the staff is there to support me for ADL and general living. An IC must support any job goals I can manage." -Survey respondent***

## Housing Shortage for Adults with I/DD

When adults with I/DD cannot secure affordable, accessible homes, they are displaced into Medicaid-funded, provider-controlled settings (group homes, host homes or institutional placements) or become homeless. **In 2024, the Colorado Homeless Management Information System (HMIS) reported 28,491 Coloradans with disabilities experienced homelessness, and other research suggests that 12-39% of people experiencing homelessness have an intellectual disability.[14,15]**

### Adults with I/DD employed

**8,000**

Even when working, this population is extremely low income.[9]

### Avg. less than 13 hours a week

**$13.65/hr**

With SSI, total monthly income ~$1,400 if working at this rate[10]

### Affordable housing gap

**162,000**

Huge shortage of units at or below $1,100/month statewide.[12]

### Colorado ranks 8th least affordable state

**8th**

One of many populations who need affordable housing. [8]

### Monthly Income from SSI

**$967**

Most rely on this maximum Supplemental Security Income (SSI) disbursement.[13]

### Available Affordable Homes

**26**

for every 100 extremely low-income renter households in Colorado.[11]

The Mission Supports Program of Rocky Mountain Human Services is a long-standing Denver program that identifies adults with I/DD experiencing homelessness or unstable housing and assists them to access housing, wrap-around services and other public benefits.[16]

*"We work with those who had to leave their stable housing and support due to the loss of a family caregiver, or who have distanced themselves from their family member who has an I/DD. Evictions, a lack of intensive supportive housing models, lower Medicaid reimbursement rates, and a lack of property managers who consider disability accommodations, are why our participants unfortunately have a difficult time reaching any kind of housing stability."*

-Arnie Swenson, Associate Director, Mission Supports Program

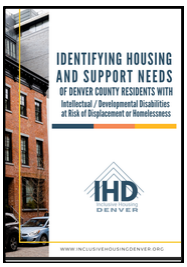
## Demand for Intentional Communities

Beyond the 93% of survey respondents that indicated they may or would like to live in an intentional community, several studies conducted in Colorado have demonstrated the desire by adults with I/DD and/or their family members for intentional communities:



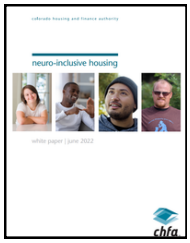

### APRIL 2020

Developmental Pathways hired the Autism Housing Network to conduct a needs assessment on the preferred housing and support options for community development. 62% of respondents were interested in a "planned community with built-in support" and 52% had interest in living in a "cohousing community" – both various development types of intentional community.[17]




### DECEMBER 2021

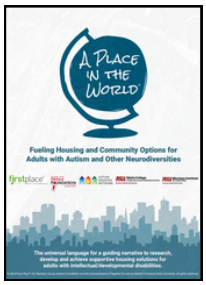
Denver Human Services IDDEAS Program and Laradon partnered with eight other organizations including Denver Housing Authority, Rocky Mountain Human Services, The Arc of Colorado, Arc Thrift, Easter Seals of Colorado, Cottonwood Community Alternatives and CFPD and hired Neuro-Inclusive Housing Solutions and the Autism Housing Network to conduct a Housing Market Analysis (HMA) for those in Denver County.[18] The study found 53% of respondents desired the option to live in a mixed-use neuro-inclusive community, 43% in a planned neuro-inclusive community, and 40% in a cohousing community. The plain-language survey representing self-advocates who needed the cognitive accommodation reported 42% would like to live in a community designed for people with disabilities.




### JUNE 2022

The Colorado Housing and Finance Authority (CHFA) conducted a statewide survey resulting in a white paper that indicated "Planned neurodiverse community/neighborhood with built in supports" was the preferred housing option for people with I/DD surveyed.[19] 36.8% of respondents chose "great fit for me" and 39.7% chose "neutral/maybe a good fit for me."

### ONGOING




Neuro-Inclusive Housing Solutions and First Place Global Leadership Institute have since conducted or are currently conducting other HMA's across the country. Data aggregated from all studies completed thus far represent over 1,850 stakeholders in which 46% desire the option to live in a neuro-inclusive mixed-use community, 40% in a neuro-inclusive planned community and 21% in cohousing.[20]



# A HISTORY THAT MUST NEVER BE REPEATED

Policies and funding streams shape the very landscape in which adults with I/DD build their lives. The following offers insights into the decades of evolving policy and funding that shaped residential options for adults with I/DD in the US. There has been a shift from institutional segregation to Medicaid-supported community-based services, to voluntary clustering of adults with I/DD in emerging supportive housing options. The rest of the report will explore why Coloradans with I/DD want to live in intentional communities and what policies are needed to ensure these communities never morph into the dehumanizing institutions of the past.

## Evolution of Residential Options in the USA

### Pre-1970's: The Rise of Institutions

Long before the surge of large state institutions in the mid-20th century, adults with I/DD were largely hidden from view, shuttled between family care when relatives could manage and becoming a ward of the state when they could not. Towns provided poor farms and almshouses as places to house and support those in need. Individuals with disabilities, criminals, and the homeless were often lumped under one roof.[21] Some options were led by religious organizations and others by medical professionals such as Dr. Kirkbride's model that encouraged fields, farms, and workshops to support patient health. Most were located in rural areas and these placements were often involuntary.

***"I come to present the strong claims of suffering humanity. I come to place before the Legislature of Massachusetts the condition of the miserable, the desolate, the outcast. I come as the advocate of helpless, forgotten, insane men and women; of beings sunk to a condition from which the unconcerned world would start with real horror. - Dorothea Dix, 1843 in her letter to the Legislature of Massachusetts protesting against the confinement of persons with disabilities in almshouses and prisons." [22]***

It wasn't until reform advocates like Dorothea Dix began pressuring legislatures in the 1840s that more purpose-built institutions for people with disabilities emerged through state funding. By 1915, all 48 states reported at least one publicly funded "school for the feeble-minded" or "institutional training schools" in their annual budgets tying them into state mental hygiene boards, public health campaigns, and even eugenics-era policies. This caused a shift in perspective, and residential options became deeply grounded in the treatment of people as medical patients rather than providing support to people to participate in community life. At that time, there were few restrictions on eligibility for this funding or established standards for oversight. Even so, doctors would routinely recommend families place their infants and children with I/DD into an institution and counsel them to "try again."[23]

## Pre-1970s: The Rise of Institutions

In October 1961, President John F. Kennedy convened the President's Panel on Mental Retardation that declared people with I/DD in the United States faced exclusion from schools, community activities, and many spheres of public and private life.[24] Their report led to a proposed legislative package with objectives regarding the rights of people with I/DD.

In 1965, then New York Senator Robert Kennedy paid an unannounced visit to Willowbrook State School; his sister Rosemary had intellectual disabilities, but did not live in this publicly-funded institution.[25] He called it a "snake-pit" and found thousands of residents "living in filth and dirt, their clothing in rags, in rooms less comfortable and cheerful than the cages in which we put animals in a zoo."[26]

In response to evidence of the horrific conditions in which people with I/DD were living without any regulatory oversight, Congress established the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) program, formerly Intermediate Care Facilities for the Mentally Retarded, as an optional Medicaid program.[27] State or local government funding could now be matched by federal funds for institutional services as long as they abided by set regulatory standards. By the late 1970s, more than 200,000 people with I/DD resided in these facilities.

***"We didn't have no freedom, we didn't have no rights at all. They decided when we go to bed. We weren't allowed to take naps. We couldn't go to lie down on your own bed if you wanted to relax or take a little nap or something. They controlled everything we did." - Resident, Fairview Training Center***[28]

Without alternative options being funded, families or people with disabilities were still forced to accept segregation and be admitted to an institution to receive any publicly-funded support or services. These sprawling state institutions and training schools cut people off from the rhythms and relationships of ordinary community life.

It took a young investigative reporter, Geraldo Rivera, sneaking into Willowbrook and documenting the dehumanizing practices, abuse and dangerous overcrowding (more than 2,000 people over its intended capacity of 4,000) to outrage the American public.[29] This led to the organizing of parent advocacy groups to take action in federal court, and gave renewed attention to the disability rights movement demanding de-institutionalization of persons with disabilities.[30]

In 1975, the Developmentally Disabled Assistance and Bill of Rights Act (DD Act) was introduced. This is now the bedrock of funding for essential federally funded programs such as state Developmental Disabilities Councils (Colorado Developmental Disabilities Council), University Centers for Excellence in Developmental Disabilities (University of Colorado Denver, JFK Partners), Protection & Advocacy Systems (Disability Law Colorado) and Projects of National Significance.[31,32,33] The legislation has since been amended several times, most recently in 2000, to provide additional clarity and reflect progress made in the disability rights movement.[34]

***"..assure that individuals with developmental disabilities and their families participate in the design of and have access to needed community services, individualized supports, and other forms of assistance that promote self-determination, independence, productivity, and integration and inclusion in all facets of community life ..." - Developmental Disabilities Assistance and Bill of Rights Act of 2000***

Since the DD Act was enacted, it has come to represent a fundamentally different vision of what it means to live with a developmental disability. Adults with I/DD should have the right to live independently, exert control and choice over their own lives, and fully participate in and contribute to their communities. Today, these entities act nationwide to drive advocacy, innovation, and systems change for the rights of people with I/DD.

## 1980's-2000s: The Push for De-Institutionalization & Civil Rights

With the passage of the Omnibus Budget Reconciliation Act in 1981, for the first time in history, states could redirect Medicaid funds to a new program called Home and Community-Based Services (HCBS).[35] This program "waives" the state's requirement to provide services to people with disabilities eligible for placement in an ICF/IID, to choose to be part of the voluntary HCBS program and receive services in a smaller setting or their family home in the greater community.

This was a monumental shift, allowing for the development of group homes in typical neighborhoods. **Colorado was one of the first states to implement a waiver in 1983**.[36] The Home and Community-Based Services for the Developmentally Disabled (HCB-DD) waiver is still in use today (often called the DD waiver) and provides a robust set of services and supports for people to live in a provider-controlled (group home or host home) or consumer-controlled setting (one's family or own home).[37]

After the introduction of the HCBS program, community placements were steadily on the rise, and institutions, once thought immutable, began to empty. Federal HCBS regulations prohibit the use of HCBS funding to contribute to cost of room and board, thus service providers were largely relied upon to find and maintain housing for adults with I/DD or they stayed in the family home when affordable, accessible housing could not be secured otherwise.

In 1982, 140,752 people with I/DD lived in ICF/IID's while only 1,381 received services through waiver.[38] By 1995, more people with I/DD received services in the community than were living in an ICF/IID. By 2020, 94% of people received services in community-based settings. On December 11, 2023, the last six residents of the Grand Junction Regional Center (GJRC) campus moved into community-based homes, marking the first time in nearly 103 years that not one resident fell asleep or woke up on the campus.[39]

At one time, GJRC served 3,069 residents. Colorado no longer has any ICF/IID's with more than 16 residents. [40]

Landmark civil-rights victories infused fresh momentum into the de-institutionalization movement. The Americans with Disabilities Act (ADA) of 1990 affirmed people with disabilities had equal rights to access and participate in community life just as non-disabled citizens.[41] The ADA was a critical component for the 1999 Supreme Court Olmstead decision, setting the principle that forced segregation in institutions when a person desires and can be supported in the greater community is discrimination and violates federal law.[42] States scrambled to comply, deploying initiatives like Money Follows the Person (MFP) in the 2000's to transition thousands of individuals from institutions back into neighborhoods, apartments, and homes.[43]

***"It would be unreasonable, it would be a tragic event, then, were the Americans with Disabilities Act of 1990 to be interpreted so that States had some incentive, for fear of litigation, to drive those in need of medical care and treatment out of appropriate care and into settings with too little assistance and supervision." -Justice Kennedy's opinion in the 1999 Supreme Court Olmstead decision***[44]

Even into the 2000's, there were still limitations of HCBS programs and service delivery models for adults with I/DD to be supported in their own homes. For example, it wasn't until 2013 that adults with I/DD in Colorado on the Supported Living Services (SLS) waiver and the Developmental Disabilities (DD) waiver could self-direct (directly hire their own staff instead of going through an agency) their LTSS despite other waiver populations having access in 2003, ten years earlier.[45,46] By that time, the affordable housing industry and policy had progressed without recognizing adults with I/DD as a key population, leading to today's major shortage of housing programs that consider adults with I/DD.[47]

## 2000's- Present: Balancing Medicaid Reform & Emerging Neuro-Inclusive Intentional Communities

Young adults with I/DD today have had the benefits of being raised with the ADA, Olmstead and the Individuals with Disabilities Education Act (IDEA), yet many continue to graduate onto the couch and most live with family caregivers.[48,49] Many individuals lack viable alternatives when public and private housing markets fail to offer affordable, accessible units.[50]

AARP's Making Room: Housing for a Changing America shares that while only **20% of today's households are nuclear families, the majority of the housing stock available was created for their needs.**[51] Housing developers are responding to this change of demand. Multifamily Executive Magazine reports the following design trends for the typical housing development industry in 2025: community connections, AI-integrations, user-centric design, coworking space, mini-markets and both playful property amenities like giant swings and wellness or restful amenities such as quiet rooms or meditation spaces.[52]

Additionally, **one in five Americans will be seniors by 2030, including the nearly one million households where an adult with I/DD is living with a caregiver over 60.**[53] Trends in the senior housing sector and 55+ communities are geared toward independent, health-focused baby boomers rather than traditional healthcare-centric models. Protected by the Housing for Older Persons Act, seniors now have unique choices that offer highly segmented, amenity-rich communities designed around specific lifestyles and life stages.[54] Between 2020 and 2022, nearly 25,000 new active adult units opened nationwide, achieving occupancy rates above 92% as residents prioritize tailored social programming, technology integration, and neighborhood-style design over institutional settings.[55]

Reflecting the immense innovation in multi-family and senior housing trends targeting singles or couples, it is no wonder a surge of specialized supportive housing has emerged to meet the distinct needs of adults with I/DD.[56,57] This approach treats adults with I/DD as a defined market with developments combining independence with targeted supportive amenities—such as on-site job coaching, peer mentorship spaces, 24/7 front desk staff, pedestrian-oriented site planning and adaptable common areas. Properties embed sensory-friendly finishes, wayfinding strategies, quiet zones, dining options and assistive-technology hubs into community design. Yet, residents at these properties may be primarily adults with I/DD, thus echoing congregated housing of the past that advocates worked so hard to change. This neuro-inclusive housing movement has emerged at the same time Medicaid was reforming in response to the Affordable Care Act.[58]

In 2008, the US Center for Medicaid & Medicare Services (CMS) embarked on a multi-year journey to collect public comments about an upcoming change to the federal regulations of how and where people with I/DD could receive HCBS.[59] The goal was to ensure that people using HCBS were not being served in an institutional setting such as nursing facilities, institutions for mental disease, ICF-IID, and hospitals; but that this limited funding source was preserved for settings that were home-like and based in the community. They provided drafts for public comment in the official Notice of Proposed Rulemaking related to HCBS in 2008, 2009, 2011, 2012, 2013 and finally released the new "Final Rule" in 2014.[60]

***"In this final rule, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of individuals' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics."***

***-CMS HCBS Fact Sheet***[61]

The Final Rule offers a specific list of federal requirements for any setting where a person with I/DD that may use a HCBS waiver for LTSS. Some of these requirements include:[62]

- The setting is integrated in and supports full access to the greater community,
- The setting is selected by the individual from among setting options,
- The individual's rights to privacy, dignity, respect, and freedom from coercion and restraint are upheld,
- The individual has independence in making life choices, and
- The individual has a choice regarding services and who provides them.

For provider-owned or controlled residential settings such as group homes or host homes, there are additional requirements:

- The individual has a lease or other legally enforceable agreement providing similar protections,
- Individuals must have privacy in their living unit including lockable doors,
- Individuals sharing a living unit must have choice of roommates,
- Individuals must be allowed to furnish or decorate their own sleeping and living areas,
- The individual controls his/her own schedule, including having access to food at any time,
- The individual can have visitors at any time, and
- The setting is physically accessible.

The Final Rule not only required states to assess their HCBS programs and settings to determine if they met the new criteria, it also required every HCBS recipient to have a person-centered plan. This person-centered planning process is supposed to ensure that the individual with I/DD has been meaningfully informed of their service and setting options and document a plan to meet their support needs and preferences. Changes to the Final Rule requirements are possible, but must be detailed in the person-centered service plan with very specific requirements addressing any assessed need for modification.

During the proposed rulemaking for the Final Rule, stakeholders pushed back on CMS prohibition of a "disability specific complex," arguing that the use of the phrase could have unintended adverse impacts on affordable housing options. To avoid those consequences, CMS eliminated the use of the phrase from the Final Rule.[63] Instead, CMS described settings "presumed to have the qualities of an institution" and thus ineligible as a HCBS setting:

- any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,
- any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, or
- any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS."[64]

Shortly after the release of the Final Rule in 2014, CMS released guidelines that named the following types of settings as "settings that tend to isolate:" farmsteads, gated/secure communities for people with disabilities, residential schools, and settings that operationally co-locate multiple settings by the same provider. [65]

Due to significant stakeholder pushback by people who lived in these types of communities and those who were developing other intentional community-type of options, this guidance was rescinded in 2019. CMS states, "The criteria of an isolating setting have been revised and examples of settings that may have isolating effects have been removed."[66]

**CMS replacement guidance for states to determine whether or not a setting has the effect of isolating residents is as follows:**
**Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities for interaction in and with the broader community, including with individuals not receiving Medicaid-funded HCBS,**
**The setting restricts beneficiary choice to receive services or to engage in activities outside of the setting, or**
**The setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services, consistent with a beneficiary's person-centered service plan.**

The Final Rule was an important step to ensure limited HCBS funding was not being used in institutional settings, but in homes and in the community. States have the option to create additional state-specific regulatory guardrails if desired, but most states have not.

In 2018, Colorado unanimously passed House Bill 18-1326, Support for Transition from Institutional Settings, which codified the results of Colorado's Money Follows the Person (MFP) demonstration grant into a permanent, sustainable state statute.[67] The demonstration project data clearly showed that living in home and community-based settings cost less and improved health outcomes for 702 Coloradans who transitioned from institutional settings to the community.



Colorado was the first state in the nation to successfully obtain federal approval and state legislation to embed MFP efforts and transition services into Medicaid state plan and waiver services.

## Institutional Characteristics Defined Abroad

Although there is no single agreed definition of an 'institutional setting', many characteristics have been described by various authoritative entities across the globe:

The World Health Organization (WHO) defines an institution as "any place in which persons with disabilities, older people, or children live together away from their families. Implicitly, a place in which people do not exercise full control over their lives and their day-to-day activities. An institution is not defined merely by its size."[68]




**Independent Living for People with Disabilities, European Union Agency for Fundamental Rights**

The United Nations Convention on the Rights of Persons with Disabilities offers further guidance on how to identify institutions, *"Although, institutionalized settings can differ in size, name and setup, there are certain defining elements, such as: obligatory sharing of assistants with others and no or limited influence over by whom one has to accept assistance, isolation and segregation from independent life within the community, lack of control over day-to-day decisions, lack of choice over whom to live with, rigidity of routine irrespective of personal will and preferences, identical activities in the same place for a group of persons under a certain authority, a paternalistic approach in service provision, supervision of living arrangements and usually also a disproportion in the number of persons with disabilities living in the same environment."* [69]

The Common European Guidelines on the Transition from Institutional to Community-based Care describe an institution as a setting where, *"residents are isolated from the broader community and/or compelled to live together; residents do not have sufficient control over their lives and over decisions which affect them; The requirements of the organisation itself tend to take precedence over the residents' individualised needs."* The Common European Guidelines also stress that: *"The small size of accommodation does not in itself guarantee elimination of institutional culture in the setting. There are a number of other factors, such as the level of choice exercised by the service users, the level and quality of support provided, participation in the community and quality assurance systems used which impact on the quality of the service."*[70]

In 2017, experts from across the European Union (EU) gathered to share research conducted by 28 EU Member States on characteristics of different types of institutional and community based services.[71]

According to the summary report by the EU Agency for Fundamental Rights, *"there was a broad agreement among the experts present that physical features of institutions include isolated locations; segregation and compulsion; impossibility to live with families; and long length of admission. Social/cultural features include depersonalised services; lack of choice and control; lack of privacy and intimacy; lack of liberty and free expression of wishes; lack of accountability; strict schedules and regimes; requirements of the institution taking precedence over the needs of residents; residents are viewed as disabled; strict separation between staff and users; and the place of residence is contingent on the provision of care."*[72]



## Survey Respondent Themes: Characteristics of Institutional Settings

Just as stakeholders from the US provided feedback to influence federal regulations, and international stakeholders have come together to promote the de-institutionalization of persons with disabilities across the globe, it was important to ask Coloradans what they felt were institutional characteristics.

