SoHum Housing Opportunities Proposal for Street Outreach Program

RFP #2021-01

Housing Trust Fund & Homelessness Solutions Committee

Humboldt County Planning and Building Department

March 12, 2021

(amended on April 6, 2021)

1.0 Introductory Letter

SoHum Housing Opportunities (SHO), founded in 2016, is submitting this proposal for the amended amount of $46,836.00 to support a Street Outreach project in Garberville and surrounding communities. Even though SHO has been providing outreach to unhoused folks living on the street or in encampments since 2016, it has not obtained funding to support paid staff positions until very recently. With the onset of the pandemic in 2020, SHO received funding from the Humboldt Area Foundation and Humboldt County to provide wrap-around services for folks sheltering in place at a local motel. The contracts will end soon and folks sheltering in place will return to encampments. SHO is currently working to get the most vulnerable housed but our work won't end there.

SHO will employ full time staff to provide outreach and case management to unhoused folks living on the streets and encampments to assist with getting people housed as quickly as possible. This will build and expand on existing work that is being facilitated by volunteers. It will also enable SHO to deepen its scope of work and implement targeted services based on vulnerability assessments (VISPDAT) to prioritize and match services more appropriately.

All outreach activities will be delivered by qualified, efficient, and discreet employees and volunteers who will complete personnel trainings, shelter operations trainings, case management/documentation/HMIS trainings, evidence-based practices trainings, confidentiality/HIPPA trainings, and additional safety trainings. Prior to project implementation SHO will facilitate focus groups to gain insight and suggestions for the project from currently houseless folks, community-based providers, and business owners.

SHO meets the requirements of this RFP. SHO is incorporated as a designated 501(c)(3) nonprofit organization. At the time of contract execution SHO will have written policies and procedures and best practices to best serve the target population, policies and procedures that adhere to the County's Housing First Principles, written conflict of interest, grievance procedures, accessibility policies and procedures, written data collection policies and procedures including HMIS data requirements, fiscal and accounting policies and procedures to adequately operate and track the emergency shelter and street outreach. SHO emergency shelter case managers/outreach workers will provide housing navigation services. SHO will also prioritize matching project clients with the appropriate programs and services utilizing the County's Coordinated Entry system. SHO will have written policies and procedures towards the preparation and maintenance of project related records in compliance with local, state, and federal regulations/laws.

Carla Harris, SHO Board Vice President can be contacted either by email at [redacted] or cell at ([redacted].

TABLE OF CONTENTS

3.0 - SIGNATURE AFFIDAVIT……………………………………………………………………………………

4.0 - PROFESSIONAL PROFILE……………………………………………………………………………………2

A. SHO'S HISTORY……………………………………………………………………………………………3

B. SHO QUALIFICATIONS/EXPERIENCE

SHO PROGRAMS AND IMPACT………………………………………………………………………5

STRATEGIC PLAN - ORGANIZATIONAL GOALS AND OBJECTIVES ……………………… 7

STAFF RECRUITMENT AND TRAINING/JOB DESCRIPTIONS……………………………… 8

5.0 – PROJECT DESCRIPTION…………………………………………………………………………………12

PROGRAM LOGIC MODEL……………………………………………………………………………………13

PROGRAM EVALUATION PLAN………………………………………………………………………………14

SCOPE OF WORK…………………………………………………………………………………………… 14

HOUSING FIRST …………………………………………………………………………………………… 15

CASE MANAGEMENT ASSESSMENT TOOLS …………………………………………………………… 15

HOUSEHOLD BUDGETS …………………………………………………………………………………… 16

HOUSING SUSTAINABILITY PLANS………………………………………………………………………… 17

CASE NOTES ………………………………………………………………………………………………… 18

PROJECT BUDGET/NARRATIVE………………………………………………………………………………20

6.0 – SUPPLEMENTAL DOCUMENTATION……………………………………………………………………24

SHO NONPROFIT DETERMINATION LETTER…………………………………;…………………………24

SHO CERTIFICATE OF INSURANCE……………………………………………………………………………26

EVIDENCE BASED PRACTICES ………………………………………………………………………………… 26

MOTIVATIONAL INTERVIEWING/OARS…………………………………………………………………26

TRAUMA INFORMED SERVICES……………………………………………………………………………28

ACES (ADVERSE CHILDHOOD EXPERIENCES)……………………………………………………………29

CLIENT CENTERED SERVICES……………………………………………………………………………29

SHO OUTREACH POLICIES/PROCEDURES……………………………………………………………………32

7.0 – EXCEPTIONS, OBJECTIONS AND REQUIRED CHANGES…………………………………………52

8.0 – REQUIRED ATTACHMENTS……………………………………………………………………………52

REQUEST FOR PROPOSALS – NO. 2021-01
PERMANENT LOCAL HOUSING GRANTS PROGRAM
ATTACHMENT A – SIGNATURE AFFIDAVIT

REQUEST FOR PROPOSALS – NO. 2021-01 ***SIGNATURE AFFIDAVIT***	
NAME OF ORGANIZATION/AGENCY:	*SoHum Housing Opportunities*
STREET ADDRESS:	
CITY, STATE, ZIP	Garberville, CA 95542
CONTACT PERSON:	Carla Harris or Cathy Miller
PHONE #:	
FAX #:	
EMAIL:	

In signing this Proposal, I certify that this firm has not, either directly or indirectly, entered into any agreement or participated in any collusion or otherwise taken any action in restraint of free competition; that no attempt has been made to induce any other person or agency to submit or not to submit a Proposal; that this Proposal has been independently arrived at without collusion with any other Proposer, competitor or potential competitor; *that this Proposal has not been knowingly disclosed prior to the opening of Proposals to* any other Proposer or competitor; that the above statement is accurate under penalty of perjury.

The undersigned is an authorized representative of the above-named organization and hereby agrees to all the terms, conditions and specifications required by the County in Request for Proposals No. 2021-01 and declares that the attached Proposal and pricing are in conformity therewith.

Carla Harris ______________ 4/06/2021
Signature **Date**

Carla Harris ______________ *4/06/2021*
Name **Date**

This agency hereby acknowledges receipt / review of the following Addendum(s), if any)
Addendum # [x] Addendum # [3/25/21] Addendum # [ ] Addendum # [ ]

4.0 – Professional Profile: Organization Overview

Located at [redacted], Garberville, CA 95542, SoHum Housing Opportunities (SHO) is a 501 (c)(3) organization committed to the idea that adequate shelter for all benefits our whole community.

> "Our mission is to explore all options for creating this, including transitional housing villages; safe legal camping; and eventually permanent housing."

This is what we have been exploring since 2018. We are also looking into the possibility of finding property for a Resource Center, that we envision as a place houseless people would be able to go to for assistance such as information regarding mental health counseling, drug use/abuse counseling, health resources, job training programs, phone charging, mail pick up, food assistance, washer/dryer, showers, etc.

When COVID 19 hit, we put that mission on pause for a while. With funding from the Humboldt Area Foundation we were able to provide the most at-risk homeless with temporary housing at a local motel to shelter in place during the first month of the pandemic. After the initial funding ran out the Humboldt County DHHS (Department of Health and Human Services) Roomkey Program enabled us to continue to shelter folks at the motel. Recently SHO was Community Development Block Grant funding enabling us to keep houseless people at risk safe as well as decreasing community spread. We are also providing masks, information about COVID, and tools to keep themselves and the community safe.

SHO provides food assistance to homeless encampments once a week in which several community volunteers gather at the Mateel once a week to roll burritos, pack expanded lunches and distribute them to the homeless encampment trailheads. Houseless folks are also provided COVID information, masks, and hand sanitizers for when they need to leave the encampment to receive essential services. We also installed hand-washing stations. Now that these programs are up and running, we are able to resume with our goal of looking for housing opportunities for our homeless clients we serve.

When homeless people have access to shelter/low income housing, they are much more likely to get help for mental, physical, and behavioral health issues such as substance use/abuse. Once these barriers are addressed, the likelihood of people's ability to find and maintain employment and become contributing members of society leading happier lives increases. This results in positive community impact as crime goes down and there is less litter/panhandling, which leads to Garberville becoming a more attractive place for tourism and overall community well being.

When we participate in giving people a second chance at life, it's a double blessing: one for our community and one for the individuals we serve. We understand that not all people will make changes overnight and instead it's a gradual process with the

appropriate supports in place and some may not change. SHO has been able to assist houseless folks to be more food secure, address behavioral/mental health issues, and temporarily shelter the most at risk during the COVID 19 crisis our country is currently experiencing.

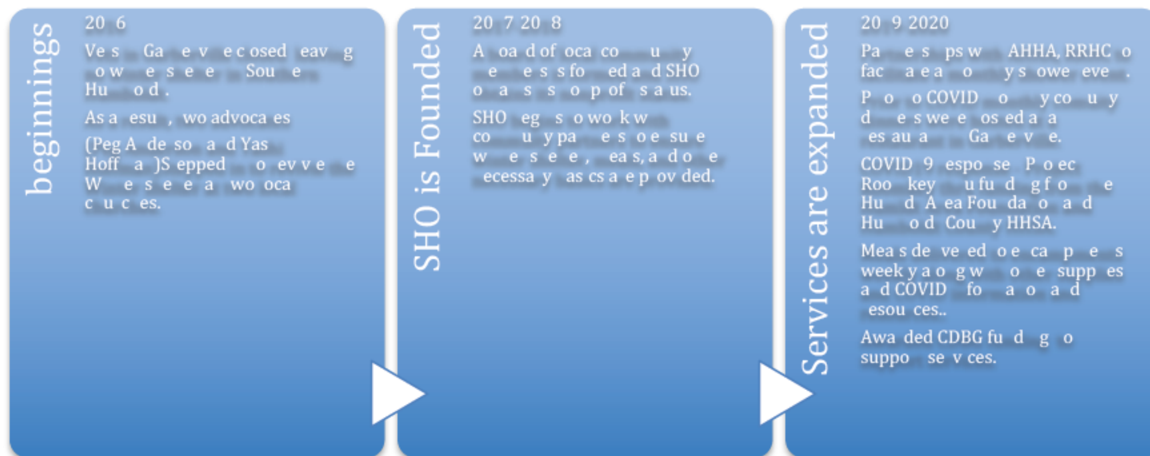
Mission – SHO is committed to the idea that adequate shelter for all benefits the whole community. Our mission is to explore all options for creating this, including transitional housing villages; safe, legal camping; and eventually permanent housing.

Vision - We envision a healthy community where every individual is acknowledged for their right to affordable shelter, basic sustenance, and opportunities to improve their lives.

Who We Serve – Anyone in our community who is un-housed.

Where We Operate – We provide services to anyone who is un-housed in and around Garberville. We provide outreach to local encampments and shelter/supportive services at a local motel in Garberville, CA located in Southern Humboldt County.

SHO's History



After the Vet's Hall in Garberville closed, Southern Humboldt was left without a location for an Extreme Weather Shelter. In early 2016, longtime residents a local advocate, Peg Anderson and Yashi Hoffman worked to revive this effort. By that winter, they and a small group of dedicated volunteers were able to offer a hot meal and shelter on the coldest and wettest winter nights. The First Baptist Church in Redway and Presbyterian Church in Garberville were the primary locations, along with a few nights at the Healy Senior Center and the Mateel. That year was particularly stormy and there were 17 shelter nights. Some of the volunteers spend Christmas Eve and/or Christmas Day night

with the sheltered. Although it was certainly different, it was a wonderful Holiday, complete with spiced cider, candy canes, and a visit from Peg's young grandchildren. Out of that group of early volunteers came the beginning of SHO, and four of its original Board Members.

