Housing Unit Handbook

Revised
October 2018

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SECTION 1

HOUSING UNIT OVERVIEW

The Humboldt County Department of Health & Human Services (DHHS) Mobile Outreach Team includes street outreach services and housing support services. This program utilizes innovative approaches for engaging clients by meeting them in the community and bringing DHHS program services and community based service referrals out to the furthest corners of Humboldt County.

STREET OUTREACH SERVICES

Street outreach services seeks to engage people with a serious mental illness who are experiencing homelessness and to connect them with DHHS programs and other community based resources. This includes supporting them in preparing for and obtaining housing. Preparing for housing includes such things as: enrolling them in the Homeless Management Information System (HMIS) database, Coordinated Entry System; obtaining an ID and birth certificate; supporting them in accessing mental health services; and signing them up for appropriate waiting lists such as affordable housing projects and the Housing Authority Section 8 list. Once all of the necessary items are in place, a client, with support from staff, can begin completing rental applications and interviewing with potential landlords.

HOUSING SUPPORT SERVICES

Housing support services include working with clients to secure affordable rental units, supporting them in maintaining housing, engaging and maintaining positive relationships with landlords and property managers, and working with other community partners to support clients' housing needs. Once a client obtains housing, services may include periodic check-ins, counseling, coordinating service needs such as medical appointments, food bank, IHSS, and skill and good habit coaching such as maintaining units' cleanliness, avoiding lease

STEP 1

Preparing a client for housing starts with an intake and enrollment in the ***Coordinated Entry System (CES),*** *including completing a* ***Homeless Management Information System (HMIS)*** *intake assessment and a Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)*

violations and being a good neighbor. Staff use client-centered service delivery model to link clients to services that best meet their individual needs.

HOUSING FIRST

The Housing Unit utilizes the Housing First Model which is a homeless assistance approach that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible – and then providing voluntary supportive services as needed. Housing First programs share critical elements: a focus on helping individuals obtain and sustain permanent rental housing as quickly as possible; a variety of services delivered to promote housing stability and individual well-being on an as-needed and entirely voluntary basis; and a standard lease agreement to housing. Eligibility is not contingent on sobriety, minimum income requirements, lack of a criminal record, completion of treatment, or participation in services.

OVERALL PROCESS TO OBTAIN HOUSING

Obtaining affordable housing is difficult at best for anyone in Humboldt County. It is especially difficult for someone who has: a disability; mental health issues; limited or no income; who is currently homeless; and may have credit or criminal issues in their background. With that being said, it is not impossible. While it is often a long process, many dozens of clients have obtained housing utilizing the steps in this handbook.

There are four steps in the overall process in supporting a client who is currently homeless to obtain housing that are described in this handbook:

Step 1. Enrollment in HMIS

Step 2. Obtain documentation for housing applications

Step 3. Support Letter

Step 4. Commitment Letter

PLEASE NOTE: Two things that the Housing Unit and this handbook is NOT able to provide:

1. We do not provide emergency housing such as motel vouchers. The purpose of this Unit and handbook is to support clients to obtain permanent housing meaning the client has a rental or lease agreement in their own name with a landlord or property manager.
2. We must use the private rental market. We do not “place” people or have any access to units to “place” people. We do not have access to any units except on the private market which require a rental or lease agreement with a landlord/property

management. This means that ultimately it is up to a landlord to agree to enter into an agreement with the client/tenant.

DHHS does have agreements in place with two properties that provide a type of rental subsidy, The Lodge and Arcata Bay Crossing. Both of these properties are also considered low income housing and require the client to be on their waiting list. As with all low income housing properties, as units become available, the next person on the list is processed through their tenant approval process and ultimately it is up to the property as to whether or not they will rent to the client/tenant.

Ultimately it is up to a landlord to agree to enter into a rental agreement with a client/tenant.

It is true that if a particular applicant/client is applying for a unit and has a case manager, CHOW or peer coach that has built trust with that landlord then that client most likely has a better shot at being accepted.

In addition to low income property waiting lists, units are also advertised to general public through things like craigslist, property management websites, or even a "For Rent" sign in the window or front lawn of the property.

Whether a client is coming up on a low income property list or applying to an advertised property, it is to their benefit to have a DHHS Housing Unit Letter of Support.

On occasion, a landlord notifies the Housing Unit that a unit is coming available and they will consider one or more of our client's applications. When this occurs, all staff with outstanding Support Letters are notified. Considerations such as the client's homelessness status, type of funding and clinical concerns are weighted to determine applicants.

Also, important to note is that it is very rare that an already vacant unit comes available. Low income housing properties start "working" applications off of their lists as soon as they know a unit is likely going to be available which is often two to three months before the unit is actually vacated. Similarly with other landlords and property managers. As soon as a tenant gives notice or when a tenant receives a 30/60/90 day notice to leave they will immediately begin the process to find another tenant.

Probably the most important thing to know about supporting clients in obtaining housing is that landlords and property managers are business people and the rental unit is their business. Their primary objective is to have a tenant that pays the bills on time, does not damage the property, and is a good neighbor. Therefore, the most common way that a client is able to obtain housing is when that client's support person and support team has established a level of trust with the potential landlord or property manager and has proven to be responsive and dependable. It is true that if a particular applicant/client is applying for a unit and has a case manager, CHOW or peer coach that has built trust with that landlord then that client most likely has a better shot at being accepted.

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SECTION 2

REQUIRED DOCUMENTATION FOR HOUSING APPLICATIONS

There are common documents that all people need in order to apply for a rental such as an ID. There is also documentation that is necessary in order to understand if a client is qualified for financial housing assistance.

OPEN TO MENTAL HEALTH SERVICES

In order to be considered open to Mental Health Branch services a Mental Health Assessment must be completed by a clinician and entered into Avatar

HOUSING UNIT MASTER RENTAL APPLICATION

This is a form that the Housing Unit developed that, once complete, contains all of the information that may be asked on any landlord or property manager lease application.

LOW INCOME HOUSING WAIT LISTS

There are a number of rental housing units that are restricted to persons that are at or below certain income levels in Humboldt County. Rents are capped at certain levels because government subsidies helped develop these properties. The wait period can be over a year before a unit becomes available, so it is important to ensure that our clients are signed up as soon as possible. It is important to ask how long the wait period is and the estimated wait time as well as how the facility uses their wait list as it differs for each apartment complex. Once the client gets closer to the top of the list the low income housing complex will start the background check, credit check and references. It is important the client respond to correspondence in a timely manner or they may be removed from the wait list. Staff should be in periodic contact with the low income housing unit property managers to ascertain where the client is on the wait list. Staff should

STEP 2

1. *Open to Mental Health Branch Services*
2. *Complete a Housing Unit Master Lease Application Form*
3. *Sign up for all low income housing wait lists*
4. *HMIS enrollment*
5. *VI-SPDAT*
6. *Client ID*
7. *Documentation of Income*
8. *Proof of Disability*
9. *Proof of Chronic Homelessness*
10. *Section 8 Application*

attempt to obtain releases of information from the clients that allow us to communicate with each property manager by explaining that this will improve the client's chances of renting one of these affordable units. If the client consents, we should request that the property managers address all written correspondence to the client, "care of" DHHS Mobile Outreach, 929 Koster St., Mod G, Eureka, CA 95501.

A HOMELESS MANAGEMENT INFORMATION SYSTEM

A Homeless Management Information System (HMIS) is a Federal HUD required database used to collect client-level data, track outcomes and to produce reports. . Enrolling a client in HMIS is the first step in documenting that they are currently homeless. Subsequent contacts with a client are also logged into HMIS.

THE VULNERABILITY INDEX

The Vulnerability Index – Service Prioritization Decisions Assistance Tool (VI-SPDAT) is a pre-screening, or triage tool that is designed to be used by all providers within a community to quickly assess the health and social needs of persons who are homeless and match them with the most appropriate support and housing interventions that are available.

STATE OF CALIFORNIA IDENTIFICATION CARD

DMV issues identification cards (ID) to persons of any age. The ID card looks like a driver license (DL) but is used for identification purposes only.

To apply for an ID card you will need to do the following:

- Complete a Driver License or Identification Card Application
- Visit a DMV office (appointments are recommended)
- Provide your social security number. It will be verified with the Social Security Administration while you are in the office
- Verify your Identity. If your current name no longer matches the name on your Identity document, see "True Full Name" and "How to Change Your Name" for more information
- Present your acceptable residency document if you have never had a California driver license or California identification card
- Pay the application fee. (No fee for a senior citizen ID card)
- Give a fingerprint scan
- Have your photograph taken

Clients may pay a reduced application fee for an original or renewal identification (ID) card if they meet income requirements from a public assistance program. If eligible, we can help complete the Verification for Reduced Fee Identification Card form (DL 937) to take to DMV to apply for the reduced fee ID card.

DOCUMENTATION OF INCOME

Types of income include employment, Social Security Insurance (SSI), Social Security Disability Insurance (SSDI), General Relief (GR) and Veterans Administration (VA) benefits.

Documentation of income includes a Benefits Verification letter, paycheck stub, or a bank statement.

PROOF OF DISABILITY

In order to verify chronic homelessness, we must verify that the individual or head of household meets the U.S. Department of Housing and Urban Development (HUD) definition of a homeless person with a disability, which is a condition that is expected to be of long-continued or indefinite duration **and** which substantially impedes the person's ability to live independently. Any person that meets criteria for our specialty mental health services meets this definition.

Proof of disability can be through written verification of the disabling condition from a professional licensed by the state to diagnose and treat the condition, or written verification from the Social Security Administration or Veteran's Administration. If a person is currently receiving SSI, SSDI or 100% VA disability, the Benefits Verification Letter can also serve as proof of disability.