Respondents to the surveys repeatedly contrasted institutional settings with homelike, person-centered culture. **These core themes emerged:***

**Institutional Architecture & Signage**

Large, monolithic buildings with numbered corridors, enclosed spaces and uniform signage reinforcing a sense of confinement and hierarchy.

**Clinical, Sterile Atmosphere**

White walls, harsh lighting, and sparse décor creating a hospital-like feel that many described as cold and impersonal.

**Rigid Schedules and Limited Autonomy**

Fixed meal times, regimented waking and sleeping hours, and staff-driven routines leaving little room for personal choice.

**Lack of Privacy and Personal Space**

Shared bedrooms or communal bathrooms, minimal secure storage, and thin walls undermining a sense of ownership and dignity.

**Staff-Controlled Environment**

Decisions—from daily activities to medical care—are made by staff, restricting residents' self-direction.

**Group-Based, Depersonalized Living**

Residents are treated as a collective "batch" rather than as individuals with unique preferences and talents.

**Segregation from the Broader Community**

Gated campuses or fenced-in perimeters to "keep people in," cutting people off from neighbors, local businesses, and spontaneous social interactions.

**Emphasis on Safety over Independence**

Locked doors, constant in-person surveillance, and risk-averse policies that feel overly restrictive.

*All open ended responses can be found in Appendix.

## The Cost of Doing Nothing: Risk Re-Institutionalization

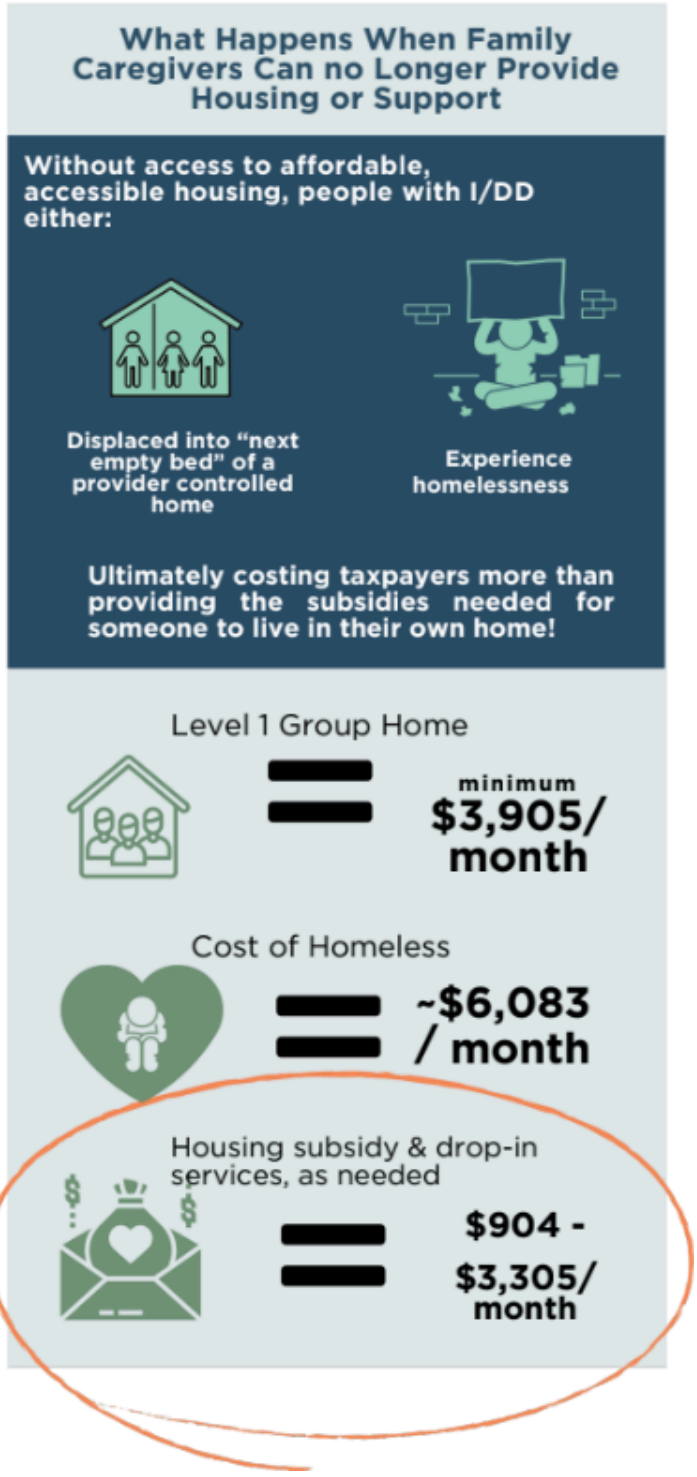
The impact of lack of housing options is stark. Adults with I/DD, particularly those with aging caregivers or on waitlists, face heightened risk of housing crisis due to sudden loss of a support system when their parents pass. Rental unaffordability and insufficient rental assistance programs drive many individuals with I/DD into provider-controlled or institutional settings when they cannot secure or sustain housing. Adults with I/DD are also disproportionately at risk of homelessness, as their fixed incomes (often limited to SSI) and accessibility needs make competitive housing acquisition nearly impossible.

Displacement from their community into the "next empty bed" of a host home or homelessness is not only traumatic for a person with I/DD, it is considerably more expensive for taxpayers. This outcome violates the spirit of the Americans with Disabilities Act (ADA) and the landmark Olmstead Supreme Court decision, which guarantee the right to integration and community-based living.

**Without immediate planning to meet the housing and support needs of adults with I/DD, Colorado risks re-institutionalizing this population as a crisis response, facing potential litigation from the Department of Justice.**

When policy evolves alongside self-advocates, it unlocks pathways to housing that honor autonomy, foster genuine community ties, and dismantle the barriers that once relegated people to institutions. By tailoring funding streams and regulatory frameworks to lived realities—sensory needs, cognitive differences, and the desire for choice—policy becomes a catalyst for true inclusion and person-centered solutions.

**Infographic below from the Denver Neuro-Inclusive Housing Market Analysis**





# A GROWING MARKETPLACE OF HOUSING CHOICES

## Intentional Communities within the Neuro-Inclusive Housing Framework

There is no one-size-fits all model for intentional communities that are designed to include adults with I/DD. They differ in development type, urban to rural locations, design features, built-in supports, cost and funding options.

The Neuro-Inclusive Housing Framework outlines three distinct elements to consider when exploring a residential solution: **Housing, Individualized Long-term Support Services (LTSS), and Supportive Amenities.** Each element can be led by the same organization or in partnership with others. For example, affordable housing developers build the housing, Medicaid-approved service providers (Program Approved Service Agency- PASA's) offer the needed individualized LTSS support, and existing community-based organizations can offer supportive amenities for the property.

| | What? | Who? | How is it paid for? | Existing state regulators? |
|---|---|---|---|---|
| **Housing** | Rental or for sale, market-rate or affordable, neuro-inclusive design features | Typical housing developer, affordable housing developer, group of people who work with a home builder, local partnerships | Rent or mortgage from earned income. Other sources include SSI, SSDI, or Special Needs Trust. Housing Choice Voucher can subsidize rent. | Colorado Housing & Finance Authority, Colorado Department of Housing, local planning departments |
| **Individualized Long-term Support Services** | Individualized support that people need to live in their home and community, often addressing a person's need for support in activities of daily living. | For-profit or non-profit service providers e.g. PASA's, host home providers, CNA's, PCA's, etc. | Private-pay, Medicaid-funded through a waiver (several waiver options in CO), ICF-ID | Colorado Health Care Policy & Financing |
| **Supportive Amenities** | Built-in supports that are tied to a property to benefit all residents. E.g. community life coordinator, life skills classes, etc. | Local community-based organization who serve adults with I/DD, PASA's, recreational therapists, occupational therapists, etc. | Private-pay, volunteerism, health insurance, subsidized by organization through fundraising or grant funding | None. |

## Important Distinctions in Intentional Communities

In order to explore the diversity of intentional community options in Colorado, the following distinctions within the Neuro-Inclusive Housing Framework should be considered.

### LTSS vs. Supportive Amenities

These two elements are not one and the same as they may be for other populations who have permanent supportive housing options (mental illness, chronically homeless, etc.).

Long-term support services (LTSS) is a broad term for many programs available to help people who have disabilities or older adults with their daily activities.[73] LTSS includes HCBS waiver and several other programs which have different requirements to qualify. LTSS has various models of service delivery for in-home assistance including rotational staff as needed (agency-based or self-directed), a live-in caregiver (shared living or a host home), and remote/virtual support. If an adult with I/DD does not qualify, is waiting for or receives insufficient LTSS, the cost must be paid out-of-pocket or, most often, provided by family caregivers.

Supportive Amenities are additional supports that are tied to a property to benefit all residents (with or without I/DD). This may include a front desk or concierge, community life coordinator, life skills or health/fitness classes, meal service, job coaching or social enterprise, community resource navigation, benefits counseling, transportation assistance, or on-site resident assistants as a safety-net or for emergencies. For residents with I/DD who are ineligible for LTSS, yet do not have the capacity to live independently without any support, having access to supportive amenities may be able to help them be connected to community, employed and housed.

### Property Relationship to LTSS

Understanding how a resident's home may or may not be tied to their LTSS provider is important because Medicaid has distinct requirements for provider-controlled settings.

- *Provider-controlled setting:* Properties where the housing provider is also the sole LTSS provider. Residents cannot change their LTSS provider in a provider-controlled setting without moving to a different home as the provider is the owner or operator of the home and/or intentional community.
- *Consumer-controlled setting:* Properties where the housing provider is not inherently connected to residents' LTSS provider(s). Each resident chooses their LTSS provider(s) and preferred services. Residents may change their service provider and/or services and stay in their home at the intentional community. In some consumer-controlled intentional communities, the housing provider may also be an LTSS provider; but residents still have the option of choosing or changing to a different LTSS provider while staying in the same home.
- *Hybrid setting:* In some cases, a property may include both consumer-controlled and provider-controlled settings. For example, a host home or group home within an intentional community would make the community a hybrid setting.

### Sustainable Affordability

Housing is generally considered affordable when a person spends less than 30% of their income on housing.[74] Even without anyone making a profit, in order to make housing affordable, the cost to develop housing or the monthly payment of one's home must be subsidized. There are no I/DD-specific affordable housing subsidies, incentives or prioritizations in Colorado. (See Other State Initiatives in Discussion section for examples.)

One of the only tools that people with I/DD currently have to help subsidize rent (or in some cases a mortgage) in the typical housing stock is using a tenant-based Housing Choice Voucher (HCV). Although extremely difficult to access, a HCV voucher allows the person to pay 30% of their income towards rent of a home they find, and the voucher pays the difference. Using HCV's in the typical housing stock presents several challenges that can be overcome in an intentional community designed to be neuro-inclusive:

- **Discrimination:** People with disabilities reporting discrimination based on disability accounted for the majority (52.61%) of Fair Housing complaints in 2024.[75]
- **Lack of accessible housing:** Only 6% of US households are accessible to an individual with a mobility impairment.[76] The lack of housing for those who have cognitive accessibility needs is not measured, but features like sensory-friendly aesthetics and acoustics, ease of maintenance, pedestrian orientation, and wayfinding strategies are typically not considered in the general housing market.
- **Landlord rent bumps:** Housing costs can fluctuate year to year based on what the market can bear. In order to use a HCV voucher, the landlord needs to agree to accept partial payment from a Public Housing Authority (PHA) and the rent of a home must be within a specific range or "payment standard". Although Colorado passed a source-of-income anti-discrimination law, a landlord does not have to maintain the rent within this payment standard year after year. If a landlord raises the rent beyond the payment standard, a tenant using a HCV voucher may no longer be able to live there.[77]



## Intentional Communities Across the USA

To compare intentional communities in the US, a matrix of properties was created from the Autism Housing Network Housing Directory which uses a filter system based on *A Place in the World* terminology.[78] The filters applied to generate the list of properties included: 'intentional community' and 'presales/leasing,' 'available,' 'waitlist.' This sample is self-report and thus does not represent a comprehensive list of properties across the country.

### Resident Spotlight: Unity on Park





**Growing up in a military family, moving was a way of life for Nate. His most recent transition to Unity on Park marks a significant milestone in his family; it is his first experience living independently at a time his mother was also transitioning in an assisted living community. For Nate, one of the biggest advantages of living at Unity is its convenience. Now that he can walk to Wellspring Community, he is able to attend his chosen day program more often, "Heaven knows I want to be here!" On the tour, he and his neighbors with disabilities spoke about the importance and value of peer support. Nate is also learning activities of daily living like managing laundry expenses and preparing his meals. Nate looks forward to karaoke nights with other residents at Unity. His go to songs? "Time Warp" from The Rocky Horror Picture Show and "For Crying Out Loud" by Meat Loaf.**

A total of 70 properties identified as existing intentional communities. The following are key insights captured:

## KEY INSIGHTS

**27** Different states with neuro-inclusive intentional communities

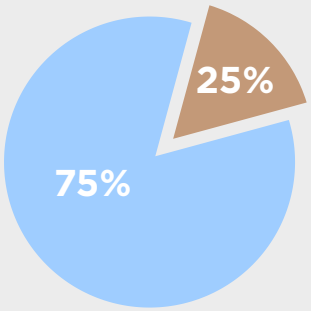
**45%** of properties include residents using HCBS waivers for LTSS

**22%** represent affordable rental properties

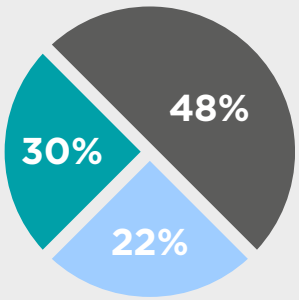
**64%** included at least one resident who had at least 24-7 support needs

**6** average amount of supportive amenities at properties

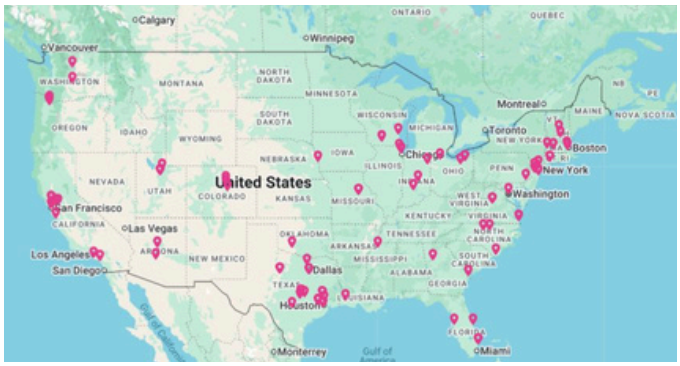
**7** average amount of unique neuro-inclusive physical design choices or amenities




25% were scattered site
75% various multi-family development types




48% consumer controlled
22% hybrid
30% provider-controlled




Autism Housing Network Directory

### Site Visits to Colorado Intentional Communities

Members of the research team and of the Colorado Developmental Disabilities Council were invited to participate in a tour of three intentional communities in Colorado. Prior to the site visit, a checklist was drafted based on the literature review of institutional characteristics. This checklist can be found in the appendix. None of the properties visited met the criteria identified as institutional except for the high density of persons with disabilities.

### Resident Spotlight: Trailhead Community

**Lexi knows how to brighten a room and make someone feel loved. She is a staunch disability advocate and has spoken at many conferences in the past, including Housing Colorado. Her spirit of leadership was instilled by her mother Barb who is the founder of Trailhead Community, and a decade earlier started a PASA called Stepping Stone Support Center. Unfortunately, her mother passed away just months before residents moved into the building. Although her sister lives close, having the support of people in the building that Lexi has known for years, right at hugs reach, has made a big difference when waves of grieving occur. Lexi works at Red Robin, has the eye for interior design and is a foodie. She hopes to see other communities like Trailhead as soon as possible.**

| | 30PRL | Trailhead | Unity on Park |
|---|---|---|---|
| **Location** | Boulder | Littleton | Castle Rock |
| **Development Type** | New construction, mixed-use | New construction, mixed-use | Rehabilitation of former hotel, mixed-use |
| **Affordable units** | Yes | Yes, but also market rate units | Yes |
| **Rental/Homeownership** | All rental | Rental and Homeownership | All rental |
| **Number of total units** | 120 units across 3 buildings | 81 units | 40 units |
| **Unit options** | Studio, 1-bedrooms, 2-bedrooms | Studio, 1-bedrooms, 2-bedrooms | Studio, 1-bedrooms |
| **Density Expectations** | 20 units in one building for residents with I/DD in the Bluebell Independent Living Program | No mandated density, aiming for 60% adults with I/DD and 40% seniors | 20 units for adults with I/DD (50%), 1 unit for resident assistant and 1 unit for DSP staff on-site |
| **Relationship to LTSS** | Consumer-controlled, PASA on-site | Consumer-controlled, co-developed by PASA | Consumer-controlled, co-developed by PASA |
| **Residents can use HCBS** | Yes | Yes | Yes |
| **Supportive Amenities (all voluntary)** | Organized social events, health and wellness classes, partner with foodbank for on-site pick-up | Organized social events, life skill classes, 24-7 concierge, dining hall with meal plan | Organized social events, life skill classes, front desk during working hours, partner with foodbank for on-site pick-up, transportation assistance with two vans (need more) |
| **Physical Amenities (not comprehensive list)** | Common sitting area, balcony and community gathering space with refrigerator and microwave, in-unit washer/dryer | Indoor sports court, art room, theatre room, community gathering space with tables and chairs, meeting rooms (open to greater community) | Front desk during working hours, community gathering space with tables and chairs (open to greater community), wayfinding colors, dimmable lights, outdoor gathering area |
| **Website** | boulderhousing.org/properties/30prl/ | trailheadcommunity.org | wearewellspring.org/unity-on-park/ |

Additionally, the following questions were asked to residents present to better understand day-to-day life:

- Tell me what a typical day is like for you?
- Why did you want to move here instead of somewhere else?
- What is your favorite part of living here?
- If you had a magic wand, what would you change about where you live?
- What would you say to someone else who is thinking about moving here?

## Site Visit Resident Quotes:

***"I like that there are people to help me when I need it. The staff is nice and they make sure I'm safe. Sometimes it's nice to have meals cooked for me and activities to do. It's comforting to know help is nearby."***

***"Teaching life skills is hard without a teaching kitchen. If you provided the space, neighbors would take over the space to cook and eat together."***

***"This place is radically inclusive. It's a different generation."***

***"People here understand me, they have disabilities too. I'm safe and accepted."***

***"To be free, to be yourself is so important. I feel free."***

***"Being independent. I come down for events or go back to my room whenever I want."***

***"It's really fun. I invite my friends over. It's really great."***

***"Failed twice with host homes, so I wanted my own place."***

***"It's difficult when we have to eat alone. It's more comfortable to do things or eat together."***

***"I like that I can chill out and not worry about anything."***

***"It's natural to live with people with disabilities, to be together because they get it."***

## Site Visit Staff Quotes:

***"80% of parents have no plan. They trust us (PASA) to help them figure it out."***

***"Every property should have a PASA [or other I/DD-focused community organization] attached to it because property management companies do not understand people with I/DD–there needs to be a bridge."***

***"Access to vouchers would be a game changer because most are using most of their SSI disbursement on rent."***

***"We want the residents to be in control of the rules."***

## Reflections from Residents on Recommendations

The following are important reflections from residents of existing Colorado intentional communities to consider for future intentional communities:

- **Feeling safe should be a top priority:** Residents shared the high value of peer and natural supports at the property. They shared stories of friends who had moved into other affordable housing settings and were challenged with discrimination or feeling unsafe due to behaviors from other tenants (drugs, knocking at door with requests, etc.)