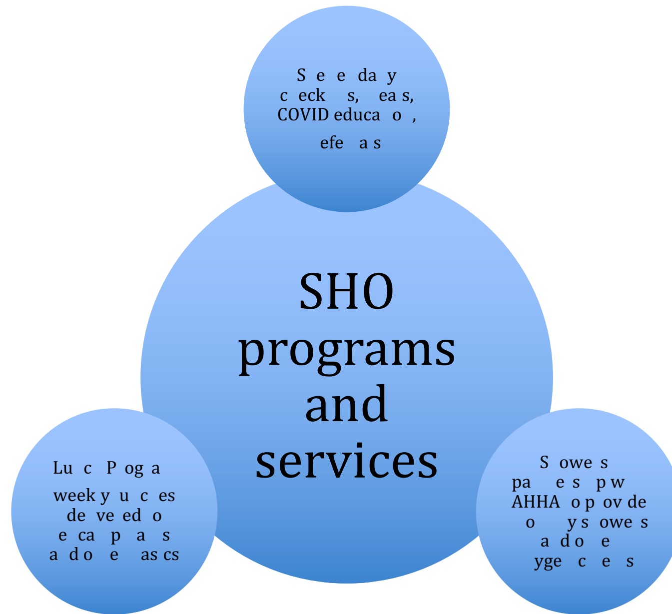
In 2018 the board had expanded and SHO became an official 501 (c) 3 non-profit organization. We have since collaborated with Affordable Humboldt Housing Alternatives (AHHA), and Redwoods Rural Health Center (RRHC) to facilitate a monthly Shower event with AHHA's 3-bathroom trailer that they bring down. People in need are provided toiletries, a hot shower, a clean set of clothing, the use of towels and food-to -go at the event. We also hosted monthly Sunday community dinners at a restaurant in Garberville that winter, all the while researching and working on our main goals of starting a Resource Center for people who find themselves homeless, and a Safe Camp. Availability of appropriate local property and funding are our main challenges.

When COVID 19 hit rural Northern California in March of 2020, we started a "Shelter In Place" program at a local hotel in Garberville, for the 20 most at-risk houseless in our area, with funding granted by the Humboldt Area Foundation. The Department of Health and Human Services took over funding us to facilitate the Roomkey program a few weeks later, and has committed to continue their support of Roomkey, at least through December of this year. DHHS also helps fund the once-a-week expanded lunch program we are running to assist So Hum's houseless campers to shelter in place which in addition to food provides masks, crucial info about COVID and the availability of social services including mental health, drug & alcohol counseling, and other resources. Recently, DHHS began funding wrap-around services on a half-time basis for the Room key program, which was previously done only by volunteers. In response to COVID SHO installed hand-washing stations at three locations in Garberville and Redway.

On August 25th of this year, the Humboldt County Board of Supervisors approved the allocation of a California Development Block Grant to SHO. Out of a field of 200 applicants our tiny non-profit was one of the four chosen to receive funding from CDBG. The amount initially awarded was $41,000, which was recently increased to $56,000 and will be released in November.

Throughout SHO's short history, from the Extreme Weather shelter nights; to the monthly Sunday dinners when folks left with full bellies, warm socks and knitted caps; to our ongoing hot shower events; right up through today with SHO's lunch program for houseless campers, and Roomkey, one abiding light has remained constant: our hard-working volunteers. It's their faith, dedication and compassion that keep this going. People sacrifice their free time to prepare meals, attend meetings, deliver food, comfort people in need, arrange for support services, and any number of tasks that are needed to help. SHO remains dedicated to helping people in need of shelter and resources, giving people the chance to live a safe, healthy and fulfilling life

PROGRAMS AND IMPACT



<u>Shelter and Supportive Services</u>

- Outputs since March 2020, 20+ of our most at-risk houseless folks are currently sheltering in place and receiving supportive services and three meals daily at a local motel.

- Outcomes Since sheltering in place many of our clients have experienced a decrease in mental health symptoms and active substance use/abuse. This is primarily due to just having a safe place to be, access to showers/toilets, access to food daily, emotional support, and access to ancillary services. This has enabled folks to become more housing ready and feel hopeful.

- Impact Since sheltering in place there has been less negative community impacts due to less folks on the streets, sheltering in front of local business establishments, etc. This has enabled the community at large to feel safer especially during the current pandemic.

<u>Outreach/Lunch Program</u>

- Outputs Up to 100 lunches are delivered weekly to houseless folks in encampments. Provide masks, COVID information, and referrals.

- Outcomes   Folks are more food secure leading to a decrease in anxiety, stress and illness and an overall increase in energy and physical wellness. Houseless folks are less likely to get COVID if they don't have to leave the encampments to search for food and they are provided COVID information and tools to stay safer. This decreases their contracting and spreading COVID -19, anxiety, and increases personal safety.

- Impact   Less houseless folks are panhandling which can create a safety concern, less folks from the encampments are in the community thereby decreasing the risk of COVID community spread.

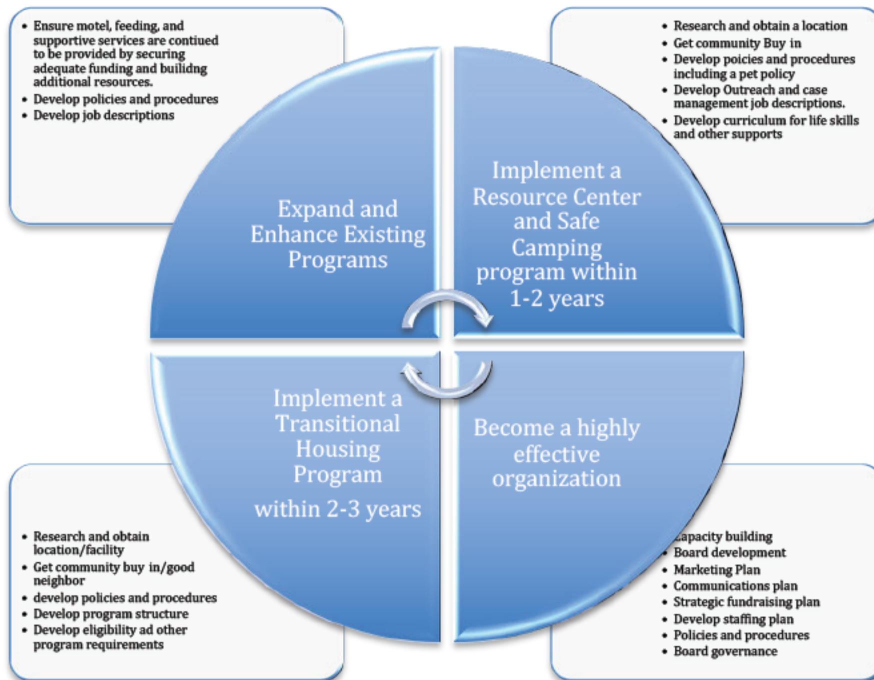
Community Showers

- Outputs   Once monthly houseless folks are able to access showers.

- Outcomes   When asked what is most needed of persons experiencing houselessness, the reply is usually the same   a shower! Person's experiencing houselessness feel better about themselves internally after having a hot shower. This also helps them to improve their individual presentation to perspective employers, etc.

- Impact   When persons are able to maintain personal hygiene it keeps them not only emotionally healthier, but it also impacts their physical health, which decreases community health costs (less ER visits, etc.)

SHO's Strategic Plan



SHO's Board of Directors convened for a strategic planning session facilitated by an area consultant. The above diagram illustrates the goals and objectives of the five-year strategic planning. The 2021 – 2026 Strategic Plan is the driving force of SHO's mission and is reviewed quarterly to update progress.

Fiscal controls

SHO employs a part time bookkeeper who is overseen by the Board Treasurer. SHO utilizes Quickbooks for accounting and tracking expenditures, income, and in-kind services and donations. SHO uses a two signer checking system to manage risks. Financial reports are submitted and reviewed at monthly board meetings. Program codes are used to track specific contracts payables and receivables. Employees for this project will enter time related tasks by program code to accurately track contract related deliverables and payroll requirements. SHO is in the process of contracting with ADP payroll services.

STAFF QUALIFICATIONS/EXPERIENCE

For the last five years SHO has been the leader in homeless/houseless services in Humboldt County utilizing volunteers until the recent pandemic. This project represents SHO's strategic goals and objectives to expand and deepen its impact in the community. SHO will recruit, hire, and train direct services staff to implement high effective high quality services to the target population residing on the streets and in encampments.

Project Staff Recruitment and Training Plan

Activity	Description	Timeline	Responsible party	Progress
Recruit Staff	Project Director, Case Manager, Outreach Workers.	30 days from award date	Board Executive Committee will recruit the Project Director. The Project Director will recruit, interview, and hire staff.	
Staff/Volunteer Training	**Training Manual** • Client Services, • Professional Boundaries • De-Escalation, • Substance Use (Harm Reduction), • Mental Health (Suicide, 5150, Mental Health symptoms/signs), • Child Abuse, Elder Abuse (mandated reporter) • Working with Seniors • Domestic Violence • Community Resources **Evidence Based Practices** Motivational Interviewing, ACES, Trauma-Informed Care, Client-Centered Approach.	Manual training will be completed within 30 days of hire. Orientation/Personnel Policies – within 2-weeks of hire. • HIPPA, • Confidentiality, • CPR, • Infectious Diseases, • Disaster Preparedness, • Safety • Grievance procedure. • Sexual Harassment, • Non-violent communication • On-Call procedures • Incident Reporting Evidence based practices – within 3 months of hire.	Project Manager and hired Trainers	

Project Director Job Description
Reports to: Executive Director
Hours: 9a.m. – 5:30p.m. Monday thru Friday
Rate of Pay - DOE

Job Description – The Project Director is responsible for overseeing the emergency shelter program and related services including coordinated entry and outreach. The Project Director will directly supervise all staff positions and maintain compliance with all funding sources including contracts management, confidentiality, HIPPA, and additional local/state/federal dictates related to the provision of homeless services. Specifically:

- Hire, train, and be a motivating mentor to staff.
- Lead large group discussions to answer questions and remedy complaints.
- Build a strong team through open communication and by collaborating on decision-making responsibilities.
- Create and nurture effective communication within the organization.
- Initiate and set goals for programs based on the organization's strategic objectives.
- Plan programs from start to finish, including identifying processes, deadlines, and milestones.
- Develop and approve operations and budgets.

Educational Requirements
The Project Director position requires at least a bachelor's degree in psychology, social work, counseling or related degree. A master's degree is highly desirable.

Experience
At least 5 years experience managing/directing programs that serve individuals and/or families that are experiencing homelessness and/or housing insecurity is highly desirable. Experience with relevant contracts and grants management, grant writing, supervising staff, managing budgets, developing budgets, facilitation of small and large group meetings, and other relevant

SHO Project Director (interim) Relevant Experience and Qualifications
Carla Harris possesses over 20 years experience directing and managing human services programs including but not limited to homeless/domestic violence shelters, transitional housing projects, substance abuse treatment (outpatient/residential), Child Protective Services, Youth projects (TAY) homeless services, and in-prison programs.

Carla possesses a BA in Psychology from Syracuse University, a MPA (Masters in Public/Nonprofit Administration) from San Francisco University, and relevant CEUs's as well as a certification in nonprofit fundraising. Carla has raised well over 1M in grants/contracts and possesses over 20 years in contracts compliance and management.

Carla will serve as the Interim Project Manager for at least six months and will be tasked with completing all operations manuals, policies and procedures, staffing plans, training of newly hired staff and supervision.