PROOF OF CHRONIC HOMELESSNESS

A chronically homeless individual or head of household of a family has been homeless living in a place not meant for human habitation, a safe haven or in an emergency shelter for at least 12 months either continuously or on at least four separate occasion in the last three years, where the cumulative total length of the four occasions equal at least 12 months.

Mental Health Services Act

Full Service Partnership (FSP)

If your client is an FSP, the only additional documentation required is a screen shot from the Data Collection and Reporting (DCR) database and they may not require proof of chronic homelessness

Proof of chronic homelessness includes HMIS entry, signed letter, hospital/emergency room admittance or discharge. Clients can certify up to 3 months of their chronic homelessness. Staff complete the proof of chronic homelessness themselves and/or verbally verify through a third party.

SECTION 8 APPLICATION

All clients should be assisted in filling out and submitting a Section 8 application with the Housing Authority. The Housing Authority requires certain documentation in order for the client to be placed on the Section 8 wait list. Below are the steps and documents required for a Section 8 application.

All **BOLD** items should be saved and uploaded in ACT.md

1. **Identification Card**
2. **Social Security Card**
3. **Birth Certificate**
4. **Proof of Income**
5. Fill out Section 8 application packet
6. Ensure Housing Authority sends correspondence to "care of" Housing Unit address
7. **ROI - Mental Health.**
8. **ROI - Housing Authority with name of primary care coordinator.**

9. **ROI - Housing Authority with name of Housing Unit Sec 8 Tracker.**

10. Return application packet to Housing Authority for them to review in person for completeness. **Get receipt stamp-scan and save to ACT.md**

11. **In 2-4 weeks look for "Placement on Waiting List" letter from the Housing Authority. No further action needed until . . .**

12. **In 10-12 months look for "Applicant Review" letter from the Housing Authority.**

13. Ensure client signs "Applicant Review" letter and return it to Housing Authority by the due date on the letter which is 2 weeks.

14. **When submitting "Applicant Review" letter, have the Housing Authority received date and time stamp.**

15. Schedule an Event 6 months out to contact Housing Authority and ask for the status number.

16. **Look for "Attention Housing Choice Voucher (HCV) Program (Section 8) Applicants" letter from the Housing Authority.**

17. Schedule pick up of "Screening Packet" within the 4 day window provided on the "Attention Housing Choice Voucher (HCV) Program (Section 8) Applicants" letter. Be sure to bring said letter with you to pick up packet.

18. Pick up "Screening Packet" and the "Do Not Take This Packet Apart" letter.

19. Schedule an Event for the Screening appointment on the date contained in the "Do Not Take This Packet Apart" letter.

20. Complete the "Screening Packet" including all of the required documents on the "Documentation Checklist" even if you have already provided them to the Housing Authority previously.

21. **After the "Screening Packet" appointment, upload the "Screening for Section 8 Housing Voucher Program" form provided by the Housing Authority. Make sure to ask for a copy of this form before you leave.**

22. **After 2-3 months look for a "You are invited to attend a Housing Voucher program (HVC) briefing on:" letter from the Housing Authority.**

23. Schedule an Event for the date on the "You are invited . . ." letter.

24. **Once you receive the voucher at the "You are invited . . ." meeting, upload a copy to ACT.md.**

25. Schedule a Task 50 days from the date of the voucher. If a unit is not obtained within 60 days of receiving the voucher, a "Record of Search for Housing" must

be submitted to the Housing Authority by day 58 in order to ask for a no guarantee extension.

26. Once a landlord has agreed to rent to the client, complete the "Request for Tenancy Approval Checklist" packet and return to Housing Authority.

27. When submitting the "Request for Tenancy Approval Checklist", you will be given the "Lease – Up Checklist" which will include the "estimate tenant rent".

28. Schedule an Event for the date on the "Lease – Up Checklist" and ensure the client (or if vacant unit the landlord) is there and the utilities are turned on.

29. Notify Housing Unit Coordinator - Fiscal Liaison of the date that the Section 8 voucher will begin.

SECTION 3

FINANCIAL HOUSING ASSISTANCE

Once all of the required documentation is in place, it is possible to determine if a client qualifies for financial housing assistance. Generally, if a client is experiencing chronic homelessness and is open to mental health services, there should be some assistance available. However, the amount and the length of time can only be determined on a case by case basis. This is because DHHS funds that may be spent on housing are limited and there are more people that are eligible than the agency can subsidize, so in general the Housing Unit endeavors to spend the smallest amount of money required to end each client's homelessness and to prevent returns to homelessness. We have a few funding sources and each one has its requirements that can impact things like whether we can use that source on a particular client and/or a particular unit so it's important to stay in contact with the Housing Unit Coordinator when staff are providing housing search assistance services to a given client.

Even if a client is not qualified for any financial assistance, they should still be provided assistance by staff in obtaining housing.

HOUSING UNIT SUPPORT LETTER

After it is determined that a client qualifies for financial assistance, a Housing Unit Support Letter is generated. The purpose of a Support Letter is to let property managers know that an individual has been screened and qualifies for housing assistance. A Support Letter is addressed to the property manager and identifies the potential tenant by name as well as the staff person supporting them. Letters are generated and signed by a program manager.

STEP 3

A Support Letter informs property managers that an individual qualifies for housing assistance. It is addressed to the property manager and identifies the potential tenant by name.

SECTION 4

HOUSING UNIT COMMITMENT LETTER

The Commitment Letter is DHHS's promise to a landlord that/property manager that we will provide housing assistance payments on behalf of the client for a specific rental unit, and it defines the terms of the payments including amounts and duration of assistance. Only a Program Manager may make such commitments on behalf of the agency, and only after staff have provided them with a copy of the lease or rental agreement signed by the landlord and the client.

STEP 4

*A **Commitment Letter** informs a specific property manager that DHHS will provide housing assistance and lists the amount and frequency of the assistance.*

SECTION 5
HOUSING UNIT INFORMATION AND RESOURCES

AMRENT BACKGROUND CHECK

AmRent is a tenant background check provider and DHHS has contracted with them so that we can identify potential barriers to housing a client and attempt to mitigate those barriers. This is the same company used by the largest property management company in Humboldt County- it is very comprehensive and it's our expectation that it includes all of the negative information that might show up on any tenant screening report. It includes credit report information, criminal convictions and civil judgments including evictions. Clients must be given a copy of the FCRA Rights Summary and they must provide written consent by signing the FCRA Authorization Form before we may request this report. The authorization form explains that information obtained through this process will never impact eligibility for our programs, and staff should ensure that clients understand this when attempting to obtain consent.

BENEFITS VERIFICATION LETTERS

Benefit Verification letters are provided by the Social Security Administration (SSA) and serve as a proof of income. This letter is sometimes called a "budget letter," a "benefits letter," a "proof of income letter," or a "proof of award letter." If a client needs proof they get Social Security benefits, Supplemental Security Income (SSI) or Medicare, they can request a benefit verification letter online by using their on-line "my Social Security" account. A client can open up a SSA online account and print the document at Sign in or Create an Account or by calling 1-800-772-1213 (TTY 1-800-325-0778), Monday through Friday from 7 a.m. to 7 p.m. The local SSA office has a freestanding workstation that clients can access on a first-come-first serve basis. There is an SSA Release of Information form to request a Benefit Letter on someone's behalf, however, there is a charge.

CALWORKS HOMELESS ASSISTANCE PROGRAM (HAP)

The CalWORKs Homeless Assistance Program uses the Rapid Rehousing model that reduces the amount of time families spend on the street or in an emergency shelter. Eligible families must be enrolled in or qualified for CalWORKs, which provides needy families with time-limited cash assistance and welfare-to-work services, and must be residing in a place not meant for habitation, or in an emergency shelter, or be in receipt of a court ordered judgment for eviction. The HAP funds include but are not limited to:

- Housing search activities

- Rent assistance and deposits
- Rent arrears
- Assistance with rental applications
- Renters' education classes

CERTIFIED COPY OF BIRTH CERTIFICATE (CALIFORNIA) AFFIDAVIT OF HOMELESS STATUS FOR FEE EXEMPT

If a client was born in California, a fee exempt copy of a birth record may be obtained from the local registrar or county recorder office in the county where the registrant was born. A fee exempt copy cannot be obtained from the State Registrar. Each eligible person may only receive one fee exempt birth record, per application. Requests for fee exempt copies are still subject to other requirements outlined in the county application for obtaining copies of birth records.

CERTIFIED COPY OF BIRTH CERTIFICATE (NOT CALIFORNIA)

Inquire with state of birth's Vital Records Department. This may take an extended period of time. As long as there is an ongoing effort to obtain an out of state birth certificate, the client may still be able to obtain a Support Letter.

GENERAL RELIEF HOUSING AND DISABILITY ADVOCACY PROGRAM (HDAP)

HDAP assists disabled individuals who are experiencing homelessness to apply for disability benefit programs while also providing housing assistance. HDAP has four core requirements: outreach, case management, disability advocacy, and housing assistance. All four components must be offered to every individual. The individual must not be receiving any federal disability benefit at point of intake into the program. HDAP is for individuals who are disabled or likely disabled and who are experiencing homelessness. HDAP utilizes the Housing First Model, which includes housing individuals without preconditions and helping clients secure permanent housing as soon as possible.

HUMBOLDT COMMUNITY RESOURCE LIST

The Humboldt Community Resource List is a list that DHHS and St. Joseph Hospital staff update. They do not endorse listed services, and cannot guarantee accuracy or completeness. For information only.