- **Food insecurity:** Properties partnered with food banks out of necessity. One has a community pantry/refrigerator to share food, others work with local food banks and grocery stores to increase access. Residents at properties without a dining option said they would welcome a voluntary meal service.

- **Noise from neighbors:** Quiet hours and/or additional sound-proofing was shared as a need. This may be due to some people with I/DD having heightened sensitivity to noise.

- **Intentional path for resident voices:** Two properties have a resident advisory council that met monthly and staff shared this was important for direct feedback. Residents at the property that did not have one wanted more of a voice.

- **Support needed beyond property management company:** Property management companies have difficulty communicating and considering the support needs of residents with I/DD. Having access to a resident assistant, PASA, or staff on-site 24-7 is needed.

- **Housing stability:** Residents with disabilities were being laid off of work due to DEI transitions, concerned about housing stability. Properties that did not have project-based vouchers, and residents who did not have tenant-based vouchers, shared that making ends meet every month was very difficult despite being within the required affordability range (based on local Area Median Incomes).

- **Parking and drop-off space:** Accessible parking, free parking for direct support staff and/or drop-off area for Access-a-Ride is needed and should not be overlooked, especially in areas without parking requirements.

- **Adequate common spaces needed:** As desire for connecting with other residents outside of one's home is high, both indoor and outdoor common spaces are needed.

- **Pre-development community engagement:** Engaging adults with I/DD early in the development process is instrumental in property planning, function and programming.

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- **Funding gap for needed built-in supports:** A source for supportive amenities funding is needed. These vital amenities should not have to rely on fundraising or fees from low income residents.



# UNDERSTANDING THE DESIRE FOR INTENTIONAL COMMUNITY: THEMES FROM COLORADO STAKEHOLDERS

The same presentation used in online materials was used to guide focus group discussions. Eight plain-language focus groups were held in Aurora, Boulder, Broomfield, Carbondale, Colorado Springs, Fort Collins, Littleton, and Montrose in May and June of 2025 to capture stakeholder input from Coloradans with I/DD and those who support them. Responses in focus groups were written by hand on large post-it notes to ensure accuracy of feedback and ideas. Thousands of lines of data from surveys and focus groups were coded and analyzed using AI tools.

## Open-Ended Response*

In response to the question, "Why do you or those you support want to live in an intentional community instead of another housing option?" the following major themes emerged in order from most common to least common:

### 1. Social Connection & Belonging

Participants want easier access to friends and other people. The most prevalent theme in responses is the desire for a strong sense of community, belonging, and opportunities for socialization. Respondents emphasize the importance of living among peers, forming friendships, participating in group activities, and feeling connected rather than isolated.

This includes references to combating loneliness, having a circle of friends, and being part of a welcoming environment.

In the Inclusive Housing Denver study, only 15% said they were able to see friends as much as desired and 36% of participants reported not having any friends at all.[79] Focus group participants shared their belief that in an intentional community, neighbors would act as natural supports, helping each other and looking out for one another.

***"I won't be as lonely if [I live] with others like me."***

***"A. has lived by himself for 5 years and is so lonely that it affects almost everything he does. And now he is withdrawing into himself further with grocery delivery, food delivery, etc. If I (dad) didn't see him 3+ times weekly, even though he has external PASAs, I think it would go badly for him."***

***"It sounds like a fun way to make friends. It would make me feel more supported and I would not feel lonely."***

*All responses in Appendix.

### 2. On-site Access to Support/Supportive Amenities

A significant portion of participants highlighted the need for an accessible, reliable safety net of support. They expressed a desire for a familiar staff person or concierge who was on site 24/7, staff who "know me and my situation," and understand person-centered supports. They approved of the idea of sharing direct support staff. They also wanted built-in support for health needs, such as visits from a mobile clinic, certified people in the building to provide clinical support and assistance distributing medication (mental health, occupational therapist, etc.)

**"*While I'm working and living independently as an adult with ASD, I feel like I'm isolated without social or ADL support. I struggle with ADL activities like cleaning dishes and laundry, and having an IC support would help with that. I also would like an IC that provides for the social elements that are missing in I/DD lives. Having the options for Fun Fridays or outings where the group is supported and can do social events on a regular schedule. This would provide the I/DD adults with a full opportunity to enjoy a independent life. I picture an IC like a hotel with concierge service. We can come and go freely, and the support staff is there to help us with ADL as well as the social services we need assistance with. We should have access to case workers who can help us with legal matters, ISS, DVR, taxes, etc., to give us the fullest measure of independence as possible, and support our family members as well."***

***"Inconsistency of staff always becomes our problem when it isn't our problem."***

### 3. Safety & Security

Participants expressed a strong desire to live in safe locations with layers of additional security, including safety technology, cameras/surveillance, check-in/check out procedures, and someone who could respond to emergencies quickly. Safety concerns included protection from predatory people and those seeking to exploit their vulnerabilities (financial, social, abuse).

These concerns are underscored by research: 66.5% of those with autism and 62.5% of those with another form of I/DD report being survivors of physical, emotional, or sexual abuse;[80] 90% said it occurred more than once with 33% not knowing where to report. One in three adults with intellectual disabilities have experienced sexual abuse in adulthood with only 19% reporting it [81.82] and 80% of autistic adults reported experiencing mate-crime (someone becoming a friend for exploitation).[83] Adults with I/DD also have a significantly greater risk of becoming victims of assault and/or a serious violent crime than other persons with disabilities.[84]

***"Because it's inclusive and more like a neighborhood of friends who look out for you"***

***"We don't have to watch our backs. Feel like home and not sketchy."***

***"Someone to track or know if strangers are trying to get in."***

***"Safety leads to freedom"***

### 4. Autonomy & Independence

Many respondents express the desire for greater independence and autonomy within a supportive community. They value opportunities to make choices, live self-directed lives, and have freedom while still having access to necessary supports. This theme includes references to building autonomy, having options for personal growth, dignity of risk, choices around roommates, ability to have pets, and help with life skills (managing money, cooking, housekeeping) while respecting their rights.

***"I want my freedom (not a host home)."***

***"Supported independence"***

***"flips the institutional model upside down"***



### 5. Understanding Neurodiversity

Respondents frequently mention the importance of inclusion, acceptance, and understanding of neurodiversity and disabilities. They seek communities that are welcoming to people of all abilities, where differences are respected and valued, and where individuals are not rejected or isolated due to their disability. They seek more opportunities for interaction with people who "just get it" where they don't have to "mask [as neurotypical]." Adults with I/DD do not want a top-down approach in their home, but an inclusive culture driven by residents with I/DD.

"**I *would be interested in living in an intentional community run by & for neurodivergent people, because it really is important for us to be able to build community together rather than being isolated in normative housing settings or denied autonomy in institutional settings."***

***"I want to live in a community where people understand and accept me for who I am. I want friends who get me and a place where I can be myself without judgment. It's about feeling safe, happy, and included."***

***"It is essential that these communities are not just for people with disabilities, but built with them—grounded in equity, dignity, and long-term sustainability."***



### 6. Purposeful Engagement & Planned Activities

In alignment with their desire for social connection and belonging, participants wanted intentional communities that offered planned events and activities, exposure to new things through supported activities, and proximity to community and vocational opportunities. Specific examples cited include shared meals, participating in meal prep, cooking classes to learn to make different foods, relationship counseling, life skill classes, day programs within walking distance, and access to vocational opportunities and job coaching.

***"Planned activities are important because its hard to keep up as family caregivers age."***

***"The ideal community for our daughter would allow her to participate in activities in the community (work, day program, therapeutic rec, special hockey, etc.), and provide social activities within the intentional community, hopefully, including group meals. The community would provide her with a sense of independence, but be supportive. Host homes and individual apartments (with or without a care provider) can be isolating. People often move frequently, and are not always able to participate in activities that they have enjoyed for years. They are often removed from friends and social networks. Some host home providers and caregivers are great. Some are not... My daughter, with help from her family, and those closest to her, should be able to decide what housing option works best for her, and intentional communities with supports should be one of those options."***



### 7. Cognitively Accessible & Supportive Design

Discussion topics that were important to people included having more than just a studio as a unit option, with bright and cheery yet home-like physical features. Strong preferences were expressed for sound sensitive architecture and user-friendliness for ongoing communications for those who don't read text. Participants prefer buildings designed with I/DD-friendly amenities on-site, such as enabling technology, transportation, etc., as well as the ability to walk around the neighborhood safely without risk from cars.

***"Built for them- First time they (people with disabilities) are put first."***

***"I want to live in a community that is equipped with universally designed infrastructure to accommodate my cognitive, physical and social challenges. Living independently in a ordinary neighborhood would require a lot of external support such as home renovations or support personnel to help with trips outside or chores. Much of this could potentially be avoided if a community has built-in disability accommodations."***



### 8. Stable & Resident-Centered

A notable group of respondents were concerned with long-term stability, permanency, and the ability to age in place. They want intentional communities to provide lifelong housing solutions, reduce frequent moves, and ensure continuity of care and natural supports as family caregivers age or pass away. This includes a whole-person perspective, not just long-term support services with third-party advocates and property management that understands disabilities. Desire for more homeownership opportunities expressed.

***"Changing host homes every few years disrupts all natural support systems we work hard to create."***

***"Need people who know and understand my odd behaviors when in the community. Need everyday activities easily accessible, need friends, want to be settled in a community so when my parents die I don't have to move."***

***"I think intentional community is inviting because people's autonomy are respected and their physical, mental, emotional, spiritual, social, and financial access needs are being met. Intentional community is very intentional and rooted in being inclusive and sustainable. As someone with a disability I believe that its our communities that sustain us and it will continue to be our communities that sustain us. I believe that intentional communities are laying the framework, the blueprint to a more inclusive and sustainable future for the collective that is being guided by people with IDD's."***

## Influential Features of Intentional Community

When asked to rank influencers of whether or not a specific characteristic of intentional communities were 'not influential' to 'very influential' in a closed-response ranking question, more than 40% respondents ranked the following "very influential" features in the decision to live in a neuro-inclusive intentional community. In order of greatest number of "very influential" responses:

1. Affordability, access to rental subsidies
2. Third-party organization to assist in monitoring well-being when family no longer present
3. Easy access to maintain a natural support system (friends who care about you)
4. 24-7 access to in-person help (not just your service provider)
5. Neighbors who want to foster neurodiverse relationships
6. Additional safety features (cameras, keyfobs, etc.)
7. Additional transportation options
8. Cognitive accessibility features (easy-to-clean, wayfinding, etc.)
9. Planned social activities with transportation (off-site) / Walking distance to social activities or opportunities
10. Access to prepared meals and a dining hall
11. Physical amenities within the intentional community (sports court, garden, pool, etc.)
12. On-site life skill classes

## Voices Against Intentional Communities

It is also important to represent voices that do not believe intentional communities should be an option for adults with I/DD in Colorado. The following provides a snapshot of quotes from those who participated and are opposed to this housing choice:

***"Ideally, the goal of integrated community settings is to expose both the individual with I/DD and their surrounding community members to understand each other and become connected in a natural way. An intentional community may cater too heavily to those with a diagnosis which could (and statistically would) cause an increase in problematic behaviors due to both caregiver and person in services lack of typical community involvement. As we've seen, our population we serve do mimic behaviors. That includes behaviors that are seen as socially unacceptable."***

***"If we stick to ourselves, others won't be educated about disability- and then not be afraid."***



***"NO! 'Intentional Community' IS A SNEAKY WORD FOR SEGREGATED, DISCRIMINATORY HOUSING, the urging of people with IDD into grouped or clustered living arrangements. One can easily substitute the word 'segregated' for 'special' in any type of service provision, be it recreation, housing, health care or education. People with IDD are harmed by limiting their access to the wide, typical community at large. These limitations are very paternalistic in their values... Such communities violate the intent of the federal Settings Rule and should not use my or anyone's public dollars to segregate individuals. Also, when non-public/private dollars are used for such planned communities, often there is economic segregation as individuals without families or with families of low income, are not included in such communities. No individual with IDD should be subjected to segregation based on economic status. Shame on ANY parent, who, due to their own future fears, assists their adult child into segregated/special housing that is intended "intentionally" for individuals living with IDD."***

## Stakeholder Recommendations for Future Intentional Communities

When asked directly in an open-answer format, both in the survey and during focus groups, stakeholders had rich and robust insights into what they would like to see as safeguards to ensure intentional communities do not become institutional. Below are eight overarching themes distilled from this open-ended question. Under each theme, key recommendations are summarized:

**Governance & Resident Voice**

- Require resident advisory boards or committees at every property,
- Ensure residents can influence governance, planning, and ongoing decisions,
- Include people with disabilities on boards and in leadership roles, and
- Use transparent scorecards and regular reporting to track responsiveness to resident input.

**Oversight & Accountability**

- Mandate third-party oversight, regular site visits or inspections,
- Shut down or sanction communities that fail to comply with rules or codes,
- Assign a dedicated third-party advocate (distinct from case managers) to every resident, and
- Include transparent evaluation processes with input from residents and families.

**Accessibility & Built Environment**

- Design units with in-unit washer/dryer, trash chutes on every floor, and carpeted bedrooms,
- Provide a mix of studios, one- and two-bedrooms to suit varying support needs,
- Install full HVAC rather than wall units for comfort and air quality,
- Create common spaces for both residents and the broader public to foster natural supports, and
- Prioritize new, modern construction that meets universal design standards.

**Regulation & Compliance**

- Ensure that residents choose who they live with, how they spend their time, and what supports they want—on their terms,
- Avoid rigid routines or group-based programming that limits individual freedom,
- Remove limiting policies (e.g., three-person rule on SLS waivers) that restrict housing options,
- Prohibit overly rigid integration mandates (e.g., reverse-integration bans) while balancing safety, and
- Ensure rights are protected regardless of disability status or benefit eligibility.

**Support & Services**

- Guarantee that each resident has access to the supports needed for success,
- Provide "authorization to assist" forms for accommodation requests when natural supports are absent, and
- Strict selection of staff: trained in neuro-affirming support, trauma-informed, staff that listen openly.

**Community Integration & Inclusion**

- Incentivize quality of life and tenant diversity over pure profit motives,
- Prioritize community engagement during planning phases,
- Offer shared public-use spaces to increase informal neighbor supports, and
- Require neurotypical/able-bodied residents to participate in emergency support and community activities.

**Training & Capacity Building**

- Mandate regular safety drills and first responder training tailored to each property,
- Provide ongoing education for housing industry professionals on I/DD-inclusive design and supports,
- Ensure property management companies are trauma-informed and versed in diverse disability needs, and
- Develop orientation materials that set clear expectations for community values and peer support.

These themes capture a wide breadth of policy recommendations generated by survey respondents and focus group participants. They served as the foundation for drafting report recommendations that focuses on policy related to intentional communities in Colorado.

**The following are additional recommendations of note that did not fit within the summarized points above:**

*"No mandatory activities or rules beyond a typical rental agreement (but there should be optional social opportunities)"*

*"Keeping families and friends involved, actively promoting building of natural relationships in the greater community."*

*"Residents should have person-centered programs with the opportunity to check-in and change housing if they choose."*

*"Thoughtful selection of residents"*

*"Have mechanisms for feedback, conflict resolution, and ongoing learning to ensure the community evolves with its people."*

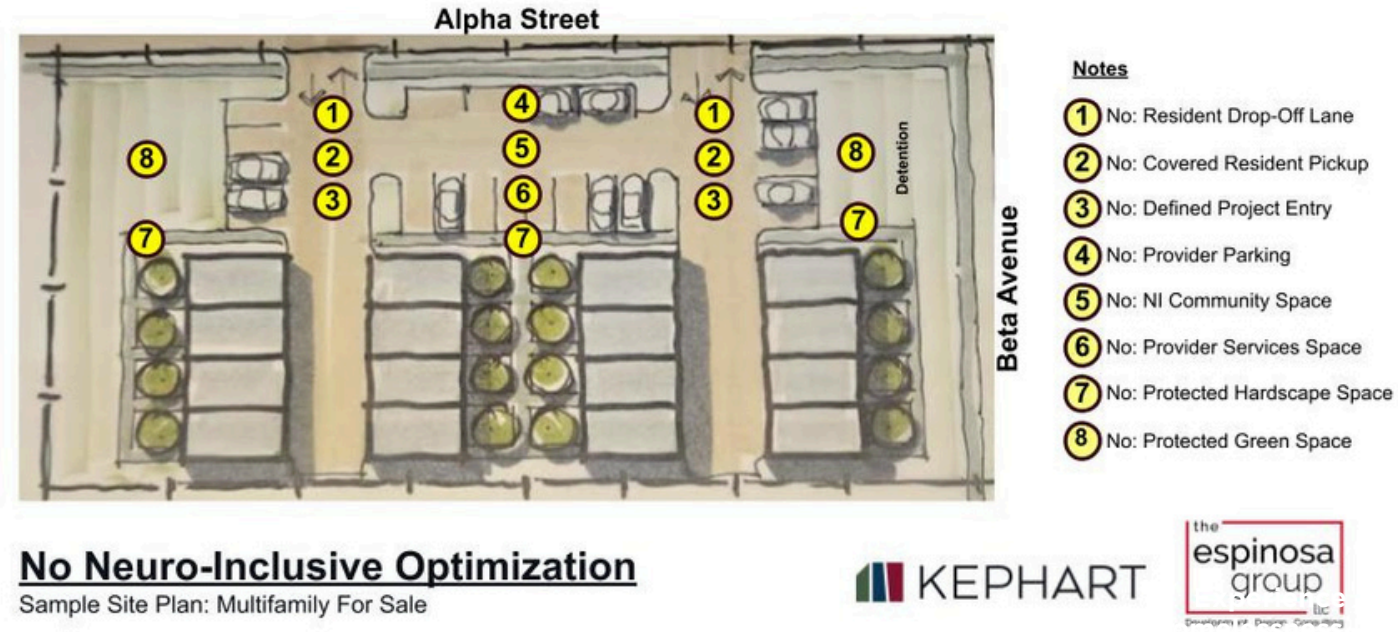
*"More emphasis needs to be paid towards those with higher needs, as well as helping families navigate options for those with higher needs." (medical and behavioral)*

*"Community engagement needed prior to development for people with disabilities because disability housing is often ADA/wheelchair focused."*



## Stakeholder Themes in Design

**The following renderings and explanations are provided by architect Joseph Espinosa of the Espinosa Group and KEPHART to illustrate themes of stakeholders incorporated into neur-inclusive design strategies versus non-optimized properties:**