Case Manager
Case Manager Job Description
Reports to: Project Director
Hours: 9a.m. – 5:30 p.m.
Rate of Pay - $22 - $25 per hour DOE

Job Description – The case manager will provide direct case management services to either individuals and families at risk of homelessness and individuals who are currently houseless and meet the federal definition of homelessness. Case Management duties include intake assessment, data entry into HMIS, case management (housing sustainability plans, case notes, weekly meetings with clients, referrals to ancillary services, discharge planning, and continuing care) and other duties as assigned. Specifically:

- Assessing clients' physical and mental wellness, needs, preferences and abilities, and developing plans to improve
- Working with clients, family and friend support networks, and other care professionals to put care plans in place
- Listening to clients' concerns and providing counseling or intervention as required
- Recording clients' progress, charting referrals.
- Evaluating clients' progress periodically and making adjustments as needed
- Following up with discharged clients to ensure they are satisfied with services and still in good physical and mental health

Qualifications

- Propensity for compassion and ability to relate to clients with various needs
- Ability to motivate clients to follow care plans utilizing motivational interviewing and other client engagement practices.
- Great communication skills and ability to work in partnership with clients to develop strengths based case plans (housing sustainability plans).

- Excellent organizational, time management, and record-keeping skills, as well as the ability to manage multiple cases.
- Sound critical thinking and problem-solving skills to assess clients, analyze feedback from health care and social workers, and determine the best care plans
- Computer literacy to maintain and manage case records – HMIS, etc.

Educational Requirements - The Case Manager position requires at least a bachelor's degree in psychology, social work, counseling or related degree. Experience may meet some of this requirement.

Experience - Experience providing direct services to individuals and/or families that are experiencing homelessness, housing insecurity is highly desirable. At least one year in a paid position as a case manager is required.

Outreach Worker
Outreach Worker Job Description
Reports To – Project Director
Hours – 9:00a.m. – 5:30p.m.
Rate: $18 - $22 per hour DOE

Duties: The Outreach Worker works in the field to inform and engage houseless individuals and families on services to assist them out of homelessness. The Outreach Worker will coordinate food distribution and other necessary items to increase well-being such as COVID related information, resources, and protective supplies. The Outreach Worker will coordinate monthly shower events for street level homeless folks including those in encampments. As part of the emergency shelter team the Outreach Worker will work collaboratively with shelter staff to facilitate shelter, case management, and supportive services this may include transporting people to shelter and other necessary services.

The Outreach Worker will document statistical daily activities, case notes, and additional forms to facilitate access to services such as Release of Information Forms.

Other duties as assigned.

Qualifications and Experience: The Outreach Worker must possess a high school diploma or a GED. Some coursework in human services is highly desirable. The Outreach Worker must possess at least one-year experience working directly with the target population. Must having a working knowledge of Outlook, Word, Excel.

The Outreach Worker must possess a positive attitude, time management skills, and consistency.

PROJECT DESCRIPTION

SHO proposes to expand and deepen its impact with Southern Humboldt County's houseless population including individuals and families residing on the streets and in encampments in Garberville and surrounding communities. Using a variety of evidence-based practices, SHO will engage and link individuals to supportive services that will assist in over-coming barriers to housing and overall well-being. Upon placement into permanent housing, SHO will continue to case manage towards sustaining housing and supportive services.

The Project Director will directly supervise the Case Manager, Outreach Worker, and Support Staff. The Case Manager will possess at least one year of experience providing case management services, a related degree, and will be provided applicable training towards enabling him/her to effectively provide quality services. The Outreach Worker will possess the necessary experience that will enable him/her to effectively engage street level homeless persons in services.

Case Management services will include assessment, service plan development and client progress reporting. Each client will have a case file that includes vulnerability index assessment (VI-SPDAT), emergency quick assessment, service plan, progress notes, referral logs and follow up, and additional information. When a client is permanently housed, case management services will continue for at least six months or until the client has fully adapted to his/her new environment. However, case management services will not continue for more than a year unless approved by the Project Director. Service Plans will be developed in partnership with the client and will be client centered. The Case Manager will complete the initial assessment within three business days of the client volunteering to engage in services. The Housing Sustainability Plan will be completed with five business days from the date of initial assessment and the VISPDAT.

Referrals will include mental health, physical health, substance abuse treatment and/or substance abuse supports, social services (eligibility, SSI, etc.), educational/vocational training, employment readiness training, and other identified ancillary services.

The Outreach Worker will engage street level homeless folks in and around Garberville and surrounding communities including encampments. He/she will educate folks on resources and COVID related safety measures and provide folks with masks, brochures that will include health related services and other essential services in the community such as food banks. He/she will provide a quick health assessment/screening for COVID symptoms and provide necessary referrals and transportation as needed to clinics. SHO will work collaboratively with Redwood Rural to ensure clients access and follow

through with any necessary health related services. The Outreach Worker will work collaboratively with the Case Manager and provide referrals and engage clients in services including necessary transportation and services support.

Project Logic Model:

Inputs	Activities	Population	Short-term outcomes	Medium-term outcomes	Long-term outcomes
Staff – Project Director, Case Manager, Outreach Worker, Staff Training. Funding: ESG-CV funding. PHLA funding. Evidence Based Practices. Housing First, Motivational Interviewing OARS, Trauma-Informed Care, Person Centered practices.	Street Outreach to encampments to provide information, resources, access to shelter services, COVID education and personal protective equipment and safety brochures, and transportation to appointments. Provide quick assessment of pressing/emergency needs. Conduct Assessment (VISPDAT) to prioritize needs based on vulnerability. Provide case mgmt services (housing sustainability plan). Provide Referrals and transporation to ancillary providers – mental health, substance abuse, health, social services (benefits – SSI/SSDI, MediCal, EBT, SNAP, CalWorks, Lifeskills programs, job	Houseless individuals/families residing in the streets and/or encampments who meet the federal definitions of homelessness including transition age youth.	Engage and link at least 55 homeless folks residing in encampments to shelter and supportive services. Reduce emergency room visits by at least 25% during first year of operations. Reduce law enforcement contact with homeless folks by at least 25% during first year of operations. Place at least 45% shelter clients and street level homeless individuals/families into permanent housing within nine months of entry into services. Reduce street level homelessness by at least 25% during first year. Increase length of time that individuals and families are permanently housed by at least 10% during first year of operations.	Reduce encampment popu at on by at east 35%. Increase overa hea th and we be ng of home ess nd v dua s and fam es by 50%. Reduce emergency room v s ts by at east 40%. Reduce aw enforcement ca s by at east 40%. Reduce street eve home ess popu at on by 45%. Reta n nd v dua s and fam es n permanent hous ng beyond two years	Increase overa hea th and we be ng of house ess nd v dua s and fam es by 75% w th n 5 years. Decrease encampment and street eve home essness by 50% w th n 5 years. Reduce returns to home ess by 75% w th n 5 years. Reduce emergency room v s ts by 60% w th n 5 years. Reduce st gma and n mby sm by 50% w th n 5 years.

	training, vocational training, education. Assistance with Rapid Rehousing, Permanent Supportive Housing, and unsubsidized housing applications and landlord negotiations assistance				

Program Evaluation Plan

Data collected will quantify project outputs, short/medium/long term outcomes. SHO will partner with the local emergency rooms to collect emergency room contacts by folks who report being homeless at baseline (prior to project implementation) and annually thereafter. SHO will collect Law Enforcement transient related calls prior to implementation, at 6-month intervals thereafter. HMIS data will be collected to determine numbers served, demographic data, discharge and exits including destinations, increases in income, job obtainment, permanent housing obtainment, and housing subsidies information. Qualitative client surveys will be provided at intake and at 3-, 6-, and 9-month intervals to measure well-being and overall programs satisfaction. SHO will participate and collect data of the PIT (Point in Time) Counts and compare numbers over the next 5 years commencing with the most recent PIT count. This will help to determine whether or not the number of homeless is increasing or decreasing. Surveys will assist in determining reasons that led to homelessness so that prevention strategies can be put in place. SHO will also conduct community focus groups at baseline and annually thereafter to measure community perceptions, stigma, and nimbyism.

SCOPE OF WORK

Street Outreach – SHO will hire and train an Outreach Worker to engage individuals and families living in the streets and encampments. The Outreach Worker will also provide health education such as COVID and other presenting health concerns. He/she will provide a quick assessment of needs and provide referrals as needed. SHO currently provides lunches to the encampments weekly, and the Outreach Worker will work closely with the case manager and volunteers to facilitate weekly lunches and other necessities. He/she will work closely with community-based organizations and their staff to coordinate services and avoid duplication of services. SHO's case manager will meet weekly with clients where they shelter and/or in the office to complete intake

assessments, the VI-SPDAT, progress meetings, provide referrals/follow up, and supportive counseling.

Housing First - SHO embraces a "housing first" approach to ending homelessness by first helping people find or maintain permanent housing with stability and then connecting them with community, health, human, and financial services they need to prevent future experiences of homelessness. Through coordinated entry and assessment, SHO prioritizes housing and services based on vulnerability and need rather than on a first come, first serve basis. Through progressive engagement, consumers are given just as many services and support they need to success in order to preserve costly interventions like permanent supportive or subsidized housing for families and individuals with significant and lasting barriers to housing stability.

SHO embraces Humboldt County's Housing First Principles:

- Participants are moved into permanent housing as quickly as possible with no services of program readiness requirements.
- The projects rules are limited to participant safety and do not try to change or control participants or their behaviors.
- The project uses a trauma-informed approach.
- The project does not require detox treatment and/or days of sobriety to enter.
- The project does not conduct drug testing
- The project does not prohibit program entry on the basis of mental illness diagnosis and does not have a policy requiring medication and/or treatment compliance to enter.
- The project does not bar participants based on past, non-violent rules infractions.
- The project accepts all participants regardless of sexual orientation or gender identification and follows all fair housing laws.
- The project does not exclude participants with zero income and/or limited to no work history.
- The project does not terminate program participants for any of the above listed reasons. The project also does not terminate participants for:
    - ✓ Low or no income;
    - ✓ Current or past substance use;
    - ✓ History of domestic violence;
    - ✓ Failure to participate in supportive services;
    - ✓ Failure to make progress on a service plan;
    - ✓ Criminal records, with exceptions of restrictions imposed by federal, state, or local law ordinance
- If the project entails housing placement and/or housing stability services, program staff treats eviction and/or termination of housing as a last resort. Before termination/eviction, staff should engage as many other alternative strategies as are applicable and reasonable, including, without limitation:

- ✓ Conflict resolution
- ✓ Landlord mediation
- ✓ Support with rental/utility arrears
- ✓ Tenancy skills building
- ✓ Relocation

Case Management Tools and Assessment Policies

Vulnerability Index Service Prioritization and Decision Assistance Tool (VISPDAT)

The VISPDAT is an evidence-informed approach to assessing an individual's or family's acuity. The tool, across multiple components, identifies the areas in the person/family's life where support is most likely necessary in order to avoid housing instability. The VISPDAT is used as both a prioritization tool and as a case management tool in SHO's programs and services. As a prioritization tool, the VISPDAT is completed with households by the case-manager to determine the most appropriate housing intervention for the household, and to determine the types of assistance that may be appropriate to assist the client. The VISPDAT is used to determine the household's priority in being served, in the event that there are not enough resources to serve all households in need of services.

As a case management tool, the VISPDAT is used by case managers and households to identify areas of strength and challenge the household may face in maintaining housing stability, and to develop Housing Stability Plans that address the household's barriers. The VISPDAT is intended to be completed frequently during intake/ enrollment (or within 5 days of entering a shelter), and regularly thereafter. In the emergency shelter, this may include updates every 30 days. In Rapid Re-Housing, this includes updates at least once every 90 days. The caseworker completing the SPDAT is expected to share the assessment with the household's other caseworkers. In many cases, it may be appropriate for a household's other case worker(s) to be interviewed or present during the completion of the SPDAT in order to ensure that the household's history is being reported accurately.