JAIL VISITATION PROTOCOL

If a provider is attempting to visit an inmate at the jail, it is recommended that they call the Legal Office Assistant (LOA) Officer (the visiting lobby office) at 441-5122 in advance of their visit. The LOA officers are being directed to use the visiting areas on the 4th and 6th floor as they are available rather than the bail bondsman's booth. Between the hours of 11:00am and 12:30pm and after 4:00pm inmates are in "lock down" and unable to visit. So it's better to try to visit before 11:00am or in the afternoon between 12:30 and 4:00.

LANGUAGE LINE SOLUTIONS

When a client would like to communicate in a language other than English, staff has access to interpretation services via Language Line Solutions. To Access an interpreter:

- Dial: 800 874-9426
- Provide: Client 1D 501181
- Indicate: Language
- Provide: MH Access Code – 1170424 and your first and last name

MEDICAL TRANSPORT

There are two options for client transportation for medical appointments, Medical Transportation Management and Partnership Health. Together with client, make that initial call (with member i.d. and other information) to determine coverage and begin planning.

Medical Transportation Management (MTM)

- Phone: 1 888 828 1254
- Non-Emergency
- For ambulatory clients able to get to transport vehicle and get in and out on their own (independent of driver)
- They have contracted drivers here in Humboldt
- Call 5 days prior, Client must provide Member ID # (Partnership), DOB, Name, Address and Telephone, with this information MTM determines if the client has coverage
- Must be medical related such as medical or dental appointment, psychiatric health, or trip to a pharmacy
- Mileage limit is broad, 400 miles one way

Partnership Health

- Phone 1 800 809 1350

- Non-Emergency, Non-ambulatory
- Partnership Health is the go to if the client is non-ambulatory (can't get in vehicle without help, requires wheelchair van or ambulance)
- Medical only, no dental
- Physician or physician's office must prescribe or can call 1 800 809 1350 to discuss
- Form DHCS-6182 is the simple, prescriptive form

NAMI SUPPORT GROUPS

National Alliance of Mental Illness (NAMI) and Humboldt County Mental Health (HCMH) Support Groups meet weekly or bi-weekly in Eureka, Fortuna and Redway to offer support, education, resources and hope to family, friends and caregivers who are supporting persons with mental health challenges. Eureka and Redway Support Groups contact is Lea Nagy at 707 845-3233 or email at leanagy@yahoo.com. Fortuna Support Group contact is Sharon at 707 725-8853 or email at sharonbenda@att.net.

REQUIRED DOCUMENTATION FOR RVS AND TRAILERS

The RV must be owned by the client and there must be written approval by the Park for the RV prior to the signing of the lease agreement and the commitment to funding of the rental space.

Proof of ownership includes:

- DMV title
- DMV registration
- Proof of insurance, in the client's name

We may be able to provide financial assistance for a security deposit and space rent.

We cannot provide financial assistance for the purchase, registration, license, etc. for an RV.

SECTION 6
DEFINITIONS

ACT.MD

ACT.md is the care coordination platform and phone app that the Housing Unit staff utilize to: communicate and execute shared accountability for client tasks and appointments; Reduce duplication through clear roles and responsibilities; and operational best practices.

ARCATA BAY CROSSING

The Arcata Bay Crossing is a low income6 apartment building in Arcata with a total of 32 units, 15 of which are reserved for mental health clients who have a diagnosis of severe mental illness and are homeless or at risk of homelessness. There is an on-site property manager, laundry room, community room, and community kitchen and meeting room. Mental Health services are provided on-site.

COMMUNITY INTEGRATION

To foster empowerment and self-determination. Connecting people with community resources and helping them build a natural circle of support. Social, recreation, political, and religious activities. Employment, volunteering, social/cultural events.

COORDINATED ENTRY

Coordinated entry is a process of intake and assessment that is easily accessible to homeless individuals and streamlines the process for an individual to access housing and other services. The primary goal of Coordinated Entry is to ensure that assistance is allocated in the most effective manner possible and regardless of where or how an individual presents. Coordinated Entry is oriented in such a way that individuals can be housed as quickly as possible without preconditions or service participation requirements.

THE LODGE

The Lodge is a low income older adults apartment building in Eureka with a total of 50 units, 15 of which are reserved for mental health clients who have a diagnosis of severe mental illness and are homeless or at risk of homelessness. There is an on-site property manager, laundry room, community room, and community kitchen and meeting room. Mental Health services are provided on-site.

MEASURE Z

Measure Z is a half-cent sales tax in Humboldt County to pay for maintaining and enhancing public safety services. EPD and DHHS have partnered, with funding from Measure Z, to provide outreach and service linkages to connect individuals in Eureka who have a serious mental illness are homeless to services. Funding is available for deposits, short and medium-term rental assistance, detoxification services as well as 30-day residential treatment programs.

MENTAL HEALTH SERVICES ACT (MHSA)

With the passage of Proposition 63 in 2004, California voters acted upon a widespread perception that state and county mental health systems were still in disrepair, underfunded, and requiring a systematic, organizational overhaul The MHSA provided the first opportunity in many years for increased funding, personnel and other resources to support county mental health programs and monitor progress. The Act addresses a broad continuum of prevention, early intervention and service needs. A portion of the funds may be used for community services and supports, including housing for persons with serious mental illness who are homeless or at risk of homelessness.

NORTH COAST HEALTH IMPROVEMENT AND INFORMATION NETWORK

North Coast Health Improvement and Information Network (NCHIIN), is a California non-profit providing both health information exchange and care improvement in Humboldt county. NCHIIN connects health and social and community providers to improve the health of community members using electronic technology while maintaining patient privacy and data security. Health Information Exchange (HIE) supports care givers and care quality by providing immediate information to providers in both an efficient and cost effective manner. Community members may receive care in settings across our county and HIE allows for the coordination of care based access to appropriate information across the community and care givers.

PATH

Projects for Assistance in Transitions from Homelessness (PATH) provides assistance to individuals who are homeless and have serious mental illness. Among services that are provided:

- Outreach services
- Community mental health services
- Referrals for health care, job training and educational services
- Case management services

PERMANENT SUPPORTIVE HOUSING

“Permanent” means that residents have the same rights and privileges of tenancy that any other person would have when renting an apartment. There is no limit on length of stay, unlike transitional housing where length of stay is limited to 24 months or less. Each resident controls access to his or her own unit. Tenants can keep their housing as long as they pay the rent and do not violate the terms of their lease agreement. Tenants cannot be compelled or required to participate in any type of program or services as a condition of their lease agreement. The terms of the lease agreement (e.g. about pets, visitors or use of shared facilities) are the same for all residents with or without a mental health diagnosis or disability. Tenants pay no more than 30 percent of their income for rent.

“Supportive” means that tenants may receive a range of recovery-oriented services, including mental health, substance abuse, case management and other assistance designed to help them keep their stable housing.

POINT IN TIME (PIT) COUNT

HUD requires the Point-in-Time (PIT) count every two years. It is a count of sheltered and unsheltered homeless persons on a single night in January.

RAPID RE-HOUSING

Rapid Re-Housing is for individuals and families who are experiencing homelessness (residing in emergency shelters or on the street) and need temporary assistance in order to obtain housing and retain it.

US DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT CONTINUUM OF CARE (HUD COC)

The HUD CoC Program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness.

Preventing reinfection with hepatitis C: What you need to know

PROJECT INFORM
projectinform.org/pwidtoolkit

The intent of this publication is to highlight how hepatitis C (HCV) could be transmitted and provide you information to make decisions on how to protect yourself.

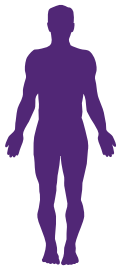
You can get hepatitis C (hep C) more than once.

This is weird and a little confusing, and to date we've not done a great job of talking about it or preventing it from happening. This fact sheet will explain what hepatitis C reinfection is, why it's important, and review ways to prevent it from happening.

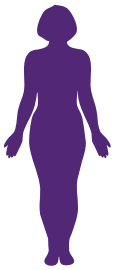
What is hep C reinfection?

Hepatitis C reinfection is when a person has detectable hep C virus after he/she has been either cured through treatment or after they have spontaneously cleared the virus on their own.

TWO EXAMPLES OF REINFECTION WITH HEPATITIS C



Tom shared a cooker with hep C infected blood in it and becomes infected with hep C. He tests positive for both hep C antibodies and viral load. He waited 6 months to see if he is chronically infected, and found out he cleared the virus on his own. Two years later, Tom shares a syringe with hep C infected blood in it, and becomes infected with hep C again. He waits 6 months to see if he's infected, tests positive for the virus and learns that he is chronically infected. He will only be able to clear the virus now through treatment.



Amy shared a syringe with hep C infected blood in it and becomes infected with hep C. She waits 6 months to see if she was chronically infected, and her test result tells her that she is. She goes on treatment and is successfully cured. One year later, she shares a syringe with hep C infected blood in it and becomes reinfected with hep C. She waits 6 months to see if she's chronically infected again, and her viral load test comes back positive, indicating that she is. She will need treatment again in order to clear it.

Background

With many viruses (like the herpes virus that causes chicken pox) or even other hepatitis viruses (hepatitis A or B), you can get it and your body develops antibodies and immunity to fight off any future infection. In other words, if you get it once, you're not going to get it again.

> Not so with hep C: With hep C, you can get it and clear it but you can get it again and again.