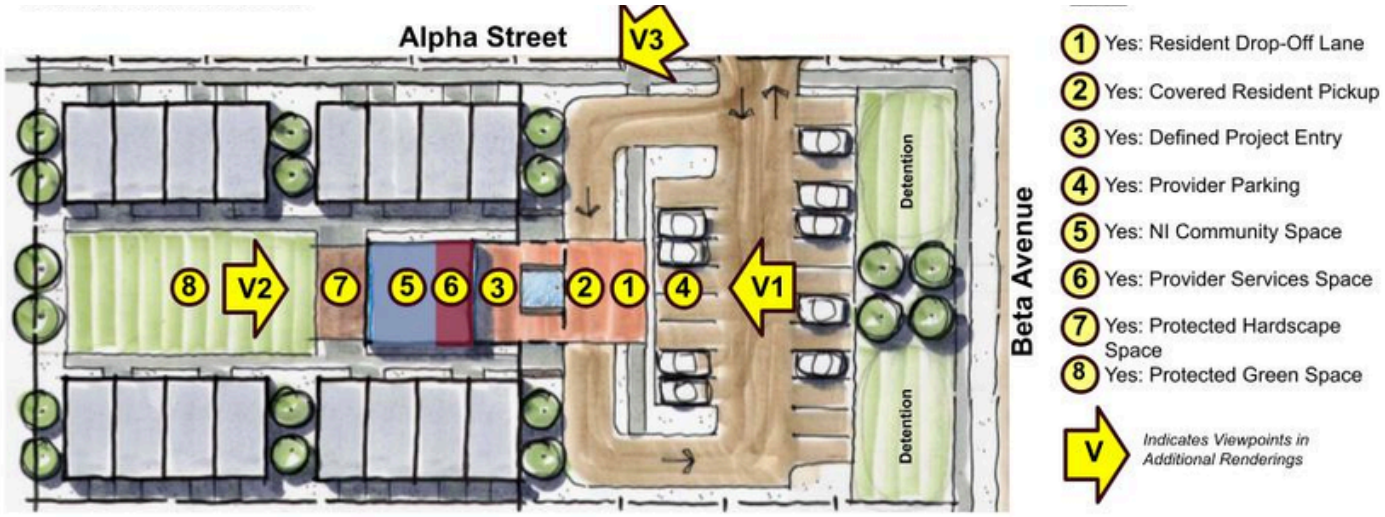



**No Neuro-Inclusive Optimization**
Sample Site Plan: Multifamily For Sale

KEPHART

the espinosa group llc

*"Above is a sample plan for multifamily for sale, without neuro-inclusive optimization considerations. A typical market rate for sale project would target higher parking rations, higher bedroom counts, hierarchy of bedrooms, privacy, and maximization of resale value."*



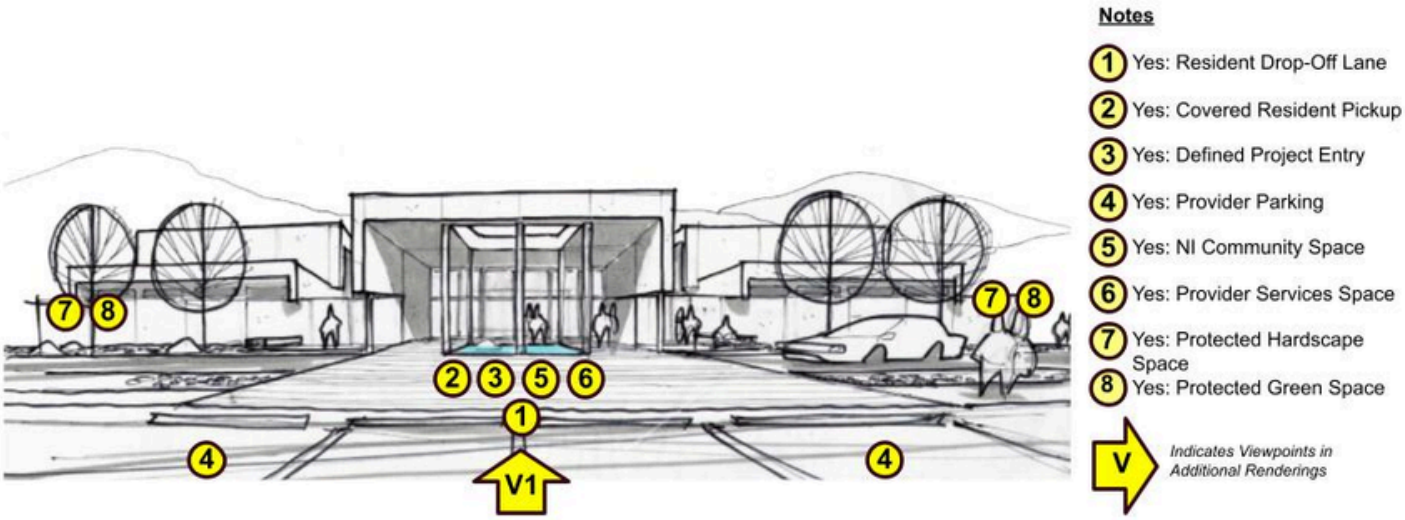

**Neuro-Inclusive Optimization**
Sample Site Plan: Multifamily For Sale

KEPHART

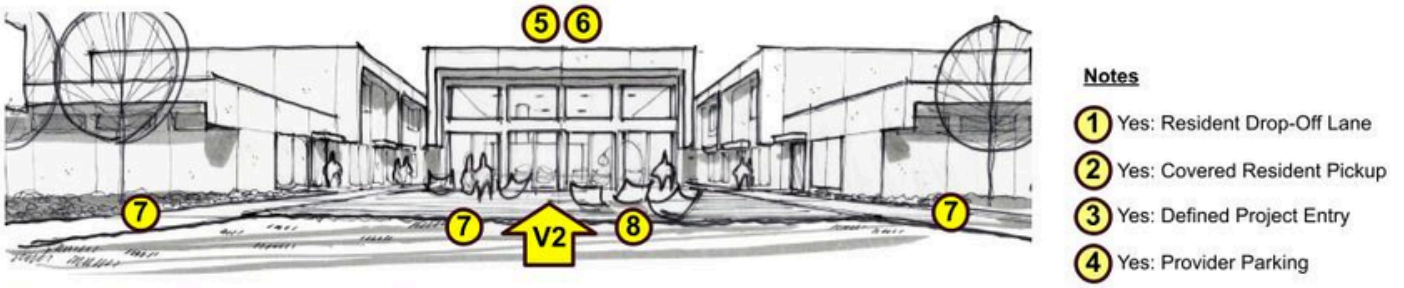
the espinosa group llc

*"This neuro-inclusive for sale site plan adds protected community space, defined entries, and accessible circulation. This pedestrian friendly design aligns with the neuro-inclusive housing framework by fostering autonomy, natural supports, and social integration."*

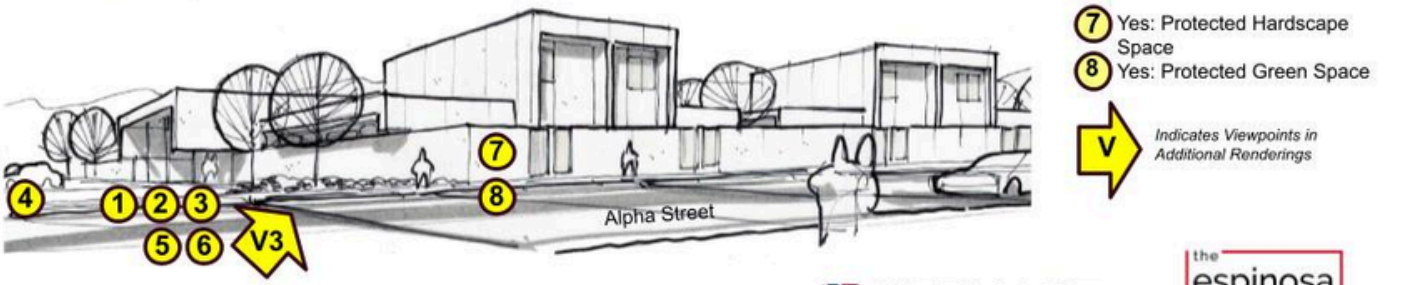
*"These renderings of a neuro-inclusive for sale design demonstrate how neuro-inclusive optimization enhances the needs of adults with I/DD in their everyday experiences, such as clarity and thoughtfulness from project vehicular drop off to pedestrian entry points, defined social and provider spaces, balanced open space, and natural wayfinding is present as a part of this intentional design."*




**View #1: Multifamily For Sale**
Neuro Inclusive Optimization




**View #2: Multifamily For Sale**
Neuro Inclusive Optimization

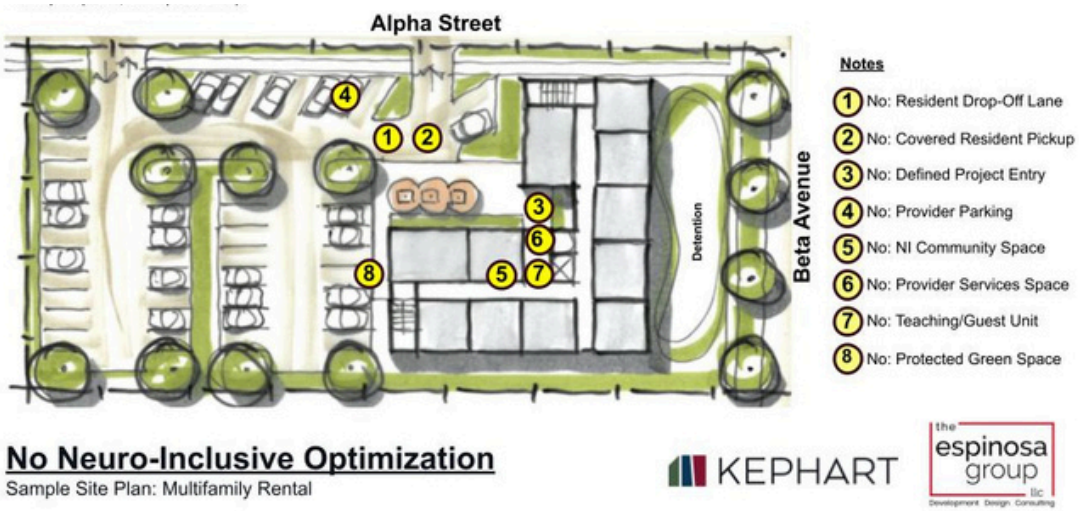



**View #3: Multifamily For Sale**
Neuro Inclusive Optimization

KEPHART

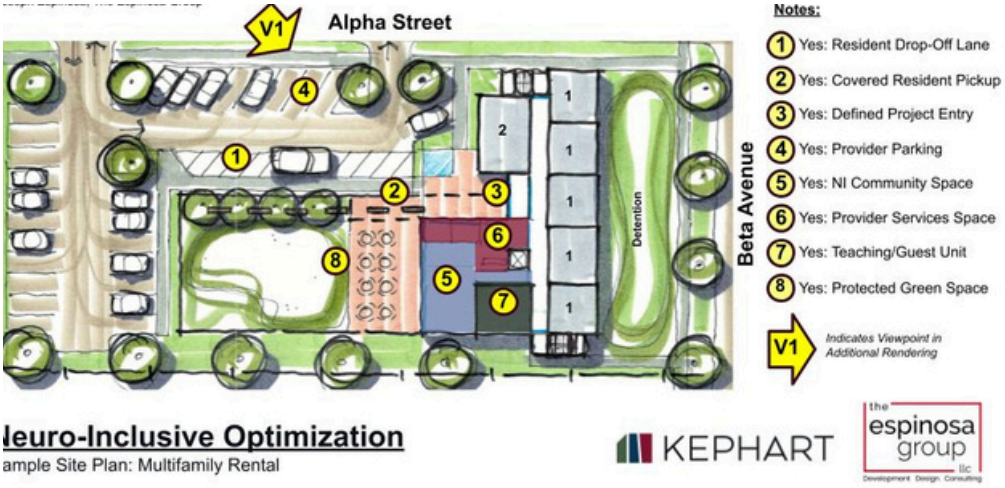
the espinosa group llc
Development Design Consulting

*"This sample site plan for multi-family rental without neuro-inclusive features communicates a typical market rate site layout, but it also highlights missing neuro-inclusive design elements such as community space, provider offices, and defined open space."*




**No Neuro-Inclusive Optimization**
Sample Site Plan: Multifamily Rental

KEPHART the espinosa group llc

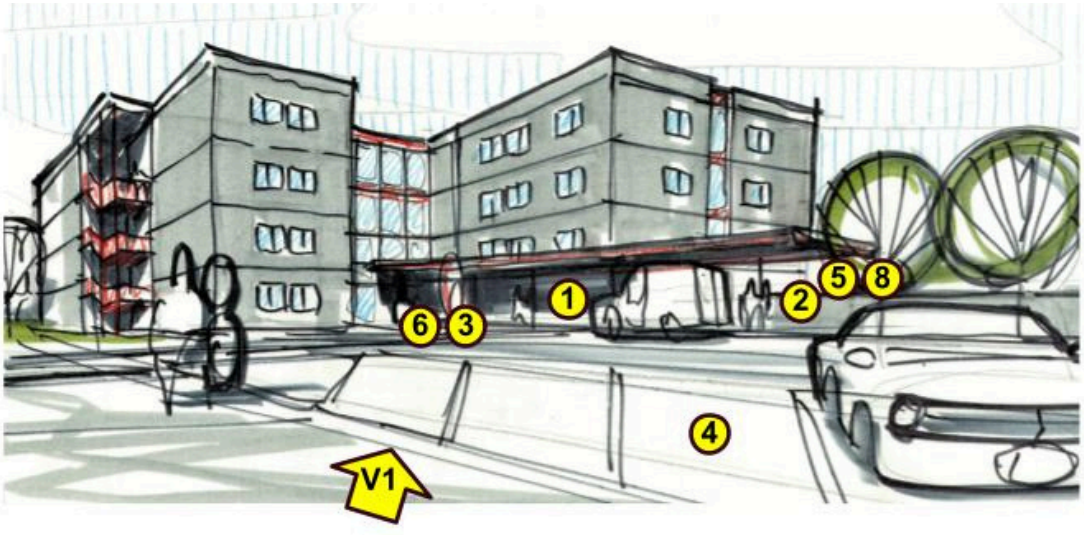



**leuro-Inclusive Optimization**
ample Site Plan: Multifamily Rental

KEPHART the espinosa group llc

*"This neuro-inclusive optimized site plan illustrates the integration of resident drop-off lanes, community space, provider services and parking, protected green area, and teaching or guest units. These design choices directly address stakeholder concerns by promoting safety, accessibility, and a deep sense of belonging for residents."*

*"This elevation illustrates neuro-inclusive optimization from the site plan. The design emphasizes drop-off access, visual clarity, community presence, and limited entry/exit points for safety."*




**View #1: Multifamily Rental**
Neuro-Inclusive Optimization

KEPHART the espinosa group llc



# DISCUSSION OF ISSUES TO CONSIDER FOR INTENTIONAL COMMUNITIES IN COLORADO

Policies and funding streams shape the very landscape in which adults with I/DD build their lives. When policy evolves alongside self-advocates and their support networks, it unlocks pathways to housing that honor autonomy, foster genuine community ties, and dismantle the barriers that once relegated people to institutions. By tailoring funding streams and regulatory frameworks to lived realities, policy becomes a catalyst for true inclusion and person-centered solutions. The following are discussion items related to existing regulatory guardrails and stakeholder feedback that could influence future intentional communities in Colorado.

## Current Colorado HCBS Setting Requirements

Colorado is a state with both robust regulatory enhancements and ongoing training and compliance efforts for implementing the HCBS Final Rule.[85] Colorado's approach embeds the federal requirements in its statutes and elaborates with specific operational policies, especially around transportation, restrictive measures, and ongoing training. There is heavy emphasis on documentation, personalized planning, and proactive engagement with stakeholders, including numerous training modules for providers and case managers, and public videos for HCBS participants. [86]

Colorado's ongoing HCBS compliance measures include formal site assessments, validation protocols, and corrective notices where compliance issues emerge. The official Colorado regulation (10 CCR 2505-10 section 8.7001) incorporates the federal requirements with several distinctive additions that may influence intentional communities:[87]

- **Transportation Support:** Colorado does not require providers to furnish their own transportation but does mandate active assistance with using public/Medicaid transportation. Providers are expected to coordinate and support individuals in accessing community transportation, including providing schedules and facilitating logistics. Providers must document unmet needs in transition plans. As transportation is not a required service, location of property and potential inclusion of transportation assistance as a supportive amenity may be beneficial.

- **Expectations for Community Integration:** Colorado considers "reverse integration," inviting the public into disability settings, is insufficient for community integration compliance.[88] There is a strong, explicit emphasis on supporting individuals in activities outside the setting with a focus on greater community participation and competitive employment.

Specifically, Colorado regulators require and want to ensure:

- individuals can come and go freely- i.e. lack of a curfew, provision of keys/key codes when the outer door is locked,
- the setting provides information about and supports individuals in accessing the greater community,
- the setting has policies, practices, and staff training in place to support person-centered thinking and approaches- i.e., putting the person first, recognizing that they are the expert in their own life and should have positive control over it, and valuing their contributions to their community,
- individuals going out into the community are not singled out from other community members by being required to wear (or be accompanied by staff wearing) uniforms, standardized clothing, vests, badges, name tags, and the like, and
- individuals in fact engage in desired activities out in the community when they wish to do so.

Although these are important protections beyond the federal requirements to safeguard autonomy, some participants of the study felt reverse integration was a positive characteristic and should be encouraged. Modifications to these and other HCBS requirements are permissible, but must be documented and person-centered, not setting-specific.

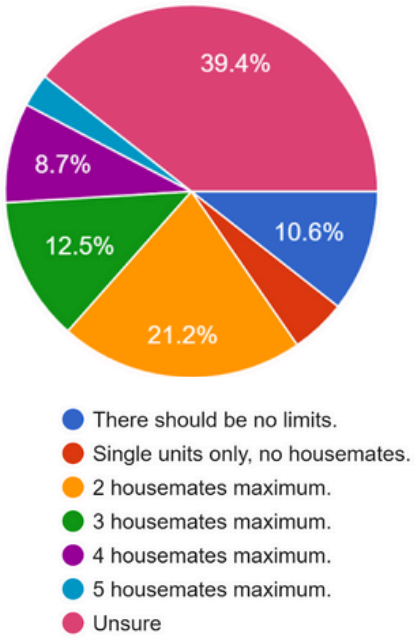
- **Prohibition of cameras:** General-use cameras in private or common areas are broadly prohibited, allowed only through individualized care plans with consent and periodic review. This guidance refers to a person's specific residence, not the property in general, but implications should be considered if investment into enabling technology or remote support is explored within individual units.[89] Cameras on the exterior sides of entrances/exits and cameras typically found in integrated settings generally do not raise privacy concerns, so long as their use is similar to that practiced at non-HCBS settings.



- **Restriction of number of housemates:** In consumer-controlled settings, where housemates do not have 24/7 support needs and may have different service providers, Colorado does not allow more than three waiver recipients to live in the same home.[90] Therefore, without changing current regulations, intentional communities should not plan to develop units where more than three individuals using services would live together in the same household.

The Intentional Community Research Project survey asked about limitations of number of housemates: 39.4% responded as unsure there should be a limit, 10.6% responded that there should not be a limit, 4.8% said there should only be single units, 21.2% said there should be a maximum of 2 housemates, 12.5% said there should be a maximum of 3 housemates and 10.6% said a maximum of 4 or 5 housemates. Therefore, approximately 72% of respondents preferred to not have a 3-person maximum on future choices.