A copy of every VISPDAT should be provided to the household and maintained in the client's case file. The VISPDAT should be used in conjunction with the Household Budget to develop the Housing Stability Plan. It is expected that the components in the SPDAT that are identified as barriers to housing stability are addressed in the Housing Stability Plan. It is expected that as the components increase or decrease in acuity, a summary of these changes are reflected in the client's Housing Stability Plan, case notes, and Re-Assessment, as appropriate. In this way, the VISPDAT forms the basis of case planning with SHO clients.

Household Budget

An accurate understanding of a household's income and budget is a necessary tool to help clients maintain permanent housing. Prior to obtaining permanent housing,

budgets help clients identify their housing price range based on their current income, and even the feasibility of renting a unit of their own if other options exist.

After obtaining housing, budgets help clients plan for bill payments, keep track of expenses, and manage spending and saving. SHO's standard Household Budget provides a common template for use with all clients and their case managers. SHO case managers will develop and update a Household Budget with enrolled clients. Budgets should be updated any time income or expenses change. In Rapid Re-Housing, Budgets must be updated any time income or expenses change, or at least every three months during Re-Assessment.

Budgets should be reviewed with a client during development of the Housing Stability Plan, so that clients can set goals and action steps related to income/ benefits based on this budget.

Housing Stability Plans

One of SHO's primary goals is to help people experiencing homelessness move to permanent housing as quickly as possible. To do so, case managers in all programs help clients establish goals and action steps to obtain housing quickly, and to maintain that housing long-term. SHO's Outreach Program is required to create Housing Stability Plans for all enrolled clients when providing assistance to clients through Street Outreach.

The Housing Stability Plan is a standard template that allows case managers and clients to jointly identify goals and to detail the steps needed to achieve those goals. Goals identify the major achievements for gaining housing stability. Goals may be related to obtaining permanent housing, as well as other activities that will help the household maintain that stability long-term, such as connecting to health services, increasing income, or maintaining the terms of a lease. Goals are informed by the client's VISPDAT, budget, and other related sources of information available to the client and the case manager. For each goal, additional action steps are created.

Action Steps are specific tasks that the client and case manager will take to reach the goals identified in the plan, with due dates listed for each task. Both the client and the case manager must sign the Housing Stability Plan for it to be considered complete. It is the case manager's responsibility to ensure that the Housing Stability Plan is complete. Typically, a Housing Stability Plan includes medium- to short-term goals and action steps that can be accomplished within the next 1-2 meetings, or covering the next 30 days. A new Housing Stability Plan is created once those action steps are completed.

Clients and case managers develop goals and action steps jointly. To the extent appropriate, clients should be setting their own goals for housing stability, with support from case managers so that they are reasonable, actionable, and timely. Case managers should use techniques such as motivational interviewing, active listening, housing-

focused case management, and strengths-based case management to assist clients in developing goals and action steps.

In order to increase collaboration and consistency between the multiple providers a client may be working with, all Housing Stability Plans must be jointly created and/or shared with all case managers that are working with the same client in SHO's network. This may include a joint session in which all case managers working with the client develop and sign the Housing Stability Plan together, or it may be that a primary case manager will develop the Housing Stability Plan with the client and then share it with the client's other case managers. In either case, it is the responsibility of every staff person or provider to make any Housing Stability Plan they create with a client available to the client's other case managers.

The current Housing Stability Plan is updated at every case management meeting between a client and a case manager until all action steps on the plan have been addressed. Updates would include recording the actions taken by the client and case manager to achieve the goals/ action steps, as well as when goals/ action steps are completed.

If a client requires financial assistance from in order to achieve their goals, the Housing Stability Plan must clearly describe any conditions related to receiving that financial assistance, such as amount of client contribution, when client contribution is due, and how the client will demonstrate that their contribution has been paid. In this way, the Housing Stability Plan clearly establishes expectations for both case managers and clients for providing/ receiving financial assistance and provides a written record of that agreement. As noted above, all progress on meeting the goals related to financial assistance must be recorded (i.e., case managers must document on the Housing Stability Plan that a client did or did not pay their portion of a bill on time). This includes all Housing Counseling clients receiving financial assistance.

All Housing Stability Plans must be maintained in the client's file and be made available to SHO's Director in the event of monitoring, client appeals, or otherwise as requested by the Project Director.

Case Notes
All interactions between clients and SHO staff must be documented in Clarity with a case note corresponding to the date of the interaction. Case notes must include the mode of communication (in person meeting, email, text, phone call, office visit) and date. It is expected that case management notes are written using proper grammar, spelling, etc., and that they convey the professionalism with which the services are provided.

The case note must include a summary of the discussion and any information provided by the case manager to the client. This summary is to be written in objective language only and should not contain any language that reflects the writer's assessment or subjective opinion. Case notes documenting case management meetings should provide a full accounting of the work done during the meeting. This includes case management support provided during the meeting, such as progress on meeting goals, new action items identified, income and budget work, review of service connections, etc. Any discussion that could be referenced later for an appeal- such as a discussion regarding compliance with the program's agreement policy or progress on meeting goals- must be documented clearly in the case notes.

Any time a new Rapid Re-Housing Re-Assessment, VISPDAT, or budget is completed, the case note must indicate this and include a summary of the result. It is the expectation that case notes are submitted into Clarity in a timely manner, reflecting current status and real-time. Case notes are to be entered no later than 1 week from the encounter, outreach, phone call, or other contact made with the client.

All case notes for each program are to be entered into Clarity by end of business day Monday for the week prior. Case notes must reflect all contact or attempted contact made (which includes voicemails left, calls put in, texts exchanged). If a case note is not entered, it did not happen.

Records Retention – Client records will be retained for at least 7 years in a double locked facility. Current client records will be kept in the office in a locked file cabinet behind a locked door. No client files will be left on desks when they are not being used.

Confidentiality/HIPPA – All staff and volunteers adhere to confidentiality standards and HIPPA compliance. All staff and volunteers are trained on confidentiality and HIPPA.

ATTACHMENT B – PROPOSED BUDGET

<table>
<tr><td colspan="2">A. Personnel Costs
Formula for salary calculations and any benefits should be clearly identified</td></tr>
<tr><td>Title: Project Director
Hourly Rate of Pay or Salary Calculation: .25FTE @ $30/hr.
Duties Description: mgmt., training, supervision, operations including contract compliance and budget mgmt.</td><td>$14,400.00</td></tr>
<tr><td>Title:
Hourly Rate of Pay or Salary Calculation:
Duties Description:</td><td>$0</td></tr>
<tr><td align="right">Total Personnel Costs:</td><td>$14,400.00</td></tr>
<tr><td colspan="2">B. Operational Costs</td></tr>
<tr><td>Item: Office Rent
Description: house staff for data entry (HMIS), individual client meetings, etc.</td><td>$12,000.00</td></tr>
<tr><td>Item:
Description:</td><td>$</td></tr>
<tr><td align="right">Total Operational Costs:</td><td>$12,000.00</td></tr>
<tr><td colspan="2">C. Supplies</td></tr>
<tr><td>Item: 1 laptop
Description: field work (data entry), etc.</td><td>$1,000.00</td></tr>
<tr><td>Item: 1 cell phone
Description:</td><td>$1,200.00</td></tr>
<tr><td>Item: paper, ink, printer/copier,
Description: client files, brochures, informational flyers.</td><td>$2,000.00</td></tr>
<tr><td align="right">Total Supply Costs:</td><td>$4,200.00</td></tr>
<tr><td colspan="2">D. Transportation/Travel (Travel expenses must follow Humboldt County Travel Policy Limits)</td></tr>
<tr><td>Item: Mini Van
Description: Transport clients to appointments, shelter as needed (out of MTA bounds)</td><td>$</td></tr>
<tr><td>Item: Client Bus Passes
Description: appointments (mental/behavioral health, health care, social services)</td><td>$</td></tr>
<tr><td align="right">Total Transportation/Travel Costs:</td><td>$</td></tr>
<tr><td colspan="2">E. Other Costs</td></tr>
<tr><td>Item: client incentives, costs for ID’s, emergency needs
Description: gift cards (grocery store, costs of ID’s, housing readiness - back utility bills</td><td>$13,416.00</td></tr>
<tr><td>Item: 10% indirect costs
Description:</td><td>$2,820.00</td></tr>
<tr><td>Item:</td><td></td></tr>
</table>

A. Personnel Costs ***Formula for salary calculations and any benefits should be clearly identified***	
Description:	
Total Other Costs:	$16,236.00
Grand Total:	$46,836.00

Budget Narrative

The Project Director will implement the Outreach Project including but not limited to recruit, hire, train or facilitate trainings, and directly supervise the case manager and outreach worker. He/she will oversee all contracts and grants, report directly to SHO's Board of Directors once monthly to provide program reports. He/she will complete monthly, quarterly, annual reports to funders and facilitate invoicing with contractors monthly. He/she will provide oversight of HMIS data and complete administrative HMIS reports, work with Shelter Staff to correct HMIS errors, and be in direct contact with the County HMIS lead. He/she will possess a master's degree and 5 or more years' experience with the target population administering and directing programs.

The Case Manager will work 5 days per week and is responsible for all client files and will work with other shelter employees to ensure that all files are kept up to date. He/she will be responsible for all HMIS data entry, intake (completion of VISPDAT), weekly case management sessions with clients, referrals, documentation, and discharge planning. He/she will work closely with other community providers to ensure a seamless system of care. He/she will assist client to obtain permanent housing in collaboration with the county and landlords. He/she will resolve any landlord tenant issues and assist with housing vouchers, etc.

The Outreach Worker will work full time and is responsible for outreach into encampments and other street level homeless folks in the surrounding communities. He/she will provide information and engage clients in services towards becoming permanently housed. He/she will complete all required documentation and work as a team by participating in weekly case management meetings and any other necessary community-based meetings.

Operational Costs – SHO is requesting funding to support the costs of office rent to support HMIS data entry and case records management and ensure confidentiality when meeting individually with clients.

Office Supplies – SHO will need to purchase computers and laptops. The field outreach worker will need a laptop and the case manager will need a laptop so that they can

enter notes into databases in the field and/or in individual appointments in client rooms. Desktop computers, phones, and a copier will be housed in the staff office.

Transportation – SHO will purchase a new minivan to assist with transporting clients to appointments (not accessible thru public transportation), delivery of food to encampments, and outreach activities. Maintenance costs will cover any maintenance of the van. Bus vouchers will be provided to folks without resources to obtain vouchers. SHO will maintain liability insurance and all other necessary insurances reflected in the proposal and budget.

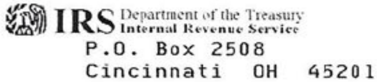
Other Costs – include client needs such as costs of gathering documents needed for housing applications, cost of housing applications, basic personal needs (hygiene, food, etc.), old utility bills, client incentives (assist with engagement and retention), and any unforeseen barriers towards permanent housing and overall health and well-being.