About 1 in 4 (25%) people clear hep C in the first 6 months of infection. They'll have HCV antibodies but no more virus to damage their liver. Although there is some evidence that they may have partial immunity to future infections, they can still be reinfected and get hep C again. Some people can clear the virus multiple times, but there's always a risk that the next time will lead to chronic infection.

Why is this a problem for people who inject drugs?

Reinfection is a major reason why people who use drugs are denied hep C treatment. There is a belief that PWID who get cured will get reinfected if they continue to inject drugs. As a result, many insurance plans will deny access to hep C treatment until a person has been off drugs for a period of time (varies by plan).

While it is true that reinfection can happen in people who inject drugs after hep C treatment, it's actually not as common as many people assume it to be. Some studies show higher rates of reinfection, especially in areas where there are a lot of people infected with hep C, while others have found the rates of reinfection to be low.

Overall, reinfection rates are lower than the rates of first-time infections. So, people who get infected with hep c once, and then clear it or get cured from it, are less likely to get reinfected again.

We also know that if more people are treated and cured of hep C, you're less likely

to come into contact with it if you share a syringe or other injecting equipment. Also, if people who inject drugs are given good access to harm reduction tools like opiate substitution therapy or syringe access, they are less likely to get reinfected.

Finally, active substance use and fear of reinfection should not be barriers to getting hep C treatment. If you're ready for treatment, talk to your medical provider about it. If you feel like your life is a little too chaotic right now to start, make a plan to get ready.

PREVENTING REINFECTION

Reinfection of hepatitis C can be avoided.

If you're ready to stop injecting drugs, that's the most direct way to keep reinfection from happening. This is not always easy: Sometimes it can be hard to get into a treatment program, there may not be one that is a good fit for you, or you may not be ready to stop yet.

If you can't stop, and you want or need to keep injecting drugs, there are things you can do to prevent reinfection. There are several practices for preventing hep C that longtime injectors who have never been infected use to protect themselves. The following list describes them and could be things you can do too:

1. **Set up your own personal rules about not sharing injecting equipment and disposing of syringes**

   If possible, don't share anything: syringes, cookers, water, cotton filters and tourniquets for both preparation and injection. If you need to re-use a syringe, clean it out with bleach or other disinfectants (check out the "What Kills Hepatitis C" fact sheet for more info), and do the same with cookers. Cotton filters and water can't be disinfected if HCV blood gets in them. You'll need to discard them and get unused cotton filters and fresh water.

   When done with syringes and works, put them in a sharps container.

2. **Take charge of your drug preparation and injection**

   Try to take time to slowly and carefully prep your injection. Wash your hands with soap and water before you begin. Wipe down the surface where your drug prep is going to happen with bleach or other cleaners. If you don't have anything, lay down some newspaper or napkins to prep on.

   Prep your own drug mix. If you're injecting with others, volunteer to do the prep and split it with them in a way that does not lead to blood getting into the process. For example, split the drug up before preparing it all so each person has their own. You can also use an unused syringe to draw up the prepped drug and use it to put into each person's syringe ("backloading" or "frontloading"; check out the Harm Reduction Coalition's "Getting Off Right" booklet for more safe injecting info).

3. **Separate and/or mark your equipment**

   Mark your syringes and injecting equipment to avoid mixing your stuff with others'. You can use a permanent marker or scratch off a number on the barrel of a syringe and so on. Store your equipment in a kit that is clearly yours.

   If possible, keep an extra stash or two of unused syringes and injecting equipment. You can keep one for yourself, and have one for someone else who might need something.

4. **Prepare and plan ahead**

   If you inject heroin, avoiding withdrawal symptoms and getting dope-sick can lead a person to take more injecting risks than they usually would. Snorting or smoking a little before injecting could take the edge off while you prepare your injection (remain mindful of the risk of drug overdose: inject less if you took a little before). Stockpiling a little methadone or buprenorphine can help during these times, too.

5. **Take a break from injecting for awhile**

   If you can sniff or smoke your drug, do that for a while. That will give your veins a break and make injecting later a little easier. If there's no unused syringes or injecting equipment, try sniffing or smoking the drug to avoid sharing works.

   If you smoke, try not to share pipes, especially if you have cracked lips or sores in your mouth. Blood from a pipe is less likely to transmit HCV, but it can happen. The same is true with sniffing: sharing straws can lead to blood-to-blood contact in the nose. Again, it's less likely than injecting, but still possible. Grab a few extra straws from a coffee shop so you have some on hand when needed.

Follow-up hepatitis C testing after cure or spontaneous clearance

If you've been cured of hep C or are one of the 25% of people who clear it naturally, and you've stopped injecting and don't have other risks, you don't need to continue to testing for reinfection.

If you still inject, keep testing for hep C. You will still have HCV antibodies, so you don't need an HCV antibody test anymore. To detect if you've been reinfected, take the HCV viral load test (sometimes called an HCV RNA test or HCV PCR test). You'll want to take this test at least once a year, or more often. Talk with your medical provider or HCV test counselor about how often.

For more information on hepatitis C testing, read the Project Inform fact sheet, "Hepatitis C testing for people who inject drugs: What you need to know."

Final thoughts

Hepatitis C reinfection is not inevitable. If you've cleared the virus naturally or through treatment, you can stay hep C negative from here on out by introducing some of the practices in this fact sheet and doing what you can to avoid sharing syringes and other injecting equipment. You likely already use safe injection practices, and the techniques and idea in this fact sheet and "What Kills Hepatitis C" can help even more.

If you want to talk about safer injecting and hep C prevention, and develop a strategy to stay negative, call HELP-4-HEP (877-435-7443) and talk with a counselor.

POLICY & PROCEDURE	
Humboldt County Department of Health and Human Services Public Health	
Program: Healthy Communities, North Coast AIDS Project	Number: HE-16-102
Review Schedule: (1 yr.) 2 yr. 5 yr. Other_____ (circle one) (specify)	Reference: Governmental Code Section 8630 et seq., CA H&S Code 11364, CA Health & Safety Code 121349 et seq.

Approved by: _____ 9/11/18
Director, Public Health Date

✓ Check here if additional signatures are required (Health Officer, County Counsel, etc.)

Signature: _____

Title (print): Donald Baird, Health Officer

Date: 10/2/18

SYRINGE SERVICES PROGRAM (SSP)

POLICY: Public Health staff will offer sterile syringes, syringe disposal, and provision of harm reduction services in accordance with best practices and as appropriate for the Humboldt County community.

PURPOSE: To prevent the spread of communicable diseases such as sexually transmitted infections, HIV, and hepatitis C (HCV) through prevention practices and early identification, reduce harm and deaths associated with substance use and abuse, link people to needed services such as treatment for substance use disorder and communicable diseases.

PROCEDURE:

1. The program is overseen by the County Health Officer with support from the appropriate staff.
2. North Coast AIDS Project (NorCAP) staff is responsible for implementing SSP procedures and training other Public Health staff as appropriate.
3. Senior Health Education Specialist is responsible for management of inventory and purchasing.
4. Senior Health Education Specialist ensures program staff have up-to-date knowledge of current best practices in harm reduction and local referral resources,

as well as annual training in blood borne pathogens and infection control. Staff providing testing services will have required certifications.

5. Program staff ensures that sterile syringes are stored in a locked cabinet or drawer.
6. SSP takes place on the NorCAP mobile outreach van throughout Humboldt County in locations where people at risk for HIV and HCV congregate. Venues will not include locations that are within 1000 feet or less of schools, playgrounds, or other areas where children are present. Appropriate locations may include:
    a. Homeless encampments
    b. Free meal services
    c. Partnering agencies/organizations
7. SSP may take place at a fixed site (such as the Community Wellness Center), however, before exchange occurs at a fixed site, each site must have its own protocol detailing storage and safety procedures and be approved by the Public Health Branch Director.
8. Program participants must be 18 years of age or older.
9. Clients are given NorCAP's SSP outreach van schedule and information about additional SSPs in the community. They are also told that they may call SSP outreach staff at any point during business hours and staff will make reasonable efforts to meet them at an appropriate location.
10. Clients are given information about additional syringe disposal options such as kiosks and the Humboldt Waste Management Authority (HWMA), etc.
11. SSP services are offered anonymously. Program participants are asked to identify a unique identifier which will be used to document program activity.
12. Program staff documents the location where exchange occurred, the gender, race and birth year of client, client's zip code, drug of choice, number of units returned and dispensed per encounter, number of sharps containers dispensed, number of Naloxone kits dispensed. Staff also documents whether the client is housed and if health insurance, treatment and/or mental health was discussed or if a referral was made, the number of people client is exchanging for, if they are a new client and additional data as determined by the program coordinator.
13. Program participants are responsible for placing used syringes directly into approved sharps container.
14. The Community Health Outreach Worker visually assesses the number of syringes being returned based on the size and fullness of the disposal container. This number is verified by the client. Staff maintains data collection sheets showing the number of syringes in and the number of syringes out.
15. SSP staff provides sterile syringes and ancillary supplies including, but not limited to hygiene kits, alcohol prep pads, various sizes of personal sharps containers, and safer sex supplies.
16. Program participants are offered the following:
    a. HIV and HCV testing
    b. Medical care referrals
    c. Mental Health referrals
    d. Basic needs resources
    e. Overdose prevention training
    f. Narcan/naloxone

g. Health insurance referrals
h. Substance abuse treatment referral
i. Additional options for safe disposal of used syringes.