***Should there be a limit to the number of housemates in a home within the intentional community, assuming each housemate would have their own room? (104 responses)***

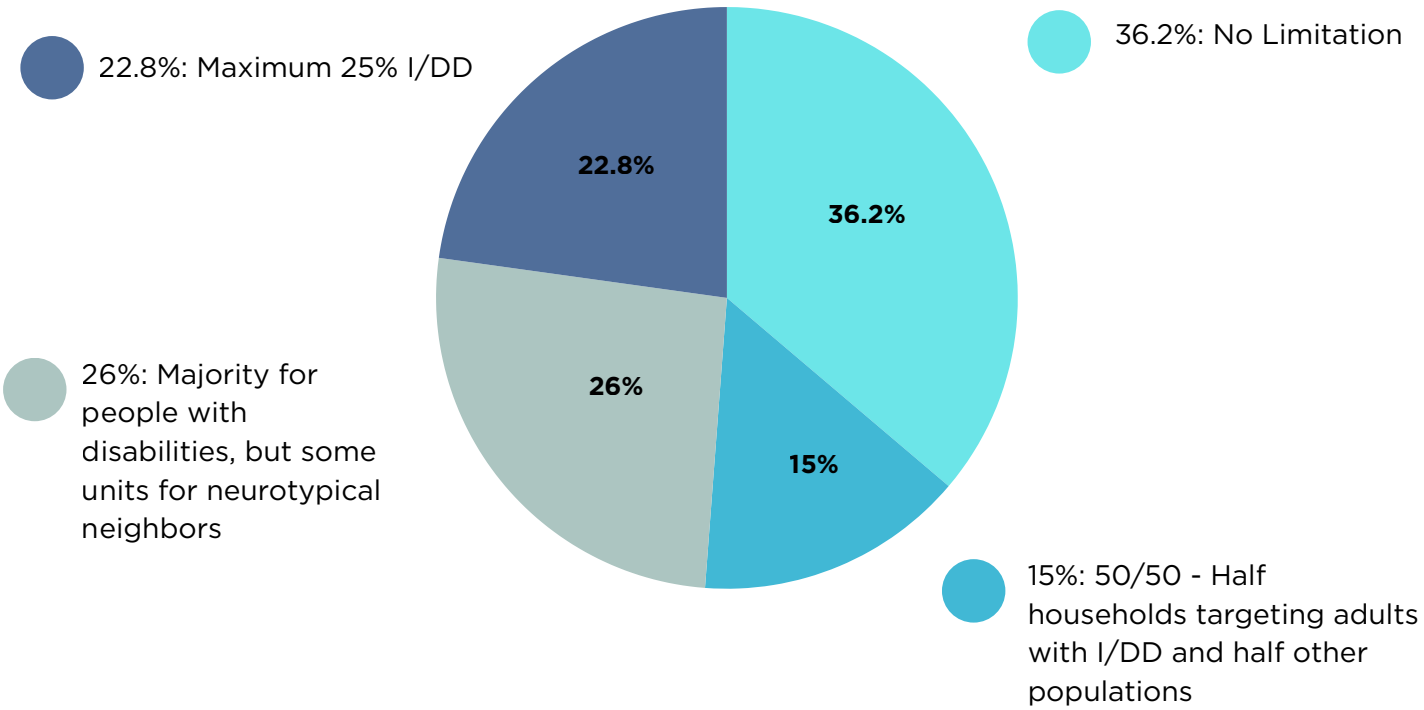


## Density of Persons with I/DD in Intentional Communities

Some states and HUD's Section 811 Project Rental Assistance Program use a 25% density limit to encourage the development of integrated settings when using public dollars to make housing affordable. For example, this strategy would mean an intentional community of 40 units would be able to secure only 10 of those units for adults with I/DD and the rest of the units would have other required qualifications such as income-limits, age-restriction or other set-aside units for a different non-disabled population.

**When asked about maximum percentage of adults with I/DD who should live in an intentional community, Intentional Community Research Project survey reflected diverse responses:**

***Should there be the maximum number of people with I/DD who live in an intentional community?***




***"Give families and providers the freedom to innovate and create dream communities that residents and staff will thrive in. Don't micromanage. Put in place oversight mechanisms to prevent low quality and abuse, but don't micromanage details and don't add bureaucracy. Create adequate financing mechanisms that families/residents control. If they don't like the conditions, they can move to another place, ie, vote with their feet."***

**-Expanded survey respondent**

**This question generated a lot of discussion both in the survey and in focus groups. Additional quotes from survey respondents related to density limits:**

*A number metric doesn't make sense. It's more important who is running it and what control do residents have...*

*No. Assigning a maximum number is naive as a metric.*

*I want 100% people with disabilities, because you don't know what people without disabilities might do to you.*

*50/50 because it helps property be more safe when people know their neighbors and can help with medical issues.*

*Options in all housing stocks should be an option. Some may wish to live in majority or exclusively IDD community. I feel these should be integrated into the larger community rather than at the fringes. But for others, proximity to an inclusive community where supports can be easily accesses while otherwise living in a "normal", though preferably affordable, independent housing situation would be most welcome.*

*Given that it's so challenging to find affordable rent for caregivers, it might be worth considering having housing options for staff and their families in the intentional community.*

*Unsure. Need to balance level of support, "triggers" of others, aggressive behaviors or screaming stims"*

*No Limits. Different ratios appropriate for different communities. 100% I/DD is not segregation if it is a choice. Talking about high quality options that support community access.*

*50% disability of any kind, 50% neurotypical, but non criminal backgrounds, no drugs*

*To help people get out in an emergency, 60% people with disabilities and 40% neurotypical/able-bodied.*

*I think there shouldn't be a limit, but I also think other populations need to be included in order to create an inclusive and sustainable world.*

*Its not the number of us (disabled people) that make a place institutional, but controlling, abusive or negligent systems that define institutions.*

*I believe an intentional community would be ideal for senior to elderly parents to stay with their loved ones up until their own death without having to move their family member with disabilities out of the family home.*

*Unsure, but size matters if only people with I/DD. Cultural mix important and "eyes" to prevent abuse.*

*No %- this makes me angry.*

## Renderings Reflecting Themes

In-person focus groups allowed for greater discussion and nuances to emerge. When asked whether or not Colorado should consider limitations on the density of persons with I/DD in future intentional communities, the following themes were represented:

- **Integration and Natural Supports**: Stakeholders frequently emphasized the value of having able-bodied or neurotypical neighbors in the same building to provide informal help in emergencies, share day-to-day support, and foster genuine community bonds. Proponents suggested specific ratios, often around 60/40 or 50/50, to strike a balance between safety nets and inclusion. Many framed this as a way to ensure residents know and look out for one another rather than relying solely on paid staff.

- **Safety and Security:** Supporters of caps argued that without enough outside "eyes and ears," people with disabilities might be at greater risk for abuse, lack of help during a medical emergency or behavioral incident. While others had strong concerns over abuse from residents without I/DD, arguing that people without disabilities sometimes exploit or take advantage of more vulnerable residents. These stakeholders prioritized safeguarding against predatory relationships over broad integration.

- **Autonomy, Personal Choice, and Non-Discrimination:** Many respondents flatly opposed any quota, viewing percentage limits as an infringement on individual freedom and housing choice. They argued that caps treat people with disabilities like interchangeable cogs rather than neighbors, clashing with Fair Housing principles. Some described limits as discriminatory, outdated, or naïve, insisting that each project's composition should emerge from resident preferences and community context, not rigid rules.

- **Skepticism of Percentage Metrics:** Across both supporters and opponents, there was strong doubt about using a single number as the primary gauge of inclusion. Comments described percentage-based caps as a "box-checking" exercise that ignores nuance, like varying support levels or neighborhood dynamics. Instead, many urged flexible, context-driven approaches that prioritize housing quality, resident mix, and local needs over arbitrary thresholds.

- **Minimum Thresholds for Disability Presence**: Several participants expressed ambivalence, seeing the logic in both integration and solidarity, but worrying that fixed percentages could limit options or become mere compliance targets. A smaller but vocal group rejected maximum caps in favor of minimum requirements, often around 50%, to ensure enough people with disabilities live together and support one another. They feared that too few residents with disabilities would undermine the social and advocacy networks within a building, or risk tokenism.

- **Inclusion of Staff, Family Members, and Seniors:** Some stakeholders expanded the conversation beyond just disabled and non-disabled residents, advocating for on-site staff housing, family apartments, or senior tenants. They saw mixed-generation or multirole households as enriching the community fabric, offering both formal and informal support without isolating any one group.

| THEME | SUMMARY |
|---|---|
| **Integration and Natural Supports** | Mixed-ability neighbors provide informal help, foster friendships, and reduce reliance on staff. |
| **Safety and Emergency Preparedness** | Non-disabled residents can act as first responders in crises, boosting overall building safety. |
| **Autonomy and Non-Discrimination** | Fixed caps are viewed as infringing on personal choice and potentially violating fair housing principles. |
| **Skepticism of Percentage Metrics** | Doubt about using a single ratio; many favor flexible, context-driven approaches over rigid numbers. |
| **Minimum Disability Thresholds** | Some advocate for minimum percentages (e.g., 50%) to ensure solidarity, peer support, and avoid tokenism. |
| **Inclusion of Staff, Family, and Seniors** | Proposals to include on-site staff housing, family members, or seniors to enrich support networks. |
| **Concerns About Exploitation** | A few prefer 100% disability settings to protect residents from predatory relationships. |
| **Conditional/Unsure Perspectives** | Ambivalence about fixed limits; emphasize nuance, risk of "box-checking," and need for tailored solutions. |

In current guidance, HCPF has specifically addressed whether or not HCBS waiver participants can receive HCBS services in a setting that serves only people with I/DD. **Colorado guidance documents provide the following existing guardrails that would impact intentional communities who choose to set aside all or the majority of units for adults with I/DD:**[91]

"5. May a setting serve people that all have disabilities or a specific kind of disability?

*Yes. Everyone must have the opportunity to make an informed choice among options, including non-disability specific settings… Where individuals elect through their person centered planning process to receive services at a disability-specific setting, they do so because that setting best meets their needs, including needs for habilitative services that will help them achieve even more community integration in the future… Settings that have the following two characteristics alone might, but will not necessarily, meet the criteria for having the effect of isolating individuals [and thus being potentially subject to heightened scrutiny]:*

- *The setting is designed specifically for people with disabilities, and often even for people with a certain type of disability.*
- *The individuals in the setting are primarily or exclusively people with disabilities and on-site staff provide many services to them."*

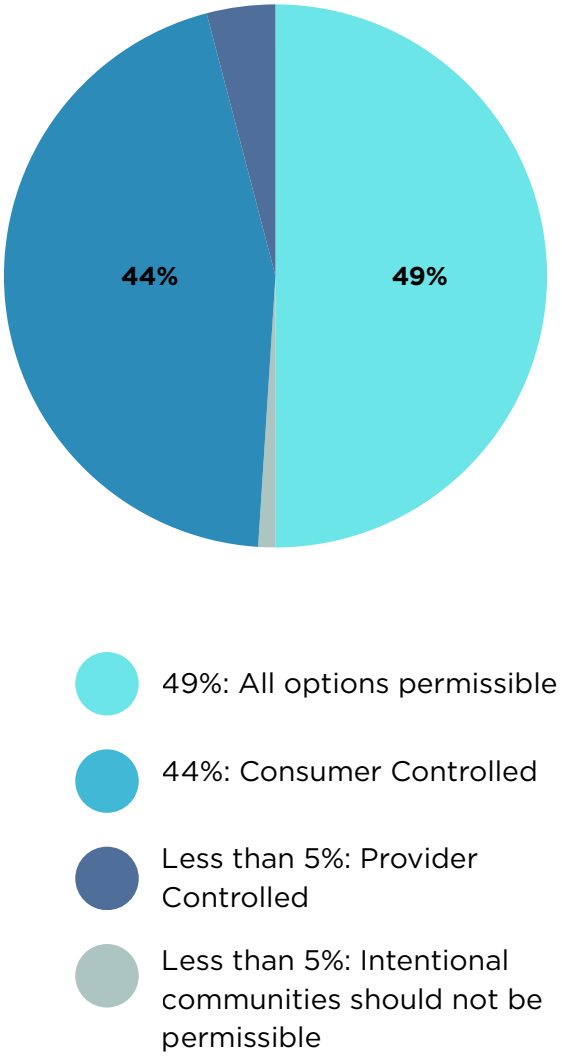
Therefore, Colorado already has precedent to use the density of people with I/DD living at a property as a marker for exploring if residents at that property are being isolated from the greater community. This is an important safeguard already in place, although Colorado stakeholders largely did not believe the density of a setting alone is an adequate metric for evaluating whether or not residents are being isolated or supported to be integrated within the greater community. Due to stakeholder feedback, initiating a maximum density of persons with I/DD is not recommended.

### Connection Between Long-Term Support Services & Housing Provider

Colorado must consider the challenges and opportunities of Medicaid-funded LTSS providers owning and/or operating intentional communities. Some states restrict housing providers from also being service providers due to potential conflict of interest. When Colorado stakeholders were asked their opinion, 49% of respondents indicated that both provider-controlled and consumer-controlled settings should be permissible. 41% had a preference for only consumer-controlled options. Therefore, it is recommended that Colorado allow for PASA's to be owner/operators of intentional communities, but ensure residents also have the freedom to choose their preferred PASA as desired.

***"While I believe we should not limit possibilities, one service provider w/ only individuals w/ IDD is where I believe individuals are most at risk and extra "eyes" should be considered."***

***What type of relationship should one's service provide (PASA) have with the intentional community?***



The following chart offers some benefits and considerations of PASA's also being the owner/operator of intentional community properties:

| ASPECT | BENEFITS | CONSIDERATIONS |
|---|---|---|
| Integrated Care & Support | Provider-controlled settings offer seamless coordination between housing and LTSS; 24/7 access to supports with ability to share staff | Potential conflict of interest between landlord and service provider; blurred lines in roles and accountability |
| Resident Autonomy & Choice | Person-centered service plans integrated with housing decisions | Limited ability for residents to switch providers |
| Financial Sustainability | Economies of scale from combined rent and service revenues, predictable cash flow through Medicaid reimbursements | Risk of reduced LTSS choices if only a small set of specific services are offered |
| Regulatory Compliance | Direct control to ensure HCBS Final Rule and state standards are met | Requiring LTSS provision would exclude non-LTSS funded residents if they could not private-pay |
| Quality Assurance & Outcomes | Unified data collection for continuous improvement, greater oversight of environmental safety and care protocols | Mission drift toward property management at the expense of care quality |

## Disparities in Rural and Mountain Towns

Roughly 12.3% of Coloradans—about 714,000 people—live in non-metro (rural and frontier) counties, yet these areas have far fewer LTSS and healthcare resources than urban parts of the state.[92] For example, **there is only 1 mental health provider for every 1,282 residents in rural Colorado.** In rural areas, mental health professionals serve an average of 479 people each compared to 234 people in non-rural areas. Adults with I/DD in mountain communities often wait six to twelve months for essential diagnostic or therapeutic services and frequently must travel two to three hours one way to urban centers for evaluations or follow-up care.[93]

With the exception of mountain resort communities, housing in Colorado's rural and mountain towns is markedly more affordable than on the Front Range, but the stock is old, small, and often inaccessible: aging single-family homes with few universal-design features, manufactured and mobile homes lacking ADA-compliant modifications, and scattered USDA Rural Development Section 515 properties, most built before 1990 with limited barrier-free units. Furthermore, building deeply affordable housing in rural communities is significantly more difficult than in urban settings. Lower population density, limited financing options, higher per-unit development costs, and sparse infrastructure create a perfect storm of barriers.[94]

Studies in Colorado and national research reflect that lack of transportation is a major barrier to community integration, access to needed healthcare and social relationships.[95,79] In rural communities, public transportation is not an option, thus properties may need to offer transportation assistance even if residents may not want to "go to town" everyday. CMS underscores rural living or a farmstead is a distinct lifestyle choice that must be documented in one's person-centered plan; they should have the same opportunity to access their community in a similar manner as those without disabilities.[96]

***"Rural is different. We don't get the same resources. Rural is not as supported"***

Intentional communities may be especially needed in areas where support is sparse. Aligning neuro-inclusive strategies with rural affordable housing by embedding sensory-friendly finishes, community-based partnerships, identifying a PASA for LTSS, and telehealth-enabled supports can further reduce displacement risk for adults with I/DD and create truly sustainable communities.

***"New, modern, not just what's leftover"***

## Lack of Disability- Specific Affordable Housing Programs

### FEDERAL SOURCES

#### Mainstream and Non-Elderly Disabled (NED) Vouchers

The Mainstream Voucher and Non-Elderly Disabled (NED) Vouchers program provides tenant-based rental assistance specifically for non-elderly persons with disabilities and their families (not specifically adults with I/DD). These vouchers are administered by local PHA's under the HCV rules but are funded and reported separately to target individuals under age 62 who qualify as disabled.

Nationally as of May 2025,

- 71,217 Manstream vouchers funded with 83% already being used
- 54,727 NED vouchers funded with 82% already being used.[97]

Therefore, this is an extremely limited program to meet the demand of all persons with disabilities who may need it in the US.

#### Section 811 Supportive Housing for Persons with Disabilities

US Department of Housing & Urban Development (HUD) Section 811 program is designed to expand affordable, community-based housing opportunities for very low- and extremely low-income adults with disabilities (not I/DD specifically).[98] It ensures rental units are paired with voluntary supportive services.[99] There are two program components:

1. Traditional Capital Advance & Operating Subsidy
   - Provides interest-free capital advances to nonprofit sponsors to finance construction, rehabilitation, or acquisition of supportive housing,
   - Includes ongoing operating subsidies so rents remain affordable for residents earning very low incomes, and
   - Advances need not be repaid as long as the housing remains available to persons with disabilities for at least 40 years.

2. Project Rental Assistance (PRA)
   - Offers project-based rental assistance through state housing agencies,
   - Covers the gap between a tenant's share of rent (typically 30% of income) and the actual rent charged, and
   - Enables more units—owned by nonprofits or private landlords—to serve adults with disabilities without requiring new construction.

**The primary challenge of the 811 program is that the need far outpaces the extremely limited funding allocation.** Additionally, no more than 25% of the total units in eligible multifamily properties can: 1) use Section 811 PRA funds, 2) be used for supportive housing for persons with disabilities, or 3) have any additional occupancy preference for persons with disabilities.[100]

## Colorado Disability-Specific Housing Programs

### CO Mainstream and Non-Elderly Disabled (NED) Vouchers

As of May 2025 Colorado has:

- 1,715 Mainstream vouchers funded with 88% already being used,
- 2,416 NED vouchers funded with 82% already being used.[101]

### CO Section 811 Supportive Housing for Persons with Disabilities

In Colorado, HUD's Section 811 PRA vouchers are administered by the Colorado Division of Housing (DOH) in partnership with local PHAs. Colorado holds a total of 360 HUD Section 811 PRA vouchers statewide. These are allocated across seven PHAs to support non-elderly adults with disabilities:

- Denver Housing Authority (DHA): 120
- Pikes Peak Regional Housing Authority (PPRHA): 60
- Boulder Housing Authority (BHA): 40
- Larimer County Housing Authority (LCHA): 35
- Jefferson County Housing Authority (JCHA): 35
- Colorado Springs Housing Authority (CSHA): 50
- Pueblo Housing Authority (PHA): 20

### Prioritization in Qualified Allocation Plan

Colorado's Low-Income Housing Tax Credit (LIHTC) program has financed the creation of tens of thousands of affordable rental homes through federal tax credits. The LIHTC Qualified Allocation Plan (QAP) describes how Colorado prioritizes and allocates those credits to projects that meet specific needs. Colorado's QAP does not reserve or "set aside" credits exclusively for people with disabilities nor adults with I/DD.[102] It does offer the following prioritizations and incentives that relate to disability:

DISCUSSIONS OF ISSUES

- **Special Needs/Supportive Housing Category**
  - Bonus points for integrated supportive services are available, but not required. Projects that include on-site supportive services for special-needs populations (homeless, chronically ill, people with disabilities, etc.) compete under a single designated "Supportive Housing" prioritization. These earn extra points, but the category is broad—it isn't broken out by disability or I/DD specifically.

- **Accessibility Requirements**
  - Every LIHTC project must provide a minimum of 5 percent mobility-accessible units and 2 percent units for hearing/vision impairments. Projects that exceed minimum requirements, utilize universal design or provide visitability and adaptability features receive extra points, thus providing a competitive scoring advantage.

- **Income-Targeting Bonuses**
  - Projects that commit a share of units to extremely low-income households (30 percent or 20 percent of area median income) receive higher scores. Most adults with I/DD fall into these income bands, so they benefit indirectly.