Street Outreach Project full 2021-2022 Budget

SHO Street Outreach Budget	Request ESG-CV

Item	Description	Costs	Costs
Staff			
Project Director	.25FTE @ $30hr	$14,400	$14,400
Case Mgr.	1FTE @$25hr	$62,400	$62,400
Outreach Worker	1FTE @$22hr + 30% benefits	$54,912	$54,912
Staff Training	HIPPA, EBP's, safety, policies	$3,000	$3,000
Total		$134,712	$134,712
Facilities			
Rent	office space	$12,000	
Utilities	Electric, water, sewage	$5,000	$5,000
Total		$17,000	$5,000
Supplies			
Computer/laptops	2 laptop, 1 desktop computers	$5,000	$4,000
cell phones	direct services staff	$2,400	$1,200
Copier	1 office copier	$3,600	$2,400
food/water/PPE’s	Encampment/street homeless	$9,000	$8,000
paper/ink/etc.	Informational brochures, case files, etc.	$3,000	$2,000
Total		$23,000	$17,600
Transportation			
mini van		$38,000	$38,000
gas/mileage	transport to out of reach appointments	$1,000	$1,000
maintenance/repairs		$2,000	$2,000
bus passes	client bus passes	$1,500	$1,500
Total		**$42,500**	**$42,500**
Misc./other	Client needs – emergency assistance, ID’s, back utility bills, incentives.	**$12,000**	
Project Total		**$217,212**	**$199,812**
indirect cost	10% of total request	$21,721.00	$19,981
Total Request		**$229,913**	**$219,793**

6.0 Supplemental Documentation
IRS Determination Letter

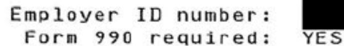


P.O. Box 2508
Cincinnati OH 45201

In reply refer to: 0752146255
Apr. 29, 2019 LTR 4168C 0
83-2347520 000000 00
00053137
BODC: TE

SOHUM HOUSING OPPORTUNITIES
% DAVID ORDONEZ

80828

Employer ID number: 
Form 990 required: YES

Dear Taxpayer:

We're responding to your request dated Apr. 18, 2019, about SOHUM HOUSING OPPORTUNITIES

We issued you a determination letter in DECEMBER 2018, recognizing you as tax-exempt under Internal Revenue Code (IRC) Section 501(c)(03).

We also show you're not a private foundation as defined under IRC Section 509(a) because you're described in IRC Sections 509(a)(1) and 170(b)(1)(A)(vi).

Donors can deduct contributions they make to you as provided in IRC Section 170. You're also qualified to receive tax deductible bequests, legacies, devises, transfers, or gifts under IRC Sections 2055, 2106, and 2522.

In the heading of this letter, we indicated whether you must file an annual information return. If you're required to file a return, you must file one of the following by the 15th day of the 5th month after the end of your annual accounting period:

- Form 990, Return of Organization Exempt From Income Tax
- Form 990EZ, Short Form Return of Organization Exempt From Income Tax
- Form 990-N, Electronic Notice (e-Postcard) for Tax-Exempt Organizations Not Required to File Form 990 or Form 990-EZ
- Form 990-PF, Return of Private Foundation or Section 4947(a)(1) Trust Treated as Private Foundation

According to IRC Section 6033(j), if you don't file a required annual information return or notice for 3 consecutive years, we'll revoke your tax-exempt status on the due date of the 3rd required return or notice.

You can get IRS forms or publications you need from our website at www.irs.gov/forms-pubs or by calling 800-TAX-FORM (800-829-3676).

If you have questions, call 877-829-5500 between 8 a.m. and 5 p.m.,

0752146255
Apr. 29, 2019 LTR 4168C 0
83-2347520 000000 00
00053138

SOHUM HOUSING OPPORTUNITIES
% DAVID ORDONEZ

local time, Monday through Friday (Alaska and Hawaii follow Pacific time).

Thank you for your cooperation.

Sincerely yours,

Teri M. Johnson
Operations Manager, AM Ops. 3

SHO Insurance Certificate

Control Number: 64241
Applicant: Sohum Housing Opportunities

Loc # Address: [redacted]

ADDITIONAL COVERAGES

Class Code(s) 47366

61227

Exposure Premium 33,600 (p) $182

100 (a) $42

$150

LIABILITY COVERAGES AND LIMITS

Q1-2020-64241

General Aggregate $ Products-Completed Operations Aggregate $ Personal and Advertising Injury $ Each Occurrence $ Damage to Premises Rented to You $ Medical Expense $	**Limits**
Limits	Liquor Liability Aggregate/Common Cause $1,000,000/$1,000,000
3,000,000 3,000,000 1,000,000 1,000,000	
500,000 20,000	

EVIDENCE BASED PRACTICES – SHO has adopted the Evidence Based Practices relevant to the target population and all staff are trained on these practices within their first 30 days of employment.

<u>Motivational Interviewing/OARS</u>
"Motivational Interviewing is an Evidence Based collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and

exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.” (Miller & Rollnick, 2013, p. 29). All shelter staff will be trained on Motivational Interviewing within the first 90 days of employment and will be trained on OARS within the first 30 days of employment.

Motivational Interviewing (MI) is a **guiding** style of communication, that sits between **following** (good listening) and **directing** (giving information and advice). MI is designed to **empower** people to change by drawing out their own meaning, importance and capacity for change. MI is based on a **respectful** and **curious** way of being with people that facilitates the natural process of change and honors client autonomy.

MI is framed as a method of communication rather than an intervention, sometimes used on its own or combined with other treatment approaches. There are a number of benefits of learning MI amongst other approaches to helping conversations:

- MI has been applied across a broad range of settings (e.g., health, corrections, human services, education), populations (e.g., age, ethnicity, religion, sexuality and gender identities), languages, treatment format (e.g., individual, group, telemedicine) and presenting concerns (e.g., health, fitness, nutrition, risky sex, treatment adherence, medication adherence, substance use, mental health, illegal behaviors, gambling, parenting).
- MI compares well to other evidence-based approaches in formal research studies.
- MI is compatible with the values of many disciplines and evidence-based approaches.
- Although the full framework is a complex skill set that require time and practice, the principles of MI have intuitive or “common sense” appeal and core elements of MI can be readily applied in practice as the clinician learns the approach.
- MI has observable practice behaviors that allow clinicians to receive clear and objective feedback from a trainer, consultant or supervisor.

MI is practiced with an underlying **spirit** or way of being with people:

  - **Partnership**. MI is a collaborative process. The MI practitioner is an expert in helping people change; people are the experts of their own lives.
  - **Evocation**. People have within themselves resources and skills needed for change. MI draws out the person’s priorities, values, and wisdom to explore reasons for change and support success.
  - **Acceptance**. The MI practitioner takes a nonjudgmental stance, seeks to understand the person’s perspectives and experiences, expresses empathy, highlights strengths, and respects a person’s right to make informed choices about changing or not changing.

- **Compassion**. The MI practitioner actively promotes and prioritizes clients' welfare and wellbeing in a selfless manner.

OARS is the attending to the language of change and the artful exchange of information:

- **Open questions** draw out and explore the person's experiences, perspectives, and ideas. Evocative questions guide the client to reflect on how change may be meaningful or possible. Information is often offered within a structure of open questions (Elicit-Provide-Elicit) that first explores what the person already knows, then seeks permission to offer what the practitioner knows and then explores the person's response.
- **Affirmation** of strengths, efforts, and past successes help to build the person's hope and confidence in their ability to change.
- **Reflections** are based on careful listening and trying to understand what the person is saying, by repeating, rephrasing or offering a deeper guess about what the person is trying to communicate. This is a foundational skill of MI and how we express empathy.
- **Summarizing** ensures shared understanding and reinforces key points made by the client.
- **Attending to the language of change** identifies what is being said against change (sustain talk) and in favor of change (change talk) and, where appropriate, encouraging a movement away from sustain talk toward change talk.
- **Exchange of information** respects that both the clinician and client have expertise. Sharing information is considered a two-way street and needs to be responsive to what the client is saying.

Trauma Informed Care - Trauma-Informed Care understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize. Trauma-Informed Care (TIC) is an approach in the human service field that assumes that an individual is more likely than not to have a history of trauma. Trauma-Informed Care recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life- including service staff.

On an organizational or systemic level, Trauma-Informed Care changes organizational culture to emphasize respecting and appropriately responding to the effects of trauma at all levels.[1][2] Similar to the change in general protocol regarding universal precautions, Trauma-Informed Care practice and awareness becomes almost second nature and pervasive in all service responses. Trauma-Informed Care requires a system

to make a paradigm shift from asking, “What is wrong with this person?” to “What has happened to this person?”[3]

The intention of Trauma-Informed Care is not to treat symptoms or issues related to sexual, physical or emotional abuse or any other form of trauma but rather to provide support services in a way that is accessible and appropriate to those who may have experienced trauma. [3] When service systems operating procedures do not use a trauma-informed approach, the possibility for triggering or exacerbating trauma symptoms and re-traumatizing individuals increases. [3]

Re-traumatization is any situation or environment that resembles an individual’s trauma literally or symbolically, which then triggers difficult feelings and reactions associated with the original trauma. [4][5] The potential for re-traumatization exists in all systems and in all levels of care: individuals, staff and system/organization. Re-traumatization is often unintentional. There are some “obvious” practices that could be re-traumatizing such as the use of restraints or isolation, however, less obvious practices or situations that involve specific smells, sounds or types of interactions may cause individuals to feel re-traumatized.[3] Re-traumatization is a significant concern, as individuals who are traumatized multiple times frequently have exacerbated trauma-related symptoms compared to those who have experienced a single trauma. Individuals with multiple trauma experiences often exhibit a decreased willingness to engage in treatment. Re-traumatization may also occur when interfacing with individuals who have history of historical, inter-generational and/or a cultural trauma experience. (http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html).

Client- Centered Approach
All SHO staff will adhere to the Client-Centered Approach through all phases of working with the clients. Best practices for a client-centered approach include:

- Assisting participants in clarifying their key values, challenges, and strengths.
- Allowing participants to drive the process of identifying goals.
- Asking motivating questions to prompt participants to determine the best course of action and to take action when ready.
- Informing participants of expressed interests and desires of the participant.
- Helping participants understand the pros and cons of different approaches and supporting them when they decide how best to meet their goals.
- Making referrals to services in partnership with participants’ motivation and timeline, on the assumption that the participant is the expert

ACES (Adverse Childhood Experiences)
All SHO staff will receive training and be sensitive to ACES. SHO staff will not facilitate ACES assessments but is important to understand the longer-term effects of childhood trauma. Adverse Childhood Experiences (ACEs) have a tremendous impact on future

violence victimization and perpetration, and lifelong health and opportunity. Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years). For example:

- experiencing violence, abuse, or neglect
- witnessing violence in the home or community
- having a family member attempt or die by suicide

Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with:

- substance misuse
- mental health problems
- instability due to parental separation or household members being in jail or prison
- References

- 1. Substance Abuse and Mental Health Services Administration. (2014). Concept of Trauma and Guidance for a Trauma-Informed Care Approach. U.S. Department of Health and Human Services.
- 2. Bloom, S. L. (1997). *Creating sanctuary: Toward the evolution of sane societies*. New York: Routledge.
- 3. Harris, M. & Fallot, R. D. (Eds.) (2001). *Using Trauma Theory to Design Service Systems. New Directions for Mental Health Services*. San Francisco: Jossey-Bass.
- 4. Jennings, A. (2015). Retraumatization [PowerPoint slides]. Retrieved from http://theannainstitute.org
- 5. Substance Abuse and Mental Health Services Administration (2014). A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services, Tip 57. U.S. Department of Health and Human Services, 14-4816.
- 6. Bloom, S. L. (2010). Organizational stress as a barrier to trauma-informed service delivery. In M. Becker & B. A. Levin (Eds.), *Public Health Perspective of Women' s mental health* (pp. 295–311). New York, NY: Springer.