17. Sharps containers are securely closed and locked and transported to the Public Health Clinic for safe disposal. Sharps containers with contaminated waste are properly secured at all times to avoid spillage. They are then collected by a contracted medical waste disposal company.
    If a community member calls the outreach team requesting syringe litter pick-up, staff will respond as staffing allows following http://bit.ly/2Fm2nHU guidelines for safe syringe handling practices.
18. DHHS, Public Health, Healthy Communities, North Coast Aids Project Syringe Services Program compile and analyze program data to show program activity, trends and other results. This reporting is shared monthly with the Director of Public Health.
19. Program activity data will be reported to the Humboldt County Board of Supervisors biennially.
20. Staff will have received hepatitis A & B immunization series, provided either by the County PH Clinic or by the employee's choice of provider.
21. In case of employee injury or needle stick:
    a. Staff will immediately contact company nurse at 877-854-6577
    b. Staff will report all injuries to supervisor and complete and route the county incident report form within 24 hours.

The Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families

Implementation Quick Start Guide

Warm Handoff

Agency for Healthcare Research and Quality

What Is a Warm Handoff?

In this strategy, a warm handoff is a handoff that is conducted in person, between two members of the health care team, in front of the patient (and family if present). It includes the patient as a team member so that he or she can hear what is being discussed about the clinical problem, current status, and plan of care.

The term "warm handoff" originated in customer service where it is used to describe referrals that ensure that the customer is connected to someone who can provide what he or she needs. In health care, this typically means that one member of the health care team introduces another team member to the patient, explaining why the other team member can better address a specific issue with the patient and emphasizing the other team member's competence.[1] Often it is used to describe the handoff between a medical provider and a behavioral health specialist.

In this strategy, the emphasis of the warm handoff is specifically on engaging the patient and family in the handoff within the primary care practice. A warm handoff can occur between any two members of the health care team, including clinicians, medical assistants, front and back office staff, and members of the extended care team (e.g., pharmacist, diabetic nurse educator, social worker).

Why Use Warm Handoffs?

Warm handoffs engage the patient and are a safety check. Communication breakdowns within the health care team or between the team and the patient or family can result in medical errors.[2-4] Research demonstrates that reliable and effective communication is essential for patient safety and improved clinical outcomes.[5-7] Successful handoffs among clinical staff require open communication and teamwork.[8]

Warm handoffs use both open communication and teamwork and add another layer of protection to prevent communication breakdowns. The warm handoff is similar in concept to bedside rounding on inpatient units. It moves conversations between members of the health care team from outside the exam room into the exam room to engage the patient. Warm handoffs allow the patient (and family member) to verify the information being communicated between the health care team and to offer additional context as needed.

Warm Handoff in Action

At a primary care practice in Wisconsin, a medical assistant brought the patient to the exam room and started taking the chief complaint and vitals. As she went through his medications one by one, asking him how he was taking each, the patient acknowledged that he was only taking one of them "about half the time." When she finished with the rooming process, she went to get the doctor and they came back into the room together for the warm handoff. She briefed the doctor in the room with the patient on all the information she had gathered. When she got to the medication that the patient was only taking sometimes, the patient interrupted. "I take it every morning. I just forget to take it most nights, so I end up taking it about half the time." The doctor immediately responded, "Then take both pills in the morning." With the warm handoff, patient safety and outcomes were improved.

Program Performance:

December 1, 2014

Michael Weiss
Program Manager
Humboldt County
908 7th Street
Eureka, CA 95501

CONRACT # **13-20050**
FISCAL YEAR 2013-2014
JULY 1, 2013– MARCH 31, 2014

Dear **Michael**:

This letter serves as *Notice of Approval* for monitoring of Contractor/Service Provider by the HIV Care Program (HCP) for the contract and fiscal year listed above. If applicable, site monitoring included HCP and Minority AIDS Initiative (MAI) contracts.

Conducted on **October 7, 2014**, contract monitoring resulted in a request for a Corrective Action Plan (CAP) regarding specific items for clarification, technical assistance, improvement, implementation, or correction.

As submitted, your CAP validates contractual and programmatic compliance in meeting the requirements of Health Resources and Services Administration (HRSA) and your contract with HCP (and MAI if applicable) for receiving Ryan White Part B funding.

Your dedication to providing HIV/AIDS-related client care is commendable. If you have any questions regarding this correspondence, please contact me by phone at **(916) 650-0170 or email address: michael.cunningham@cdph.ca.gov.**

Sincerely,

Michael Cunningham
Care Operations Advisor
HIV Care Operations, Office of AIDS

December 5, 2016

Michael Weiss
Program Manager
Humboldt County
908 7th Street
Eureka, CA 95501

CONRACT # **13-13-20050**
FISCAL YEAR 2015-2016
APRIL 1, 2015– MARCH 31, 2016

Dear **Michael**:

This letter serves as ***Corrective Action Plan (CAP) Notice of Approval*** submitted by the Contractor or Contractor/Service Provider by the HIV Care Program (HCP) for monitoring of the contract and fiscal year listed above.

Conducted on **October 20, 2016**, the Site Monitoring Visit (SMV) Tool report indicated your program required a CAP regarding specific items for clarification, technical assistance, improvement, implementation, or correction.

As submitted, your CAP validates your program meets the Health Resources and Services Administration (HRSA) regulations and Office of AIDS (OA) contract requirements for receiving Ryan White Part B funding.

Your dedication to providing HIV/AIDS-related client care is commendable. If you have any questions, please contact me by phone at **(916) 650-0170** or email address at **michael.cunningham@cdph.ca.gov .**

Sincerely,

Michael Cunningham
Care Operations Advisor
HIV Care Operations, Office of AIDS

Enclosures:
SMV Tool report for Contractor or Contractor/Service Provider (including CAP)
ARIES report for Service Provider(s), if applicable

November 30, 2017

Michael Weiss

Program Manager

Humboldt County

Eureka, CA 95501

FISCAL YEAR 2016 - 2017
CONRACT # 15-11054
APRIL 1, 2016 – MARCH 31, 2017
CONTRACT# 16-10847
NOVEMBER 30, 2016-SEPTEMBER 20, 2017

Dear Michael:

This letter serves as a *Notice of Completion* for monitoring of Contractor or Contractor/Service Provider by the HIV Care Program (HCP) for the contract and fiscal year listed above.

Conducted on November 1, 2017, the Site Monitoring Visit (SMV) Tool report indicates your program meets the Health Resources and Services Administration (HRSA) regulations and Office of AIDS (OA) contract requirements for receiving Ryan White Part B funding.

Your dedication to providing HIV/AIDS-related client care is commendable. If you have any questions, please contact me by phone at (916) 650-0170 or email at Michael Cunningham@cdph.ca.gov.

Sincerely,

Michael Cunningham
Care Operations Advisor
HIV Care Operations, Office of AIDS

Enclosures:
SMV Tool report for Contractor or Contractor/Service Provider

Contractor Name: Humboldt County Public Health **Completed by:** Michael Weiss

Contract Number: 13-20050 **Date Completed:** 06/28/2016

Reporting Period: April 1, 2015 – March 31, 2016 (12 months)

The National HIV and AIDS Strategy (NHAS) goal is to inform all HIV positive persons of their status and bring them into care in order to improve their health status, prolong their lives and slow the spread of the epidemic. The goals of the California Department of Public Health, Office of AIDS (CDPH/OA) are to: (1) minimize new HIV infections; (2) maximize the number of people with HIV infection who access appropriate care, treatment, support, and prevention services, and (3) reduce HIV/AIDS-related health disparities. The services required by the HIV Care Program (HCP) and Minority AIDS Initiative (MAI) Scope of Work (SOW) and Management Memos are consistent with, and are designed to support these goals.

Responses to the questions included in this Progress Report should demonstrate your progress during the report period toward meeting these program goals.

I. Service Provision

HCP contractors are required to coordinate comprehensive, ongoing outpatient/ambulatory medical care (OAMC) to individuals with HIV/AIDS. HCP funds may be apportioned to other services only after contractors have ensured and documented that OAMC services are adequately provided in their geographic region and how they are funded.

1. Describe any issues related to the availability of HIV care in your geographic region that have impacted the services to HIV positive clients. (e.g., Medi-Cal Expansion and Covered California) and efforts to address these issues.

   RESPONSE: Humboldt County has two HIV specialist medical providers. The Open Door Health Center is a Federally Qualified Health Center (FQHC) and the primary provider of Ryan White services. In Southern Humboldt the Redwoods Rural Health Center is supported with an HIV services grant from Dr. Marshal Kubota at Mendocino Community Health Clinic. The primary challenge is access to transportation for clients. Humboldt County has a limited public transportation system, and clients who live out in very remote areas may have challenges

getting to their appointments. The North Coast AIDS Project (NorCAP) provides supportive services through case management which includes assisting clients with direct transportation or coordination of other services that help with accessing care.

2. Compare the estimated number of unduplicated clients to be served (Budget Form D) and actual unduplicated clients served as reported in ARIES (Reports menu, Finance > HCP Summary Tracking report). Were the actual clients served on track with your estimated client counts? If not, what are the reasons?

   RESPONSE: 51 unduplicated clients were reported seen in ARIES for Non-Medical Case Management compared to the 50 estimated. This is within a normal range for the program. The number slightly fluctuates annually based on client need.

3. Describe the process for Partner Services referral and counseling among your HCP providers (see Management Memo 15-06).

   RESPONSE: Partner Services happen at every point of contact for clients who are HIV positive.
   - Ryan White medical providers refer clients to NorCAP Case Management for Partner Services.
   - Surveillance staff coordinates partner services with NorCAP Case Management.
   - Outreach / Testing staff provide partner services during testing and counseling sessions upon disclosure of initial HIV positive test results as well as refer clients to the medical provider and NorCAP Case Management staff where Partner Services are offered again.