By comparison, other states direct more funding towards the development of neuro-inclusive housing or units for adults with I/DD through explicit set-asides, extended affordability periods, and integration with Medicaid service systems.

**"The capital plans change completely for rural to urban development. Government funding sources are becoming more difficult than ever before."**
**- Housing Developer**

In 2020, CHFA commissioned a neuro-inclusive housing taskforce that led to an evaluation of the full housing continuum and various ways new and existing programs and business areas throughout CHFA can support I/DD needs and incorporate I/DD considerations. In June 2022, they published the CHFA Neuro-Inclusive Housing White Paper to map the unique housing needs, barriers, and emerging best practices for adults with I/DD across Colorado.[103] This study catalyzed recognition of adults with I/DD as an affordable housing need in Colorado within the affordable housing industry.

Since that time, CHFA has added 'neuro-inclusive' as a targeted population across multiple existing programs and has supported housing and community-based solutions for adults as follows:

- Allocated tax-credits to neuro-inclusive properties,
- Financed neuro-inclusive developments,
- Provide pre-development technical assistance to landowners who seek to explore small-scale, neuro-inclusive housing on vacant or rehab properties [104]
- Enhancements to single family loan products to better serve the needs of I/DD borrowers and their families, and
- Specified those with I/DD as a 'top consideration' in the evaluation of applications for CHFA's Direct Effect Awards, which provide grants to mission-aligned nonprofit organizations.[105]

**CHFA has allocated nearly $1,000,000 to 54 unique organizations serving I/DD populations in Colorado, providing direct funding for supports and services crucial to this community.**

## Challenges of Existing Affordable Housing Funding Streams

There is no specific funding source for intentional communities or other forms of neuro-inclusive housing designed to be accessible and affordable to adults with I/DD. Therefore, when developing affordable properties that would be seeking local, state, or federal support to be affordable, the property has to comply with very specific regulations that were not created with the unique needs of adults with I/DD in mind. Affordable housing programs were designed as a temporary solution for low-income, neurotypical or able-bodied households as a bridge to market rate housing options. Other supportive housing programs have been designed specifically for those experiencing chronic homelessness, mental health challenges, seniors, veterans, those with HIV/AIDS, etc. [106]

As part of this study, fifteen developers and/or operators of existing affordable, neuro-inclusive housing gathered to discuss the challenges encountered when using existing funding streams. The following were shared as obstacles to meeting the demand for neuro-inclusive housing:

"*There are no incentives for developers to design neuro-inclusive properties nor supportive amenities; the tax credit application was overwhelming."*

*"Upfront capital is needed for initial phases of development."*

*"There is a lack of funds available for needed programming and supportive amenities."*

*"There is high competition with other properties applying for extremely limited funding sources."*

*"When only 25% of units could be set-aside for adults with I/DD, it limits the return on investment of time, land, and potential supportive amenities."*

*"Developers often have no control over the lease process or tenant selection (people with I/DD or neurotypical/able-bodied)"*

*"Families seek out trusted service providers to help solve the housing crisis they face; however, since there are restrictions on whether the owner/landlord could provide waiver services, residents are either forced to change service providers, or affordable units end up going to those who can privately pay for support. Both outcomes are counter-intuitive."*

*"Existing funding and incentives are burdensome and require agreements that prevent developers from getting things donated."*

*"Completing and maintaining compliance paperwork for adult residents with I/DD is repetitive and inaccessible."*

*"The application and access to needed housing vouchers is difficult for individuals and families. The biggest barrier is that systems do not want people with I/DD to be clustered; cannot afford the risk due to various interpretations of Olmstead."*

*"Ongoing education of neurotypical tenants about the variety of individuals who live in the building, and how to interact or not interact especially when dysregulation occurs. Many voice that they don't know how to interact or if they should interact, so our nonprofit engages in frequent education efforts about the I/DD population that lives in the building. Activities and social events we sponsor play a huge role in getting everyone comfortable with one another."*

*"The LIHTC process lumps in seniors, vets, farmworkers, multi-family, homeless and I/DD into one "special needs" competition category. This unfairly positions I/DD communities in competition with developments where they cannot succeed. Most I/DD communities are not 100+ units."*

*"At the time we were funded, we were ranked #1 in the state funding priorities but the world has changed significantly since then and unless new categories are created for I/DD communities only, it will be difficult to compete."*



*"...community integration is NOT a place but a concept. Typical apartment residents only stay in one place for 1-3 years, but those with IDD typically like to stay in one place. We are not a "neighborly" society any longer and to specify how many people with IDD can live in a complex is discriminatory."*

Colorado also faces many of these challenges. Most notably in relationship to stakeholder feedback is the challenge of limitations on tenant selection, limited housing vouchers, lack of funding for supportive amenities and sources of funding for housing development.

## Other State Initiatives Related to Intentional Communities

Other states have developed programs or initiatives that impact the emergence of intentional communities. The following are a few examples that Colorado could explore further:

- **Require that every city and county housing evaluation include people with I/DD (CA):** Under California Government Code Section 65583(a)(7), as amended by SB 812 in 2010, every city and county housing element in this state must include an analysis of the special housing needs of persons with disabilities, explicitly including "persons with developmental disabilities." Jurisdictions are mandated to estimate the number of residents with developmental disabilities, assess their housing needs, and discuss potential resources or programs to address those needs.[107]

- **Grants for Persons with Developmental Disabilities program plus 5% LIHTC set-aside (FL):** The Florida Housing Finance Corporation (FHFC)'s competitive Grants for Persons with Developmental Disabilities program is paired with a 5% set-aside in the FL QAP for those with a "disabling condition." Since starting about a decade ago, FHFC has awarded grant funding to 14 developments that have a minimum of either 50% or 80% residents with I/DD.[108,109,110]

- **I/DD Fund within Washington State Housing Trust Fund (WA):** In the 2025-2027 cycle, the WA Housing Trust Fund will allocate $50M specifically to develop affordable housing units for adults with I/DD. Requires provision of support services and encourages single-family, scattered site homes and use of smart home technology.[111]

- **Integrated Supportive Housing (ISH) program (NY):** NY's Developmental Disability Agency (OPWDD, equivalent to HCPF in CO) provides housing developers (1) rental subsidies and supportive services once in operation; or (2) rental subsidies and capital funding if they set-aside units for people with I/DD. Developers of affordable housing opportunities receive scoring incentives in NYS Homes and Community Renewal applications (equivalent to CHFA in CO) for partnering with an OPWDD provider agency and giving tenant preference for people served by OPWDD. Under this program, OPWDD will provide funding for up to 25% of the total number of units in a development application.[112]

- **Set-aside 12.25% of total LIHTC allocations (IN):** Called the 'Community Integration set-aside,' developments must reserve at least 20% but not more than 25% of the total development units for households in which at least one member is a person with an intellectual disability, developmental disability, or traumatic brain injury.[113]

- **Bonus points in LIHTC scoring for Resident Coordinator and/or Clinical Partnership (CT):** On-site credentialed resident services coordinator staff, working a minimum of one full-time equivalent hours per week (2-points) or part-time (1 point), and a property budget line item or evidence of an arrangement with a third party provider specifying the funding source for the resident services coordinator salary, benefits and annual training is required..



A Clinical Partnership is the provision of service coordination in partnership with a local wrap-around or comparable services agency to assist residents in developing and implementing plans for success in supportive housing and continuing the linkage to supportive services, as needed

- **LIHTC set-aside for four supportive housing properties targeting specifically designated populations (PA):** PA defines supportive housing as: (1) Housing that is made available to members of a targeted population, and (2) Housing that has services targeted specifically to members of that population. The Agency will reserve Competitive 9% Tax Credits to, at a minimum, two (2) developments in each Pool [urban and rural/suburban] which promote supportive housing opportunities to targeted populations including non-homeless households requiring supportive services including those with mental, physical, sensory, or developmental disabilities. In the rural/suburban pool, a minimum of fifteen (15%) of the units must be set aside to qualify for this preference. In the urban pool, a minimum of 25% of the units must be set aside to qualify for this preference. [114]

- **Pre-development Community Integration Review process (NJ):** for emerging multi-family developments where multiple waiver recipients will live in close proximity and/or a day program exists onsite, the NJ Division of Developmental Disabilities (DDD) will conduct a Community Integration Review that looks at a variety of factors, including individual experiences, to determine whether the people who reside in the setting will be integrated into the community based on their needs, interests, strengths, and hopes/dreams. New development sites seeking Medicaid HCBS funding for services or DDD Housing Subsidies must be reviewed and approved. Settings that are not approved by the Division risk the ability to receive funding for housing and services. [115]

- **I/DD-specific Ombudsman (NJ, TX, CT, WA, and others):** Some states have established a dedicated I/DD ombudsman unit where residents can confidentially report grievances about governmental or government-funded programs. This could include a reporting outlet for emerging institutional practices (e.g., overly regimented schedules, locked exits), abuse of power, neglectful service providers, etc. The ombudsman investigates complaints and issues binding remediation directives. Colorado currently has a general ombudsman office for long-term care and child welfare.[116,117,118,119]

## Considerations for a Neuro-Inclusive Housing Funding Stream

***"Capital is the hardest part of development. There are no market funding sources"***

Focus group participants strongly recommended the need for a funding source for neuro-inclusive housing. Doing so would address the challenges that exist using current affordable housing sources of funding. It could also allow for I/DD-specific guardrails and incentives such as:

- Require community engagement with the I/DD community during pre-development,
- Require minimum expectations for neuro-inclusive design and supportive amenities,
- Allow for the development of both affordable rental or affordable homeownership options,
- Allow for those who are not eligible for LTSS in Colorado to access supportive housing,
- Require property to be affordable in perpetuity and not allow displacement of residents due to expiration of affordability,
- Allow funding or at least do not penalize applicants for including needed common spaces and neuro-inclusive design features,
- Include an operational funding boost for built-in supportive amenities that can be provided by PASA's or other community-based organizations,
- Require developers to partner with disability organizations for resident outreach, marketing, and service integration,
- Require developers to have Memorandums of Understanding with PASA's or community-based organizations that serve adults with I/DD and descriptions of how they intend to support residents,
- Require Community Integration Plans approved by HCPF to plan for HCBS compliance,
- Offer guardrails on tenant selection and resident-mix to persuade against predatory relationships,
- Provide support and streamline paperwork for residents which could also ensure residents have the support needed to be successful living independently,
- Require Resident Advisory Boards that meet at least quarterly and document resident requests and subsequent action, and
- Failure to meet standards would result in a loss of ongoing funding.

**Colorado is the eighth least affordable state for housing, with only 26 affordable homes for 100 extremely low-income households.**

## State Tax Credit

CHFA administers three housing tax credit programs: the Colorado State Affordable Housing Tax Credit (state AHTC), Transit-Oriented Communities (TOC) credit, and Middle-Income Housing Tax Credit (MIHTC). These "credits" are sold to private investors in exchange for equity capital to reduce project debt. To date, these programs have generated approximately $5.4 billion in equity for affordable rental housing in Colorado. A Neuro-Inclusive Housing State Tax Credit could be created.

## Social Impact Bond (SIB)

Denver's Supportive Housing Social Impact Bond (launched 2016) marshaled $8.6 million in private investments to provide permanent, Housing First units and wrap-around services for 250 chronically homeless individuals. Investors are repaid only if pre-specified outcomes are met. Over a three-year period, participants enjoyed 560 additional days of housing assistance, a 40 percent reduction in shelter use, 30 percent fewer jail stays, and half of program costs offset by savings in emergency services.

## Housing Trust Fund (HTF)

Administered by Colorado Division of Housing (DOH) within the Department of Local Affairs (DOLA), the National HTF awarded Colorado $3 million to increase rental housing for households ⩽ 30 percent of AMI, with the first priority to projects linking supportive services for people with disabilities. The Colorado Housing Investment Fund (CHIF) is Colorado's state-level housing trust fund capitalized with $36 million from the Attorney General's custodial funds, CHIF provides competitive grants and loans for affordable rental housing statewide, including technical assistance to nonprofit developers and local governments.

## Pool of Project-Based Vouchers (PBV)

Project-Based Vouchers attach rental assistance directly to specific units rather than following a tenant. PHAs allocate a portion of their Housing Choice Voucher funding as PBVs, ensuring residents pay no more than 30% of income toward rent. These vouchers must remain with the project for a minimum of 15 years and are renewed annually at current payment standards. The DOH could administer state-funded project-based vouchers targeting developments that include adults with I/DD as tenants.

## Earmarked Funding in the State Budget

Colorado's annual appropriation process through the Long Bill allows the General Assembly to designate ("earmark") line item funds for targeted programs. This could take the form of a dedicated appropriation within the DOLA or HVPF for neuro-inclusive intentional communities. State budgets are crafted based on General Fund and Cash Fund revenues, with budget narratives outlining specific grant or program allocations.



This funding stream could be created in various ways including:

1. Develop a Colorado Neuro-Inclusive State Tax Credit program,
2. Develop a Colorado Neuro-Inclusive Housing Trust Fund,
3. Create a Neuro-Inclusive Housing Social Impact Bond,
4. Develop a pool of state-funded neuro-inclusive project-based vouchers, increasing as need increases,
5. Create a Neuro-Inclusive Revolving Loan fund to help local communities jumpstart solutions with local partners,
6. Earmark an annual state budget line item allocation using the General Fund or Cash Funds (statutory "special-purpose" accounts funded by fees, fines, or earmarked taxes) that funds a minimum number of units per year of neuro-inclusive housing,[120] and/or
7. Explore how the newly created Colorado Disability Opportunity Office could offer a stronger role of support towards neuro-inclusive developments.[121]

Understanding the landscape of possible funding streams is critical for seeding, sustaining, and scaling intentional communities that serve adults with I/DD.

To the left, each mechanism is defined and then strengths and limitations highlighted along with key administration details noted in table.

## Summary Comparison Table

| Funding Source | Mechanism | Scale & Duration | Key Pros | Key Cons |
|---|---|---|---|---|
| **State & Housing Tax Credit** | Competitive tax credits sold to investors | $100 M+ awarded annually; 15-year compliance | High equity leverage; stable financing | Contract complexity of partnerships; slow to deploy |
| **Social Impact Bond** | Performance-based contracts with private investors | $TBD pilot; 3–5 year term | Outcome metrics tied to funding; attracts new capital | Contract complexity; pilot scale |
| **Housing Trust Fund** | Dedicated grants/loans from public revenues | $3–36M per cycle; variable | Flexible disbursement; gap filler | Politically variable; smaller pools |
| **Project-Based Vouchers (PBV)** | Rental assistance tied to specific units | Limited voucher count; ongoing | Resident rent capped; stable subsidy | No capital for development |
| **Earmarked State Budget Funding** | Legislative line-item appropriations | Annual appropriation cycle | Direct control; can be structured as recurring appropriations | One-year unless codified; budget shifts |

Each funding source brings unique benefits and constraints. Blending multiple streams—equity + debt + subsidy + performance + public appropriation—will maximize capital leverage, ensure ongoing affordability, and center lived-experience guardrails. The next step is to map specific project budgets against these mechanisms, calibrate timelines, and engage stakeholders (self-advocates, developers, PHAs, legislators) in co-designing the funding architecture.

**Denver's Social Impact Bond (SIB) program is an example for how cities can fund supportive housing through outcomes-based investment—and it holds real promise for scaling neuro-inclusive housing for adults with I/DD. Launched in 2016, Denver's SIB initiative targeted individuals experiencing chronic homelessness who frequently interacted with emergency services and the criminal justice system. Intentional communities for adults with I/DD often face funding gaps due to fragmented housing and service systems. SIB models work because they align financial incentives with equity outcomes, center lived experience in service design, leverage public-private partnerships to scale innovation, and demonstrate cost-effectiveness for policymakers and funders.**



## Pathways of Partnerships for Data-Driven Solutions

Due to the quickly approaching need for more housing options, no one single government entity or department should be relied upon for solutions. Colorado should plan for a coordinated effort amongst the public, private, philanthropic and not-for-profit communities.

Zoning ordinances have influence on neuro-inclusive housing development.[122] Stakeholders repeated the desire for community engagement prior to developing solutions, yet the housing industry has little opportunity to develop relationships with PASA's, community-based organizations and/or adults with I/DD and their families. Due to the diversity of adults with disabilities, there is not a specific list of design or physical amenity features that make a property accessible to all, but more of an array of options to consider based on the intended population to be served.[123] Furthermore, selection of onsite amenities and common spaces should be balanced with what is accessible to residents in the greater community.

Colorado's HB23-1296 Task Force on the Rights of Coloradans with Disabilities, included a dedicated Housing Subcommittee charged with identifying barriers that people with disabilities face in securing and maintaining affordable, accessible, and attainable housing.[124] Their recommendations, although broader than increasing access to intentional communities, underscores the need for collaboration at the state and local level.

Although the Inclusive Housing Coalition hosts a Neuro-Inclusive Housing Summit, additional opportunities and outreach is needed to local communities across Colorado to help them understand and plan for their residents with I/DD. Intentional communities should be one of several solutions presented.



# CONCLUSION & RECOMMENDATIONS

The convergence of Colorado's housing affordability crisis and the unmet needs of adults with I/DD demands immediate and coordinated action. Considering over 20,000 adults with I/DD may be living with a caregiver over age 60, Colorado needs to urgently plan for additional housing options and assistance programs. Left unchecked, the status quo will perpetuate a cycle of homelessness, institutionalization, and social exclusion—outcomes that violate both the spirit of the ADA and the Olmstead decision.

It is clear that many Coloradans with I/DD and their families do not believe intentional communities are not synonymous with institutional settings. Coloradans desire intentional communities as an alternative choice to scattered-site apartment living or host home placement due to convenient access to social opportunities, built-in cognitively accessible features, safety net of support when LTSS is not available, and layered informal and formal security measures.

Colorado must provide the guardrails needed to lock in person-centered planning, safeguard rights and ensure voices of adults with I/DD and their families are being heard. At the same time, expanded state investment, targeted rental subsidies, bold QAP incentives, and funding for supportive amenities can serve as rocket boosters, catalyzing a surge of innovative, affordable intentional communities across Colorado.

Stakeholders at every level—state agencies, local planners, housing developers, service providers, self-advocates, and families—must unite behind a shared vision: a network of thriving, diverse, neuro-inclusive housing options where adults with I/DD live free from isolation, exercise genuine autonomy, and contribute meaningfully to the broader community. The path forward is clear, the stakes are high, and the time to act is now.

***"We should have a voice in the process"***

***-Self-advocate***

## Recommendations

The Colorado Developmental Disabilities Council is a Governor-appointed council that works to create the individual, community and systems level conditions that allow people with I/DD the ability to achieve their vision of a meaningful life. Of the 24 members, 15 are people with I/DD, their family members or caregivers and nine are federally required subject matter experts from state agencies and nonprofit organizations.

The recommendations to the CDDC that follow were created based on robust stakeholder feedback toward priorities that matter most: safety, independence, and social connection. These recommendations build on stakeholder insights—centering resident control, informal supports, and ongoing quality checks—to guard against the drift toward institutional norms and excluding measures Colorado already enforces by other means:

**Utilize outcome-oriented standards and transparent evaluation versus arbitrary density limitations**

It is clear advocates did not believe a maximum percentage of units for adults with I/DD or limitation of housemates were adequate to ensure residents' rights were not being violated or if the setting was contributing to involuntary isolation. Reflecting the federal precedence, any additional regulatory layer beyond current HCBS compliance efforts should be person-centered and outcome-oriented, not based on an arbitrary percentage or density limitations. Shifting perspective from occupancy counts to resident-reported metrics such as social participation, sense of belonging, and autonomy can ensure that properties do not become institutional. This can be implemented through property requirements if utilizing Colorado-funded programs through CHFA, DOLA, HCPF or other regulatory entities.