Street Outreach Policies and Procedures
(will be complete by project implementation date)
Table of Contents

Humboldt County (ESG Standards – Street Outreach……………………………………………………32

Housing First Policy………………………………………………………………………………………………32

Client Rights and Responsibilities Policy………………………………………………………………….34

Grievance Procedure………………………………………………………………………………………………..34

Substance Use Policy………………………………………………………………………………………………..34

Substance Use Procedures and Harm Reduction………………………………………………………34

Coordinated Entry Policy…………………………………………………………………………………………35

Coordinated Entry Procedure…………………………………………………………………………………..36

Intake Instructions…………………………………………………………………………………………37
Intake Check List……………………………………………………………………………………………39
Intake Survey Introduction to Client……………………………………………………………40
Consent to Share Information………………………………………………………………………42
Consent Form (client signs)…………………………………………………………………………..42
VI-SPDAT………43

Case Management Policy…………………………………………………………………………………………..44

Case Management Procedures – Housing Stability Planning……………………………45
Case Management Tools and Assessment Policies……………………………………………..46
Housing Sustainability Plan Procedure……………………………………………………………47
Case Notes Procedure………………………………………………………………………………………..49

Staff Training Policy & Procedures…………………………………………………………………………50

Humboldt County ESG Standards for targeting and providing essential services related to Street Outreach

ESG funding may be used for costs of providing essential services necessary to reach out to unsheltered homeless people; connect them with emergency shelter, housing, or critical services; and provide urgent, non-facility-based care to unsheltered homeless people who are unwilling or unable to access emergency shelter, housing, or an appropriate health facility. For the purposes of this section, the term ‘‘unsheltered homeless people’’ means individuals and families who qualify as homeless under paragraph (1) (i) of the ‘‘homeless’’ definition under 24 CFR Part 576.2. As outlined in 24 CFR Part 576.101, essential services consist of:

1. Engagement;
2. Case management;
3. Emergency health services – only when other appropriate health services are inaccessible or unavailable within the area;
4. Emergency mental health services – only when other appropriate mental health services are inaccessible or unavailable within the area;
5. Transportation; and
6. Services for special populations

SHO outreach/case management staff determine an individual or family’s vulnerability and willingness or ability to access emergency shelter, housing, or an appropriate health facility, prior to providing essential services under this component to ensure that ESG funding is used to assist those with the greatest need for street outreach assistance.

Policy – Housing First

SHO embraces a “Housing First” approach to ending homelessness by first helping people find or maintain permanent housing with stability and then connecting them with community, health, human, and financial services they need to prevent future experiences of homelessness. Through coordinated entry and assessment, SHO prioritizes housing and services based on vulnerability and need rather than on a first come, first serve basis. Through progressive engagement, consumers are given just as many services and support they need to success in order to preserve costly interventions like permanent supportive or subsidized housing for families and individuals with significant and lasting barriers to housing stability. The major components of SHO include:

- Coordinated entry in partnership with Humboldt County and/or Community Based Organizations,
- Coordinated screening and assessment using the Vulnerability Index Service Prioritization and Decision Assistance Tool (VISPDAT),

- Community Queue to prioritize households for housing and services based on vulnerability and severity of need.
- Housing-Focused Emergency Shelter services, including centralized shelter bed management of Housing Counseling services to divert people from entering shelter or becoming street homelessness
- Connections to mainstream and community services, including childcare, food security, physical, mental and behavioral health, employment and job training, public benefits access and veterans' services, among others

SHO complies with Humboldt County' Housing First Policy

- Participants are moved into permanent housing as quickly as possible with no services of program readiness requirements.
- The projects rules are limited to participant safety and do not try to change or control participants or their behaviors.
- The project uses a trauma-informed approach.
- The project does not require detox treatment and/or days of sobriety to enter.
- The project does not conduct drug testing
- The project does not prohibit program entry on the basis of mental illness diagnosis and does not have a policy requiring medication and/or treatment compliance to enter.
- The project does not bar participants based on past, non-violent rules infractions.
- The project accepts all participants regardless of sexual orientation or gender identification and follows all fair housing laws.
- The project does not exclude participants with zero income and/or limited to no work history.
- The project does not terminate program participants for any of the above listed reasons. The project also does not terminate participants for:
  - ✓ Low or no income.
  - ✓ Current or past substance use;
  - ✓ History of domestic violence;
  - ✓ Failure to participate in supportive services;
  - ✓ Failure to make progress on a service plan;
  - ✓ Criminal records, with exceptions of restrictions imposed by federal, state, or local law ordinance
- If the project entails housing placement and/or housing stability services, program staff treat eviction and/or termination of housing as a last resort. Before termination/eviction, staff should engage as many other alternative strategies as are applicable and reasonable, including, without limitation:
  - ✓ Conflict resolution
  - ✓ Landlord mediation
  - ✓ Support with rental/utility arrears
  - ✓ Tenancy skills building
  - ✓ Relocation

CLIENT RIGHTS

1. The right to receive help finding and staying in suitable housing on a long-term basis;
2. The right to be treated with respect regardless of your race, status, gender, sexual orientation, age, religion, or beliefs;
3. The right to be informed of your human, legal, and civil rights and to speak up when you feel they have been violated;
4. The right to be part of the decisions made about you;
5. The right to confidentiality in accordance with the Private Information Protection Act and the Freedom of Information and Protection of Privacy Act;
6. The right to receive help when applying for income assistance, employment and health services, educational opportunities and other support services; and,
7. The right to make a complaint of appeal a decision you do not agree with and receive an answer that makes sense to you.

Grievance Procedure - If a client expresses a concern or makes a complaint with his/her services, s/he can take the following steps:

1. The client is encouraged to discuss the matter with the Project Director, who will make a decision on any corrective action required within the boundaries of his/her authority. The Director will notify the Board of the client's concerns and actions taken.
2. If the client is still unsatisfied with the outcome, the client may submit a required for intervention to the Executive Director. The Project Director will communicate the clients concerns and actions taken. The Executive Director will take any corrective action required within 10 days and inform the client in writing of the resolution.
3. Clients have the right to ask assistance of another person to speak on their behalf or help fill out a grievance form.
4. Client grievances are reported in the Quarterly and Annual reports. The Board of Directors will review all grievance providing a level of review that does not involve the person about whom the complaint was made or the person who reached the decision.
5. Copies of all documents are placed in the client file.

Substance Use Policy - We offer a non-judgmental approach that attempts to meet clients "where they are at" with their substance abuse. Instead of denying services to clients who are using, we try to give opportunities for the clients to minimize the harms associated with substance abuse.

Procedure:

Staff should help clients recognize that some ways of using substances are clearly safer than others. Staff should recognize that the realities of poverty, class, racism, social isolation, past trauma, sex- based discrimination and other social factors that affect clients' vulnerability to and capacity for effectively dealing with substance use.

Practicing Harm Reduction - Staff should support clients with their harm reduction plans. Examples of this include:

- Encouraging a client who has decided to reduce the amount of substance s/he consumes in a day;
- Listening and honoring a client's story about how s/he became dependent on prescription medication;
- Helping a client to get past the shame of being addicted so that s/he can make conscious choices about what s/he wants to do about it;
- Giving a client information on how to use more safely to keep him/herself disease free, which will lead to more options in the future.

COORDINATED ENTRY POLICY

By centralizing intake and program admissions decisions, a coordinated entry process makes it more likely that families and individuals will be served by the right intervention more quickly. In a coordinated system, each system entry point ("front door") uses the same assessment tool and makes decisions on which programs people are referred to based on a comprehensive understanding of each program's specific requirements, target population, and available beds and services.

<u>Guiding Principles of Coordinated Entry:</u>

• Phased assessment- The assessment tools are employed as a series of situational screenings and assessments that allow the assessment process to occur over time and only as necessary.

• Necessary information- The assessment process only seeks information necessary to determine the severity of need and eligibility for housing and services and is based on evidence of the risk of becoming or remaining homeless.

• Participant autonomy- The protocol for filling out assessment tools provides the opportunity for people receiving the assessment to freely refuse to answer questions without retribution or limiting their access to assistance.

• Person-centered- The assessment process provides options and recommendations that guide and inform client choices, as opposed to rigid decisions about what individuals or families need.

• Cultural competence- Staff administering assessments use culturally competent practices, and tools contain culturally appropriate questions.

• User-friendly- Tools are brief and effortlessly administered by non-clinical staff (including outreach workers), minimize the time required to utilize, and are easy for those being assessed to understand.

• Privacy protections- Privacy protections are in place to ensure proper consent and use of client
information.

• Meaningful recommendations- Tools are designed to collect the information necessary to make meaningful recommendations and referrals to available housing and services.

• Sensitive to lived experiences- Providers recognize that assessment, both the kinds of questions asked and the context in which the assessment is administered, can cause harm and risk to individuals or families, especially if they require people to relive difficult experiences. The tool's questions are worded and asked in a manner that is sensitive to the lived and sometimes traumatic experiences of people experiencing homelessness.

COORDINATED ENTRY PROCEDURE

Intake Procedure Contents:

1. Instructions (for Surveyor): Brief guidelines for best application of this survey - further instructions are available at www.lahsa.org/hmis, under Provider Tools: Document Library and Video Library, and on the CES Website at ceslosangeles.weebly.com (Forms & Resources)
2. Checklist: A list of the steps involved in making the respondent eligible for referrals through CES.
3. Instructions (for Respondent): A script of instructions to be read aloud to the respondent.
4. Consent: Required form to gain legal permission to share respondent answers in Homeless Management Information System.
5. Part 1 The VI-SPDAT is a triage tool designed to recommend the best type of permanent housing solution for someone experiencing homelessness. It is a holistic survey and is written in a manner designed to be understood more easily by respondents. Part 1 of the survey also includes a set of basic intake and eligibility questions to help begin identifying resources and supports that the respondent may qualify for immediately.

6. Part 2 (Program Intake questions) The program intake assessment captures all additional data that is required when entering a program. This assessment should be completed when the client is entering into any homeless service program or upon engagement in outreach and assessment only programs.
7. Supplemental: VA The VA release of information should be filled out for any client that identifies as a US veteran. While typically the VA supplemental assessment is completed by VA staff, this can also be completed by the surveyor.. It does not have to be filled out exclusively by VA staff. 8. Contact Sheet: A sheet with follow-up contacts that you may wish to provide the respondent upon request. 9. Additional Consents (*If Provided): Additional authorization, release and consent forms may be provided by your agency or coordinator to allow for seamless coordination with other supports or resources.

I. Intake Instructions

- THE CONSENT MUST BE COMPLETED AND SIGNED (FOR HOUSEHOLDS, EVERY ADULT MEMBER MUST SIGN). In the case that respondent refuses consent, or answering affirmatively in the domestic violence section, you may still proceed, however please note these special instructions: Do not enter Personal Identifiable Information (PII) into HMIS. HMIS will automatically generate an anonymous ID. Please retain at least the first page of CES Survey Part I (with HMIS ID & Client Name) for your records and future matches since you will not be required to enter identifying information into HMIS.
- FOLLOW A MODEL OF PROGRESSIVE ENGAGEMENT.
  The various sections of the survey (Part 1, Part 2, and Supplemental sections) may be completed at one time or over various engagements, based on the comfort and preference of the respondent. Allow respondents to go at a pace that is comfortable for them. This may mean doing multiple sections, one section, or even just portion of a section.
- REFERRALS AND NEXT STEPS.
  Initial eligibility questions for specific resources are located throughout the survey. Next steps are listed for these questions in the body of survey as well as in the office only section. Complete the next step (either a supplemental assessment or a referral) based on the comfortability and preference of the respondent.
- RESERVE JUDGEMENT.
  Regardless of the outcome of the survey responses, please remain neutral in your response and reserve judgment and unsolicited advice.
- DO NOT BE DISAPPOINTED IF THE RESPONDENT DOESN'T WANT TO BE SURVEYED.
  Negative experiences with past services may cause the respondent to be distrustful. Reversing course on that is a process, and your positive interaction and respect of their boundaries will help future engagements.
- DO NOT PROMISE HOUSING OR SERVICES.