4. If you had Early Intervention Services in your budget please respond to the following questions:

   a. Describe what data was used in identifying PLWHA not in care?

      RESPONSE: Public Health Epidemiology/Surveillance data was utilized to review the demographic profile of those newly infected over the past 5 years in Humboldt County. Staff identified young MSM as the most impacted and vulnerable population.

b. Describe the activities taken to link clients to care.

RESPONSE: NorCAP outreach staff implemented reoccurring testing sites that target young MSM. Outreach staff have increased HIV testing on the Humboldt State University Campus, at the local LGBTQ Pride Festival, and at the monthly Queer Dance Night. High risk individuals were referred to PrEP services. Preliminary positives were referred to the HIV medical provider for a confirmatory test and then followed up with Case Management services.

Data to Care Question for Alameda, Orange, San Diego, and Riverside Counties ONLY:

5. Please describe what Data to Care activities took place during the reporting period regarding data to care. Please include any supporting documents and/or data to show the activities implemented.

   RESPONSE: N/A

II. Care Continuum and Service Integration

Contractors must develop and implement a comprehensive system of care and support services that actively engages individuals who know their HIV status but are not accessing services, that reaches out to people who are HIV positive but unaware of their HIV status, and that is coordinated and integrated with other service delivery systems as appropriate. Contractors must develop and maintain working relationships, and coordinate an integrated system of service delivery, with entities that provide key points of entry into medical care (e.g., testing sites, correctional facilities). The coordinated, integrated system of care must be informed by HIV epidemiological data and other data sources and should include leveraged resources.

6. Describe the linkage to care process in your LHJ/CBO. Be sure to include how you coordinated with other programs/agencies/organizations (e.g., MAI, Prevention, Sexually Transmitted Disease clinics, HIV Surveillance, medical providers, homeless shelters, mental health programs, etc.) to link clients to care.

   RESPONSE: NorCAP has a long history of working closely with the local HIV medical providers since the mid 1980's. Staff participates in regular client case

conferences and clients are referred to services back and forth between the programs. Often, NorCAP is the point of first contact for new clients who test positive in a medical setting other than the HIV care program. NorCAP Case Managers work closely with clients to assist with establishing necessary HIV medical care. Over the past year, NorCAP has implemented a PrEP Navigator program which includes working closely with medical providers who do sexual health and coordinating a quarterly Sexual Health Task Force. New relationships include Planned Parenthood, Humboldt State University Student Health, and the Public Health Clinic. This program has increase the number of providers who are familiar with the NorCAP services and who now refer clients with a new HIV positive test result.

This year NorCAP staff has initiated meetings with the correctional facilities and homeless youth agencies to establish regular onsite HIV testing and coordination of clients' services. Further coordination with the STD Controller has been implemented to start reviewing local epidemiological data to do outreach to individuals who know their HIV status but are not accessing services.

a. If there were any challenges, describe proposed activities to address those challenges.

   RESPONSE: None at this time

7. Describe the retention in care process in your LHJ/CBO. Be sure to include how you coordinate with other programs/organizations to retain clients in care.

   RESPONSE: Staff participate in monthly case conferences with medical service providers. Staff and medical providers discuss client support systems needed to keep clients connected to services. Case Managers coordinate services.

   a. If there were any challenges, describe proposed activities to address those challenges.

      RESPONSE: Transportation and housing are the biggest barriers for clients to maintain in care. Case Managers work with clients to locate or maintain stable housing and coordinate needed transportation to medical visits. Staff provide direct transportation or bus and dial-a-ride tickets.

8. Describe the reengagement process in your LHJ/CBO. Be sure to include how you coordinate with other programs/organizations to reengage clients in care.

   RESPONSE: Case managers contact clients every 6 month to maintain contact, provide any needed support, and to re-engage anyone who may have fallen out of care. Efforts are being made to coordinate with the surveillance team to identify and contact clients who are not currently in the NorCAP case load, but may have fallen out of care and in need of services.

   a. If there were any challenges, describe proposed activities to address those challenges.

      RESPONSE: none at this time

   b. Have you run the new performance measures on Gaps in Medical Visits and/or Medical Visit Frequency in ARIES (Reports menu > Compliance > HAB Quality Management (QM) indicators)? If so, do you find the reports useful in identifying clients who need reengagement?

      RESPONSE: We could use some technical assistance in learning how to understand how to use the report effectively and integrate it into our work.

9. Describe how HCP funds have been used to provide wrap around services for all clients who are insured through Medi-Cal, Denti-Cal, Medicare, private insurance, or other payer sources (e.g., a private insurance plan, which does not allow for more than two mental health visits).

   RESPONSE: HCP funds are utilized to provide HIV non-medical case management. Case Managers are able to assist clients in coordinating appointments, transportation, applications, and housing searches.

III. Client Eligibility, six-month and annual Recertification, Outreach Enrollment

Contractors are required to ensure clients are eligible for HCP services in accordance with program policy. Screening and reassessment of client eligibility must be completed and documented at least every six months to determine continued eligibility for HCP services. Self-Attestation forms stating eligibility requirements have not changed since last reviewed are acceptable. The Self-Attestation forms must be signed and dated by clients. Self-Attestation forms cannot be utilized to meet the annual eligibility

certification requirement. Contractors are required to vigorously pursue enrollment of clients who are eligible for comprehensive health care coverage (e.g., Medi-Cal, Medicare, Covered California, employer-sponsored health insurance coverage, and/or other private health insurance) and adhere to specific documentation requirements of those activities.

10. Describe your process for ensuring that HCP clients are low-income.

a) **RESPONSE**: All clients go through an annual re-certification in June and a six-month re-certification in January. Staff verifies income, insurance for all clients. All income information is entered into ARIES and supporting documents are kept in client charts. Staff ensures that Ryan White Part B funds are the payer of last resort. Clients are not charged fees for any of the funded HCP Tier Two services. If the Humboldt County Department of Health and Human Services were to impose client fees, a schedule of charges will apply following current HRSA guidelines. Clients would be given a financial assessment to determine ability to pay and eligibility for other social / governmental support services.

    a. Describe any challenges with this process?

       RESPONSE: none at this time

    b. If there were challenges, do you have suggestions to make the process more efficient and equitable?

       RESPONSE: none at this time

IV. Data Collection/Entry

Contractors shall collect the HCP minimum data set. The HCP minimum dataset includes data elements required by (a) HRSA to complete the Ryan White Program Service Report (RSR), selected HAB Quality Management (QM) indicators, and the Women, Infants, Children, and Youth Report, and (b) CDPH/OA for its development of estimates and reports and to conduct program activities. Those data must be entered into ARIES within two weeks from a client's date of service.

11. Describe any challenges you have had with your data collection efforts.

RESPONSE: Staff have improved their data lag time last year to an average of 5 days. Challenges include teaching new Interns each year to maintain 2 week requirement of data.

12. If you have used ARIES data for grant proposals, planning, data publications, or other special projects, please provide a brief description.

    RESPONSE: none at this time

13. If you have technical assistance needs that have not already been addressed by the ARIES Help Desk and/or State staff, please describe your need(s).

    RESPONSE: none at this time

V. Monitoring Activities

Contractors shall conduct site visits and document/monitor the activities of subcontracted agencies to ensure contractual compliance not less than once every year. Develop a Corrective Action Plan (CAP) for all deficiencies cited in the contractor's monitoring report and submit it to the State for approval. Once approved, implement and monitor the progress of the plan.

14. If you subcontract, list the subcontractor monitoring site visits completed during this reporting period.

    a. Of those, identify any who had CAPs.

       RESPONSE: N/A

    b. Describe what steps the subcontractor has taken to address the issues documented in the CAP.

       RESPONSE: N/A

    c. Have the CAPS been submitted to OA Program Advisor? If not, please explain why and when you will submit the CAP.

       RESPONSE: N/A

VI. Quality Management

Contractor must ensure all client service providers have a QM program in place. The QM program should fit within the framework of the client service providers' other programmatic quality assurance and quality improvement activities.

15. Describe any HIV related Quality Management (QM) activities conducted by your program and/or your subcontractors' programs, including any methodology used for QM (e.g., Plan-Do-Check-Act (PDCA) Cycle, Six Sigma, etc.).

    RESPONSE: NorCAP incorporates the HIV QM activities into the program overall strategic plan. Methodology is the "Strategic Prevention Framework": Assessment, Capacity, Planning, Implementation, and Evaluation.

16. Please describe your process for monitoring the required performance measures for clients served by subcontractors and following up on missed visits.

    RESPONSE: N/A

17. Please describe your process for assessing patient satisfaction – if a survey was completed during this grant year, please submit a summary of results.

    RESPONSE: A client Quality of Life survey is conducted every three years. The new survey will be administered in FY 16-17. Surveys are sent to all NorCAP Clients. For the last survey, the program had a 73% response rate. The average client ranked at a 69.64% satisfaction rate.

18. Provide the results of the outcome indicators listed in your QM plan.

RESPONSE: Below are the outcome measures followed by the results for FY15-16.

1. All required data elements of ARIES are complete for all clients. **All required data elements are entered into AREIS**
2. All client services data are entered into ARIES within two weeks of service. **Current Data is entered on average of 12 days.**
3. 50% of clients are virally suppressed. **83.7% of clients are currently virally suppressed**
4. 90% of clients are enrolled with an HIV primary care provider. **100% of clients were linked to care.**
5. 75% of clients will have a minimum of one visit every six months with their HIV medical provider. **81.8% of clients who had a medical visit in the first and last half of the year**

a. If quality issues are identified, describe steps planned or taken to address them.