**Intentional communities should remain consumer-controlled, yet allow PASA's to own/operate as well**

Ensuring properties remain consumer-controlled ensures tenants with I/DD can select the support providers and service delivery models they need and prefer, including a PASA that may also be the owner/operator of a property. This allows for trusted service providers to partner with affordable housing developers to develop properties that could be affordable in perpetuity.

**Require Resident Advisory Boards with third-party onsite reviews of intentional community properties**

Intentional communities should be required to give tenants with I/DD a voice tied to a corrective action plan if needed. CHFA, DOLA or HCPF could require neuro-inclusive intentional communities that use state-funded programs to form a Resident Advisory Board (RAB) including a majority of residents with I/DD. A RAB should be empowered to provide constructive criticism, explore additional opportunities to meet the needs of residents, and resolve disputes. Bi-annual onsite reviews from a third-party entity for neuro-inclusive properties could review notes from RAB and ensure residents rights are not being violated. (See checklist used for site visits in Appendix as example.)

**Create a new funding stream for the development of neuro-inclusive housing**

The need for a funding stream to drive neuro-inclusive housing development cannot be understated. Some options from the Discussion section include: a state tax credit, housing trust fund, social impact bond, pool of project-based vouchers or annual earmarked funding in the state budget. The funding source could develop additional guardrails from current regulatory standards and provide a strong incentive for the housing industry to advance and become more proficient in developing relationships with the local I/DD community for targeted solutions.

**Leverage existing affordable housing funding streams by creating incentives for properties that set-aside units for adults with I/DD**

Echoing recommendations from Colorado's HB23-1296 Task Force on the Rights of Coloradans with Disabilities, direct Colorado Office of Economic Development and International Trade (OEDIT) and the Division of Housing (DOH) to analyze and report to the Governor and legislature on opportunities to leverage available funds to increase the inventory of accessible housing. Sources of existing funding include programs in DOH, Colorado Housing Development Grant Fund, allocation of Low Income Housing Tax Credits (thus advocating change in the Quality Allocation Plan), Proposition 123 Colorado Affordable Housing Financing Fund, Community Land Trusts, etc. Depending on the source of funding, this could include adding I/DD as a specific prioritization of need, providing bonus points in scoring, setting aside a certain percentage of units or the funding source targeting adults with I/DD or neuro-inclusive development.

**Educate and advocate to the public sector and the philanthropic community to develop grants for supportive amenities which community-based organizations could provide at existing and/or emerging properties**

For those ineligible for HCBS waiver, a property with supportive amenities may be the determining factor in keeping an adult with I/DD housed and connected to a natural support system. Planned social activities to thwart loneliness, money management classes to assist with implementing budgets, healthy cooking classes or walking clubs to support healthy lifestyle choices are just a few examples. A funding source for providing supportive amenities would leverage the existing network of community-based organizations and PASA's to provide these property-specific enhancements that may result in greater emotional and mental wellbeing, physical health and less needed crisis response.

**Colorado must develop a Colorado I/DD Housing Plan to prevent the displacement and/or institutionalization of people with I/DD**

This plan should outline the need and include tools and resources that could be shared in both the housing industry and at the local level through DOLA and the Division of Local Government in order to reach planning departments and local appointed and/or elected officials in all areas of Colorado. This could occur as part of the emerging Community Integration Plan, (HB) 25-1017.

***"I feel strongly that we need all options. People with I/DD should have choice in where they live and who they live with. One size does not fit all." -Survey respondent***

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# APPENDIX

## Checklist Used in Site Visits to Identify Institutional Characteristics

**Checklist: Institutional Characteristics of Residential Communities for Individuals with Intellectual and Developmental Disabilities (IDD)**

| Institutional Characteristics | Yes | No | Somewhat | N/A |
|---|---|---|---|---|
| **GENERAL CHARACTERISTICS** | | | | |
| 1. **The majority of residents have disabilities.** The setting is designed specifically for people with disabilities and residents are primarily or exclusively people with disabilities. | ☐ | ☐ | ☐ | ☐ |
| **ISOLATION AND SEGREGATION** | | | | |
| 2. **The location is isolated.** The residential community is located apart from the broader community and residents are more isolated than others living in the same geographical area. | ☐ | ☐ | ☐ | ☐ |
| 3. **Opportunities to access the broader community are limited.** Residents have limited opportunities for interaction in the broader community. The residential provider does not facilitate access to the broader community and access to public transportation is limited, resulting in reduced social interactions and integration. | ☐ | ☐ | ☐ | ☐ |
| 4. **Care and services are centralized.** The residential community provides a variety of billable services within the same facility or on the same grounds as the residential facility (residential, day program, medical, behavioral health, etc.) and residents are restricted from receiving services outside the community. Place of residence is contingent on the provision of care. | ☐ | ☐ | ☐ | ☐ |
| 5. **Access is controlled.** Access into and out of the residential community is restricted beyond what is necessary to ensure resident safety. Doors are locked and residents do not have keys. | ☐ | ☐ | ☐ | ☐ |
| **PERSON-CENTEREDNESS, INDIVIDUALIZATION, CHOICE & CONTROL** | | | | |
| 6. **The environment is structured and regulated.** The residential community follows strict routines, policies, and regulations to maintain order and consistency. The requirements of the organization take precedence over the residents' individualized needs. | ☐ | ☐ | ☐ | ☐ |
| 7. **Personal autonomy is limited.** Residents have restricted decision-making opportunities regarding daily activities and personal choices. | ☐ | ☐ | ☐ | ☐ |
| 8. **Services are not individualized.** Care is often standardized rather than personalized, limiting services tailored to individual needs. | ☐ | ☐ | ☐ | ☐ |
| 9. **Residents do not choose care providers.** Residents share care providers and do not have the option to choose from whom they receive care. | ☐ | ☐ | ☐ | ☐ |

| Institutional Characteristics | Yes | No | Somewhat | N/A |
|---|---|---|---|---|
| 10. **Residents do not choose with whom they live.** Residents do not have a choice of roommate, and/or people with whom they live in close proximity. | ☐ | ☐ | ☐ | ☐ |
| 11. **Residents can't personalize their space.** Residents have minimal opportunities to customize their living spaces, such as choosing wall colors and furniture. | ☐ | ☐ | ☐ | ☐ |
| 12. **Personal items are restricted.** Residents have limited ability to bring personal belongings, such as photos, artwork, personal bedding, or pets. | ☐ | ☐ | ☐ | ☐ |
| 13. **Individuals cannot control the temperature in their rooms.** Residents do not have the ability to control the climate in their personal living spaces. | ☐ | ☐ | ☐ | ☐ |
| 14. **Mealtimes are fixed with limited flexibility.** Residents must eat at scheduled times with little to no choice about when meals are served. | ☐ | ☐ | ☐ | ☐ |
| 15. **Menus are pre-determined.** Meals are planned in advance with limited customization based on individual preferences or cultural considerations. | ☐ | ☐ | ☐ | ☐ |
| 16. **Food preparation is centralized.** Food is prepared in a central kitchen rather than allowing residents to cook or participate in meal preparation. | ☐ | ☐ | ☐ | ☐ |
| 17. **Residents have minimal access to kitchen facilities.** Residents have little or no access to kitchens for independent cooking or food storage. | ☐ | ☐ | ☐ | ☐ |
| **PRIVACY & DIGNITY** | | | | |
| 18. **Residents are monitored with cameras.** Security cameras are present in community living spaces. | ☐ | ☐ | ☐ | ☐ |
| 19. **Bedrooms are shared.** Residents live in shared dormitory-style housing with limited personal privacy. More than one person shares a bedroom. | ☐ | ☐ | ☐ | ☐ |
| 20. **Bathrooms are shared.** The facility has shared bathrooms as opposed to private, en-suite bathrooms. | ☐ | ☐ | ☐ | ☐ |
| 21. **Residents cannot lock their doors.** Residents' living spaces do not have locks on the doors or the resident does not have the key. | ☐ | ☐ | ☐ | ☐ |

| Institutional Characteristics | Yes | No | Somewhat | N/A |
|---|---|---|---|---|

## PHYSICAL CHARACTERISTICS

22. **The facility is large in scale with a uniform design.**
The buildings is large and designed with a repetitive layout which may include long corridors and identical rooms. The layout prioritizes staff oversight over resident independence.

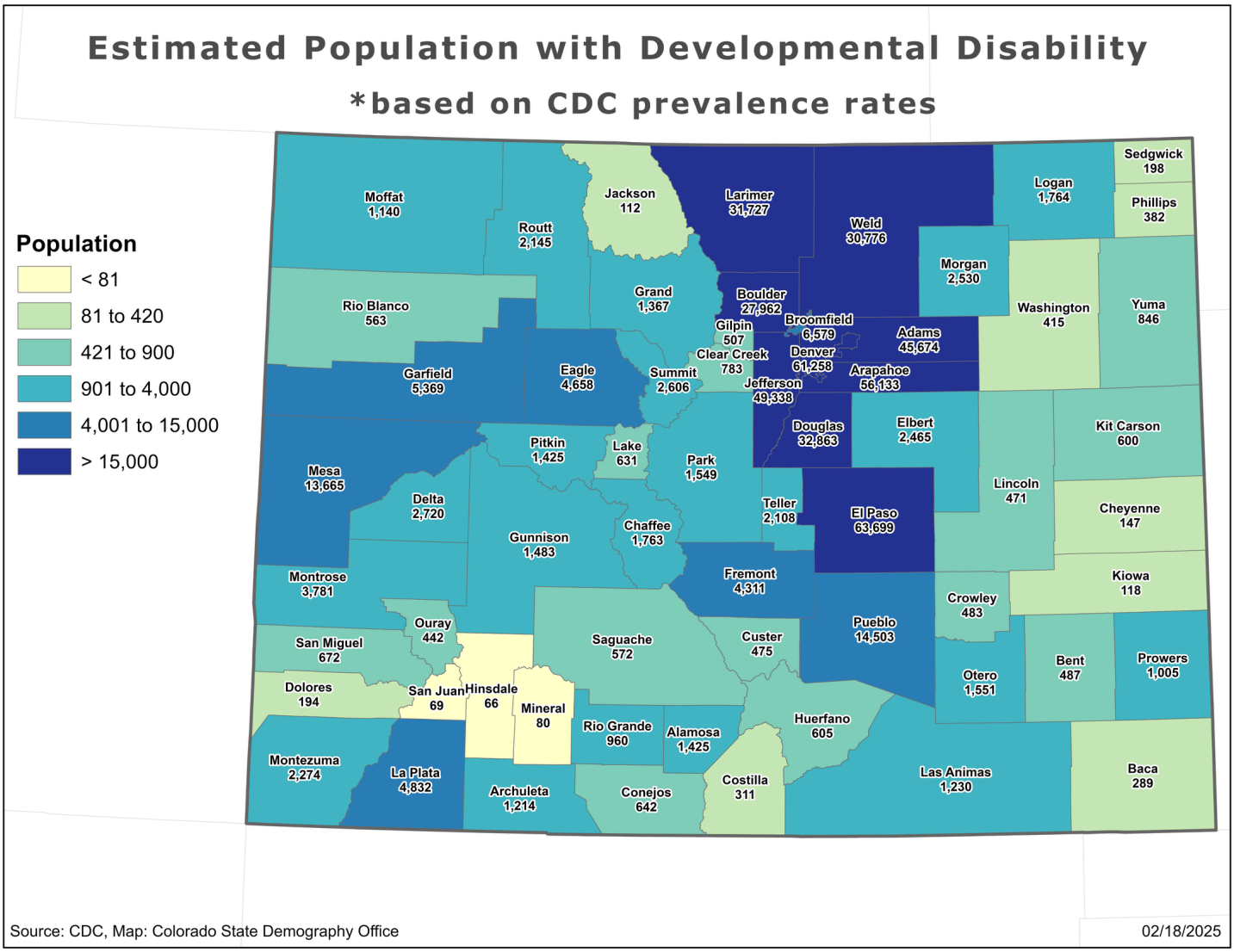
23. **The facility has large-scale dining areas.**
Communal dining halls resemble cafeterias rather than homelike environments.

24. **The atmosphere is institutional.**
Overall, the facility, including communal spaces, is designed for efficiency rather than to create a homelike atmosphere. Neutral, industrial-style materials prioritize function over aesthetics.

25. **The furnishings are institutional.**
Furniture is standardized, durable, and chosen for maintenance ease over comfort. Residents' rooms are furnished with identical, non-personalized furniture which may be bolted down or difficult to rearrange.

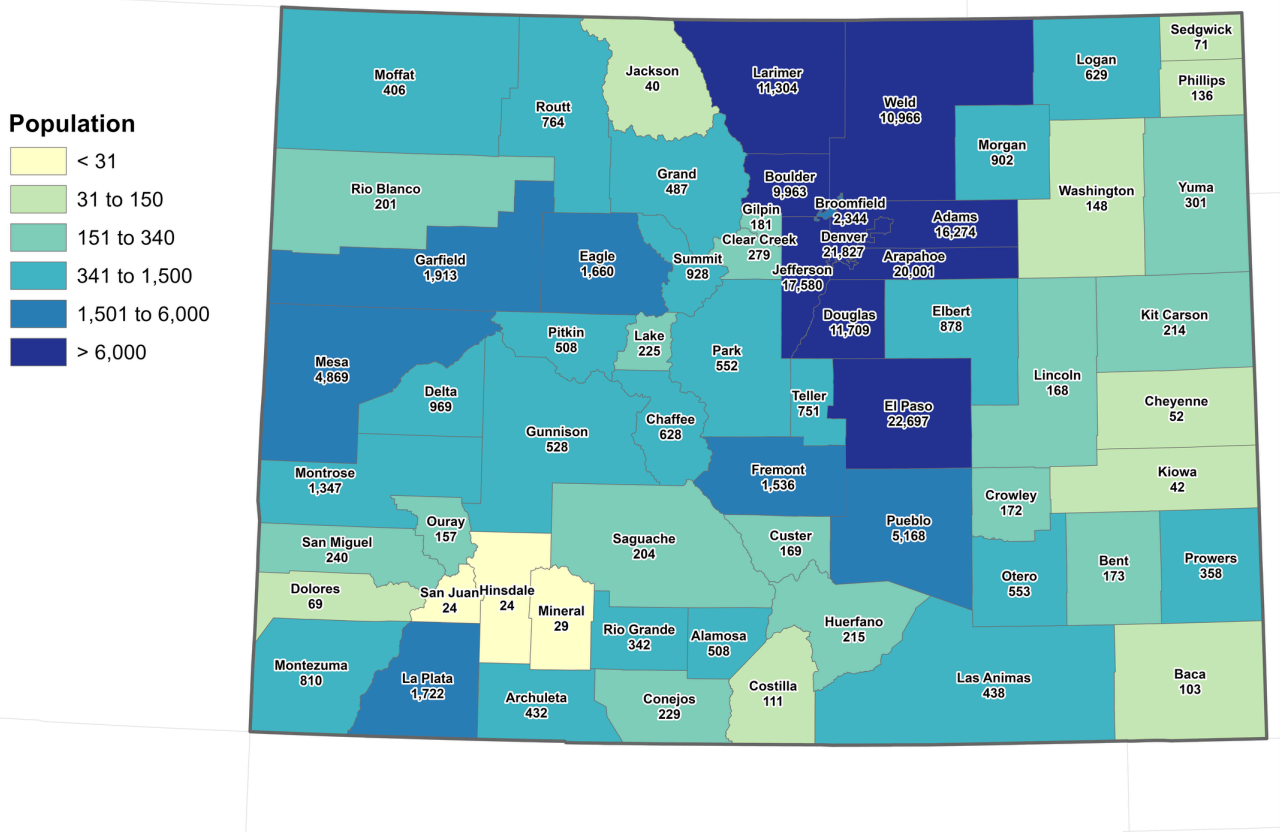
26. **The finishes are institutional.**
Interior finishes are clinical rather than residential (flooring, lighting, paint colors, window coverings).

27. **There is minimal connection to nature.**
There are limited windows and access to outdoor and green spaces.


Estimated Population with Developmental Disability
*based on CDC prevalence rates
Population
< 81
81 to 420
421 to 900
901 to 4,000
4,001 to 15,000
> 15,000
Moffat 1,140
Routt 2,145
Jackson 112
Larimer 31,727
Weld 30,776
Logan 1,764
Sedgwick 198
Phillips 382
Morgan 2,530
Washington 415
Yuma 846
Rio Blanco 563
Grand 1,367
Boulder 27,962
Gilpin 507
Broomfield 6,579
Adams 45,674
Clear Creek 783
Denver 61,258
Arapahoe 56,133
Garfield 5,369
Eagle 4,658
Summit 2,606
Jefferson 49,338
Douglas 32,863
Elbert 2,465
Kit Carson 600
Pitkin 1,425
Lake 631
Park 1,549
Mesa 13,665
Delta 2,720
Teller 2,108
El Paso 63,699
Lincoln 471
Cheyenne 147
Gunnison 1,483
Chaffee 1,763
Fremont 4,311
Montrose 3,781
Kiowa 118
Crowley 483
Ouray 442
Saguache 572
Custer 475
Pueblo 14,503
San Miguel 672
Bent 487
Prowers 1,005
Dolores 194
San Juan 69
Hinsdale 66
Mineral 80
Rio Grande 960
Alamosa 1,425
Huerfano 605
Otero 1,551
Montezuma 2,274
La Plata 4,832
Archuleta 1,214
Conejos 642
Costilla 311
Las Animas 1,230
Baca 289
Source: CDC, Map: Colorado State Demography Office
02/18/2025