Though you may be trying to be helpful, false promises will only add to their distrust and disinterest with future engagements.

- DO NOT MANIPULATE RESPONSES.
  Major eligibility criteria are officially verified later so it does not benefit the respondent to be dishonest.
- DO NOT VOLUNTEER THE SCORE OR THE SCORING PROCESS.
  You may share the general housing recommendation, but we do not want people being referred to as numbers.
- YES AND NO ANSWERS ARE FINE, IDEAL EVEN. AVOID FOLLOW UP QUESTIONS.
  Respondents do not need to explain themselves. Explain questions if further clarification is needed, but try to keep the conversation short and clear to respect their time. Make note of items you may want to come back to, but allow engagement/case management to happen separate from the survey itself.
- COUNT BACKWARDS AND PAUSE.
  For any question that asks a date range, count backward to the first date – so if today is January 1, 2021 and the questions asks "in the last 6 months," say in "in the last 6 months…December, November, October, September, August, July. So since July 2014 …" Also, for any question that states "anything like that," add an intentional pause between "or anything (pause) like (pause) that" to help emphasize that you have read a list.
- BE PREPARED TO EXPLAIN LENGTH OR QUESTIONS
  If a respondent finds a question offensive or is frustrated by the length, please explain that each question will help to avoid some inappropriate referrals and hopefully save them time in the long run. For other questions with more obvious answers, you may explain that you wanted to give them the ability to speak for themselves.
- PRACTICE.
  As you become more comfortable with the survey, you should notice a gradual reduction in the amount of time it takes to complete.

Intake Check-list

Prepare

__Review: Instructions for the Surveyor
__Read Aloud: Instructions for the Respondent
__Request Signature: Consent Form

Survey (portions may be completed together or at separate times)

__Verbally Administer: Survey Part 1 (VI-SPDAT v2, basic intake, initial eligibility questions)
__Verbally Administer: Survey Part 2 (Program Intake)
__Verbally Administer*: VA Release of Information; Supplemental: VA (if applicable; can be referred to VA staff)
__Take picture: Client may decline. Ask if you can take a picture of their ID instead or take a picture with them.
__Provide: Contact sheet if you or your coordinator are willing to be available for follow-up contact

Follow-Up

__File Consent: Keep record of consent and/or distribute to appropriate party in your SPA
__ Data Entry: Enter survey responses into HMIS
__Upload: client picture, copies of documents, additional signed consents, to HMIS The following steps may be taken over by a Housing Navigator.
__ Obtain Documents (*if not already in possession): Birth Certificate, ID & Social Security. Although not immediately required, please be prepared to quickly prepare income verification documents as well. Possessing documents required for housing is the final step in becoming “match-ready” for most housing in CES.
__Data Entry: Note receipt of documents and upload scanned copy of documents into HMIS if possible.

Intake Survey Introduction

Hello! My name is _______________ and I am with a group called________________ (organization name). I have a survey I would like to complete with you.

- There are a few parts to this survey. The first part takes about 20-30 minutes to complete. Let's complete the first part and after that, we can see if we want to do more today, or wait for a different day.
- Most questions only require a "yes," "no" or other one-word answer. If you have more to share about an answer, I'd be happy to discuss that after the survey, but let's try and finish the survey first.
- This is not a housing application, but the answers will help us understand your health and housing needs and the needs of our community, and may help us make better referrals for you in the future.
- All that to say, I'm not using the answers you give to make any personal judgments about you.
- This survey is for anyone who is experiencing homelessness – not just people with a certain type of need.
- Some questions are personal in nature, but again, every question is designed to help us help you. You can skip or refuse any question that you don't feel comfortable answering, but the more questions you're willing to answer, the better.
- Someone may follow up with you to assist in getting documents needed to access resources, so it's important that we have accurate contact information for you.
- There is no need to take this survey twice, but from time to time we may want to update it with you, to make sure the information is accurate.
- Afterward, you may request a contact sheet and refer to it if you have questions.

Before we begin, I need to get your permission to do this survey with you. Please review the following form and let me know if you have any questions.

CONSENT TO SHARE PROTECTED PERSONAL INFORMATION

HMIS (Homeless Management Information System) is a local electronic database that securely record information (data) about clients accessing housing and homeless services within the Greater Humboldt County. This organization participates in the HMIS database and shares information with other organizations that use this database. This information is utilized to provide supportive services to you and your household members.

What information is shared in the HMIS database?

We share both Protected Personal Information (PPI) and general information obtained during your intake and assessment, which may include but is not limited to:

- Your name and your contact information
- Your social security number
- Your birthdate

• Your basic demographic information such as gender and race/ethnicity
• Your history of homelessness and housing (including your current housing status, and where and when you have
accessed services)
• Your self-reported medical history, including any mental health and substance abuse issues
• Your case notes and services
• Your case manager's contact information
• Your income sources and amounts; and non-cash benefits
• Your veteran status
• Your disability status
• Your household composition
• Your emergency contact information
• Any history of domestic violence
• Your photo (optional)

How do you benefit from providing your information?
The information you provide for the HMIS database helps us coordinate the most effective services for you and your household members. By sharing your information, you may be able to avoid being screened more than once, get faster services, and minimize how many times you tell your 'story.' Collecting this information also gives us a better understanding of homelessness and the effectiveness of services in your local area.

Who can have access to your information?
Organizations that participate in the HMIS database can have access to your data. These organizations may include homeless service providers, housing groups, healthcare providers, and other appropriate service providers.

How is your personal information protected?
Your information is protected by the federal HMIS Privacy Standards and is secured by passwords and encryption technology. In addition, each participating organization has signed an agreement to maintain the security and confidentiality of the information. In some instances, when the participating organization is a health care organization, your information may be protected by the privacy standards of the Health Insurance Portability and Accountability Act (HIPPA).

Intake Survey: Consent FORM

By signing below, you understand and agree that:
• You have the right to receive services, even if you do not sign this consent form.
• You have the right to receive a copy of this consent form.
• Your consent permits any participating organization to add to or update your information in HMIS, without asking you to sign another consent form.
• This consent is valid for seven (7) years from the date the PPI was created or last changed. • You may revoke your consent at any time, but your revocation must be provided either in writing or by completing the Revocation of Consent form. Upon receipt of your revocation, we will remove your PPI from the shared HMIS database and prevent further PPI from being added. The PPI that you previously authorized to be shared cannot be entirely removed from the HMIS database and will remain accessible to the limited number of organization(s) that provided you with direct services.
• The Privacy Notice for the LA/OC HMIS contains more detailed information about how your information may be used and disclosed. A copy of this notice is available upon request.
• No later than five (5) business days of your written request, we will provide you with:
  o A correction of inaccurate or incomplete PPI
  o A copy of your consent form o A copy of your HMIS records; and
  o A current list of participating organizations that have access to your HMIS data.

Aggregate or statistical data that is released from the HMIS database will not disclose any of your PPI.
• You have the right to file a grievance against any organization whether or not you sign this consent.
• You are not waiving any rights protected under Federal and/or California law.

SIGNATURE AND ACKNOWLEDGEMENT Your signature below indicates that you have read (or been read) this client consent form, have received answers to your questions, and you freely consent to have your information, and that of your minor children (if any), entered into the HMIS database. You also consent to share your information with other participating organizations as described in this consent form. __ I consent to sharing my photograph.

Client Name: ____
DOB:______________ Last 4 digits of SS_________
Signature ____Date
____

Head of Household (Check here) Minor Children (if any):

Client Name: ______________________ DOB: ___________ Last 4 digits of SS _________
Living with you? (Y/N)

Client Name: ______________________ DOB: ___________ Last 4 digits of SS
____

Living with you? (Y/N)

Client Name: ______________________ DOB: ____________ Last 4 digits of SS _________
Living with you? (Y/N)

____
_________________________________ Print Name of SHO Staff Print Name of Organization

____
_________________________________ Signature of Organization Staff Date

Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)

<u>VISPDAT Instructions</u>

Before Completing the VI-SPDAT:

1. Check in HMIS to see if the individual/family has already completed a VI-SPDAT by looking under the Assessments Tab.

2. Upload a Signed Client Consent Form into HMIS: No information, including the VI-SPDAT, may be entered into HMIS until a signed client consent form (aka Release of Information or ROI) is uploaded into HMIS. Completing the VI-SPDAT: 1. Select the appropriate version of the VI-SPDAT: a. VI-SPDAT for Single Adults – Use this version for adults age 25 or older with no children in the household. b. VI-SPDAT for Families – Use this version for households with at least one child under the age of 18. c. TAY VI-SPDAT – Use this version for transition age youth (age 18-24) and unaccompanied minors. 2. Introduce the VI-SPDAT: Explain to the client what you are doing using the introductory script on the next page.

3. Complete All Questions: Complete the VI-SPDAT and follow-up questions, including the additional questions on the last page of this packet.

4. Enter the VI-SPDAT in HMIS: You can find the VI-SPDAT under the Assessments tab in the menu bar at the top of the screen in HMIS. This is a universal assessment that is not connected to any specific program.

   If the Assessment Score is 4 or Higher: Refer the assessment to the community queue in HMIS.

After Completing the VI-SPDAT:

1. Collect Contact Information: Collect as much contact information as possible (phone, email, service provider or case manager that the individual/family works with, locations that they frequent, etc.). It is critical that we have as much contact information as possible in case any referrals become available for the individual/family. Ask them to come back and update their contact information if it changes.

2. Share information with the individual/family: Do NOT share the numerical score from the VI-SPDAT. If the person is interested, you can provide an explanation of the type of housing program that looks like the best fit for the individual/family.

3. If the score falls into the “no housing intervention” category (0-3): Explain that the assessment shows that they have the skills and ability to get back into housing with limited assistance. Refer the individual/family to resources in the community that will help them address barriers, such as: public benefits, employment programs, security deposit assistance, etc.

HOUSING CASE MANAGEMENT POLICY

Case Managers provide Housing Counseling to assist consumers in resolving their housing crisis and assist with the development of a Housing Counseling plan that is actionable, consumer-directed, and time- limited. Housing Counseling helps families and individuals to develop plans to overcome barriers to permanent housing.

Case Files - The basis of all determinations (eligibility, assistance needed, assistance provided, etc.) must be supported by the evidence documented in the case file. Documentation will enable a supervisor or other entity charged with monitoring the program to readily identify the factors and process that resulted in the determination that each participant assisted met SCCDC and HUD requirements. Minimum Documentation should include but is not limited to:

1. Proof of eligibility - Documentation of Homelessness, must follow HUD’s prioritization of documentation of homelessness and 24 CFR 576.500.
2. Program Intake Documents such as: a. HMIS Release of Information, b. Notice of Privacy Practices,
   c. Participant grievance,

   d. Participant consent form,
   e. Participant identification, if applicable f. Release(s) of Information if applicable,

3. Case Plan that shows the street outreach worker and program participant developed a plan to assist the program participant to enter into permanent housing or sheltered services.
4. Case notes that reflect the program participant met with the street outreach worker to work on case plan goals.

5. Back-up documentation for the services and assistance provided to that program participant, including, as applicable, gas voucher, bus pass, DMV receipt, etc.
6. Referrals made by the subrecipient to program participant to obtain mainstream and other resources as needed.
7. Program Discharge/Exit paperwork

Case Management Procedures
The Initial meeting will assess the client's current housing situation and complete the following:

a. Household budget
b. Vulnerability Service Prioritization and Decision Assistance Tool (VISPDAT)
c. Housing Stability Plan

At least weekly one-on-one case management thereafter to help the household obtain permanent housing as quickly as possible. Case management must follow the goals outlined in the Housing Stability Plan to obtain permanent housing. Case managers are trained and useskills like motivational interviewing, housing-focused case management, and progressive engagement to assist the client in obtaining permanent housing while using the least amount of system resources necessary. Case management should focus on goals related to obtaining permanent housing, obtaining mainstream benefits, connecting to community and other supports that will help maintain housing stability long-term, and increasing income.