RESPONSE: none at this time

b. Describe what strategies are used to ensure that clinical services funded by the RW Part B program adhere to HIV/AIDS treatment guidelines. (e.g., Peer Review, Chart Review).

RESPONSE: NorCAP HCP program participates in annual chart review site visits from the State Office of AIDS.

VII. Other

6. If applicable, describe at least one innovative practice/service provided by you or a subcontractor over the last year.

RESPONSE: NorCAP has implemented a PrEP Navigation Program. Staff assist sexual partners of clients with accessing PrEP

7. If applicable, provide a success story or anecdote that highlights the positive impact your program has had on an individual, group, or community. (E.g., linking a client to care, assisting a client obtain housing, etc.)

RESPONSE: Staff have assisted 7 clients who have been chronically homeless to establish permanent supportive housing and maintain regular HIV medical care.

8. Do you or your service providers require any technical assistance? If so, please describe?

RESPONSE: more help with data to care

9. Do you have training needs? If so, please describe?

RESPONSE: none at this time

Contractor Name: County of Humboldt **Completed by:** Michael Weiss

Contract Number: 15-11054 & 16-10847 (X08) **Date Completed:** 5/22/17

Reporting Period: April 1, 2016 – March 31, 2017 (12 months)

Responses to the questions included in this Progress Report should demonstrate your progress during the report period, unless otherwise indicated.

1. Please attach your Partner Services policy that shows compliance with https://archive.cdph.ca.gov/programs/aids/Documents/HCPMM15-06PartnerServices.pdf. Have you had challenges implementing your Partner Services policy? If so, what were they and how did you address them?

   RESPONSE: The Partner Services Coordinator is located in the Nursing division of Public Health which is in another building and separate division. HCP staff has provided referrals for partner services for many years. Coordination of Disease Investigation Services (DIS) information and partner services needs to be improved. HCP staff would benefit from direct training from the state. Staff has requested Partner Services training from the Office of AIDS. Manny Rios, the HIV Partner Services Specialist recently contacted NorCAP to discuss the upcoming Northern California Partner Services training for program coordinators in Redding on July 26-27 and to coordinate a follow up training for staff and community partners in Eureka on August 22-23.

2. Describe how you worked with an HIV planning or advisory body to improve linkages to care, strengthen the continuum of care, and inform your decision-making process regarding your HCP and MAI budgets.

   RESPONSE: The AIDS Task force attendance has depleted over the past few years to 2-4 attendees. There have been many challenges getting consumers to the table. In an effort to improve the advisory process the group was renamed to the Sexual Health Task Force in September 2016 which has expanded participation to 30 plus individuals, who meet quarterly, including medical providers and community members. This group has restructured and is forming a

sup-committeethat will address HIV-related services to act as the advisory body to NorCAP.

3. If you have used AIDS Regional Information and Evaluation System (ARIES) data for **budget or program planning**, grant proposals, data publications, or other special projects, please provide a brief description.

   RESPONSE: The ARIES HAB QM (HIV/AIDS Bureau Quality Management) Indicators Summary report is helping inform the development of the new three year strategic plan.

   The program planned to hire a Health Education Specialist (HES) to specifically work on DIS (outreach to individuals who have fallen out of care or are not reaching undetectable status, or those who are HIV positive and also test positive for other STI's). The county hiring process is extensive. The program was able to hire an extra-help temporary HES in the fall, but the person needed to leave the area. The recruitment for the permanent HES job class was approved by the Board of Supervisors and the process is in progress. Interviews may not happen until June or later. The ARIES data will guide the HES in working with people who have fallen out of care and those who have not achieved viral suppression.

4. HCP is participating in the National Quality Center's End Disparities Campaign. Our initial focus will be on the disparities in viral load suppression rates among youth (ages 13-24). We will be holding webinars later this spring on this project. To prepare, please quality check your ARIES data for this population.

   In ARIES, go to the Reports Menu, select Clients, and then click on the **CQM: Viral Loads in Youth Age 13-24** link. Enter **HCP 16/17 CA/OA** as the contract name. Enter the results below for each of your funded agencies. (Note: If you have subcontractors, run the report through your Administrative Agency account.)

CQM: Viral Loads in Youth Age 13-24			
Agency Name (Add row for each subcontractor)	All Clients	All Clients with a Viral Load	All Clients with a Viral Load 200 or Less
Humboldt County Department of Public Health	1	1	1

- NorCAP			

a. Do the results appear accurate? If not, why? (If your data appears to have missing or in accurate values, please run the Fix-It: Viral Load report in ARIES. For instructions, go to the Training section of - https://archive.cdph.ca.gov/programs/aids/Pages/OAARIESUserManual.aspx.)

RESPONSE: The data is accurate. There is only one client within this age range.

b. If the overall viral load suppression rate among youth with a viral load test is less than 80%, what barriers do you encountered in achieving viral load suppression in this population?

RESPONSE: N/A

c. If the overall viral load suppression rate among youth with a viral load test is greater than 90%, what best practices do you have to share with other providers?

RESPONSE: Regular contact with clients, especially in a rural community, is imperative to providing necessary support for keeping medical appointments and adherence. Social support such as a buddy or support group provides a safe space for clients to discuss challenges and stigma.

5. Describe at least one innovative HCP and/or MAI practice/service provided by you or a subcontractor over the last year.

RESPONSE: Humboldt is participating in a State Food Delivery Pilot project. This has been highly successful in addressing issues of food insecurity. Clients have reported feeling less stress about finances. Outreach to HCP clients on topics such as PrEP for partners, meningitis, HIV advisory group, and Narcan is continuing individual and as part of our 3 year strategic planning process, we are

planning to collaborate with the medical provider to host workshops and vaccine clinics.

6. Provide a success story or anecdote that highlights the positive impact your HCP and/or MAI program has had on an individual, group, or community (e.g., linking a client to care, assisting a client obtain housing, etc.). Please do not include actual client names.

   RESPONSE: NorCAP has a grant from HUD through our local housing continuum that provides permanent supportive housing for chronically homeless people living with HIV. The HCP program provides supportive case management to assist clients in locating housing and acting as a liaison between landlords and clients.

   In November 2016, HCP staff starting working with a new client who is 49 years old and has a history of chronic homelessness and has never had his own home. He was recently released from prison and became homeless again. The client spent two months at the local homeless shelter while HCP staff worked with him to: identify his goals; connect him with an HIV medical provider; obtain income through General Relief;obtain CalFresh benefits, and locate stable housing. In January, he entered into his first lease and apartment of his adult life. The client has been extremely stable since Jan. and is now motivated to find employment and return to school.

7. Do you or your service providers require any training or technical assistance for HCP, Housing Plus Project (HPP), MAI, and/or ARIES? If so, please describe?

   RESPONSE: Partner Services and DIS training

8. After reviewing the *California Integrated Surveillance, Prevention and Care Plan* (https://archive.cdph.ca.gov/programs/aids/Documents/IP_2016_Final.pdf), please answer the following questions:

   a. Which Objectives, Strategies, or Activities have the most impact on your community?

      RESPONSE:

Strategy A: Improve PrEP Utilization. Since August of 2015, NorCAP has focused on developing a PrEP Navigation Program. Activities include:

- provide training and capacity building assistance to local medical providers to raise awareness about PrEP prescribing practices;
- assist key population in accessing insurance and patient assistance programs;
- promote PrEP awareness in key populations through outreach, presentations and social media;
- improve linkage to access through navigation services and regular follow up for treatment and program retention.

Strategy K: Integrate Syringe Exchange into Existing HIV Programs. Through community collaborations, NorCAP provides training, technical assistance and capacity building to other local Syringe Exchange Programs in areas including HIV, HCV, and naloxone. New relationships have developed with local Native American Tribes and University Student Health Systems.

b. As we move forward and are focused on "Getting to Zero", what is the biggest challenge in your community?

RESPONSE: Funding and staffing are often the most challenging issues in a rural community. It is necessary to leverage resources from a variety of programs, grants, and community partners to address all services in the continuum of HIV care

c. What do think will be the most effective way to address this challenge?

RESPONSE: Capacity Building Assistance from the state is vital for a rural county with very few resources. These opportunities have enabled the program to expand services and train staff. It is extremely helpful when the state is able to cover the costs of sending staff to state conferences. The opportunity to share and learn from other county programs enhances creative thinking in program development.

9. Early Intervention Services (EIS) Questions ONLY for HCP Contractors who budgeted for EIS:
Check here if not applicable ☐

a. Describe what data and or activities were used to identify PLWHA not in care?

RESPONSE: Program has a mobile outreach van that travels throughout Humboldt County to isolated and extremely rural places where people cannot easily access services and target individuals who are most at risk for HIV transmission such as Injection Drug Users, sex workers, MSM, and transgender individuals. Staff provides syringe exchange services, HIV/HCV testing, referrals to treatment, and PrEP services during this outreach.

b. Describe the activities taken to link clients to care.

RESPONSE: All preliminary positives are linked to care through a warm handoff to HCP case managers. NorCAP has an established relationship with local HIV medical service providers. Collaboratively we have adopted the RAPID model of care from UCSF. Clients who test positive are able to get a confirmatory test and meet with the medical provider within 24 hours.

c. If HCP funds were used for HIV testing, please fill out this table.

Number of Test Conducted	Number of Positive Results	Number of Positive Linked to Care	Number of Negative linked to PrEP Provider
174	0	0	23

10. Data to Care Question required for Alameda, Orange, San Diego, and Riverside Counties. Others conducting Data to Care may also answer:
Check here if not applicable ☒

Please describe what Data to Care activities took place during the reporting period. Please include any supporting documents and/or data to show the activities implemented.