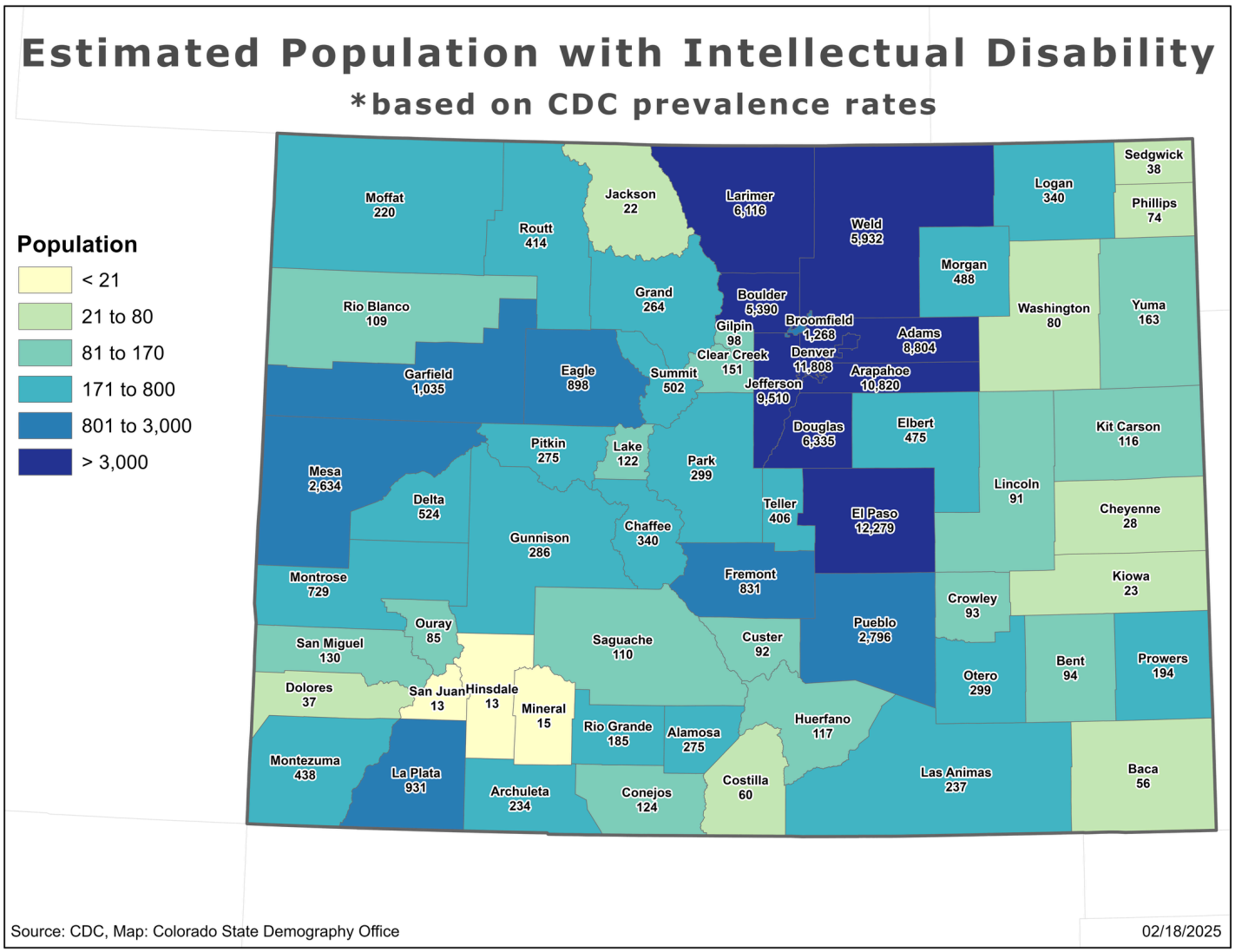
# Estimated Population with Autism

## *based on CDC prevalence rates




Source: CDC, Map: Colorado State Demography Office

02/18/2025


Estimated Population with Intellectual Disability
*based on CDC prevalence rates
Population
< 21
21 to 80
81 to 170
171 to 800
801 to 3,000
> 3,000
Moffat 220
Routt 414
Jackson 22
Larimer 6,116
Weld 5,932
Sedgwick 38
Logan 340
Phillips 74
Morgan 488
Washington 80
Yuma 163
Rio Blanco 109
Grand 264
Boulder 5,390
Gilpin 98
Broomfield 1,268
Adams 8,804
Clear Creek 151
Denver 11,808
Arapahoe 10,820
Jefferson 9,510
Garfield 1,035
Eagle 898
Summit 502
Douglas 6,335
Elbert 475
Kit Carson 116
Pitkin 275
Lake 122
Park 299
Lincoln 91
Mesa 2,634
Delta 524
Teller 406
El Paso 12,279
Cheyenne 28
Gunnison 286
Chaffee 340
Fremont 831
Kiowa 23
Montrose 729
Crowley 93
Ouray 85
Pueblo 2,796
San Miguel 130
Saguache 110
Custer 92
Bent 94
Prowers 194
Dolores 37
San Juan 13
Hinsdale 13
Mineral 15
Otero 299
Rio Grande 185
Alamosa 275
Huerfano 117
Montezuma 438
La Plata 931
Archuleta 234
Conejos 124
Costilla 60
Las Animas 237
Baca 56
Source: CDC, Map: Colorado State Demography Office
02/18/2025

## All Focus Group Responses*

### Q1: Why do you want to live in intentional community?

Fun place with things to do
Access to help when needed.
Access to friends and other people
Mobile health screening can go to property
Own apartment, close to parents
Support from nieghbors when needed
Safety technology, like to check in and check out
Safe location
I can have roommates or not (choices)
Live with people similiar to me
Share caregivers
I won't be as lonely if with others like me.
Constant social activites to choose from
Learn to cook different foods
Be able to have pets
Meal prep and meal sharing
Stay up late and party
Be independant, on my own
Provider who knows me and my situation
Help sharing (staff)
It's not about being perfect. It's about living safely.
Extra transportation options
Day program in walking distance
Help with managing and keeping track of money
Designed for sound sensitivity
Help to make good friends
Lots of flowers
Someone to track or know if strangers are trying to get in.
Bright and cheery
Respect for everyone, no matter their disability
Staff is like family, knows me well
Accessible
24/7 concierge (awake person)
Community engagement
Enabling technology, tech support and wifi
Ability to change providers
Certified people in building who can distribute medication (not just provider)
Tenant selection ensures people who need support and have planning in place
Natural supports to help eachother (particularly with seniors)
More opportunities for interaction
Social access to others
Direct support staff collaboration
Support for direct support staff
People and activities close by, no need to travel
Not forced feeling in a program, just natural
Whole person perspective, not just long term support services
Built for them, not a pull out program
First time they (people with disabilities) are put first
Flips the institutional model upsidedown
Proioritizes individual, not place or program
Kind
Protects vulnerability without hoovering
Safety technology, like to check in and check out
Ability to walk around neighborhood safely without risk of cars
Staff and support in place, no commute
Supported independence
No disability stigma
Supportive as a value of the property
Support with life skills to be more independent
Onsite-support 24-7 for emergencies or other help
Protection against vulnerabilities (financial, social, abuse, etc.)
More opportunities to do things
Dining option or access to healthy meals
Planned activities
Prefer neurotypical presence as well
Exposure to things through supported planned activites, otherwise isolated
Access to vocationla opportunities and job coaching
Relationship counseling and support, especially navigating romantic relationships
Be on my own, do my own thing, be independent
Cook by myself
Make my own bed and keep my house clean
Socialize
Easy access to support
Get extra transportation
Watch movies with others
Support for couples to live together
I want my freedom (not a host home)
Help coordinating activites in the community
Respecting my rights
Trust staff, so I can tell them whats going on in advance
Staff that listens
More outings
Safety
Support to work
Clinical support onsite
Safety from predatory people
Safe from risky behavior from nieghbors (drugs, violence, etc.)
Dining option, for social needs not due to activites of daily living
Amenities on-site, like assisted living for seniors
Homeownership as an option
Affordability
To be independant
Help manage services and supports
Have a sense of community
Safety, not anyone can have access to the property
Use of technology for safety
24/7 access to staff
Neighbors look out for one another
Feel safe
Live with others with similiar support needs
No "masking", people just get it
Less discrimination for housing voucher holders
Less likely to toss you out or evict you
Safety
Many eyes
Thriving enviroment, both people and place
Connection
Friends
Social Opportunity
Live with others who understand neurodivergent people (not neurotypical) so there is no need to mask.
Build with intent to not exclude, but create an inclusive space
Longevity of relationships
User-friendly enviroment
Intent of location for opportunities to congregate
Not medical-model, but give dignity of risk and self-determination of residents
Design accessible for I/DD and aging-in-place
Not just run/led by neurotypicals, driven by neurodivergent
Independence outside of family
Stability of housing
Third-party advocate (not just service provider)
Programming within walking distance to eliminate barrier of transportation
Voluntary and optional support as needed
Climate-friendly
Increased natural supports
Share resources and staff
Inclusive culture and promote self-determination
Eat dinner with others in dining hall or in own apartment (like senior living) so not lonely
Caregiver support to eachother
Property management will be more accessible because they understand people with disabilities (paperwork is difficult)
Natural support
Built-in people you trust when insecure or feeling unsafe
Continuity of support onsite (respite care out of home when in host home disrupts persons schedule)
Access to relationships/social activites without needing transportation
Family can age-in-place and transition together (when they live in same community)
Longterm stability
Responding to emergencies quickly
Supporting dignity of risk
Potential for sharing opportunities and interests with others

*Participants' answers are printed exactly as written.

## Q2: What makes a setting institutional in nature?

- Trapped or stuck, can't go anywhere
- Being limited
- Things can be taken away from me
- Can't do whatever I want
- Not enough support
- People yelling or hitting me
- People telling me what to do
- Not respecting personal space
- Not being able to go to day program
- Someone telling me when I have to go to sleep
- Not being able to have a job
- Removed from community life
- Being rude to me
- Hospital looking or dark
- Junk or unhealthy food served
- People are mean to me
- Strangers I don't know who are bad people
- Treat me like a patient
- Required to work at the property
- Rights taken away
- Requirement to check-in or say we are leaving
- Must take medication from staff
- Less freedom
- Being spoken down to
- Unheard
- Not treating others the same level you want to be treated
- Pre-set schedules by someone else
- Inconsistancy of staff
- Blamed it our problem when it isn't our problem
- Restrictions on whether you can come or go
- Restrictions on who or when you can have visitors
- Restrictions on who you can go do things with
- Requiring family access (people with disabilities should be able to control who they allow in their unit)
- Forced to eat in common area (people should be able to eat what they want, kitchen in unit)
- Restricted relationships
- No cohabitation with romantic partner
- Restrictions on decorating unit
- Not allowing reasonable modifications
- Being in a "lock-down facility"
- Feeling sad, no family to be with
- People in my apartment I don't know
- People using me
- Treating us like kids
- Scams, hard to tell
- People hiding stolen things in my apartment
- Drugs
- Helping when not asked, I want to do things for myself
- People being bossy
- Teasing people
- Hitting people
- Not listening to me
- Forced to stay at home
- Unsafe people or places
- Lack of choice
- Lack of freedom
- Rules, like "cannot watch TV while getting ready"
- Many people sharing a bedroom.
- Treating everyone the same, like one model fits all
- Not individualized or person-centered
- No risk taking allowed, limits potential growth
- Controlling, no choices
- Forced programming or work in social enterprises
- Abuse if only people with disabilities
- Learned helplessness, low expectations
- Just "on paper"
- Over-medicated, medically restrained
- Punishment by property
- Use of rewards or token system to control behavior
- Prioritizes institution over people
- Hovering staff
- Lack of self-governence
- Lack of choice
- Rigidity in what people can do or how they use their time
- Lack of freedom to move about
- Forced isolation
- No informal oversight of staff
- Medical model
- No resident agency or choice
- Neurotypical control residents or have power over people
- No ability for the larger community to see property
- Only internal staff oversight and action, can be corrupt
- Medical model culture
- Top-down staff approach
- Everyone does the same thing without choice of schedule
- Only worried that people ate, are "showered" and other ADL's
- Restrictions on who can live together
- Secluded, segregated
- Less access to outside oversight
- Stigma of place
- Forced compliance
- Leadership "in-charge"
- No freedom to come and go
- No choices on food, clothing, schedule

## All Focus Group Responses

### Q3: Should there be a maximum percentage of people with disabilities at a setting?

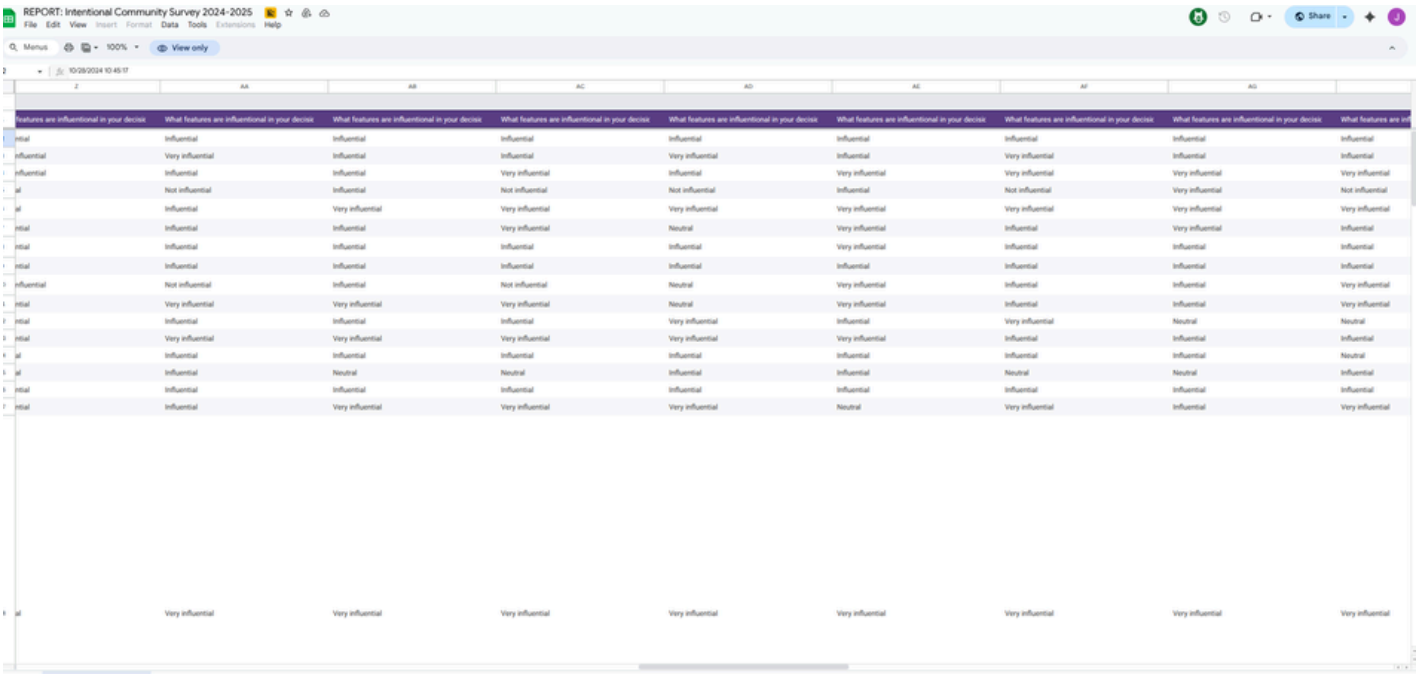
- Yes. I want able-bodied or neurotypical neighbors (not staff) to help when needed.
- No. 100% people with disabilities, because you don't know what people without disabilities might do to you.
- No. There should be a minimum of 50% people with disabilities.
- No. 100% people with disabilities.
- Yes. I want caregivers (DSPs) to live there too.
- Yes. 60% or 70% max because there should be people in the building who can help in an emergency or crisis.
- Yes. Family or seniors should be residents too.
- No. Minimum of 50% I/DD
- No. Outdated regulations.
- No. Already too many limitations.
- No. Should be family or personal choice.
- No. This makes me angry
- No. Limits are discriminatory.
- No. Disregards the nature of humanity.
- No. These aren't the models anymore.
- No. Assigning a maximum number is naive as a metric
- No. Should come from the community of people.
- No. It bothers me that external rules should be placed on what should be an intentional community.
- No. Limits tenant selection if a # is put in place.
- Yes. 80% max people with disabilities, otherwise slippery slope to 100%
- No. Should be based on project planning, the state should not decide
- Unsure. Need to balance level of support, "triggers" of others, agressive behaviors or screaming stims
- Unsure. But "just to check a box" or get to a number may limit options.
- No. We are like anyone else, all equal.
- No. No waitlists for people with disabilities.
- Unsure. Concerned about protecting people with disabilities from being taken advantage of
- No. Not enough options, we need more units.
- No. Density of units should not stop projects.
- Yes. 50/50 so it doesn't feel institutional.
- Yes. To help people get out in an emergency, 60% people with disabilities and 40% neurotypical/able-bodied
- Yes. For natural support system, but flexible because could include support staff housing
- Yes. 50/50 because it helps property be more safe when people know their neighbors and can help with medical issues
- No. There should be a minimum of 50% people with disabilities because of need.
- Yes. 80% people with disability max so others in building can help people with disabilities
- Yes. 65% people with disabilities max because they are a diverse population with high need
- No. Prefer 100% because people with disabilities can be taken advantage of due to their difficulty of recognizing predatory relationships
- No. Not good metric.
- Yes. Prefer integration.
- No. There should be no limitations, stressing safety and security
- No. No limits, should be based on specific local development.
- No. Not helpful metric, should be about choice and freedom.
- Yes. need neurotypical/able-bodied advocates around
- Yes. Not 100% people with disabilities, we don't want to create another barrier to integration or relationships like visitors but unsure if % is the right metric
- No. No other minority has limits.
- Unsure, but size matters if only people with I/DD. Cultural mix important and "eyes" to prevent abuse.

## Q4: What can policy do to prevent a setting from becoming institutional in nature?

- Site visits or inspections
- Common space for the greater community (public) to use
- Shut down if they don't follow rules
- Safety drills
- First responder training and classes
- No exceptions to city/town code
- Require a resident advisory committee
- Make sure people have support needed to be successful
- Flexibility in lease agreements
- I/DD-specific obudsman program
- Rights not taken away (regardless of disability or situation)
- Not restricted to HCBS receipients
- Washer and dryer in unit for accessibility
- Trash chutes on every floor
- Not just studios, 1 and 2 bedrooms
- Carpet in bedrooms
- Use of HVAC, not just wall units
- Board of Directors oversight
- Audited
- Use of self-direction only so money stays with the person and not the place
- Third party advocate responsible for wellbeing of individuals
- Everyone in community has a say in governence
- Incentivize people quality of life over profit
- Incentivize diversity of tenants
- Use quality of life standards to measure outcomes (meaningful outcomes, less prescriptive)
- Have a resident advisory board
- Transparency, use of a scorecard for properties
- Members have monetary stake, diffuse power element
- Create public use spaces within community to increase natural supports
- Do not use reverse integration policy
- County level planning for need
- Streamlined universal paperwork for all public benefits
- Residents must have a voice and can influence what happens in the intentional community
- Oversight to make sure residents voices are being addressed
- Resident advisory board
- Potential residents are part of the planning process
- Monthly site visits by DD Act funded organizations or other government entities
- Third-party contact for residents who need to report something
- Need a funding source for property development
- Carfeul tenant selection for both people with I/DD and the neurotypical residents
- Percentage or nuber of people with disabilties at property should trigger oversight
- Onsite oversight should be from trained people who understand person-centered practices and the I/DD community
- Mandated reporting
- Third-party advocate for each resident, not case manager
- Stability through government changes
- Keeping up with cost of living changes and price of maintanence
- Plan for long-term obstacles due to government, funding or economics
- Rural does not get the resources that the city has access to.
- People before profit.
- New, modern, not just whats leftover
- Equal expectations on quality and admission
- Needs to be affordable without a job
- Must offer activities as a rule
- Not lose support or home if I want to work
- Prioritize local residents first
- Community engagement needed prior to development for people with disabilities because disability housing is often ADA/wheelchair focused
- Pot of money for landlords to meet accomodation requests that may otherwise be cost prohibitive
- Training/education to housing industry so they can be more aware of whats out there
- Neuro-inclusive housing tax credit needed
- Funding source needed for development that understands people with I/DD
- Property management companies need to be trauma-informed and understand the diverse support needs of people with disabilities
- Ability to remove tenants who make people feel unsafe or puts self or others in unsafe situations
- Require resident advisory board
- Don't want policy to be too rigid, this is a diverse population
- Freedoms aren't free, need consequences
- "Autherization to assist" form for accomodation requests (needed for people who do not have family or other natural supports)
- First responders have a relationship and know the property if more than 80% have a disability
- Tenant-selection considers values of community
- Potential requirements of neurotypical/able-bodied residents to provide help in emergency, natural support, host activities, etc.
- Orientation process or materials to help set expectations on values and/or peer support prior to move-in
- Shift from amenities/rent/loaction to mission/purpose/values
- Monthly site visits and resident advisory council reports reviewed to make sure requests are being addressed
- Staff at state/regional level to ensure quality
- Third-party advocate that all residents can access (in lease, posters, etc)
- Age limitations because people 55+ have more options, more need for people 0-55 who want to live in intentional community
- Allow sharing of staff as government prevents us from sharing (cannot be IHSS provider for adult child and host home provider for someone else)
- Include other disabilities as well, there is a separation that doesn't make sense
- Require for a board in leadership who have power be a majority of people with disabilities
- Allow reverse integration so people can see property
- Third-party oversight
- Remove three person limit on housemates for people on the SLS-waiver
- Colorado UCEDD research needed on this topic
- Increase awareness of housing choices
- Three-person rule is limiting, should be removed.
- Onsite review monthly with residents and people with disabilities
- Resident advisory council
- Location matters- slump area limits access for people with disabilities
- Option for cameras for oversight (voluntary, not required)
- Medical needs to not be managed or required, but may need to be known for safety.
- Deeply affordable for those with little or no income

**All Expanded Survey Responses:**

REPORT: Intentional Community Survey 2024-2025



**All Plain-Language Survey Responses:**

REPORT PL Version: Intentional Community Survey 2024-2025 (Responses)