Housing Sustainability Planning
The VI-SPDAT Determinations and Shelter Housing Stability Plan empowers households to move to permanent housing as quickly as possible. To do so, the case manager uses case management planning tools to assess, identify strengths and barriers to housing stability, and create a plan for gaining and obtaining permanent housing as quickly as possible.

During their first meeting with a client the case manager completes three tools to assist in developing a plan towards housing stability- the budget, SPDAT, and Housing Stability Plan. The results of the SPDAT will inform Housing Stability Planning in the following ways:

1. Households scoring into the low acuity category will be eligible for one-time assistance to move out of shelter. Shelters will complete a Housing Stability Plan that helps the household create a plan for move out, which is financially coordinated through one of three Your Way Home Housing Resource Centers.

2. Households scoring into the medium acuity categories will be eligible for enrollment into the Rapid ReHousing Program through one of Your Way Home's

three Housing Resource Centers. Shelters will complete a Housing Stability Plan that helps the household prepare for the Rapid Re-Housing program.

3. Households scoring into the high acuity categories will be eligible for enrollment into the Permanent Supportive Housing Program (PSH) through partnerships with Humboldt County providers. Case Managers will complete a Housing Stability Plan that helps the household prepare for Permanent Supportive Housing. If PSH is not available, shelters will also help clients prepare for the Rapid ReHousing program as a temporary solution to their homelessness. In all cases, emergency shelter case managerss are encouraged to discuss the household's score on the SPDAT assessment and the options available to the households as result of that score. Households that are not eligible for more than one-time assistance, for example, should be told this as part of the Housing Stability Planning discussion. In all cases, shelter case workers must help their clients identify reasonable plans to gain housing stability based on what is available to them through SHO and/or its' partner organizations.

Case Management Tools and Assessment Policies
Vulnerability Index Service Prioritization and Decision Assistance Tool (VISPDAT)
The VISPDAT is an evidence-informed approach to assessing an individual's or family's acuity. The tool, across multiple components, identifies the areas in the person/family's life where support is most likely necessary in order to avoid housing instability.
The SPDAT is used as both a prioritization tool and as a case management tool in SHO's programs and services. As a prioritization tool, the SPDAT is completed with households in SHO's shelter by their shelter case worker to determine the most appropriate housing intervention for the household, and to determine the types of assistance that may be appropriate to assist the client. As well, the SPDAT is used to determine the household's priority in being served, in the event that there are not enough resources to serve all households in need of services.

As a case management tool, the VISPDAT is used by case managers and households to identify areas of strength and challenge the household may face in maintaining housing stability, and to develop Housing Stability Plans that address the household's barriers. The VISPDAT is intended to be completed frequently during intake/ enrollment (or within 5 days of entering a shelter), and regularly thereafter. In the emergency shelter, this may include updates every 30 days. In Rapid Re-Housing, this includes updates at least once every 90 days. The case worker completing the VISPDAT is expected to share the assessment with the household's other case workers. In many cases, it may be appropriate for a household's other case worker(s) to be interviewed or present during the completion of the SPDAT in order to ensure that the household's history is being reported accurately.

A copy of every SPDAT should be provided to the household and maintained in the client's case file. The VISPDAT should be used in conjunction with the Household Budget

to develop the Housing Stability Plan. It is expected that the components in the SPDAT that are identified as barriers to housing stability are addressed in the Housing Stability Plan. It is expected that as the components increase or decrease in acuity, a summary of these changes are reflected in the client's Housing Stability Plan, case notes, and Re-Assessment, as appropriate. In this way, the SPDAT should form the basis of case planning with SHO clients.

SHO case managers, Project Administrator, and Intake staff must be trained in use of the SPDAT before completing it with their clients.

Household Budget
An accurate understanding of a household's income and budget is a necessary tool to help clients maintain permanent housing. Prior to obtaining permanent housing, budgets help clients identify their housing price range based on their current income, and even the feasibility of renting a unit of their own if other options exist.

After obtaining housing, budgets help clients plan for bill payments, keep track of expenses, and manage spending and saving. SHO's standard Household Budget provides a common template for use with all clients and their case managers. SHO case managers will develop and update a Household Budget with enrolled clients. Budgets should be updated any time income or expenses change. In Rapid Re-Housing, Budgets must be updated any time income or expenses
change, or at least every three months during Re-Assessment.

Budgets should be reviewed with a client during development of the Housing Stability Plan, so that clients can set goals and action steps related to income/ benefits based on this budget.

Housing Stability Plans
One of SHO's primary goals is to help people experiencing homelessness move to permanent housing as quickly as possible. To do so, case managers in all programs help clients establish goals and action steps to obtain housing quickly, and to maintain that housing long-term. SHO's Emergency Shelter Program is required to create Housing Stability Plans for all enrolled clients, or whenever providing assistance to clients through Street Outreach.

The Housing Stability Plan is a standard template that allows case managers and clients to jointly identify goals and to detail the steps needed to achieve those goals. Goals identify the major achievements for gaining housing stability. Goals may be related to obtaining permanent housing, as well as other activities that will help the household maintain that stability long-term, such as connecting to health services, increasing income, or maintaining the terms of a lease. Goals are informed by the client's VISPDAT, budget, and other related sources of information available to the client and the case manager. For each goal, additional action steps are created.

Action Steps are specific tasks that the client and case manager will take to reach the goals identified in the plan, with due dates listed for each task. Both the client and the case manager must sign the Housing Stability Plan for it to be considered complete. It is the case manager’s responsibility to ensure that the Housing Stability Plan is complete. Typically, a Housing Stability Plan includes medium- to short-term goals and action steps that can be accomplished within the next 1-2 meetings, or covering the next 30 days. A new Housing Stability Plan is created once those action steps are completed.

Goals and action steps are developed jointly by clients and case managers. To the extent appropriate, clients should be setting their own goals for housing stability, with support from case managers so that they are reasonable, actionable, and timely. Case managers should use techniques such as motivational interviewing, active listening, housing-focused case management, and strengths-based case management to assist clients in developing goals and action steps.

In order to increase collaboration and consistency between the multiple providers a client may be working with, all Housing Stability Plans must be jointly created and/or shared with all case managers that are working with the same client in SHO’s network. For example- a Housing Resource Center coach must co-create and/or share the Housing Stability Plan of a client living in a the SHO shelter with the shelter case manager. This may include a joint session in which all case managers working with the client develop and sign the Housing Stability Plan together, or it may be that a primary case manager will develop the Housing Stability Plan with the client and then share it with the client’s other case managers. In either case, it is the responsibility of every staff person or provider to make any Housing Stability Plan they create with a client available to the client’s other case managers.

In cases where a client is being transitioned to another provider it is the responsibility of both provider staff to 1) share any current plans currently in use by the client, and 2) coordinate Housing Stability Planning so that there is continuity in the case planning from one provider to the next. For example, if a client in shelter has a Housing Stability Plan in place with their shelter case manager at the time of their first Housing Resource Center appointment, the Housing Resource Center case manager should include the same goals on the HRC Housing Stability Plan as are already on the shelter Housing Stability Plan, to the extent appropriate.

The Housing Stability Plan template also allows clients and case managers to keep track of progress on meeting goals, which is a critical component of case management services provided under SHO. Tracking progress allows clients and case managers to share in successes together, as well as to quickly identify and problem-solve areas of challenge. Tracking progress on the Housing Stability Plan occurs in two ways: first, the client tracks their own progress towards meeting goals in between case management appointments. Second, the case manager and client record when action steps and goals

have been completed. Typically this will happen during the case management meetings. In this way, both clients and case managers have a written record of the client's progress on meeting goals.

The current Housing Stability Plan should be updated at every case management meeting between a client and a case manager until all action steps on the plan have been addressed. Updates would include recording the actions taken by the client and case manager to achieve the goals/ action steps, as well as when goals/ action steps are completed.

If a client requires financial assistance from in order to achieve their goals, the Housing Stability Plan must clearly describe any conditions related to receiving that financial assistance, such as amount of client contribution, when client contribution is due, and how the client will demonstrate that their contribution has been paid. In this way, the Housing Stability Plan clearly establishes expectations for both case managers and clients for providing/ receiving financial assistance, and provides a written record of that agreement. As noted above, all progress on meeting the goals related to financial assistance must be recorded
(i.e. case managers must document on the Housing Stability Plan that a client did or did not pay their portion of a bill on time). This includes all Housing Counseling clients receiving financial assistance.

All Housing Stability Plans must be maintained in the client's file and be made available to SHO's Director in the event of monitoring, client appeals, or otherwise as requested by the Project Director.

Case Notes
All interactions between clients and SHO staff must be documented in Clarity with a case note corresponding to the date of the interaction. Case notes must include the mode of communication (in person meeting, email, text, phone call, office visit) and date. It is expected that case management notes are written using proper grammar, spelling, etc., and that they convey the professionalism with which the services are provided.

The case note must include a summary of the discussion and any information provided by the case manager to the client. This summary is to be written in objective language only and should not contain any language that reflects the writer's assessment or subjective opinion. Case notes documenting case management meetings should provide a full accounting of the work done during the meeting. This includes: case management support provided during the meeting, such as progress on meeting goals, new action items identified, income and budget work, review of service connections, etc. Any discussion that could be referenced later for an appeal- such as a discussion regarding compliance with the program's agreement policy or progress on meeting goals- must be documented clearly in the case notes.

Any time a new Rapid Re-Housing Re-Assessment, SPDAT, or budget is completed, the case note must indicate this and include a summary of the result. It is the expectation that case notes are submitted into Clarity in a timely manner, reflecting current status and real-time. Case notes are to be entered no later than 1 week from the encounter, outreach, phone call, or other contact made with the client.

All case notes for each program are to be entered into Clarity by end of business day Monday for the week prior. Case notes must reflect all contact or attempted contact made (which includes voicemails left, calls put in, texts exchanged). If a case note is not entered, it did not happen! For privacy issues, see policy on Case Notes in the YWH Data Systems Policies and Procedures.

Staff Orientation and Training Plan

Shelter workers will complete 40 hours of Training within their first 30 days of employment and will be provided the Shelter Training Manual. The training manual is attached and includes 8 modules:

1. Ethics and Boundaries
2. Customer Service and Professionalism
3. Effective Communication
4. Mental Health: a) Mental Health Issues in the Homeless Population b)5150: Emergency Mental Health Treatment c) Suicide Prevention: Assessment and Intervention
5. Substance Abuse: a) Addiction Basics, b)Overdose Detection and Response, c) Harm Reduction
6. Intervention with Escalating Clients
7. Working with Homeless Seniors
8. Cultural Competency and Diversity in the Shelter Setting
9. Supervision for Supervisors and Trainees
10. Cardio-Pulmonary Resuscitation (List of provider resources).

Evidence Based Practices - Trauma Informed Care, Motivational Interviewing, Client Centered Services, ACES (Adverse Childhood Experiences).

Personnel Training – HIPPA, Confidentiality, Sexual Harassment, Grievance Procedure, etc.

7.0 – EXCEPTIONS, OBJECTIONS, AND REQUESTED CHANGES

SHO does not take exception to the terms, conditions, local funding priorities, requirements, specifications and standards set forth in this RFP.

(amended April 6, 2021)
Original signature of March 11/2021

8.0 – Required Attachments are located in the Supplemental Documentation.