RESPONSE:

11. Housing Plus Project (HPP) Questions for Kern, Orange, San Joaquin, and Tulare Counties ONLY:
Check here if not applicable ☒

Compare the estimated number of unduplicated clients to be served and the actual unduplicated clients served as reported in the ARIES. To run the report, go to the Reports menu in ARIES, select Finance, and the HCP Summary Tracking. Enter Housing Plus 16/17 CA/OA as the contract name.

a. Were the actual clients served on track with your estimated client counts? If not, what were the reasons?

RESPONSE:

b. Please describe the progress you have made so far with implementing your HPP?

RESPONSE:

c. Describe any barriers/challenges with implementing your HPP other than getting contracts approved?

RESPONSE:

d. Do you think you will expand the number of clients served by HPP in the next calendar year – keeping in mind that the subsidies will remain as 50% in FY 17/18. Why or why not?

RESPONSE:

12. MAI Questions for MAI Contractors ONLY:
Check here if not applicable ☒

Go the Reports menu in ARIES and select Outreach. Then run the MAI Provider Report for MAI 16/17 CA/OA. Review your results and respond to the following questions.

a. Does the number of clients served look accurate? If no, what is the reason(s)?

   RESPONSE:

b. Are clients being linked to ARIES Care? If no, what is the reason(s)?

   RESPONSE:

c. Do you have a lot of clients with missing or incorrect racial/ethnic information? If so, what steps have you taken to improve the data?

   RESPONSE:

d. What priority populations did you serve, including any sub-populations?

   RESPONSE:

e. What were effective strategies used to reach your priority populations?

   RESPONSE:

f. Will you continue to serve the same priority populations in the next reporting period? If not, who will be your priority populations?

   RESPONSE:

13. Supplemental (X08) Funding Questions for HCP Contractors receiving additional X08 funds ONLY:
    Check here if not applicable ☐

    For X08, compare the estimated number of unduplicated clients to be served (Budget Form D) and actual unduplicated clients served as reported in the ARIES (can be found by clicking in ARIES: Reports menu > Finance Reports > HCP Summary Tracking; filter on HCP X08 16/17 CA/OA).

a. Are the actual clients served on track with your estimated client counts? If not, what are the reasons?

RESPONSE: We are on track with our client counts for EIS services; however we have been unable to hire an additional full-time case manager to work with surveillance staff on partner services and clients lost to care, so our case management clients did not increase as anticipated. We will continue to work with employee services and administration in order to hire a qualified person into a full-time position. Our Linguistic services (Spanish-speaking) client count has not increased due to delays with Spanish language materials development.

b. What impact have these additional funds had on your program/community?

RESPONSE: These funds have enabled the program to expand and improved services. The program was able to hire two extra-help part-time case managers, and two extra-help part-time Community Health Outreach Workers. Services on the mobile outreach van have doubled including HIV/HCV testing, overdose prevention and Narcan distribution, syringe services, PrEP and HCV navigation. Outreach staff has been able to incorporate additional locations for services including expanded engagement to local Native Tribes, remote areas of the county, and AOD residential treatment facilities. Additional staff has enabled the program to provide trainings and capacity building assistance to community partners.

c. What percentage of your X08 funds do you expect to be spent by September 29, 2017?

RESPONSE: We expect to expend 100%

Contractor Name: County of Humboldt **Completed by:** Anna Owings-Heidrick

Contract Number: 15-11054 & 16-10847 **Date Completed:** 5/1/2018

Reporting Period: April 1, 2017 – March 31, 2018 (12 months)

Responses to the questions included in this Progress Report should demonstrate your progress during the report period, unless otherwise indicated. For those Contractors who have subcontractors complete the report: please review their entries and summarize, if necessary, to ensure it is concise and clear, prior to submitting the report to your Care Operations Advisor.

1. Did your Ryan White Part B Program work with your county Prevention Program? If yes, explain how. If no, explain why.

Our Ryan White Part B Program is under the same umbrella program as our county Prevention Program. The programs meet together once a week at a minimum and are able to share information and resources with one another. Program staff cross promote services and provide direct navigation to other needed services in both programs.

2. Did your Ryan White Part B Program work with your county HIV/AIDS Surveillance Coordinator? If no, explain why.

   Yes

   If yes, please answer the following:

   a. What types of surveillance reports did you use, if any, and how did you use them?

There has been a new position created that will bridge our Ryan White Part B Program with Surveillance. So far, the new person in this position has completed the CalReadie training, the Passport to Partner Services training, and the HIV Partner Services training to equip him to do DIS work. This person will be prioritizing working with newly diagnosed HIV+ clients, HIV+ clients who have fallen out of care, and HIV+ clients who test positive for other STI's. He will utilize the surveillance reports

that identify these people. There have not been specific reports utilized at this point, other than Confidential Morbidity Reports.

b. Have you seen your county's *Continuum of HIV Care by Local Health Jurisdiction*? If yes, how did you use this data? If no, explain why.

Yes, we just recently received the latest report. This report is sent to the Communicable Disease division on Public Health, so we do not receive it directly. It would be helpful to receive this directly from the state. Moving forward, staff will utilize this data to identify where the need is in linkages to care.

c. Did you use client-level data from surveillance to identify clients out of care to get them back into care? If no, explain why.

See answer to 2a. Moving forward, staff will utilize this data to identify these clients and work on getting them back into care. staff will crossreference this report with the primary HIV medical providers and Casemanagers to identify barriers and support clients in accessing care again.

3. Provide a success story or anecdote that highlights the positive impact your HCP and/or MAI program has had on an individual, group, or community (e.g., linking a client to care, assisting a client obtain housing, etc.). Please do not include actual client names.

Our program has been working with a chronically homeless client, looking for housing for over a year. He has poor credit and a negative landlord reference, which has caused him to be turned down for housing multiple times. We were recently able to identify housing for him and moved him into his new residence. For the time when he was homeless, we were able to supply him with food and Subway gift cards that we bought with X08 funding so that he was able to have healthy food options. Once housing was identified for him, we housed him in a motel, paid for with X08 funding until his residence became available. The time in the motel allowed him get out of the rain and cold conditions and utilize the shower so that he felt more confident in his appearance as he met with his new landlord.

4. Do you or your service providers require any training or technical assistance for HCP, Housing Plus Project (HPP), MAI, and/or ARIES (including the ACE module)? If so, please describe.

   No

5. If you spent below 95% of your allocation in FY 2017-18, what will you do to ensure you spend 95% or more in the next contract year?

   N/A

6. Does your local health jurisdiction have a Getting to Zero committee or other group that is overseeing your implementation of the *California Integrated Surveillance, Prevention, and Care Plan*? Yes ☐ No ☒

   If yes, please provide a contact name, phone number and e-mail address for the committee/group.

7. MAI Questions for MAI Contractors ONLY:

   Check here if not applicable ☒

   a. What were effective strategies used to reach your priority populations of color, especially underserved sub-populations or geographic areas?

   b. What strategies were used to ensure MAI staff had cultural awareness and sensitivity to the priority populations they served?

   c. What type of outreach services do your MAI staff do more of:
      ☐ In-reach (meaning to existing clients who have fallen out of care)
      ☐ Out-reach (meaning to new clients not yet engaged in care)
      ☐ About the same in-reach and out-reach

8. Early Intervention Services (EIS) Questions ONLY for HCP Contractors who budgeted for EIS:

Check here if not applicable ☐

a. Describe what data and or activities were used to identify PLWHA not in care.

Our program is working closely with people in our county's DIS as well as local healthcare providers to identify PLWHA who have fallen out of care. This has been identified as one of the priorityes for the postion mentioned in 2a.

b. Describe the activities taken to link clients to care.

See 8a. We have a close working relationship with the local healthcare providers providing HIV care to the majority ot the PLWHA in Humboldt County. We communicate on a monthly basis, at the very least and plan to utilize this working relationship to faciltate getting PLWHA who have fallen out of care back into care.

c. If HCP funds were used for HIV testing, please fill out this table.

Number of Test Conducted	Number of Positive Results	Number of Positive Linked to Care	Number of Negative linked to PrEP Provider
247	1	1	10

d. If there are gaps between the test results and the number of positive linked to care and/or number of negative linked to PrEP provider, please explain why.

Not every person being tested for HIV is a good candidate for PrEP and/or at high risk for aquiring HIV. Every person testing negative for HIV is offered information about PrEP and not every person is interested.

9. Housing Plus Project (HPP) Questions for Kern, Orange, San Joaquin, and Tulare Counties ONLY:

Check here if not applicable ☒

a. How are you reaching housing insecure clients to enroll them in HPP? What has worked and what has not?

10. Supplemental (X08) Funding Questions for HCP Contractors receiving additional X08 funds ONLY:

Check here if not applicable ☐

a. What has X08 allowed you to do that you would not have been able to do without these funds?

We have been able to hire a mental health clinician who has been seeing clients weekly. Some of our clients, particularly our chronically homeless clients, need more individualized care than our case manager is able to provide. She has been successful in working through some of the deeper issues with clients.
We have also been able to provide healthy, non-perishable food and Subway gift cards to our homeless clients.
Another helpful thing X08 has allowed us to do has been to house homeless clients in a motel temporarily when they have identified housing to bridge the time between homelessness and being housed.

b. What percentage of your X08 funds do you expect to be spent by September 29, 2018? If less than 100%, answer question 10c.

100%

c. What are the barriers in spending 100% of X08 funds?

None. We expect to spend all of it.

Exceptions, Objections, and Requested Changes:

N/A – None requested

Required Attachments: